CORONERS COURT OF QUEENSLAND

FINDINGS OF INVESTIGATION

CITATION:	**Non-inquest findings into the death of Ms D**
TITLE OF COURT:	Coroners Court
JURISDICTION:	BRISBANE
DATE:	2 August 2019
FILE NO(s):	2013/3807
FINDINGS OF:	Coroner Carmody, A/Coroner
CATCHWORDS:	CORONERS: Domestic violence, suicide, mental health assessment, Queensland Domestic and Family Violence Death Review and Advisory Board, information sharing, privacy, management of prescription pain relief medication, history of attempted suicide, hydromorphone overdose.

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Background

1. Ms D was 47 years old when she died from an overdose of her prescription pain medication. She was found dead in her bedroom at the Mudjimba Cherbourg Women's Shelter on 22 October 2013. Ms D had last been seen alive by another resident 2 days beforehand. The pathologist was unable to determine the exact date that Ms D died – it was either 20 or 21 October 2013.

2. Ms D was residing at the shelter after a recent separation from her partner, Mr T. The relationship was a violent one, and Ms D concealed her whereabouts from Mr T in order to leave him. Ms D had a history of depression and had, in the month prior to her death, been hospitalised as a result of a suicide attempt.

3. At the time of Ms D's separation from Mr T, her family dynamics were complex and tightly enmeshed with his. Ms D's daughter, S, was in a relationship with Mr T's son, A. E (her son) was living with her, Mr T and Mr T's mother. Her son and Mr T shared a drug habit, with the latter supplying her son with amphetamines. Her family situation made it very difficult for Ms D to contemplate leaving Mr T: she would have been acutely aware that her own actions in leaving would have detrimental effects on her loved ones. Ms D had no support from her own family, as she was estranged from her mother and sisters.

4. The examination of the circumstances leading up to Ms D's death has revealed a number of missed opportunities for intervention by the various service and support providers from whom Ms D sought help. Ms D's tragic death occurred when she was experiencing a significant crisis and was overwhelmed by her situation. Had one or more of the missed opportunities been taken, Ms D's death could have been prevented.

5. Ms D's death has been the subject of extensive investigation and review by the service providers involved in her care, as well as an expert witness in the coronial investigation. In response to the report of the expert witness, as well as their own reviews, the various service providers have made improvements to their procedures and processes which are designed to prevent deaths similar to Ms D's from occurring in the future. These responses and improvements are detailed in this review.

6. In addition, in the time since Ms D's death, government changes to mental health services in Queensland have addressed some of the issues which were raised in Ms D's case, making it much more likely that a woman in Ms D's circumstances would have a better outcome through contact with mental health and crisis support services today.

Social and medical history

7. Ms D was the product of a traumatic and dysfunctional childhood. Her father was an alcoholic and beat Ms D's mother in front of the children. When her mother, J, left her father and became involved with a new boyfriend, that boyfriend molested Ms D from the age of 11 until she was 13. Throughout her adult life, Ms D also experienced problematic substance abuse and suffered from mental

illness, which exacerbated her vulnerability at times. Ms D had two adult children, E (20 Years) and S (23 years), to an ex-husband who she described as violent. She had been divorced from her husband since E was two.

8. Despite her prolific experiences of trauma and disadvantage Ms D had very limited contact with police. Prior to her death, there were just 15 recorded contacts with police on her QPRIME file. None of these were initiated by Ms D – she did not seek help from the police.

9. Ms D had a motor vehicle accident in 2000 where she sustained a fracture of her C4 vertebrae but no permanent paralysis. She appeared to recover from this but in 2006 whilst at work (as an industrial cleaner) she was carrying some heavy buckets of rust and steel when she experienced back pain and chest or abdominal wall pain. This led to ongoing chronic back pain. A workers compensation claim was lodged and eventually successful. Following the workplace injury, Ms D could not return to work and remained on a disability support pension.

10. In 2006 Ms D's sister, applied for a protection order against Ms D. The application was adjourned for hearing and a temporary protection order was granted, but the application was subsequently struck out.

11. From 9 June 2009, Ms D had a week long admission to the multidisciplinary pain clinic at the Royal Brisbane and Women's Hospital during which she underwent numerous therapies in attempt to manage her pain (physiotherapy, occupational therapy and hydrotherapy).

12. On 10 June 2009, Ms D was assessed by a psychiatric registrar, Dr L. Dr L took a history from her which included previous sexual abuse and workplace difficulties (sexual harassment and workplace injury which led to her incapacity). Ms D told Dr L that she had attempted an overdose when she was 16. Dr L was of the impression that Ms D had an adjustment disorder related to pain (there was no clear evidence at the consultation that the pain was psychosomatic), a major depressive disorder (moderate) which was partially treated and likely complex type II trauma spectrum. Dr L prescribed an antidepressant, Cymbalta, and recommended cognitive behaviour therapy in the community and during inpatient admission.

13. On 17 January 2012, Ms D was admitted to the Nanango Hospital as a "boarder". It is unclear what the medical reason for the admission was. During her admission, Ms D was upset and crying and required assurances to "be strong for her son and daughter". Ms D agreed to social worker input and was more settled when discharged on 19 January 2012.

14. In or around April 2012 Ms D's GP, Dr M, commenced Ms D on hydromorphone (an opioid used to treat pain which is marketed as Jurnista) 4mg to be taken once daily at night for the management of her ongoing pain.

15. On 3 May 2012, Ms D was referred to Kingaroy Hospital for social work support. The referral took into account her own sexual abuse history as well as an

apparent recent discovery that her son had been sexually abused by his cousin. Ms D attended social work appointments on 16 and 29 May 2012 with Ms P with a further appointment scheduled for 12 June 2012.

16. Ms D missed her 12 June appointment and declined any further appointments, saying that she "felt okay now". Ms D was advised that a referral to Child Protection Services had been made in relation to her son and that she could access services at a later date should she require it.

17. On 2 August 2012, Ms D was seen by pain management specialist Dr C. Dr C considered that Ms D would benefit from a trial of facet joint injection for her back pain. However as Ms D was not able to afford treatment in the private sector, he suggested she be referred back to the Royal Brisbane and Women's Hospital for consideration of treatment there. He noted that she had not been coping with the pain in the past despite having been referred to the pain clinic and this was the reason for using Jurnista 4mg daily. Dr C advised that if the Jurnista was helping, it was reasonable for Ms D to continue using it. He considered an effort should be made to ensure the dose did not escalate over time. He advised Dr M that he would inform the Department of Health that Ms D remained on Jurnista under his care.

18. Around this time, Ms D became involved in a relationship with Mr T, who she met though her daughter S. Her daughter's partner A was Mr T's son. Ms D later described Mr T as very violent, controlling and angry, and said that he used speed and cannabis heavily. Mr T had a lengthy criminal history dating back to 1990, which showed that he regularly appeared before the courts on charges relating to drugs, violence and dishonesty. Mr T had a long history of domestic violence which had been reported to police in relation to previous partners, and his sons A and J , but Ms D never reported Mr T to police for any of the incidents in which he was violent to her. Similarly, Ms D had not reported her ex-husband at any time in their relationship.

19. Ms D's discovery of her son's sexual abuse caused her to become estranged from her mother and sisters. Ms D wanted to report the abuse to the police, and her family wanted to keep it quiet. This dispute led to an incident of reported family violence on 14 October 2012. Police were called to J's address after Mr T and Ms D had entered her backyard, armed with a flexibar and a knife, respectively, and threated to kill J. Mr T and Ms D were both charged with threatening violence by words or conduct. J applied for a Domestic and Family Violence Protection Order against Mr T and Ms D, and the application was heard in the Nanango Magistrates Court in November 2012. The protection order was granted against both Mr T and Ms D for a period of 2 years.

20. On 20 November 2012, Ms D contacted Ms R from UnitingCare Community (UCC) requesting information regarding family violence and family relationship counselling. She was referred to a relationship counsellor and provided information regarding services and groups provided by UCC.

21. On 17 December 2012 Mr T was sentenced to a 9 month probation order and Ms D was sentenced to a 6 month probation order for the charges which arose

from the attack on J. A condition of their probation was that they both submit to medical, psychiatric and psychological assessment and treatment as directed by an authorised corrective services officer.[1]

22. On 8 January 2013, the medical records indicate that Ms D was referred by another GP, Dr R, to Kingaroy Community Health after she had attempted to choke herself at the Nanango cemetery. Ms D was contacted by Ms KR from the Kingaroy Hospital. Ms D reportedly advised that she was seeking ongoing long term counselling for a range of reasons, including support for court matters and ongoing stress around 'family issues'. She denied any current thoughts of suicidal ideation or self-harm, and was noted as being future oriented. Ms D reported that she would link in with a GP the following day.

23. On 11 January 2013, correspondence back to Dr R advised that Ms D had declined the offer of mental health services as she was seeking long-term supportive counselling with present stressors and historical events. The letter also indicated that Ms D would benefit from a referral to a psychologist and the Better Access/Better Minds Medicare scheme was mentioned. Dr R was invited to re-refer Ms D at a later point.

24. On 24 April 2013 Ms D was charged by police with possession of drug utensils. Ms D agreed to be referred to the Queensland Illicit Drug Diversion Initiative rather than go to court on the charge.

25. On 10 May 2013, Ms D attended the Kingaroy Hospital for her drug diversion program. She disclosed to the social worker that she used cannabis to manage her pain and that her partner Mr T used speed via needles. Ms D explained that Mr T was verbally abusive towards her. She reported that previous experience with antidepressants had made her feel like a "zombie". She denied current suicidality and agreed to continue social worker follow up, however did not attend a scheduled appointment on 21 May 2013.

26. On 20 June 2013, Ms D's file was closed as she did not make any contact, nor attend any appointment, with the social worker.

27. On 16 September 2013, Ms D was assisted to attend Nanango Hospital Community Health by Ms R at UCC. This followed an incident earlier that day in which Ms D reported that Mr T had been physically violent and choked her. A risk assessment was completed which revealed a high risk of harm. Ms R spoke to Ms D about options UCC could offer her. Ms D indicated she did not want to involve the police as this would escalate Mr T's behaviour to a dangerous degree. Ms D disclosed that she had recently attempted suicide and was again having suicidal thoughts.

[1] We have no information from Corrective Services as to whether this condition was complied with, however, there is no relevant breach of probation recorded on Mr T's criminal history. In Ms D's case, her criminal history shows that she was sentenced for a drug-related offence within the period of her probation (April 2013) and sentenced to a drug diversion program. It could be that any breach of probation was considered during that sentence, or that breach proceedings were not brought before Ms D's death.

28. Ms R rang the local GP however the surgery was closed. The medical records indicate that she then made enquiries about the process for assessment with a view to Ms D being admitted to Nanango. It appears Ms R was informed by staff that due to the doctor being away, the hospital was not able to take any patients and Ms D would need to be taken to Kingaroy Hospital. Nursing staff advised Ms R that even if Ms D was taken to Kingaroy, she may not be guaranteed an admission.

29. Ms R says that Ms D told her that it was dangerous for her to leave her son at home with Mr T and the longer she was away from home, the more upset Mr T would become and the more danger her son would be in. Ms R says that Ms D told her that she would go to hospital if she could make contact with her son and be re-assured as to his safety. Unfortunately, she was unable to contact him. They discussed the options available to her and Ms D eventually decided she wanted to go back home. Ms R says that she formulated a 'safety plan' which included hiding on her person a small card with numbers for UCC and DV connect and a code word for her son which alerted him to an agreed plan of action regarding accessing help. Ms R then drove Ms D to a location near but out of sight of her home and Ms D walked home.

Last hospital admission

30. On 20 September 2013, Ms D was taken by ambulance to Kingaroy Hospital with suicidal ideation, reporting that she had thoughts of how and the means to take her life. Ms D was seen by a doctor at 8:30pm. The doctor recorded that Ms D had stated that she wanted to hang herself today and had fashioned a noose out of an electric cable. The doctor noted Ms D had poor affect, low mood, was teary and crying a lot. The doctor assessed that Ms D had severe depression with suicidal ideation and acute situational crisis with a failure to cope. The plan was for Ms D to be admitted to the ward, to receive a Mental Health Team review on Monday, routine observations and to start antidepressants. Ms D was prescribed Lyrica, Panadol Osteo, Jurnista and Sertraline.

31. On 21 September 2013, Ms D instructed the hospital staff that she did not wish for any calls to be transferred through to her except for calls from her daughter, S, due to her home situation. Ms D also requested that only her daughter be made aware of her admission and that no one else could know of this information.

32. On 23 September 2013 at 10:45am Ms D was again reviewed by a medical officer. The doctor noted her complex social situation and that she did not feel safe to go home. When questioned about suicide risk she reportedly advised "I still have a long way to go yet", however the overall impression was that she was medically stable. The plan was for a social work review to discuss a discharge location, and mental health review.

33. At some time prior to 3:30pm that day, social worker Ms P met with Ms D. Ms P noted that Ms D told her that Mr T will "kill/shoot her if she leaves". Ms D advised that he controlled her money and had choked her in the past. Ms D expressed concern she had nowhere else to go as her daughter lived with Mr T's son and she didn't want to put them at risk of harm.

34. On 24 September 2013 at 10:00am, a mental health intake was conducted by Registered Nurse (RN) D. RN D's nursing notes indicated that Ms D had "prominent suicidal ideation" the previous day and had formed a plan involving medications. It was noted that Ms D "would use drugs to OD". RN D noted Ms D's history including "intermittent suicidal ideation since age 16 years" and "one previous attempt to strangle herself in Jan 2013".

35. RN D reported that Ms D denied current suicidal thoughts was forward thinking about the future and wanted to leave her relationship. Protective factors included her children and the possibility of one day meeting her grandchildren. RN D's plan was to discuss Ms D with the UCC case worker and social worker to manage transfer to a safe house. RN D also completed a suicide risk assessment tool. Ms D was rated as scoring a 13, which put Ms D at a medium risk of suicide.

36. Ms R spoke with Ms D's daughter in relation to the best location for Ms D to access a refuge given her goals of housing and retrieval. They discussed the difficulties for S and her partner and their parents' relationship. S was advised of the need for maintaining confidentiality in relation to Ms D's location.

37. The option of the Mudjimba Cherbourg Women's Shelter was put to Ms D. Ms D was reportedly open to this and advised that Mr T did not have transport, mix with Aboriginal people or have any connections in the Murgon/Cherbourg community. It was also agreed that Mr T would be informed that Ms D had been admitted to the Toowoomba Mental Health Unit.

38. On 25 September 2013, Ms D was reviewed by a medical officer whose opinion was that she was stable and could be discharged. The principal diagnosis on discharge was "severe depression with suicidal ideation" and "acute situational crises with failure to cope". She was discharged to Mudjimba that morning with her usual medications and mental health follow up on days 3 and 7.

Admission to Mudjimba

39. The electronic records system used by Mudjimba staff (produced by UCC) are referred to as 'SHIP records' and they are computerised entries. It is noted in Ms D's SHIP 'Summary Details' page, under 'medical information', that Ms D had chronic pain which was managed with pain medication, and was prescribed antidepressants for depression.

40. Another client, Ms G, was residing at Mudjimba at the time of Ms D's admission. During the relevant period, it appears that 3-4 Mudjimba staff members were rostered on including Ms B (a support worker), Ms W (an after-hours family worker), Ms BL (a service coordinator) and Ms C (a support worker).

41. On 26 September 2013 social work student, Ms K, from Cherbourg Community Health visited Ms D following a referral from the Kingaroy Hospital. Following Ms K's visit, Ms B completed the necessary paperwork with Ms D, including a plan outlining the steps Ms D would need to take to separate her affairs from Mr T's and to continue to look after her health.

42. RN D phoned Ms D on 30 September 2013 and noted that Ms D was anxious about all the actions she needed to take in order to retrieve her furniture from the house and sort out 'bank and Centrelink issues'. Ms D was also worried about her son and his substance misuse issues, and wanted to have him admitted to rehabilitation. It was also noted that Ms D had suicidal ideation a few days ago but was starting to feel better on antidepressant medication. Ms D reported an intention to seek assistance from UCC to help with her next steps in her separation.

43. On 1 October 2013, RN D again phoned Ms D who reported ongoing daily thoughts of suicide. Ms D reported experiencing tangential and ruminative thinking, difficulty making decisions and was overwhelmed with the changes needed and things to do. RN D arranged to call Ms D again on 8 October 2013 and advised her that if her suicidal thoughts intensified to present to Cherbourg Hospital. There is no evidence that the Mental Health Service communicated Ms D's ongoing suicidal ideation to the refuge or any other formal or informal support.

44. On the same day, Ms D met again with Ms K. Ms D reported that she was having no issues abstaining from drugs, despite reporting daily cannabis use to deal with her chronic back pain prior to moving to the refuge. Ms D reported that she was concerned for her son and the safety of her cats, and that Mr T may hurt them.

45. On 2 October 2013, the Murgon Pharmacy dispensed 28 tablets of Jurnista to Ms D. This medication had been prescribed to her by Dr M on 20 September.

46. On 3 October 2013, Ms K transported Ms D to the Cherbourg Hospital for a sexual health screen. Ms D reported feeling much better and was looking forward to being free from Mr T's control.

47. On 4 October 2013, Ms B spent time with Ms D assisting her in relation to goals and planning, medical appointments and future accommodation.

48. On 7 October 2013, Ms D's daughter reportedly informed Ms B that someone from the Kingaroy Hospital had contacted both Mr T and her ex-sister-in-law to check on Ms D's welfare after her discharge. The following day RN D sent an email updating Ms D's contact number and advising that it was not be given out to the public or to Mr T. Mr T and E had also apparently tried to contact the Toowoomba Hospital to find out when Ms D had been discharged and were informed that there was no patient by that name at the hospital.

49. On 8 October 2013, RN D phoned Ms D as part of the post-discharge follow up plan. Ms D reported improvements in her mental state and that she was feeling much clearer although was still concerned about her son and her cats who were still living with Mr T. Ms D was 'a lot better' with suicidal thinking and, while she had some thoughts in the past week, she was able to dismiss them and focus on the future.

50. On 10 October 2013, Ms D presented to the Cherbourg Hospital requesting Jurnista, Diazepam, Mometasone, Sertraline and Panadol Osteo. She was seen

by Dr S. Dr S reportedly contacted Dr M to confirm Ms D's medications and was faxed a copy of the GP medical records. Dr S prescribed Jurnista 4mg (14 tablets, 1 tablet taken daily), Zatamil lotion, Panadol Osteo 665 mg (90 tablets), Sertraline 100mg (30 tablets) and Diazepam 5mg (50 tablets).

51. An email sent from a new social worker Mr U to the RN D from Kingaroy Hospital dated 10 October 2013 stated that he had seen Ms D twice that week and that she appeared to be coping reasonably well with realistic plans for the future. It further stated that he would be away from 11 October until 21 October and that Ms D was aware of this. Mr U asked RN D to make contact with Ms D the following week.

52. On 11 October, Ms D filled her prescription for the 14 tablets of Jurnista at the Murgon Pharmacy. These had been prescribed to her by Dr S whilst she was at the Cherbourg Hospital.

53. On 14 October 2013, RN E from the Cherbourg Hospital phoned Ms D to follow up as part of her suicide risk management process. Ms D advised that she was feeling okay and denied current suicide ideation, plan or intent, but she still had ongoing concerns about her son. Plans for Ms D to engage with Mr U were discussed and Ms D was happy to continue to see him. Ms D reported that she would be presenting to the hospital for assistance in purchasing a new back brace with assistance from Mr U.

54. On 15 October 2013, Ms D attended a physiotherapy appointment through the Cherbourg Hospital for her back pain. The same day, her application for private housing in Kingaroy was declined. Ms D was reportedly "quite upset" about this.

55. On 16 October 2013 Ms B wrote in the Mudjimba records that Ms D was quite upset that morning. Ms D said that her daughter had contacted her and advised that her son had fled Mr T's house after being 'battered and bruised' by Mr T. Her daughter had retrieved one cat while another one remained with at the house, and a third had been severely injured by Mr T. Her daughter said that police had raided the house and Mr T had left with his mother, taking one of their dogs with him and leaving the other behind. Ms D also said that she'd spoken to Mr T's mother recently, and that Ms D had been physically assaulting his 83 year old mother since Ms D left. Ms B suggested to Ms D that it may now be time to organise police retrieval of her property and obtain a domestic violence protection order. Ms B arranged for the local Domestic Violence Resource Centre to assist Ms D to lodge an application.

56. The same day, it appears that her son and daughter visited Ms D at Mudjimba. Staff observed that her son had track marks on his arm and bruising around an eye. Ms W recalled that Ms D was happy after the visit.

57. On 17 October 2013 Ms D contacted the RSPCA and the Elders Abuse line to report some of her concerns. The Elder Abuse support worker advised that they would notify Kingaroy police of Ms D's concerns about Mr T's mother. According to notes, Ms D seemed pleased and less stressed after she had contacted these organisations. Further discussions with Ms B took place regarding a session with

her social worker however, Ms D had been advised that Mr U was away. Ms B informed Ms D that they would find out if there was anyone else that Ms D could see.

58. On 19 October at 6:55pm, Ms D phoned Ms B (who was on call) stating that Mr T's son, A had phoned her and wanted her to call Mr T as he was threatening to damage her daughter and A's house and kill them. Ms D confirmed she had been in contact with Mr T and that she asked him about all of the things that her daughter and son told her were going on and he denied it all. She asked him if he bashed her son, assaulted his elderly mother, held a Samurai sword to his son J's throat, shot one of the cats, punched Misty's head in (cat), shooting her son up with Speed in his sleep and not feeding the animals, [Ms D] says that he denied everything".[2] Ms D also told Ms B that Mr T had been calling her ever since, because she forgot to block her number when she called him. Ms B advised Ms D to turn off her phone until the following day and that they would look into changing the phone number if Ms D wanted to. Ms B informed Ms D that she would see her the next day.

59. On 20 October 2013 Ms B noted at 9:00am that she checked on the clients, and that "Ms D seems to be still asleep, cannot hear any movements".[3] She recorded that she had noticed during the day that Ms D's window was open and her fan was on and there was no response after she had knocked on Ms D's door and called her name. The other resident, Ms G, saw Ms D leave her room at some time after 8:00pm that day, but did not speak to her at that time.

60. At 8:48am on 21 October 2013 Ms B recorded that Mr U had phoned Mudjimba to advise that he was available for appointment at 11:00am that day. Ms B and Ms W went to Ms D's room to pass on the message. Ms B recorded that "I knocked on client's door twice and called her name twice. There was no response, client is probably still asleep".[4] The Mudjimba diary notes there was a staff meeting in Kingaroy that day, but no time is given.

61. On 22 October 2013, Ms D's daughter contacted Mudjimba advising that she had not heard from Ms D in three days. Fellow resident Ms G advised that she had not seen Ms D for over 24 hours. Ms BL got the key for Ms D's room and Ms D was discovered on the bed deceased. Police were informed and attended at the scene. Ms D wrote a suicide note in her diary in which she apologised to her children, and said "I hope to god I will die. I have had enough".[5]

Autopsy results

62. An autopsy was performed on 25 October 2013 by forensic pathologist Dr R W Guard. Dr Guard performed an external and full internal examination. He concluded that the exact date of death could not be determined: accordingly it was either 20 or 21 October 2013. The toxicology certificate showed alcohol (some of which may have been produced after death), quantities of the

[2] SHIP Case notes and Records (Uniting Care), p8
[3] SHIP Case notes and Records (Uniting Care), pp 7 – 8.
[4] SHIP Case notes and Records (Uniting Care), p 7.
[5] Diary of Ms D, p 5.

prescription anti-depressants that Ms D was taking, paracetamol, and hydromorphone (Jurnista) at lethal levels. Dr Guard gave the cause of death as an overdose of hydromorphone.

Uniting Care Community Investigation

63. Immediately after Ms D's death, UCC carried out a workplace investigation which identified a number of deficiencies in the provision of care to Ms D, particularly in relation to record keeping; case management approaches; lack of safety planning; staff qualifications; low staffing and emergency response.

64. UCC provided an investigation report dated 25 October 2013 and, in that report, made a number of recommendations aimed at improving services in the following areas:

- The use of work instructions;
- Employee training in domestic violence and sexual abuse;
- Clarity in relation to roles and responsibilities;
- Maintenance of case notes;
- Rostering including weekend requirements;
- Approaches to case management including the use of qualified counsellors;
- Establishing use of the Domestic and Family Violence Risk Assessment to prioritise an appropriate response to a client phone call, including contacting the Service Co-ordinator or attending to the service; and
- Protocols for responding to a non-responsive or missing client, including guidance on contact with the family and emergency services.

65. The UCC investigators also recommend that disciplinary action be initiated against Ms B and Ms BL.

Uniting Care Improvement actions

66. On 3 November 2016 and 10 July 2017 UCC provided the Coroners Court with information about changes UCC had made in response to Ms D's death and the workplace investigation report.

Organisational restructure

67. UCC advised that it had undergone a significant restructure and now operates as part of the Child and Family Services portfolio of Uniting Care Queensland ('UCQ'). Part of the rationale for the restructure was to achieve more responsive and accountable service delivery for the whole of UCQ, including for homelessness and housing sector services such as Mudjimba.

68. UCQ had also recently introduced the 'Care and Clinical Governance Council' to assist the executive leadership team to develop a coordinated approach to strategic and operational care. One of the Council's functions was to review and improve the areas of preventable harm which includes incident management,

management of unexpected mortality, restrictive practices and medication management.

69. Referrals to the service are received via DV Connect which is the State-wide referral pathway used by the Queensland Police Service and the Queensland Ambulance Service. All referrals made by DV Connect include screening criteria for women and children requiring shelter.

70. UCQ advise that risk information is added to and updated continuously during the client's stay in accordance with updated instructions, guidelines and forms. This includes risk assessment and exit safety planning in cases of domestic and family violence.

Training, education and qualifications for Mudjimba staff

71. At the time of Ms D's death, there was no specific training provided to Mudjimba staff in relation to suicidal ideation and self-harm. Since Ms D's death, staff members have undergone additional training in the areas of suicide intervention and recognising and responding appropriately to domestic and family violence. The roles and responsibilities of each position have also been reviewed and updated to incorporate the specific requirements of each role. Staff are trained in how to use SHIP and are required to complete shift reports at the end of each shift. All staff members are trained in how to use UCQ's electronic incident management system, and are required to record all incidents in this system.

Rostering

72. UCQ advise that the roster for Mudjimba now ensures that:

- It is open for a minimum of 8 hours per day;
- The Practice Lead is present from Monday to Friday;
- There are staff shifts on weekends if relevant to the needs of the service; and
- 4pm to 7pm shifts and sleepover shifts are managed by on call responsive staff.

Medication management

73. UCQ's recently introduced 'Medication and Healthcare Management Policy' aims to ensure clients have their medication and health care needs met with dignity and independence. Clients will be assisted with medications as required (i.e. at the request of a medical professional). Staff are required to actively seek the advice of a medical practitioner to determine a client's medication needs.

Management of non-responsive accommodated clients

74. Since Ms D's death, UCQ have updated their policy in relation to the management of non-responsive accommodated clients. The document specifically requires 'regular contact'. At a minimum, UCQ staff are expected to sight each client daily for those residing in refuge/residential settings, and weekly

for those residing in semi-independent accommodation or transitional housing. The document also considers clients who are 'high risk' and the factors which can heighten these risks. This includes clients escaping domestic violence and who have attempted suicide in the past or are currently expressing suicidal ideation. It is specified that clients who are assessed as high risk require more frequent communications and check-ins and further interaction with the residents support team (medical care providers, counsellors, family members).

Internal Quality Audit process and Safety Review Team

75. Since Ms D's death, UCQ has introduced an internal quality audit process whereby the newly formed teams perform internal audits on service providers. UCQ has also implemented a 'client safe review team' with a State-wide focus on safety monitoring and oversight of all services within Child and Family Services.

Disciplinary action

76. The UCC also advised that on 9 December 2013 a letter had been sent to Ms B which contained a formal written warning given on the basis that Ms B had:

    …..had a lapse of reasonable judgment by not pursing further care and contact with [Ms D] in the two days following the conversation with her where [Ms D] indicated a high level of distress.[6]

77. In that letter an offer of additional training was made to Ms B. Following receipt of that letter, however, Ms B resigned.

78. On 7 June 2019 UCQ provided an update to the Coroners Court in which it was advised that all of the recommendations made in the workplace investigation report following Ms D's death had been implemented.

Review by the Domestic and Family Violence Death Review Unit

79. As Ms D was in the process of leaving a violent relationship at the time of her death, her death was the subject of an extensive review by the Domestic and Family Violence Death Review Unit (DFVDRU) at the Coroners Court. The original report of the review was given on 24 March 2017, and an update was provided on 4 June 2019.

80. The review considered the evidence gathered in the coronial investigation, including the workplace investigation by the UCC and the information given in their responses following Ms D's death.

[6] UCC Response to Coroners Request dated 3 November 2016.

Ms D's risk of suicide

81. The review summarised the relevant literature which indicates that, in the period leading up to Ms D's death, there were several factors which would suggest that Ms D posed a significant risk of suicide, including:

- Ms D's history of childhood and adult exposure to domestic violence, her mental health history including depression and previous suicide attempts, her history of substance abuse and her chronic pain condition;

- Ms D's recent attempt to extricate herself from her violent relationship; and

- The recognised likelihood that women who have been exposed to coercive control by a domestic partner are more likely to blame themselves for the abuse and conflict, their need to seek refuge and the related difficulties which follow.

Contact with services

82. The review observed Ms D's frequent contact with hospital and health services and specialist domestic and family violence support services in the two years prior to her death. The review noted that these contacts linked Ms D to "a broad range of services including hospitals, mental health services, community health services and domestic violence specialist support workers in relation to her experiences of domestic and family violence and suicidal ideation".[7]

83. Despite this frequent and broad contact with services, Ms D's acute risk of suicide was not recognised. The review identifies that frontline services did not embrace a number of opportunities to properly assess Ms D's risk of suicide, and suggests that Ms D's significant risk could have been properly identified if the service providers involved had in place standardised suicide and self-harm risk screening at each intake; as well as co-ordinated case management between each service.

84. In respect of standardised screening, it was noted that:

    [t]o be effective, standardised screening at each intake should assess both chronic and acute risk to ensure a comprehensive assessment, and account for fluctuations and rapid escalation of suicide risk dependent upon the individual circumstances, history or precipitating events.[8]

85. While not seeking to place all of the responsibility for recognising client's chronic and acute risks on the Mudjimba staff, the review underlined that "refuge workers are in a unique position to engage with victims of domestic and family violence at a significant point of crisis".[9]

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[7] DFVDRU Final Review, 24 March 2017, para 25.
[8] DFVDRU Final Review, 24 March 2017, para 82.
[9] DFVDRU Final Review, 24 March 2017, para 84.

86. In respect of the lack of co-ordinated case management in Ms D's case, the review noted that, while there was some indication that various services had attempted to share information and co-ordinate Ms D's care, "meaningful engagement [between services] was impeded by multiple staff across agencies working with the deceased for a short time, or on an ad hoc basis".[10]

87. The practical outcome of this lack of service co-ordination is that Ms D had to continually tell her story to new support workers, and there was no one particular worker who was able to track Ms D's risk of suicide in response to various events, such as the escalation in Mr T's abusive tactics in the days immediately prior to Ms D's death. The review recommends that:

Where multiple agencies are working with a client, it is important that a 'key worker' is working with a client, who works as the primary case manager and has the capacity to establish effective rapport with the client, and assist them in navigating the various services and agencies.[11]

Specific opportunities missed

88. As well as noting the systemic issues that contributed to the failure to properly assess Ms D, the DFVDRU review identified a number of issues which were specific to Ms D's case. These were identified as 'missed opportunities for intervention' where, if intervention had occurred, it is likely that the protective outcomes for Ms D would have increased, and potentially prevented her death. These missed opportunities included:

- failure by a staff member of the Kingaroy Hospital to protect Ms D's privacy – Mr T was contacted by the hospital contrary to Ms D's explicit request that only her daughter know of her admission;
- failures by the UCC and by staff at Mudjimba to adhere to their service agreement in respect of the management of Ms D's case, such as adequate staffing levels, relevant staff training and proper maintenance of case notes and recording of observations;
- lack of co-ordination between Ms D's treating practitioners and the service providers which allowed Ms D to have access to lethal amounts of prescription medication;
- the failure by various service providers to assist and encourage Ms D to make an application for a protection order against Mr T;
- staff at Mudjimba allowed visitors to attend Ms D at the safe house, which was a clear breach of policy;
- the failure by Ms B to respond appropriately to the call from Ms D on 19 October 2013, which should have been recognised as a crisis and properly managed; and
- the failure by Mudjimba staff to check on Ms D on 20 and 21 October 2013.

89. In the 2019 update to the review, the DFVDRU drew attention to a number of changes which have occurred in Queensland since Ms D's death which address

[10] DFVDRU Final Review, 24 March 2017, para 88.
[11] DFVDRU Final Review, 24 March 2017, para 90.

specific issues raised in their original review. These include the Integrated Service Response Trial in Cherbourg, and the proposed introduction in Queensland of a real-time prescription monitoring system. These will be discussed in more detail in the final section of this review.

Expert review

90. As part of the coronial investigation, expert advice was sought from a psychologist, Ms B, the Director and Principal Psychologist at Suicide Risk Assessment Australia. Ms B was provided with the evidence obtained in Ms D's case, the investigation report and response of the UCC and the DFVRU Review. She was asked to comment on the adequacy of the services provided to Ms D, including those pertaining to community based care, assessment and management of suicidality, communication practices between services engaged in her treatment and care, and the capacity to which services working with Ms D could respond to her mental health needs.

91. On 27 July 2017 Ms B provided a report in which she gave her expert opinion on Ms D's case. Ms B's report is detailed and discussed in-depth the relevant Darling Downs Hospital and Health Service (DDHHS) suicide risk assessment policies and procedures in place at the time, as well as their use by particular practitioners in respect of Ms D's circumstances. She evaluated the efficacy of these identified policies against the most up-to date suicide prevention research and literature available at the time of her report. In addition she discussed Safety Planning, a clinical suicide prevention tool which she notes appeared to be missing from the DDHHS standard provisions of care.

92. Ms B's findings are most clearly and succinctly summarised in the Executive Summary of her Report:

Suicide Risk Assessment Policy, Procedures, and Methodology within DDHHS District

- *In 2013 DDHHS were adhering to assessment protocols and methodology that [were] inconsistent with current research.*
- *Consistent with this finding, mental health practitioners used suicide risk assessment scales/psychometric tools, such as the Suicide Risk Assessment Tool where those tools do not support good clinical management and formulation practices for management of patients who may be suicidal.*
- *Evidence was found of discordance between several DDHHS polices, including the Emergency Triage policy expecting brief/immediate assessment for medical emergency (less than 5 minutes) where suicidality is not adequately defined within this frame of reference.*
- *Although clinical notes and documentation alluded to another policy or protocol with respect to the management of patients discharged following suicide attempt, this documents was not available within the evidence for consideration. As such, no opinion or comment has been made on the value of this document or practice.*

- *No evidence was available for consideration herein, with respect to lines of accountability in the implementation of protocol in managing risk for suicide. As such, no opinion or comment has been made on systems for monitoring accountability in more senior levels of management with DDHHS employees.*
- *There was no evidence in the available documentation of formal inter-agency collaboration strategies underpinning suicide prevention and intervention efforts between DDHHS and external service providers.*

Human Factors and Professional Practice

- *Several factors were identified as requiring further development in DDHHS employees, in relation to documentation, assessment and management of clients presenting with suicidality.*
- *Notwithstanding the inherent problems associated with the use of the Suicide Risk Assessment Tool, concerns are identified in the administration and interpretation of results from the tool by Registered Nurse D, when administered with Ms D.*
- *Further concerns were identified in how the Suicide Risk Assessment Tool results obtained from Ms D were transcribed from the original document to the document supporting the discharge patient management plan. The original score from the Suicide Risk Assessment Tool obtained on 24 September 2013 was "Medium" yet would appear to have been transcribed to "Low" without explanation. It should be noted that there is limited evidence generally regarding post-suicide attempt management systems to qualify the approach taken with respect to Ms D's discharge and management planning.*
- *The basic document on page 104 of Form 7 – Kingaroy Hospital Community Health Records prompts the clinician to implement Safety Planning. There is no evidence that this had occurred formally, or by any mental health professional engaged in Ms D's care from when the risk was initially identified in January 2013 until her death in October 2013.*
- *In the 12 months prior to Ms D's death by suicide, there is no evidence to demonstrate that any mental health practitioner probed and documented Ms D's suicidal intent and specifically her ideated mechanisms for death, on which intervention strategies could be focussed.*
- *No evidence was available to verify or otherwise that Ms D had access to psychological interventions, by way of evidence based treatment of suicidality.*

Mechanism of Death

- *Ms D had access to lethal doses of medication that had been prescribed to her by her treatment providers. Current research consistently demonstrates the value of means restriction in preventing deaths by suicide.*
- *There is no evidence in the documentation considered to demonstrate that practitioners at any level of service provision considered means restriction as a suicide prevention strategy. It is observed that opportunities for*

suicide prevention may have been achieved though considering alteration to prescribing practices and other restricted dispensing practices.[12]

93. In respect of these findings, Ms B advised that:

[DDHHS] have a number of policies and protocols that were reviewed in the examination of Ms D's access to services. It is observed that these policies and protocols would be more effective in the assessment and management of suicidality if considered in the context of current research evidence focusing on better practice suicide risk assessment.

There is no integrated case formulation and planning evident from the notes. While each practitioner may have had an understanding of the pressures impacting Ms D, there is an absence of a key worker calling a case management meeting to ensure that not only the psycho-social stressors are being addressed, but that they were working to identify and connect Ms D to a suitably qualified and [skilled] Psychologist (or Counsellor) capable of offering treatment options for suicidality. It is unclear why this has not occurred and whether staffing, time limitations, systemic barriers or attitudes are relevant factors.

There is a lack of clarity regarding the impact of Ms D's sudden cessation of cannabis on her experience of pain and further, whether this may or may not have led her to source the additional scripts for Jurnista in the absence of a suicide plan.

Inconsistencies and problems evidences within the available documentation may reflect time pressures impacting service providers, laziness, poor clinical practice or deliberate concealment. There is insufficient evidence from which to determine the more likely explanation. Further, these tensions may be the result of short staffing, attitudinal barriers or other systemic limitations.

There is the potential that Ms D's daughter, S (and family or friends) have not been receptive or interested in receiving psycho-education on suicidality from the mental health service providers. Whilst this is a potential, there is no evidence whatsoever that she, or any support person, was ever engaged in a collaborative manner in understanding Safety Planning, help seeking or management of Ms D's suicidality. Even with the potential tension between family members and service providers regarding how to support a person evidencing suicidality, service providers have a duty of care to ensure the information is available. This is not evidence in this instance.[13]

94. Finally, Ms B noted with approval the "sound recommendations and observations"[14] which were made by UCC following their investigation, and by the DFVDRU in their Review.

[12] Expert Witness Report into the Death by Suicide of Ms LD, 27 July 2017, pp 2 – 3.
[13] Expert Witness Report into the Death by Suicide of Ms LD, 27 July 2017, p 37.
[14] Expert Witness Report into the Death by Suicide of Ms LD, 27 July 2017, p 37.

Darling Downs Hospital and Health Service improvement actions

95. On 2 November 2017 the DDHHS gave a response to the matters raised by Ms B in her report. DDHHS acknowledged the issues raised by Ms B, "particularly regarding the inconsistency of the protocols and methodology with best evidence in assisting suicidality."[15]

96. DDHHS also noted the inconsistencies and deficiencies in documentation which had been identified by Ms B, and advised that these "are considered to be a reflection of time pressures and lack of resourcing".[16]

97. DDHHS advised, however, that since 2013, they have undertaken significant work and improvements in assessing and managing suicidal risk. In respect of Ms B's comments regarding the lack of inter-agency collaboration strategies, DDHHS advised that:

    The service agrees that the fundamental aspects of evidence based safety planning processes should be incorporated into DDHHS standard provisions of care and notes the collaborative processes with third parties. In the case of Ms D, alteration to the management of her medications may have resulted in a means restriction strategy. Since the incident, the service has dedicated substantial resources to bolstering partnership and collaboration with non-government and government agencies connected to maintaining the safety of our consumers. The service has also dedicated considerable resources since the incident to refocus and build upon the collaborative relationship between Emergency Departments (including rural) and mental health. In particular, the DDHHS has implemented Nurse Navigators who are employed in rural areas and work specifically with mental health patients with complex needs. Specifically, one of the responsibilities of the Nurse Navigators is to provide a central point of communication and engagement to ensure optimal care and coordination of services along a patient's entire health care journey.[17]

98. In respect of identifying the risk of victims of domestic and family violence such as Ms D, DDHHS advised that:

    In addition, the DDHHS Allied Health department is in the process of developing clinical practice guidelines for social workers for Domestic and Family Violence (DFV).This includes a Working Party to identify key issues such as clinical response, data collection and staff awareness of leave entitlements. A DDHHS DFV Action plan is being developed and a common risk assessment has been implemented – currently 250 clinicians, both social workers and clinical facilitators have received this training to date. This referral pathway for DFV is available to all staff and is being actively promoted. These measures have been instituted to address such factors which increased vulnerability to suicide.[18]

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[15] DDHHS letter dated 2 November 2017, p 1.
[16] DDHHS letter dated 2 November 2017, p 1.
[17] DDHHS letter dated 2 November 2017, p 2.
[18] DDHHS letter dated 2 November 2017, p 2.

Changes to mental health and suicide prevention services in Queensland Health

99. Since Ms D's death, various changes have been introduced in Queensland which aim to improve mental health service delivery and suicide prevention. Some of these have been mentioned above as specific measures which may have improved the outcome in Ms D's case. Others have been introduced since the various reviews of Ms D's circumstances, but address gaps which were identified in her care.

100. Many of these reforms were implemented in response to the report delivered by the Taskforce on Domestic and Family Violence in 2015 entitled *Not Now, Not Ever: Putting an End to Domestic and Family Violence in Queensland*, following a state-wide enquiry by the Taskforce.[19]

101. As part of the investigation into Ms D's death, the Strategic Policy and Legislation Branch in the Queensland Department of Health was asked by the Coroners Court to provide information about any mental health policy reform related to suicide prevention, relevant training available to Queensland Health Staff, and Queensland Health's participation Integrated Service Response to Domestic and Family Violence Trial in Cherbourg.

Policies, plans and programs

102. In May 2016 Queensland Health released 'My health, Queensland future: Advancing health 2026', which is a plan aimed at making Queenslanders among the healthiest people in the world by promoting wellbeing, delivering healthcare, connecting healthcare and pursuing innovation. One "headline measure of success" in this strategic agenda is to reduce suicide rates in Queensland by 50% by 2026.[20] Relevant to Ms D's case, Queensland health also aims to have a single medical record shared between service providers, and underlines the importance of the new role of nurse navigator in providing integrated care to patients.[21]

103. In October 2016, the Minister for Health and Minister for Ambulance Services released 'Connecting Care to Recovery 2016–2021: A plan for Queensland's State-funded mental health, alcohol and other drug services'. This plan builds on the 'My health, Queensland future' plan by:

> *…strengthening collaboration and effective integration across our treatment service system to more effectively respond to individuals with the most severe mental illness or problematic substance misuse, either episodic or persistent….[and acknowledging that] an individual's mental health and wellbeing and substance use may be impacted by broader social and economic factors including access to housing, education, employment and social*

[19] https://www.csyw.qld.gov.au/campaign/end-domestic-family-violence/about/not-now-not-ever-report
[20] https://www.health.qld.gov.au/system-governance/strategic-direction/plans/vision-strategy at p 11 of PDF link.
[21] https://www.health.qld.gov.au/system-governance/strategic-direction/plans/vision-strategy at pp 19 - 21 of PDF link.

connectedness, as well as situations where domestic and family violence and gendered violence may exist.[22]

104. As part of ‘Connecting Care to Recovery 2016-2021’ $9.6 million in funds has been allocated over 2016 to 2019 in the ‘Suicide Prevention in Health Services Initiative’. The Initiative involves three components, all of which, if implemented as planned, would improve outcomes for patients in similar circumstances to Ms D:

   1. *The establishment and operation of a Queensland Suicide Prevention Health Taskforce (the Taskforce) as a partnership between the Department of Health, Hospital and Health Services, Primary Health Networks and people with lived experience.*

   2. *Analysis of events relating to deaths by suspected suicide of people that had a recent contact with a health service to inform future actions and improvements in service responses.*

   3. *Continued implementation of training for hospital emergency department staff and other frontline acute mental health care staff in recognising, responding to and providing care to people presenting to Hospital and Health Services with suicide risk.*[23]

Training/tools for health practitioners

105. The Queensland Centre for Mental Health Learning (QCMHL) has run mental health education programs for mental health professionals since 2006, and Queensland Health has advised that Queensland Health staff are encouraged to undertake these programs if they are relevant to their work.

106. In 2015-16, QCMHL, in collaboration with the Clinical Skills Development Service, developed the Suicide Risk Assessment and Management in Emergency Department settings training package. This training “aims to enhance Queensland Health Emergency Department staff capabilities in recognising, engaging and responding to individuals experiencing a suicidal crisis”.[24]

107. The existing QCMHL Suicide Risk Assessment and Management Training for mental health clinicians training was reviewed in 2017 to reflect contemporary clinical practice and shape it into a more experiential and practical course. The new course, entitled ‘Engage, Assess, Respond to, and Support Suicidal People’, builds on the “Suicide Risk Assessment in Emergency Department settings course with further enhancements supporting the implementation of the Zero Suicide in Healthcare within the Gold Coast Hospital and Health Service, as well as key aspects of the previous suicide risk assessment course.”[25]

[22] https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/clinical-staff/mental-health/plans-strategic at p 4 of PDF link.

[23] https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/clinical-staff/mental-health/plans-strategic
[24] https://www.qcmhl.qld.edu.au/index.php - QC25 Course handout.
[25] https://www.qcmhl.qld.edu.au/index.php - QC2 Course handout.

108. Queensland Health also advised that a review of their core suite of mental health clinical documentation began in September 2015, with the updated documentation being made available in 2017. The purpose of the review was:

> *…to ensure mental health clinicians have access to user-friendly documentation to facilitate uniform capture of clinical information to support the delivery of contemporary, high quality services for consumers.*[26]

109. The revised forms for Mental Health Services were accompanied by a new User Guide, and include:

- Triage and Rapid Assessment;
- Risk Screening Tool;
- General Assessment
- Case Review;
- Care Plan; and
- Transfer of Care.[27]

110. A range of changes to the forms were made, which were aimed at:

- Improving recognition of co-occurring conditions and patients with multiple service providers and complex needs;
- Highlighting the responsibilities of the clinician transferring the care of a patient to another service provider;
- Better identifying who provided input into the patient's case review, which may include a general practitioner or other service providers; and
- Ensuring high quality, comprehensive clinical records for patients.

Integrated Service Response Trial - Cherbourg

111. Cherbourg was chosen by the Queensland Government as one of three Integrated Service Response trial sites, which are part of the Queensland Government's ongoing commitments to implement recommendations from the *Not Now, Not Ever* Report. [28]

112. Cherbourg, Mt Isa and Logan/Beenleigh, were the first three of a total of eight trial sites, and the Cherbourg trial began 2016. Whilst this work is led by the Department of Communities, Child Safety and Disability Services, there are a number of key stakeholder agencies including Queensland Health and the DDHHS.

113. In their update on the progress of the Cherbourg trial, the DFVDRU team noted that:

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[26] Information to Coroner from The Strategic Policy and Legislation Branch in the Queensland Department of Health, 31 October 2017.
[27] https://www.health.qld.gov.au/__data/assets/pdf_file/0030/368454/qh-gdl-365-1.pdf
[28] https://www.communities.qld.gov.au/gateway/end-domestic-family-violence/our-progress/enhancing-service-responses/focus-cherbourg-integrated-service-response-trial

The integrated service response trial focuses on how service systems can work together in a timely, structured, collaborative way to ensure people affected by domestic and family violence receive quality and consistent support.[29]

114. An evaluation of the trial is currently being conducted, but outcomes are not yet known. However, funding was allocated in order to:

- Support health service staff in responding to domestic and family violence matters;
- Support and facilitate the provision of domestic and family violence training to health service staff;
- Facilitate liaison, communication and information sharing with other government agencies, community organisations and non-government service providers (high risk team); and
- Contribute to the development, implementation and review of local domestic and family violence guidelines and procedures (co-design of integrated service response).

115. Queensland Health advised that the mental health Clinical Nurse Consultant at Cherbourg Hospital has received training by the Queensland Centre for Domestic and Family Violence Research specifically for the integrated service response trial. Four other staff from Cherbourg have participated in high risk team training to improve multi-agency responses.

Improvements made by Department of Housing and Public Works

116. At the time of Ms D's death, the Department of Communities, Child Safety and Disability Services (DCCSDS) was the contract manager of the service agreement operating Mudjimba. The Department of Housing and Public Works (DHPW) took over responsibility in mid-November 2013 as a result of a government shuffle of responsibility between the two departments. Following recommendations made in the *Not Now, Not* Ever Report, however contract management reverted back to the DCCSDS in July 2016. Part of the intent of this shift was to improve service provision to victims of domestic and family violence who are separating from their partners.

117. In September 2017 DPHW advised the Coroner's Court that, despite management of the contract for Mudjimba having been handed back to DCCSDS, it had worked with that department to review and respond to Ms D's case. In addition, the DHPW advised that it had accepted responsibility for the implementation of Recommendation 88 of the *Not Now Not Ever* Report, which was that "the Queensland Government expand the range of responses to alleviate housing stress and homelessness for women and children escaping domestic and family violence, including the eligibility criteria on programs such as rental grants and bond loans".

118. The DHPW advised that, in response to Recommendation 88, it has:

[29] DFVDRU – Additional information June 2019, para 21.

- *made improvements to the Housing Needs Assessment tool to help department staff more easily identify women and children affected by domestic and family violence;*

- *[introduced] automated bond loan approvals for clients escaping domestic and family violence who have verified their circumstances;*

- *written to the Domestic and Family Violence Specialist Homelessness Service providers to clarify the supportive approach that clients escaping domestic and family violence can expect to receive from Housing Service Centres in relation to:*
  - *bond loans and rental grants;*
  - *RentConnect services;*
  - *social housing assistance;*
  - *tenants and management of social housing tenancies.*

- *developed and distributed information to Housing Service Centres that details and clarifies housing assistance available for clients impacted by domestic violence;*

- *engaged with Housing Service Centre staff to continue to strengthen their knowledge and understanding of the assistance that is to be provided to women and children escaping domestic and family violence and the support services that are available to assist so appropriate and timely referrals can be made when needed; and*

- *Reviewed existing social housing applications and transfer requests that have identified domestic and family violence and explored options for providing assistance and supportive responses.*[30]

Death Review and Advisory Board Recommendations and responses

119. The Domestic and Family Violence Death Review and Advisory Board is responsible for the systemic review of domestic and family violence deaths in Queensland. The establishment of the Board was a key recommendation of the *Not Now, Not Ever* Report. Under the *Coroners Act 2003*, the board can (among other things) make recommendations to the Minister about improving legislation, policies, practices, services, training, resources and communication to prevent or reduce the likelihood of domestic and family violence deaths in Queensland.

120. The DFVDRU has advised that, since Ms D's death, the Board has released two annual reports in which it made various recommendations, a number of which are relevant to the circumstances of Ms D's death, as well as reviewing some of the new reforms which have been put in place since Ms D's death.

121. In their 2016-17 Annual Report the Board reviewed service system contact by victims of domestic violence, and highlighted the need for suicide risk screening

[30] Department of Housing and Public Works response 1.9.2017, pp 4 – 5.

in specialist services, strengthening service systems, as well as earlier detection and targeted intervention. Recommendations relating to these issues included the following:

1. *That a targeted suicide prevention framework, which accounts for the detection of, and response to, vulnerable individuals should be developed and implemented within domestic and family violence refuges by the Department of Communities, Child Safety and Disability Services, in consultation with relevant experts and stakeholders;*

2. *That the Department of Health introduce mandatory training for staff who may come into contact with victims and their children or perpetrators of domestic and family violence;*

8. *That the Queensland Government fund and facilitate cross professional training and relationship building between mental health, drug and alcohol, and specialist domestic and family violence services to enhance collaboration, shared understandings and information sharing;*

9. *That the Queensland Government liaise with peak professional bodies to recommend all registered practitioners who may come into contact with victims and their children or perpetrators of domestic and family violence, complete specialist domestic and family violence awareness training within one year of obtaining registration or membership and be required to complete ongoing refresher training to maintain their registration or membership;* and

14. *That the Department of Health develop a mechanism to assist practitioners to identify persons experiencing domestic and family violence or high-risk families who have presented to the service previously; and to better take into account previous presentations to enhance future responses.*[31]

122. The DFVDRU has advised that Recommendations 1, 8 and 9 have been accepted by the Queensland Government, that Recommendation 2 has been accepted in part by publication of the Domestic and Family Violence Training Resources by Queensland Health (which occurred in response to the *Not Now, Not Ever* Report), and Recommendation 14 has been accepted in principle, with relevant training already in place, and more funding to be provided.[32]

123. In their 2017-18 Annual Report the Board's recommendations were not directly relevant to Ms D's circumstances. However, this second Annual Report explored the role of system advocates in service system contact by victims of domestic violence, and found that:

…advocacy is a key component of crisis intervention and is one of 10 principles for effective practice in working with victims of domestic and family violence.

[31] Domestic and Family Violence Death Review and- Advisory Board Annual Report 2016-17, pp 13 – 14.
[32] DFVDRU Additional Information June 2019, Table.

Advocacy provides a collaborative means by which victims are supported to navigate service systems effectively. Workers advocate (with consent) on behalf of the victim with other stakeholders, and also at a systems level by advocating for system change. Advocacy seeks to empower victims to identify their rights and advocate for their own needs, and the needs of their children. This is crucially important in complex cases where a victim's prior history of trauma and abuse may impede meaningful engagement with a service.[33]

124. The Annual Report notes that the integrated service response trials already in place in Queensland, including Cherbourg, incorporate:

[a] case manager (or lead professional), who has responsibility for ensuring the client receives the right mix of services, in the right order, at the right time.

[This] worker acts as a single point of contact when a range of services are involved with that family or family member and an integrated response is required. They are also required to negotiate access to services…continually assess and monitor risk…and collaborate with all identified service providers.[34]

Recommendations arising from the inquest into the deaths of WH, JS, VW and DM

125. On 21 May 2018 Coroner McDougall delivered his findings in respect of a joint inquest into the deaths of WH, JS, VW and DM. The inquest had been held in order to consider the important public health issues associated with the growing misuse of opioid prescription medication. Each of the deaths considered in this inquest occurred, as did Ms D's, following an overdose of opioid pain medication. In each case the deceased, like Ms D, had been able to stockpile (whether deliberately or inadvertently), the amount of medication which contributed to their death.[35]

126. The key recommendation made by Coroner McDougall was that "the Queensland Department of Health should urgently consider and determine how a real-time prescription monitoring system can be implemented in Queensland at the earliest opportunity, but certainly within the next two years."

127. On 1 November 2018, the Minister for Health and Minister for Ambulance Services responded:

The Department of Health provided $15 million funding to progress the implementation over the next three years of a comprehensive program of work on monitored substances that will include the implementation of a real-time prescription monitoring (RTPM) system. Queensland Health continues to work with both Victoria and the Commonwealth on progressing a system that will provide Queensland with the best outcome and allow sharing of information with other states and territories.

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[33] Domestic and Family Violence Death Review and- Advisory Board Annual Report 2017-18, p 113.
[34] Domestic and Family Violence Death Review and- Advisory Board Annual Report 2017-18, p 114.
[35] https://www.courts.qld.gov.au/__data/assets/pdf_file/0010/566920/cif-house-white-smith-milne-20180521.pdf#page=113&zoom=100,0,498

Queensland Health is monitoring the implementation of the Victorian Government's RTPM scheduled for implementation late 2018. This RTPM accesses information from the national prescription exchanges services, allowing visibility of all controlled drug prescriptions dispensed in all jurisdictions. The department is currently recruiting a project team and will undertake the appropriate steps to procure a RTPM that meets the requirements for real-time reporting and access to prescription history information for prescribing doctors and dispensing pharmacists. [36]

Conclusions

128. Ms D's tragic death highlighted various issues in mental health service delivery across the public and private sectors. These include:

- Inability by services to recognise and deal with the risks of domestic and family violence for victims;
- Ineffective suicide risk assessment policy and procedures;
- Inadequate safety and discharge planning;
- Lack of community-based care in the form of suicide prevention psychotherapy;
- Difficulties in relation to the management of chronic pain especially in rural and remote locations;
- Lack of system advocates to deal with complex, inter-service patient needs; and
- Lack of effective inter-agency collaboration and communication strategies with respect to managing patient suicidality.

129. However, in the time since Ms D's death, significant steps have been taken, both in response to her death and to the wider public issues surrounding domestic violence and suicide prevention, to address these issues.

130. Uniting Care Queensland critically reviewed the care and treatment provided to Ms D and have since made changes aimed at improving their service delivery. This includes in relation to risk assessment, staff training, record keeping and medication management.

131. Darling Downs Hospital and Health Service accepted the criticisms of Ms B in relation to the care and treatment provided to Ms D. They have since implemented various improvement actions including Nurse Navigators in rural areas to work specifically with mental health patients with complex needs. They are also developing clinical guidelines for social workers in relation to domestic and family violence.
132. Improved suicide assessment and prevention training is now being offered to clinicians State-wide via the Queensland Centre for Mental Health Learning.

[36] https://www.justice.qld.gov.au/__data/assets/pdf_file/0011/587054/qgr-house-wj-white-vj-smith-ja-milne-dk-20181113.pdf

133. Substantial reform has recently occurred across Queensland in relation to mental health strategy and planning, reducing suicide rates and responding to domestic and family violence.

134. Recommendations have been made which, if accepted, may improve the capacity of domestic and family violence refuges to detect and respond to vulnerable individuals who are at risk of suicide.

135. In all the circumstances, I do not consider an inquest is likely to result in any further preventative recommendations being able to be made. The findings required by s 45(2) of the *Coroners Act 2003* can be made on the available evidence:

Identity of the deceased: Ms D.

How she died: At the time of her death, Ms D was prescribed Hydromorphone tablets (4mg to be taken once daily at night) for the management of chronic pain. Hydromorphone is an opioid analgesic and Schedule 8 (controlled drug). In the month prior to her death, Ms D separated from her partner Mr T. Ms D's relationship was reportedly characterised by physical, psychological and verbal abuse. Ms D had recently been hospitalised as a result of a suicide attempt and was residing at a women's refuge in Cherbourg. Ms D died as a result of an intentional overdose of her prescription medication hydromorphone. Her death highlighted various system issues in the provision of hospital and community based mental health care including assessment and management of suicidality, communication and collaboration between treating services and medication accessibility**.**

Place of death: Mudjimba Cherbourg Women's Shelter, Cherbourg, QLD, 4605 AUSTRALIA**.**

Date of death: 20 October 2013 - 22 October 2013.

Cause of death: 1(a) Overdose of hydromorphone

I close the investigation.

Coroner Carmody
A/Coroner
CORONERS COURT OF QUEENSLAND
02 August 2019