IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2021 004243

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Ingrid Giles
Deceased:	Ms NXA[1]
Date of birth:	[redacted] 1966
Date of death:	11 August 2021
Cause of death:	1a: NECK COMPRESSION 1b: HANGING
Place of death:	[redacted]
Keywords:	Suicide; mental illness; tinnitus; prior suicide attempt

[1] This Finding has been de-identified by order of Coroner Ingrid Giles which includes an order to replace the name of the deceased and other persons related to or associated with the deceased, with a pseudonym of a randomly generated letter sequence for the purposes of publication

INTRODUCTION

1. Ms NXA was 54 years old when she was found deceased on 11 August 2021. At the time of her death, Ms NXA lived at [redacted], Victoria, at her father's house. Ms NXA's father, Mr EMB, was in hospital at the time of Ms NXA's passing.

THE CORONIAL INVESTIGATION

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

3. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

4. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

5. My colleague Coroner Simon McGregor originally had carriage of this investigation. I took carriage of this matter in July 2023 for the purposes of seeking additional advice from the Coroners Prevention Unit (**CPU**),[2] finalising the investigation and making findings.

6. Victoria Police assigned an officer to be the Coronial Investigator for the investigation of Ms NXA's death. The Coronial Investigator conducted inquiries on the Court's behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

7. This finding draws on the totality of the coronial investigation into the death of Ms NXA including evidence contained in the coronial brief. Whilst I have reviewed all the material, I

[2] The Coroners Prevention Unit (**CPU**) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the Coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. The CPU also reviews medical care and treatment in cases referred by the coroner. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.

will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[3]

BACKGROUND

8. Ms NXA had a history of several mental health conditions, including depression, complex post-traumatic stress disorder (**CPTSD**), panic disorder and anxiety. She also had a significant history of alcohol use disorder and had been the recipient of welfare checks by police on several occasions. Ms NXA had previously undergone inpatient treatment at The Melbourne Clinic, albeit not proximate in time to her death.

9. Ms NXA's medical records indicate complaints of tinnitus dating back to early 2021. Her journal documented significant distress associated with tinnitus over June and July 2021, which she described as "*relentless*", "*distressing*", "*intolerable*" and "*disabling*" and appears to have been linked with sleep disturbance, alcohol use, intentional prescription medication overdose, and suicidal ideation and planning. Several other psychosocial stressors were also described over this period and clearly linked to Ms NXA's suicidality in her journal.

10. Ms NXA was unemployed at the time of her passing. She had moved to Tasmania in early 2021 but prior to her death, she was temporarily staying with her father in [redacted]. Ms NXA's family were heavily divided due to financial disputes over the family's beef cattle business succession plan, and Ms NXA was involved in numerous family court proceedings as well as Family Violence Intervention Orders (**FVIOs**). Ms NXA's relationship with her brother, Mr QJF, was especially strained, with Ms NXA describing fears that he would harm her. Ms NXA was also estranged from her mother, Ms DLN.

11. Ms NXA also had a difficult relationship with police due to welfare checks (some of which were reportedly initiated by Mr QJF), refusing breath tests, and contravention of intervention orders. She viewed her interactions with police and subjection to compulsory assessment under the *Mental Health Act 2014* (**'the MHA'**), as then applied, as traumatising. She made several allegations of police harassment. Her approach to local police officers lead to intervention orders being taken out against her, and Victoria Police viewed Ms NXA to be a vexatious complainant whose allegations could not be substantiated. At the time of her

[3] Subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

passing, there were about 40 charges of either contravening FVIOs or persistently contravening FVIOs pending against Ms NXA. These were struck out after she died.

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

Circumstances in which the death occurred

12. On 9 August 2021, Ms NXA was located by cleaners at her father's [redacted] home, after consuming an intentional overdose of medication and drinking three to four bottles of wine. The cleaners called an ambulance who conveyed Ms NXA to the Northern Hospital Emergency Department (**ED**).

13. Upon her arrival at the Northern Hospital ED, a note was located at Mr EMB's home which read "*why is it so hard to kill yourself*" and "*I can't deal with this*". Ms NXA told staff that she consumed the overdose due to her tinnitus and the desire to end her life. She reported being remorseful about her attempt. Her blood alcohol concentration upon admission was 0.018 g/100mL. The clinical plan was for medical investigations, review by the Emergency Mental Health (**EMH**) team, and to transfer Ms NXA to the Short Stay Unit (**SSU**).

14. Nursing staff monitored Ms NXA for alcohol withdrawal symptoms, in accordance with hospital protocol. She initially demonstrated mild to moderate withdrawal symptoms which decreased to absent or minimal symptoms. She was also prescribed diazepam and thiamine to assist with the symptoms.

15. At about 5.00pm on 9 August 2021, an EMH Mental Health Social Worker reviewed Ms NXA in the SSU. The social worker noted Ms NXA's previous mental health history including as an inpatient admission to The Melbourne Clinic several years earlier. The social worker further noted that Ms NXA did not have a general practitioner (**GP**) in Victoria.

16. Ms NXA was noted to be irritable and disclosed that her mood had deteriorated in the previous few days due to her chronic tinnitus, which prevented her from sleeping and prevented her from completing ordinary activities. She explained that she consumed the overdose with the primary purpose of going to sleep, however would have been happy if she died. She disclosed additional and significant stressors and risk factors for suicide, including caring for her unwell father, a family history of suicide, social isolation and alcohol abuse. When she was asked about her current suicidal ideation, Ms NXA responded that she was unsure, but that she felt unsafe to go home due to a fear of another overdose.

17. Clinicians later documented that Ms NXA denied active suicidal ideation, plan or intent. The clinical impression was of depressive mood secondary to her tinnitus. The plan was for Ms NXA to remain in the SSU overnight for crisis containment, and for further EMH review in the morning.

18. At about 9.20am on 10 August 2021, clinicians held a multi-disciplinary team meeting and formulated a plan for re-review, discharge and consideration for referral to the Goulburn Valley Area Mental Health Service for follow-up.

19. At about 9.40am, the social worker reviewed Ms NXA again who reported ongoing frustration with her tinnitus and indicated that she would complete suicide if she could not obtain medical help for same. The social worker consulted with an EMH Consultant Psychiatrist who advised that as Ms NXA's distress was due to tinnitus, an inpatient admission was not appropriate. The Consultant Psychiatrist also advised that Ms NXA should receive GP follow-up to obtain a mental health care plan.

20. At about 10.40am, a medical intern reviewed Ms NXA who repeatedly told him that she was keen to be discharged in order to go home and re-attempt suicide. The medical intern approached the social worker with his concerns. The social worker advised the intern that he was not concerned. The medical intern noted that Ms NXA was to receive further medical management of her tinnitus if possible and that an inpatient admission was not indicated. The medical intern provided Ms NXA with a brochure about tinnitus and advised her to consult with her GP for audiology investigations.

21. At 10.55am, a registered nurse (**RN1**) documented that Ms NXA continued to express suicidal thoughts, stating "*I have to end it*" and that the SSU consultant had explained to Ms NXA that there was no specific treatment for tinnitus. At 12.10pm, RN1 recorded that Ms NXA stated she "*will kill herself*" "*because no one wants to help her*" and that she wanted to go home.

22. At 1.25pm, another registered nurse (**RN2**) recorded that Ms NXA stated, "*I'm going to go home and kill myself I've thought of a plan*". RN2 recorded that the doctors and the nurse in charge were aware of this statement, were not concerned, and that the SSU consultant would review Ms NXA. At 2.05pm, RN2 documented that the SSU consultant was aware of Ms NXA's statements and had directed that no further escalation was needed. The SSU consultant did not review Ms NXA.

23. Ms NXA was discharged from the Northern Hospital later that day. The medications she overdosed on were returned to her and she was advised to seek audiology and other investigations for her tinnitus, as well as follow-up from her GP to arrange mental health care support within one week. The discharge paperwork noted that Ms NXA did not have a local GP. Staff instructed Ms NXA to return to the ED in the case of severe or persistent mental health concerns, or in the event of any concerning change in her health.

24. That afternoon, Mr EMB's neighbour, Ms SJE, observed that the front door to the house was open. Ms SJE called out to her neighbour to check if something was wrong and decided to invite Ms NXA over for a cup of tea. Ms NXA opened up to Ms SJE about her family issues and ongoing conflict between family members. She also explained that she was recently in hospital because she tried to take her life, however they sent her home. Ms SJE offered to visit Ms NXA next door and keep her company, however Ms NXA declined as the house was messy. Ms SJE promised to visit again the next day to go for a walk together and to ensure that Ms NXA was not alone for a prolonged period of time.

25. At about 9.30am on 11 August 2021, an EMH clinician called Ms NXA to obtain her GP's details. Ms NXA provided her Tasmanian GP's details. The clinician also offered follow-up by the Acute Response Team (**ART**), however Ms NXA declined same. Northern Health staff attempted to call the Tasmanian GP and reportedly faxed Ms NXA's discharge summary to the practice. It is unclear if the discharge summary was received by the GP clinic, as there was no record of same on the GP medical records provided to the Court.

26. Ms NXA spoke to her close friend, Mr TBU, shortly thereafter. Ms NXA reportedly called Mr TBU "*petrified*" that the hospital was going to order a police welfare check and they spoke for an hour and 40 minutes. Mr TBU spoke to Ms NXA again at about 11.30am for a further 40 minutes.

27. Ms SJE attempted to visit Ms NXA at about 5.00pm, however upon arriving at the property, she observed Ms NXA hanging from a rope around her neck, suspended from the roof of her carport. Ms SJE called Triple Zero and attempted to lift Ms NXA down from the rope, however, was unable to do so. The call-taker instructed Ms SJE to cut the rope and perform cardiopulmonary resuscitation (**CPR**); however, she stated she did not want to commence CPR as it was clear to her that Ms NXA had been deceased for some time.

28. Ambulance Victoria paramedics arrived on scene shortly thereafter and confirmed Ms NXA was deceased. Victoria Police also attended the scene and investigated the circumstances of

Ms NXA's passing. Police noted several empty blister packs of prescription medication including meloxicam, atenolol and escitalopram on the dining room table. Also on the table, police located Ms NXA's notebook which contained her writings, including those demonstrating suicidal thoughts. In Ms NXA's bedroom, police found a green pharmacy bag with additional prescription medication, much of which appeared to be missing.

29. Police did not identify any suspicious circumstances or evidence of third-party intervention in connection with the death.

Identity of the deceased

30. On 11 August 2021, Ms NXA, born [redacted] 1966, was visually identified by her neighbour, Ms SJE.

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

Medical cause of death

32. Forensic Pathology Fellow Dr Chong Zhou, supervised by Dr Heinrich Bouwer from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an examination on 12 August 2021 and provided a written report of her findings dated 16 August 2021.

33. The post-mortem examination revealed findings consistent with the reported circumstances.

34. Examination of the post-mortem CT scan showed bilateral fractures of the greater horn of the hyoid bone with no other skeletal trauma. There was also a well-circumscribed frontal parasagittal dural-based lesion which likely represented a meningioma.[4]

[4] This refers to the most common form of brain tumour. The CPU Health and Medical Investigation Team (**HMIT**) provided an opinion that the 'well-circumscribed frontal parasagittal dural-based lesion which likely represented a meningioma' found on CT is extremely unlikely to have been responsible for the deceased's severe tinnitus as it does not involve the auditory pathways, brainstem structures related to hearing or the auditory nerve or cochlea (organ responsible for hearing).

35. Toxicological analysis of post-mortem samples identified the presence of diazepam and its metabolite nordiazepam[5], citalopram[6], olanzapine[7], atenolol[8], irbesartan[9], meloxicam[10], promethazine[11], and paracetamol[12]. Ethanol (alcohol) was not detected.

36. Dr Zhou provided an opinion that the medical cause of death was *1(a) neck compression* secondary to *1(b) hanging*

37. I accept Dr Zhou's opinion.

FAMILY CONCERNS

38. Mr EMB and Mr TBU wrote to the Court to report their extensive concerns about Ms NXA's death, the mental health treatment she received and the contact she had with Victoria Police in the context of the family disputes. Their concerns are summarised below:

    a) The conduct of several Victorian Police members, which were alleged to be harassing towards Ms NXA, and/or excessively violent or were otherwise corrupt, in particular:

        i. 23 April 2018 – welfare check requested by Mr QJF, resulting in a section 351 MHA transfer to hospital.

        ii. 30 April 2018 – welfare check requested by Mr QJF. Police left at Ms NXA's request.

        iii. 2 May 2018 – arrest with use of force for allegations of family violence.

        iv. 6 June 2020 – police contact in relation to whereabouts, resulting in a section 351 MHA transfer to hospital.

        v. 27 August 2020 – welfare check resulting in a section 351 MHA transfer to hospital.

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[5] Diazepam is a benzodiazepine derivative indicated for anxiety, muscle relaxation and seizures.
[6] Citalopram and escitalopram are selective serotonin reuptake inhibitors (**SSRIs**). Citalopram is indicated for major depression and panic disorder. Escitalopram is indicated for the treatment of major depression, social anxiety disorders, panic disorder, generalised anxiety disorder and obsessive-compulsive disorder.
[7] Olanzapine is indicated for mood stabilization and as an anti-manic drug.
[8] Atenolol is indicated for hypertension, angina, and the prevention of cardiac dysrhythmias in myocardial infarction.
[9] Irbesartan is indicated for hypertension.
[10] Meloxicam is used as an anti-inflammatory.
[11] Promethazine is an anti-histamine.
[12] Paracetamol is an analgesic drug.

b) The conduct of Ms DLN, Mr QJF and his wife, allegedly weaponising the legal system against Ms NXA.

c) That the mental health system "*failed*" Ms NXA.

d) Concerns about Ms NXA's discharge from the Northern Hospital on 10 August 2021, particularly in the context of the explicit threats she made to self-harm or take her own life upon discharge.

CPU REVIEW OF TREATMENT

39. Given the proximity between Ms NXA's admission to the Northern Hospital and her death, I requested the CPU to review the treatment she received. I directed that the CPU consider the concerns raised by Ms NXA's family and whether there were any prevention opportunities arising from her treatment.

Northern Health

Risk assessment and formulation

40. Ms NXA reported a history of comorbid mental and physical health conditions and several significant stressors during her initial assessment with the social worker. In both assessments of Ms NXA's risk of suicide, the social worker appeared to have focused heavily on tinnitus as the predominant stressor contributing to Ms NXA's suicidality, while not recognising other possible contributing factors.

41. The Consultant Psychiatrist's understanding of Ms NXA's situation appeared to be similar. He stated "*Ms NXA's mental health concerns were secondary to her ongoing medical issue of tinnitus. The tinnitus was the primary driver of Ms NXA's psychological distress*". The social worker additionally noted that Ms NXA was "*demanding medical treatment via threats*". The CPU opined that this undermined the validity of Ms NXA's mental health concerns and did not appropriately acknowledge the complexity of her distress.

42. The CPU noted that while Ms NXA was making repeated statements indicating that she would take her own life due to her tinnitus, a high-quality suicide risk formulation would explore and consider the spectrum of stressors that she was experiencing and how they might contribute to her level of distress and her suicide risk. The CPU opined that a more nuanced view of these factors, ideally in conjunction with collateral information from Ms NXA's GP

or father, might have altered the Consultant Psychiatrist's conclusion regarding the treatability of Ms NXA's suicidality by widening the focus on her precipitating factors.

43. The Consultant Psychiatrist stated that Ms NXA's suicidal ideation did not require psychiatric assessment or intervention due to the concurrent presence of distressing tinnitus. The CPU explained that there are not currently any Australian guidelines specifying appropriate action to be undertaken to address suicidal crisis in the context of tinnitus. However, the Royal Victorian Eye and Ear Hospital emphasises that untreated tinnitus can have an extreme psychological impact in individuals with comorbid mental health conditions, and psychological intervention should be considered in the management of any associated distress.[13]

44. In the United Kingdom, the National Institute for Health and Care Excellence (**NICE**) guidelines[14] for the treatment of tinnitus emphasise that individuals who have tinnitus are associated with a high risk of suicide (for example, suicidal thoughts with an intended plan) should be referred immediately to a crisis mental health management team for assessment. The CPU also noted that as tinnitus can be difficult to treat, psychological intervention such as cognitive behavioural therapy is effective and frequently used in reducing tinnitus-related distress.[15] The CPU concluded that underlying tinnitus should not preclude receiving mental health care when a patient is experiencing distress, and that psychological intervention is effective in treating tinnitus-related distress in the absence of resolution of the tinnitus itself.

45. The CPU opined that the Consultant Psychiatrist may not have been apprised of the treatment guidelines for tinnitus, and that it may not be reasonable to expect same. However, the CPU opined that it *is* reasonable to expect that the Consultant Psychiatrist would understand that suicidality should be assessed and treated, regardless of its underlying cause. It is not the responsibility of a psychiatrist to ascertain whether the underlying source of the patient's distress is changeable with psychiatric intervention, but to address the psychological distress itself. Regardless of the underlying cause of distress, help should be arranged which is proportionate to the level of risk.

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[13] Tinnitus Primary Care Management Guidelines for GPs, https://eyeandear.org.au/wpcontent/uploads/2021/11/Eye-and-Ear-Primary-Care-Guidelines-ENT-Tinnius-20130712.pdf

[14] https://www.nice.org.uk/guidance/ng155/resources/tinnitus-assessment-and-management-pdf66141841962949, pp. 44

[15] A review of Tinnitus, Royal Australian College of General Practitioners, 2018, https://www1.racgp.org.au/ajgp/2018/april/tinnitus.

46. The CPU opined that the Consultant Psychiatrist's conceptualisation of Ms NXA's difficulties mirrors an outdated paradigm in medicine and psychiatry that viewed physical and mental health as separate domains. Under this view, there was a fragmented approach to healthcare where emotional suffering caused or exacerbated by physical conditions was incorrectly viewed as a secondary consequence, rather than a primary issue to be treated. Modern psychiatry utilises a more holistic, integrated model that acknowledges the interplay between physical and mental health and recognises that emotional suffering requires independent treatment, even if it originates from a physical condition.

47. Given Ms NXA first stated intention to suicide during her second and final assessments with the social worker (noting previously she denied suicidal ideation), it would have been appropriate for clinicians to undertake a detailed risk assessment and formulation of Ms NXA's risk of suicide. This may have resulted in an offer of voluntary psychiatric hospitalisation or compulsory assessment or treatment under the MHA. This did not occur, and the CPU opined that this appeared to be due to the social worker and Consultant Psychiatrist's narrow view of the contributing factors to Ms NXA's suicidality and their flawed opinion regarding the treatability of her distress. Similarly, when the medical intern escalated Ms NXA's suicidality to the social worker, the social worker explained that there was no role for mental health reassessment or intervention.

48. The CPU concluded that the lack of high-quality risk assessment and formulation, the conclusion regarding the treatment of Ms NXA's distress, the resulting lack of psychiatric assessment and the lack of exploration of the need for inpatient admission constituted poor clinical care. The CPU opined that this represented a missed opportunity to provide Ms NXA with high quality healthcare that may have better supported her during this time of distress. However, the CPU could not conclude with certainty that this represented an opportunity to prevent Ms NXA's death.

Deterioration and lack of re-review by the SSU consultant

49. Ms NXA was last reviewed by the social worker at 9.40am on 10 August 2021 and she indicated at that time that she would suicide if no medical help was available to address her tinnitus. After this time, she made several further statements of suicidal intent to SSU staff, which was escalated by the medical intern back to the social worker following his assessment at 10.40am. RN2 first documented Ms NXA's suicide plan at 1.25pm and appropriately escalated her concerns to the SSU consultant, who did not review Ms NXA. Northern Health

indicated that this decision was appropriate, due to their perception that Ms NXA's suicidality (irrespective of plan) consistently reflected her ongoing tinnitus-related distress and did not represent a new change in her presentation that warranted a review.

50. At the time of Ms NXA's admission, Northern Health policy indicated that when a new change in suicidality is identified, a Pre MET[16] must occur. In this context, a Pre MET involved review by a medical and nursing representative and an assessment using the Columbia Suicide Severity Rating Scale (**C-SSRS**). This did not occur on this occasion, due to the SSU consultant's perception that a new change was not present. If Ms NXA's suicidality had been rated using the C-SSRS, based on her recent presentation, she would have likely scored the highest possible score range (in the High Risk) category. Northern Health further indicated that its expectation in the event of a re-review of a new change was "*that discussion be had amongst the two respective consultants from the SSU and EMH*" however this also did not occur.

51. The CPU explained that the SSU consultant's view that Ms NXA's presentation had not changed with the statement of a suicide plan was contrary to fundamental suicide risk assessment procedures, which involve query regarding suicidal ideation, plan, means and intent. A person who intends on suiciding but does not have a plan is considered at lower risk than a person who has a method devised. The CPU opined that, while Ms NXA's suicidality was consistently contextualised within her experience of tinnitus, t the first expression of a suicide plan represented a new change that should have triggered SSU and EMH consultant review.

52. The CPU noted that the EMH clinician's opinion regarding the treatability of Ms NXA's mental health concerns likely guided or influenced the SSU consultant's decision in this matter. The CPU explained that consultants will typically defer to the clinical judgment and recommendations of specialists when managing patients with complex or condition-specific needs. This is in recognition of the specialist's advanced expertise in the relevant area of care. This collaborative approach also ensures that medical decisions are informed by the most specialised knowledge available. Therefore, while the absence of a re-review represented a missed opportunity to re-discuss Ms NXA's case with EMH, the SSU consultant's actions were justifiable in that context.

[16] A clinical review of an inpatient requiring a response by the medical team within 15 minutes.

53. The CPU noted its concerns regarding the SSU consultant's explanation, namely, that there was no specific treatment for tinnitus. The CPU opined that this was both medically inaccurate and highly insensitive to a person who has stated that they would suicide if they could not access treatment for same.

Lack of medical investigation of Ms NXA's tinnitus

54. Other than a brochure and encouragement to seek investigation, the CPU noted that no active investigations/treatment for tinnitus were commenced by Northern Health. This was considered by CPU to be concerning given the Ms NXA's social and mental health circumstances and a documented suicide attempt, directly related to 'overwhelming' tinnitus, being managed by the Northen Health ED and mental health teams.

55. Basic measures, such as an examination of the patient's ears/throat to look for an obvious cause of tinnitus (for example, impacted ear wax) and a medication review for drugs that might cause of exacerbate tinnitus, do not appear to have been undertaken or recorded.

56. The CPU noted that a large metropolitan health service such as Northern Health would have its own audiology and other investigative services and an Ear, Nose and Throat (**ENT**) clinic to which Ms NXA could have been referred at no cost. Discharging such a vulnerable patient into the community and expecting them to sort out the diagnosis and treatment themselves would appear to be, in the CPU's opinion, somewhat 'optimistic'.

57. Whilst noting that tinnitus can be an extremely difficult problem to treat successfully, the CPU opined that there are a number of potentially serious and treatable causes that ought to have been excluded.

Safety and treatment planning upon discharge

58. Ms NXA was discharged from the hospital with limited mental health treatment arrangements and safety planning in place. She was advised to follow-up with her GP to arrange mental health support, however the hospital was aware that she did not have a GP in Victoria, and no GP was listed on her discharge paperwork. She was advised to return to the ED in the event of severe distress, which the CPU opined was of limited utility to a person who was expressing suicidal intent. The medications that she used to overdose were returned to her and there was no safety planning regarding her medication, or other means of suicide that may have been at her disposal. There was also no psychoeducation or offer of supports regarding Ms NXA's significant alcohol use.

59. The CPU noted that other elements of safety planning were not undertaken, such as the involvement of close friends/family and provision of emergency mental health contact information such as the psychiatric triage phone number. She was discharged home to a house that was empty as her father was in hospital, and she had limited other social support. The CPU opined that little was done to address Ms NXA's risk factors for suicide, and she did not have an accessible and immediate pathway for further mental healthcare beyond returning to the ED, which had failed to appropriately treat her suicidality. The CPU concluded that this represented extremely poor safety and treatment planning that was not proportionate to the level of risk that Ms NXA demonstrated.

60. The CPU opined that the offer of ART follow-up during the call on 11 August 2021 was appropriate and positive. However, the CPU noted that planning and psychoeducation about this service prior to Ms NXA's discharge from hospital (which did not occur) might have reduced her distress and increased her likelihood of engagement.

61. The CPU opined that the lack of safety and mental health treatment planning upon discharge may have originated from the instructions provided by EMH staff. The only notes regarding Ms NXA's discharge plan stated that she should seek a mental health care plan via her GP, who the social worker documented was not located in Victoria. The CPU opined that it would have been appropriate for the social worker to undertake safety planning with Ms NXA prior to discharge, discuss possible support options and provide an overview of this to the SSU staff.

62. The CPU opined that the lack of safety and discharge planning implemented by EMH staff was likely influenced by the clinician's perception that Ms NXA's mental health was not treatable independently of her tinnitus.

63. The Consultant Psychiatrist and the social worker indicated in their statements to the Court that they believed that discharge planning was the responsibility of the medical team, with input from the mental health staff as needed. It is not clear whether EMH staff expected SSU staff to undertake safety and treatment planning specific to mental health. Nevertheless, as Northern Health was not a designated mental health service at the time of this admission and the staff were not designated mental health service clinicians, they were unequipped to provide specialist safety and mental health treatment planning. EMH input was therefore required at that point. Mental health safety and treatment planning was the responsibility of EMH staff.

64. The CPU opined that the lack of adequate safety and treatment planning by EMH staff represented a missed opportunity to provide Ms NXA with mental health support upon her discharge. The CPU further opined that they could not conclude with certainty that adequate safety planning would have prevented the fatal incident.

Northern Health's internal review

65. Northern Health conducted an internal review into the care provided to Ms NXA during her August 2021 admission. In their initial explanation of the findings of this review, Northern Health noted:

    a) *Ms NXA's change in presentation was not captured via a trigger mechanism so that it followed a process for re-referral and escalation; and*

    b) *The complex interconnectedness of Ms NXA's physical and mental health conditions ultimately were not fully appreciated due to the limitations of the two independent models of care of the respective organisations.*

66. Northern Health further noted "*NH Emergency Services, via its Quality Review Meeting to review Northern Health procedures and liaise with NWMH to agree on escalation and re-referral processes*" and "*consider and trial a new risk assessment form and a dynamic risk review process in ED*".

67. In response to statement questions regarding the change in presentation identified in its internal review, Northern Health indicated:

> *...the procedural recommendations from the Serious Incident Review aimed to improve documentation of such expressions rather than signalling a marked change in Ms NXA's mental health*".

68. The CPU opined that it was difficult to reconcile Northern Health's statement with the internal review. Specifically, that Northern Health asserted that Ms NXA's mental health did not change, however the Northern Health internal review indicated that Ms NXA's change in presentation was not recognised. Through further correspondence with Northern Health, the Court sought to clarify this issue; however, the service denied that there were any issues with the treatment provided to Ms NXA.

69. In response to the Serious Incident Review findings, Northern Health "*trialled a dynamic risk assessment tool designed to capture and escalate new expressions of risk*" and "*refined its*

risk assessment, escalation, and discharge planning frameworks to better address complex, intersecting physical and mental health concerns". This is positive and may improve some aspects of clinical care of patients who present similarly to Ms NXA.

CPU conclusion

70. Overall, the CPU concluded that the care provided by the Consultant Psychiatrist and the social worker was not in line with the modern principles of mental health care. The clinicians focused heavily on tinnitus as the primary driver of Ms NXA's suicidality and did not adequately explore the impact of her significant psychosocial stressors. The clinicians did not appropriately recognise and respond to Ms NXA's risk of suicide due to tinnitus-related distress. Their formulation that Ms NXA's mental health concerns should not be treated due to the concurrent presence of tinnitus led to several missed opportunities to provide Ms NXA with mental health treatment and supports. Ultimately, the mental health care received by Ms NXA was not commensurate with her level of risk, compromising her safety. In addition, the medical team did not adequately investigate her tinnitus or take any steps to have her assessed by the ENT team at Northern Health.

Northern Health natural justice response

71. As a matter of procedural fairness, the Court wrote to Northern Health to provide a summary of the CPU's advice above, and to provide an opportunity to respond to the concerns identified by the Court.

72. Northern Health provided the statement of Associate Professor Vinay Lakra (**A/Prof Lakra**) dated 19 November 2025. In his statement, A/Prof Lakra explained that since Ms NXA's death, "*there has been further research in exploring the nexus between tinnitus and mental health, which has coincided with significant changes to the way that Northern Health operates, including through the relationship between medical and mental health teams*".

73. A/Prof Lakra explained that following Northern Health's disaggregation from Melbourne Health on 1 July 2022, the health service has focused on unifying the mental health service with the rest of the health service to deliver better integrated services to patients. He noted that mental health teams work with and are integrated within the services provided through the emergency department, the short stay unit (**SSU**) and through specialist care teams in the rest of Northern Health.

74. A/Prof Lakra opined that it was regrettable that no investigations were commenced in response to Ms NXA's hearing concerns, and that she was referred back to a GP who was not well-placed to manage her necessary referrals within the community. A/Prof Lakra further noted a belief that Northern Health did not have an established ENT service at the time. Notwithstanding this, he stated that it would have been preferrable for the treating mental health team to seek expert input from an ENT service, and provided appropriate direction to the GP, to comprehensively explore the cause of Ms NXA's hearing concerns.

75. A/Prof Lakra opined that Ms NXA would have received different care in response to her hearing concerns if she attended Northern Health now, compared with her attendance in 2021.

76. Nevertheless, in response to the CPU's concerns, Northern Health stated that it intends to explore education for mental health staff on the link between tinnitus and mental health in conjunction with the ENT team, consistent with the growing body of clinical evidence. A/Prof Lakra explained that the cause of tinnitus or tinnitus-like concerns are better understood and can be multifactorial, and in some instances, there are proven clinical pathways to address or reduce these symptoms, including through psychological care.

Conclusion

77. I accept the conclusions of the CPU and consider that the care provided to Ms NXA at Northern Health was deficient in a number of respects, as outlined above.

78. However, it is clear that Northern Health is operating in a significantly different environment, particularly with respect to the mental health service it provides, compared with the service it offered in 2021. The considered response of A/Prof Lakra has highlighted critical changes to the ways in which medical and mental health teams operate, in order to promote better and more holistic patient outcomes. In those circumstances, I am satisfied that I do not need to make any recommendations to Northern Health.

79. This remains the case despite my initial concerns at the contradictory and cursory approach Northern Health appears to have taken to its internal review following Ms NXA's death vis-à-vis its correspondence to the Court prior to receipt of A/Prof Lakra's response.

80. As noted in other recent findings,[17] I take comfort that the new Serious Adverse Patient Safety Event (**SAPSE**) review process under the *Health Services Act 1988*, which has commenced

[17] *See for example* the Finding into Death Without Inquest of Ms YPM, COR 2020 2609, 16 October 2020, footnote 6, available here.

since Ms NXA's death, provides a clear and rigorous process for reviewing serious adverse patient safety events (such as Ms NXA's case), including their root causes, and a clear pathway to implementation of any recommendations flowing from the review. In light of the changes made since Ms NXA's death, I have not made comment or recommendations flowing from the response to the internal review conducted by Northern Health into the care provided to Ms NXA.

General Practitioner – Launceston Medical Centre

81. Ms NXA first consulted with her GP, Dr Hoki Smoak, at Launceston Medical Centre (**LMC**) in February 2021. She attended for both physical and mental health concerns. In the three months prior to her death, she was reviewed by Dr Smoak on seven occasions.

82. The medical records indicate that Dr Smoak inquired regarding Ms NXA's mental health at each consultation and Ms NXA was recorded as experiencing anxiety and depression. She described several psychosocial stressors over the course of her appointments with her GP, including family legal disputes, insomnia, social isolation, housing uncertainty, forensic issues, her father's ill-health, poor future prospects and distressing medical concerns including tinnitus and tachycardia. Ms NXA's level of distress specifically related to tinnitus appears to have fluctuated between "*bothered*" and "*intensely upsetting*".

83. The CPU opined that Dr Smoak appropriately treated Ms NXA's depression with escitalopram, insomnia with temazepam, and anxiety with diazepam in line with therapeutic guidelines. When her levels of stress became severe, Dr Smoak prescribed a higher dose of diazepam, however appropriately balanced this by employing harm minimisation strategies, instructing Ms NXA to only use this medication twice per week. Dr Smoak also carried out suicide risk assessments when Ms NXA reported heightened depressive symptoms, at which time she disclosed ongoing suicidal ideation without a plan. He engaged in collaborative safety planning with Ms NXA and facilitated psychological intervention through a mental health care plan. Dr Smoak also provided sound therapy (masking) strategies designed to ease Ms NXA's perception of her tinnitus and related distress, which is in line with published advice.

84. The CPU opined that the mental health care provided by Dr Smoak appeared to be appropriate and considered. There was evidence that he took significant time to listen to, validate and treat Ms NXA's presenting concerns, in line with treatment guidelines. The CPU opined that this represented high-quality mental health care.

Clinical psychologist – Dr Rachel McKenzie

85. Ms NXA first consulted with Dr McKenzie on 23 March 2021. She had seven telehealth appointments with her final appointment on 28 July 2021 and one additional phone call on 29 July 2021.

86. During her sessions, Ms NXA described several significant stressors, mostly related to her criminal and family legal matters. Her experience of childhood trauma also impacted her mental health, with Ms NXA reporting repeated sexual assault by her mother's partner. Dr McKenzie's impression was that Ms NXA was experiencing CPTSD and generalised anxiety disorder (**GAD**). Dr McKenzie established treatment goals to address Ms NXA's current stressors, while her legal matters were ongoing, before later addressing her experience of childhood sexual abuse.

87. The CPU noted that Dr McKenzie formulated an evidence-based and clinically appropriate treatment plan, utilising cognitive behavioural therapy strategies to address unhelpful thinking patterns, anxiety and stress, as well as anxiety management techniques. The CPU noted that Ms NXA's treatment plan was carried out as planned, and it was adapted to pressing stressors as they arose. Ms NXA's progress in therapy was appropriately monitored.

88. Dr McKenzie appropriately enquired about Ms NXA's current suicidal ideation during their sessions together. Ms NXA generally indicated that she was experiencing suicidal ideation without a plan or intent. However, she also stated on occasion that she would suicide if she received a custodial sentence or lost her driver's licence. During periods of high stress, Ms NXA's suicidal ideation increased.

89. This was particularly evident during the session on 28 July 2021 when Ms NXA stated, "*that she wanted the 'pain' to stop and that she could only see that happening if she killed herself*". The CPU opined that Dr McKenzie dealt with this situation skilfully, by calming Ms NXA and impressing upon her the impact of suicide. They undertook safety planning together and discussed several support options. Ms NXA stated that she would attempt suicide by police shooting or would like to the CATT if police or CATT were called. She also did not want to be admitted to a private hospital for inpatient treatment.

90. Dr McKenzie and Ms NXA reached an agreement, she agreed to contact Dr McKenzie, Lifeline or a friend if she felt overwhelmed and would use psychological strategies. They also agreed to speak via phone the next day. During that call, Ms NXA denied any current intent

to harm herself but reiterated that she would suicide if she received a custodial sentence. There were no further consultations booked after this date, as Ms NXA wanted to save her three remaining sessions under Medicare for the period leading up to her pending court dates.

91. The CPU concluded that the treatment provided by Dr McKenzie was appropriate and evidence based. When Ms NXA presented with heightened risk of suicide at times, Dr McKenzie appropriately considered her risk of suicide in addition to her risk of further traumatisation through police or CATT involvement and developed an effective safety plan. The CPU opined that the quality of mental health care provided by Dr McKenzie was of a high standard.

REVIEW OF FAMILY CONCERNS REGARDING POLICE CONTACT AND USE OF LEGAL SYSTEMS

92. As noted above, Mr EMB and Mr TBU both reported concerns regarding the various criminal, FVIO and family legal proceedings involving Ms NXA. They also reported concerns regarding the contact Ms NXA had with various members of Victoria Police.

Background

93. In 2006, Ms NXA's Family Succession Plan (**succession plan**) deed was executed by Mr EMB, Ms DLN, Mr QJF and his wife, Mr TWE and his wife, and Ms NXA. The LFSP dealt with the assets of Mr EMB and Ms DLN's marriage and provided an annuity to Mr EMB and Ms DLN. It involved the transfer of land, livestock, plant, equipment and other matters.

94. While it has been alleged that the LFSP was not upheld by some members of Ms NXA's family and funds have been misappropriated, it is not within the scope of my investigation to determine the validity of these claims. I only reference the succession plan to provide context to the concerns reported by Mr EMB and Mr TBU. Although it resolved shortly before her death, I am in informed that there were protracted legal proceedings on foot for several years in relation to the succession plan. Mr EMB and Mr TBU both alleged that these proceedings contributed to Ms NXA's decision to take her life.

95. In 2017, Mr EMB and Ms DLN separated. The first interim FVIO against Ms NXA was taken out in October 2017, to protect Mr QJF. Ms NXA reported concerns about the way this FVIO was served on her. Ms NXA also reported that she was repeatedly intercepted by police for breath tests during October and November 2017.

96. Police applied for an FVIO to protect Ms DLN with Ms NXA as the respondent in December 2017. The FVIO arose from an allegation that Ms NXA assaulted her mother, resulting in a criminal charge which was later withdrawn.

97. In May 2018, Ms NXA sought a Personal Safety Intervention Order (**PSIVO**) against a particular police member. This police member sought and obtained a PSIVO against Ms NXA in July 2018. In October 2018, Mr EMB called police with concerns about Ms NXA expressing suicidal ideation/self-harm. Ms NXA was transported to hospital, and Mr TBU reported that this welfare check caused further trauma to Ms NXA.

98. In 2019, Ms NXA's LEAP 'person warning flags' were updated to include 'vexatious litigant' and 'mental health/disorder history'. In February 2019, Ms NXA pleaded guilty to driving and FVIO offences. Mr QJF's wife obtained an FVIO against Ms NXA to protect her and her children in October 2019.

99. In January 2020, Mr TBU was appointed as Ms NXA's enduring power of attorney while she was admitted to a residential rehabilitation facility. In April 2020, police applied for an FVIO against Mr QJF to protect Ms NXA, which was later contested by Mr QJF. Ms NXA's LEAP warning flags were updated in June 2020 in relation to her risk of self-harm and suicidality. In July 2020, she called Triple Zero while intoxicated and threatened self-harm. This resulted in police attendance and a mental health transfer to hospital and was followed by a voluntary psychiatric admission. In December 2020, Ms NXA was allegedly assaulted by her brother, resulting in a police application for a FVIO to protect Ms NXA. The FVIO was revoked in April 2021.

100. Ms NXA moved to Tasmania in about February 2021. She travelled back to Victoria, however due to the COVID-19 restrictions in place, she was unable to return to Tasmania. Her family legal dispute was finalised in April 2021 with final consent orders made.

101. As there were concerns raised with some specific interactions between police and Ms NXA, I have detailed these further below.

23 April 2018

102. Mr QJF reportedly requested a welfare check on Ms NXA, resulting in a section 351 MHA transfer to hospital. Upon clarification with Victoria Police, there is no LEAP record of a mental health transfer occurring on this date. However, according to correspondence between

Mr EMB and a Sergeant of police, section 351 MHA was used to transfer Ms NXA to hospital. The information that prompted the welfare check was not available for review by the Court.

103. According to Mr TBU, police members attended Ms NXA's home due to welfare concerns raised by Mr QJF. Mr TBU alleged that the members "*pursued* Ms NXA through the home, would not leave when requested and "*threatened*" her with a psychiatric admission. Following this incident, Mr EMB asked police (in writing) that he be contacted first prior to police attending his daughter. There was no record of the police response to this request.

104. It is difficult to assess the reasonableness of the police members' actions, given the lack of information. However, in circumstances where the police contact was more than three years prior to Ms NXA's death, I am satisfied that the limits of the coronial jurisdiction militate against further investigation or consideration of this, as the incident is not sufficiently proximate to Ms NXA's death.[18]

30 April 2018

105. Mr QJF reportedly requested a welfare check on Ms NXA, however police left at Ms NXA's request. There is no LEAP record relating to this contact. Mr TBU's primary concern with this contact is that one of the members who attended had contact with Ms NXA in the past, and Ms NXA allegedly had difficulties with them.

106. Given that this welfare check was conducted in a regional part of Victoria, where there are limited police resources, it would not be unusual for a member to be allocated who has interacted with Ms NXA in the past. It might be impractical to ask police to ensure that the member tasked to complete a welfare check is not a particular member, based on prior interactions. This approach would also likely delay the police response, particularly in circumstances where there are fewer police resources, and this might have adverse outcomes in the case of a welfare check.

107. Based on the information available to the Court, it appears that police attended a welfare check and left without the need for any further action. I am satisfied that the limits of the coronial jurisdiction militate against further investigation or consideration of this, as the incident is not sufficiently proximate to Ms NXA's death.

[18] *See generally in this regard*, *Harmsworth v The State Coroner* [1989] VR 989.

2 May 2018

108. On this occasion, police arrested Ms NXA for allegations of family violence and reportedly used force to affect the arrest. Mr TBU alleged that the attending members forced entry to Ms NXA's home with their firearms drawn.

109. Mr TBU further alleged that Ms NXA was assaulted by police outside the police station and she was denied access to contact a lawyer. From the records available, it appears that Ms NXA spoke with her family's lawyer. The lawyer organised for Ms NXA's voluntary attendance at a police station in their company for an interview. Ms NXA participated in an interview and was later charged.

110. Mr EMB noted that he arranged for Ms NXA to see a GP on or about 4 May 2018. The GP noted bruises/injuries consistent with Ms NXA's version of events, however the GP also noted that Ms NXA refused to provide any account of what occurred, other than that she was "*assaulted*".

111. In the circumstances, it is difficult to ascertain if Ms NXA was assaulted or sustained injuries in the course of resisting police, or some combination of these actions. It appears that the assault allegation was referred for further investigation elsewhere in Victoria Police, however the outcome of same is not known.

112. I note that arresting and interviewing people in relation to allegations of family violence is consistent with Victoria Police's pro-arrest, pro-charge policy for family violence. Ultimately, I am satisfied that the limits of the coronial jurisdiction militate against further investigation or consideration of this issue, as the incident is not sufficiently proximate to Ms NXA's death.

8 June 2020

113. From the available evidence, it appears that police attended Ms NXA's home in relation to an outstanding matter and Ms NXA reportedly barricaded herself inside her car. There is a suggestion that police forced entry into her car to remove her from same. When Ms NXA was transported to the local police station, police observed superficial self-harm marks were noted to Ms NXA's wrists and she made statements to indicate that she would self-harm. According to the available police records, Ms NXA was transferred to hospital under section 351 MHA. It is not clear, however, what action was taken in relation to the outstanding matter that police that prompted police to originally attend.

114. Given Ms NXA's response to the police presence, the evidence of recent self-harm and her intent to self-harm again, it would appear the police response to transfer her to hospital was appropriate and reasonable in the circumstances. Ultimately, however, I am satisfied that the limits of the coronial jurisdiction militate against further investigation or consideration of this, as the incident is not sufficiently proximate to Ms NXA's death.

27 August 2020

115. On 27 August 2020, Ms NXA called a crisis hotline and indicated that she had self-harmed and was making ongoing attempts to take her life. The crisis hotline appropriately referred their concerns to police, who attended to perform a welfare check. Police noted upon arrival that Ms NXA was "*hysterical and abusive*", and she asked for a police gun to suicide. She was arrested (presumably by police) and paramedics provided sedatives prior to transferring her to hospital. The available information suggests this welfare check was performed in accordance with relevant Victoria Police guidelines and the MHA.

Conclusion

116. Having reviewed all of the available evidence, it appears that Ms NXA's mental health deteriorated in the years prior to her passing and this deterioration occurred in the context of several interrelated issues. This included the ongoing dispute over the succession plan, family estrangement and contacts with police and the criminal justice system. However, Ms NXA also had a range of other psychosocial stressors that contributed to her deteriorating mental health including her trauma history, the poor health of one of her daughters, her father's poor health, her alcohol dependence and her ongoing issues with tinnitus. It also appears that she was physically isolated from two of her primary supporters, Mr EMB and Mr TBU, which was exacerbated by the COVID-19 lockdowns in place at various times during 2020 and 2021.

117. I acknowledge the strong views of some of Ms NXA's family members that her contact with police and the legal system constituted significant stressors in the lead-up to her death and that each of these instances require investigation as part of my examination of the circumstances of Ms NXA's death. While I am grateful for the issues being highlighted, I am simultaneously conscious of the limits of my jurisdiction. I consider that these issues are not sufficiently proximate to or causal of Ms NXA's death in August 2021 and have determined that further investigation or consideration of the incidents would not be appropriate or within power.

FINDINGS AND CONCLUSION

118. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:

    a) the identity of the deceased was Ms NXA, born [redacted] 1966;

    b) the death occurred on 11 August 2021 at [redacted] Victoria, [redacted], from *neck compression secondary to hanging*; and

    c) the death occurred in the circumstances described above.

119. Having considered all of the circumstances, I am satisfied that Ms NXA intentionally took her own life. I note the significant and pervasive mental health conditions that she suffered for many years prior to her passing, including chronic suicidal ideation and suicide attempts. Ms NXA experienced several significant psychosocial stressors in the years prior to her death, including protracted legal proceedings, however the evidence supports that the primary stressors at the time of her death were her distress at her tinnitus and her increasing social isolation while Mr EMB was in hospital.

COMMENTS

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

120. Although Coroner Gebert's finding into the death of Kent Thomas[19] is now more than four years old, her Honour's analysis is relevant:

> *Seventeen cases have been identified since 2009 in which tinnitus related distress was directly linked to the deceased's decision to suicide and several other cases were identified in which tinnitus was diagnosed but insufficient information was available to clearly link the decision to suicide to tinnitus related distress. All 17 cases in which the deceased's decision to suicide was influenced by their experience of tinnitus distress were male and 15 were aged 45 years or over. In multiple cases, the deceased had no or minimal mental health history prior to the onset of tinnitus.*

121. Although Ms NXA did have a significant mental health history and was female, it was evident from her recent hospital admission that her experience of tinnitus had a significant impact on her wellbeing and mental health. As her Honour stated in *Thomas*:

[19] Finding into death without inquest – Kent Thomas (COR 2018 6168).

Cases investigated have demonstrated the high importance of early intervention for tinnitus related distress and a need to raise awareness of the significant impact and distress that tinnitus can cause.

122. Ms NXA's case demonstrates not only the importance of the potential impacts of tinnitus-related distress but also of the need for holistic care that treats the 'whole person' and does not artificially bifurcate treatment pathways for what clinicians identify as 'medical' versus 'mental health' issues.

123. I cannot now determine that any deficiencies in the treatment Ms NXA received would have amounted to a prevention opportunity long-term, however, I am satisfied that there were several missed opportunities to provide Ms NXA with appropriate health care and supports that may have prevented her death in the immediate short-term.

124. Certain of these missed opportunities relate to appropriate and holistic risk assessment, safety and discharge planning, as outlined by the CPU above. I have recently addressed the broader landscape in which these issues arise by way of comment in other findings, which I will not rehearse here.[20] I simply note their relevance to Ms NXA's case, given she was discharged from hospital while expressing an intent and plan to suicide.

125. While recognising that the broader issues of risk assessment, coordination of care and safety planning are key, there is one discrete tinnitus-related recommendation proposed to me by the CPU that flows from Ms NXA's case, that I shall now make in an effort to promote better awareness amongst psychiatrists of the potential effects of tinnitus-related distress.

RECOMMENDATIONS

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

(i) That the Royal Australian and New Zealand College of Psychiatrists promote awareness to its members of the significant psychosocial impacts of tinnitus and tinnitus-related distress, including the risk of suicide.

[20] *See for example* the Finding into Death Without Inquest of Ms YPM, COR 2020 2609, 16 October 2020, available here. In particular, I consider that, in 2026, there are now additional and better resources for clinicians conducting mental health risk assessments in the context of new mental health legislation, such as the Office of the Chief Psychiatrist's '*White paper: On the principles of mental health risk assessment*', released in October 2024, the purpose of which is to assist mental health practitioners in conducting risk assessments, noted therein to be '*a foundation skill for all mental health clinical practice*'. 'Risks' are defined to include self-harm, suicide, misadventure or risks to other people or the community

ACKNOWLEDGEMENTS

I convey my sincere condolences to Ms NXA's loved ones for their profound loss. I acknowledge their participation in the coronial investigation over many years and express my thanks for their significant contributions to the same. Ms NXA will be remembered by those who loved and cared for her, not as the product of her struggles, but as someone who possessed an innate sense of social justice, joy, and care for the environment and the planet.

ORDERS AND DIRECTIONS

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

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

Ms CLX, Senior Next of Kin

Melbourne Health

Northern Health

Dr Hoki Smoak, GP

Dr Rachel McKenzie, Psychologist

Royal Australian and New Zealand College of Psychiatrists

Senior Constable Declan Fietz, Coronial Investigator

Signature:

INGRID GILES

CORONER

Date: 15 January 2026

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