CITATION: *Inquest into the death of Sabrina Josephine Di Lembo* [2018] NTLC 028

TITLE OF COURT:	Coroners Court
JURISDICTION:	Darwin
FILE NO(s):	D0136/2017
DELIVERED ON:	3 December 2018
DELIVERED AT:	Darwin
HEARING DATE(s):	23 – 25 October 2018
FINDING OF:	Judge Greg Cavanagh
CATCHWORDS:	**Anxiety, young woman, suicide, NT Mental Health Service, General Practitioners, no adequate history or assessment, no coordinated care, no referral by GP to psychiatrist**
REPRESENTATION:	
Counsel Assisting:	Kelvin Currie
Counsel for Top End Health Service:	Stephanie Williams
Counsel for Dr Britz:	Peter Mariotto
Counsel for Dr Chapman:	Miles Crawley SC
Counsel for the Di Lembo family:	Matthew Littlejohn
Judgment category classification:	B
Judgement ID number:	[2018] NTLC 028
Number of paragraphs:	114
Number of pages:	34

IN THE CORONERS COURT
AT DARWIN IN THE NORTHERN
TERRITORY OF AUSTRALIA

No. 136/2017

In the matter of an Inquest into the death of

SABRINA JOSEPHINE DI LEMBO
ON 7 AUGUST 2017
AT PARAP

FINDINGS

Judge Greg Cavanagh

Introduction

1. Sabrina Josephine Di Lembo was born in Darwin on 5 May 1998 to Michael and Lidia Di Lembo. She had two older brothers, Joshua and Anthony.

2. Her history was provided during the course of the inquest by her family in these terms:

> "Sabrina was our third child, after having two sons, Anthony and Joshua. Sabrina was cherished, loved and adored by all her family, immediate and extended. She had a happy and normal childhood. Although not outgoing, she was looked up to by her friends and elected captain of her sports team in primary school, even though she wasn't the sporty type, and she received the Thomas Lubi Award which is only give to one student at St Paul's Primary in her final year.
>
> She led a normal young life playing basketball, learning the piano and did calisthenics. She eventually grew to enjoy the gym and walking with us or her friends. After completing year 12 at Darwin High in 2015, Sabrina enrolled in a Bachelor of Laws at Charles Darwin University and was awarded the pro vice chancellor scholarship granted to only two students. Sabrina was ecstatic and we were all so proud of her achievements.
>
> Sabrina not only wanted to do well throughout her years in school and university, she was a dedicated student and pushed herself to excel. In fact, her brothers would often tell Sabrina to not study so

hard and that if she got a pass for a subject it was okay, speaking from their own experience.

Sabrina also worked as a casual employee at a number of businesses with her last job being with BreastScreen NT where she was highly regarded and respected by her work colleagues.

Sabrina was a serious but witty young woman who got on well with everyone. Her close friends who are absolutely devastated at losing their confidante and mother hen, they spent several holidays together and often caught up for coffee and lunch. Sabrina was very caring, affectionate, loyal, grounded and dedicated to whatever she put her mind to. She had so much going for her and had planned her life to work as a lawyer. She certainly knew how to mount a good argument having had a lot of experience sparring at home with her brothers and us."

3. In her second year of university (2017), toward the end of the first semester, she had an assignment and two exams approaching. The exams were on 6 and 9 June and the assignment was due on 12 June 2017. During May she studied hard, often into the early hours of the morning.

4. In the last week of May 2017 she became anxious. She couldn't sleep. She started having panic attacks three or four times a day. Her mother was away at the time. Sabrina rang her frequently for advice and support and it was arranged that her father would take her to see a General Practitioner (GP).

5. She saw a GP on 30 May 2017. She told the GP that she couldn't physically cope anymore. The GP gave her a medical certificate to assist in deferring her exams. The certificate stated: "She currently does not have the physical or mental capacity to complete these assessments at this time". The GP also provided her Restavit to help her sleep.

6. Mrs Di Lembo returned shortly thereafter and found that her daughter was still very anxious. Sabrina wanted to talk about her issues constantly, even through the night. Her mother was so concerned she slept in Sabrina's room.

7. Sabrina saw the same GP again on 2 June 2017 in the company of her mother. Sabrina told the GP that her exams had been deferred, that she was sleeping and that her panic attacks had ceased. The GP provided a medical certificate to facilitate her mother taking carer's leave to help Sabrina cope.

8. However, Sabrina continued to be extremely anxious and five days later, on 7 June 2017, her mother contacted the Access Team of Top End Mental Health Service (Mental Health Service) by telephone. She said that Sabrina had already been to a GP on two occasions in the last week. She said Sabrina was having difficulty focusing and seemed completely overwhelmed. She said she was "spiralling". She said Sabrina couldn't control her thoughts and felt she couldn't continue anymore.

9. The mental health clinician also spoke to Sabrina during that telephone call. Sabrina said she was due to commence a work placement in a week and a half and was panicking about it. Sabrina's biggest fear was that she would not be "normal", that she wouldn't be "switched on". When asked, Sabrina denied having thoughts of self-harm.

10. The mental health clinician asked for Sabrina's email address and sent to her information to do with anxiety, depression and suicide. The clinician said Sabrina's issues were not acute and could be managed by a GP. The clinician suggested that Sabrina be taken to see Dr Britz at the Tristar Medical Centre in Parap.

11. Less than two hours later at 12.26pm Sabrina and her parents attended on Dr Britz. The medical notes relating to that visit were as follows:

> **Visit Type:**
> Surgery Consultation
> **Reason for contact:**
> Anxiety

new onset anxiety
struggling with uni
struggling with everything
not suicidal

appointment with easa next week
deferred assignments

Management:
trial of efexor
trial of low dose valium
long discussion on management
review on tuesday

Actions:
Prescriptions added: EFEXOR-XR SR CAPSULE 37.5mg 1 daily
Prescription added: VALIUM TABLET 2mg 1 b.d.

Medicare Item:
44[1]

12. Dr Britz indicated in evidence that on that day Sabrina was acutely unwell. She thought looking back that she should have referred her to a psychiatrist and that if she had known about the previous two consultations with another GP in the last week she would most certainly have done so.

13. Dr Britz told Sabrina that it would take some weeks before she experienced the full benefit of the anti-depressant (Efexor).[2] The

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1. The explanation of Medicare Item 44 is in these terms:

> **Item 44:** Professional attendance by a general practitioner (not being a service to which any other item in this table applies) lasting at least 40 minutes, including any of the following that are clinically relevant:
>
> a) taking an extensive patient history;
> b) performing a clinical examination;
> c) arranging any necessary investigation;
> d) implementing a management plan;
> e) providing appropriate preventive health care;
>
> in relation to one or more health-related issues, with appropriate documentation.

[2] Otherwise known as Venlafaxine.

following day Sabrina was taken by her mother to see a psychologist at EASA (a counselling service). There followed another five sessions.

14. On 13 June 2017 at 9.07am Sabrina and her mother saw Dr Britz once more. The notes of that consultation are in the following terms:

> **Visit Type:**
> Surgery Consultation
>
> **Reason for contact:**
> Review
>
> presents for review
> better than last week
> feels that the Valium makes her spacy
> advised to take just as needed
>
> planning better
> still looking for uni options
> not sure about work
> will think about this more this week
>
> history of heavy cycles
> has had bloods and such done
> not on contraception to help manage these
> would like a certificate for her mother to be off with her this week
>
> **Management:**
> certificate done
> continue current medication
> valium prn only
> referred for uss
> review with results on friday
>
> **Actions:**
> Diagnostic Imaging requested: US – Pelvis (F)
> Letter Created – re. Certificate – parental leave to .
> Letter Printed – re. Certificate – parental leave to .
>
> **Medicare Item:**
> 36[3]

[3] The explanation of Medicare Item 36 is similar to Item 44 however for a shorter period of time. It is in these terms:

15. Of prescribing the anti-depressant Efexor Doctor Britz said: “She didn't appear resistant to trialling medication. I think she was quite keen to stop the symptoms that she was suffering”.[4]

16. Three days later on 16 June 2017 Sabrina and her mother saw Doctor Britz again. The notes of the consultation are in the following terms:

> **Visit Type**
> Surgery Consultation
>
> notes completed from visit today
> really not sure how things are going
> distressed more because she is unsure about what is going on
>
> supposed to be doing a work program over the semester break
> associated with a scholarship
> not sure if she is fit to start this
> in 2 minds whether she will go to the orientation next week or not
>
> her mother has been off with her
> needs medical certificate for this
> mother unsure if they should go away or look at a retreat or something
> pt in 2 minds about this as well
>
> **Management**
> certificate given
> certificate for mother given

> **Item 36:** Professional attendance by a general practitioner at consulting rooms (other than a service to which another item in the table applies), lasting at least 20 minutes and including any of the following that are clinically relevant:
>
> a) taking a detailed patient history;
> b) performing a clinical examination;
> c) arranging any necessary investigation;
> d) implementing a management plan;
> e) providing appropriate preventive health care;
>
> for one or more health-related issues, with appropriate documentation-each attendance.

[4] Transcript p 15

given another script of low dose efexor as I will be away
discussed services available whilst I am away
discussed general management
to continue with psychologist

Actions
Letter Created – re. Certificate – Time off medical reasons to .
Letter Printed - re. Certificate – Time off medical reasons to .
Letter Created – re. amended medical certificate to .
Letter Printed - re. amended medical certificate to .
Prescriptions printed:
EFEXOR–XR SR CAPSULE 37.5mg 1 daily

Medical Item:
44

17. At that point in time Dr Britz had seen Sabrina on three occasions in the space of 10 days. Sabrina was not improving. Dr Britz had not taken a detailed history, she had not taken adequate notes of her consultations and she had not administered any assessment tools (such as the K10 or DASS). The diagnosis and the severity of Sabrina's symptoms remained unknown.

18. The compounding feature was that the minimum recommended dose of Efexor is 75 milligrams. That is plainly stated on the information that accompanies the medication. As such, the therapeutic effect (making her more relaxed and less anxious)[5] for which Sabrina and her family were waiting was unlikely to eventuate while on 37.5mg.

19. On 19 June 2017 a mental health clinician from the Mental Health Service contacted Mrs Di Lembo. The clinician was told that Dr Britz had commenced Sabrina on Efexor 37.5mg and low dose Valium. Mrs Di Lembo said a friend, who was also a psychiatrist, had suggested to her that the anti-depressant Escitalopram and cognitive behaviour therapy may be better. The mental health clinician told Mrs Di Lembo she would

[5] Transcript p 15

need to talk to the GP or see a private psychiatrist. The clinician then spoke to Sabrina. She sounded tired. Her delivery was "monotonous, flat". She said she had lost interest in normal past-times and couldn't be bothered taking care of herself.

20. The following day her case was discussed by the Top End Mental Health morning clinical review multi-disciplinary team. It was noted that Sabrina had been commenced on Efexor 37.5mg.

21. On Sunday, 25 June 2017 a mental health clinician from Mental Health Service called and spoke to Mrs Di Lembo again. Mrs Di Lembo confirmed that Sabrina was not improving. She said Sabrina was losing hope of improving. Mrs Di Lembo asked when there would be a change. The clinician told her that the medication needed time to take effect.

22. Mrs Di Lembo asked about the possibility of trying a different medication. She was told that she was better off discussing that with Dr Britz. The clinician said that if Dr Britz needed to discuss that with the psychiatrist she could do so. Mrs Di Lembo said she wanted feedback from the psychiatrist.

23. The clinician passed that request on by email to Dr David Chapman, the psychiatrist in charge of the Access Team. Dr Chapman replied in the following terms:

> "What dose is she on currently? If 37.5mg then increase immediately to 75mg and stay on that for 1 week then increase to 112.5mg until review by Dr Britz. Tell mum to stop trying to be a doctor.
>
> If she is having trouble sleeping then mirtazapine 7.5mg nocte as required.
>
> No one seems to have asked about family history."

24. Mrs Di Lembo was trying her best to find a way to engage with the medical profession to relieve her daughter of the suffering she was experiencing. At that point in time she was attempting to resolve the

continuing deterioration of her daughter's health with the information that she may do better with different medication and therapy. In my view the suggestion by Dr Chapman, that Mrs Di Lembo be told to "stop trying to be a doctor", at best, showed a significant lack of empathy.

25. The mental health clinician called Mrs Di Lembo to tell her of Dr Chapman's recommendations. However she was not told that 37.5mg was a sub-therapeutic dose. It was not explained that increasing it to 75mg was simply raising the dose to the minimum recommended level. Mrs Di Lembo said she was hesitant about the increase and did not think Sabrina would be happy to increase the medication.

26. Four days later on 30 June 2017 Mrs Di Lembo called the Mental Health Service. She said they were concerned that Sabrina was being over-medicated. It is likely that Sabrina and her parents attributed her deteriorating condition to the medication. Mrs Di Lembo asked to talk to Dr Chapman. He refused to talk to her, saying he could not do so because Sabrina was an adult. He said she should speak to a GP.

27. That afternoon (30 June), Sabrina and both her parents went to the Tristar Medical Group at which Dr Britz practiced. Dr Britz was on holidays. They saw Dr Bernard Westley, the senior doctor and Medical Director of the Tristar practice in the Top End. Into the medical notes Dr Westley copied an email from the Top End Health Service that had been received the day before. It relevantly stated:

> "Sabrina is a Law Student and resides with her family and has developed depressive and anxious symptoms that are quite disruptive and ruminative thinking and middle insomnia, tiredness, lethargy, low mood and poor concentration.
>
> Dr Chapman makes the following suggestion for her treatment planning: "if only on Efexor 37.5mg then increase immediately to 75mg and stay on that for 1 week then increase to 112.5 until review by Dr Britz. If she is having trouble sleeping then mirtazapine 7.5mg nocte as required."

28. The medical notes taken by Dr Westley on that occasion are in the following terms:

> Update in setting of significant stressor, involvement with TEMHS and Dr Britz.
> Collateral history from Dad.
> No suicidal ideation stated.
> Wanting to minimise medications
>
> **Management:**
> Continue Efexor 75mg (when script due)
> Nil further medications
> Supp Counselling/MI approach
> Crisis management: Speak to parents, speak to aunty, reach for social interaction with mates, go for a walk, call Lifeline/MHAT
> Review next week (Wed/Thurs)
>
> **Actions:**
> Prescription added: EFEXOR-XR SR CAPSULE 75mg 75mg once daily
> EFEXOR_XR SR CAPSULE 37.5mg ceased. Reason for cessation – Completed without problems
> Prescriptions printed:
> EFEXOR-XR SR CAPSULE 75mg 75mg once daily
>
> **Medicare item:**
> 2713[6]

29. Doctor Westley said that his use of the word "continue" in the sentence "continue Efexor 75mg (when Script due)" meant that she was already on 75mg at that point in time. However that evidence is in conflict with the

[6] The explanation of Medicare Item 2713 is in these terms:

> **Item 2713:** Professional attendance by a general practitioner in relation to a mental disorder and of at least 20 minutes in duration, involving taking relevant history and identifying the presenting problem (to the extent not previously recorded), providing treatment and advice and, if appropriate, referral for other services or treatments, and documenting the outcomes of the consultation.

evidence of Dr Britz and Sabrina's parents. To that point in time Sabrina had been taking 37.5mg a day.

30. On 6 July 2017, Sabrina and her parents returned to see Dr Westley. The notes of that consultation are in these terms:

> **Visit type:**
> Surgery Consultation
>
> Sabrina describes deterioration in mood recent days. Has ceased Efexor 75mg in morning (last 2 days). Suicidal ideation recently, no clear plan. Able to action crisis plan through parents and engaging friends.
> Feeling shaky, yawning, reduced energy, concentration pressure.
>
> **Reason for contact:**
> depression with anxiety
>
> **Management:**
> Agreed to:
> (a) Continue Psychology (next Wednesday)
> (b) Cease Efexor
> (c) Nil other medication
> (d) Continue Body Balance at 7pm tonight
> (e) Review for holistic care tomorrow (include review for US and gynaecology topics tomorrow).
>
> **Medicare item:**
> 36

31. Sabrina's parents said that in the course of the consultation Dr Westley commented that if he had commenced the treatment of Sabrina he would not have prescribed Efexor. Mrs Di Lembo then sought advice as to whether they should seek the assistance of a psychiatrist. Dr Westley seemed dismissive in saying: "if you have $700 an hour to spend I can give you the name of one in Palmerston".

32. They thought the consultation ended awkwardly with Dr Westley reprimanding Sabrina for missing an appointment the day before. They

did not take up the offer of another appointment and waited for the return of Dr Britz.

33. At that point in time Sabrina had been seen by a General Practitioner at the Tristar Group on five occasions in one month. A detailed history had not been taken, the notes of her consultations remained inadequate and no assessment tools had been utilised to assist in diagnosis or gauging the severity of her symptoms.

34. During that period the psychiatrist in the Access Team at the Mental Health Service had made a recommendation to the Tristar practice about increasing the dose of Sabrina's medication. That had happened and Sabrina had taken the increased dosage for at least four days. However, in the context of worsening symptoms including having suicidal ideations she stopped taking the medication. Doctor Westley agreed with that course. However he did not provide other options. He did not provide any other form of treatment for her symptoms. He simply confirmed what she was already doing as a management plan.

35. Perhaps more importantly, he did not communicate with Dr Chapman at the Mental Health Service that the recommendations provided in the email to him were not being adopted and that Sabrina had stopped taking Efexor altogether. That became the subject of comment by one of the expert psychiatrists that provided reports in relation to the management of Sabrina. Dr Olav Nielssen said:

> "In retrospect, Dr Chapman was clearly correct to recommend increasing the dose of venlafaxine [Efexor] toward an effective level, and the tragedy is that Ms Di Lembo stopped taking the medication in the weeks before her suicide, before it could take effect."

36. Dr Westley conceded that he should have contacted the Mental Health Service for further guidance in relation to the treatment of Sabrina at that point in time.[7]

37. The experience of Sabrina was that after being on Efexor for a month she was deteriorating. She had taken Efexor on advice that it would remove her anxiety and allow her to continue her studies. However, rather than experiencing improvement she was experiencing deterioration. Her parents were deeply concerned.

38. On 12 July 2017, after the return of Dr Britz, Sabrina and her parents went to see her. The notes of that consultation are in the following terms:

> **Visit Type**
> Surgery Consultation
>
> **Reason for Contact**
> Review
>
> presents for review
> things not good whilst I was not here
> has stopped medication
> changed to louise page at easa
> feels that this is working well
>
> has decided to defer next semester
> not sure how she feels about this
> states she doesn't care
>
> was out on weekend
> then crashed
> concerned that there is something organic going on
>
> would like a referral to dr mitchell about her periods
>
> **Management:**
> referred to jenny mitchell
> continue with psychologist
> review as needed

[7] Submission by Dr Westley dated 31 October 2018

Actions:
Letter Created – re. Standard Referral Letter to DR JENNY MITCHELL
Letter Printed – re. Standard Referral Letter to DR JENNY MITCHELL

Medicare item:
44

39. That was the sixth and final interaction by the General Practitioners at Tristar Group with Sabrina and her parents. The continued belief that there was an organic issue was likely to be related to the fact that they had tried anti-depressant medication that had not assisted.

40. Doctor Britz said at that consultation Sabrina and her parents were resistant to trialling other medication because of their belief that Sabrina had a reaction to the Efexor. That is again likely to have been due to a belief that the deterioration in her mental state was due to the medication. That same belief also seems to have been adopted by Dr Britz:

> "At the time we did discuss further medication and Ms Di Lembo was quite resistant to trialling anything further as she'd had reactions to the medication I had prescribed. This is not uncommon."[8]

41. The adoption by Dr Britz of that explanation is likely to be at least in part because she was unaware that the dose that she had prescribed was sub-therapeutic. It was not until shortly before the commencement of the inquest that she became aware of that fact. During the course of her evidence she sought to defend the decision of dosage on the basis that Sabrina was "of slight stature". However when it was pointed out that Sabrina was 70 kilograms she conceded that the dose should have been the normal recommended dose.[9]

42. However, after that consultation there was no further contact between Dr Britz and Sabrina or her family. Dr Britz told me that on the way out of

[8] Transcript p 23
[9] Transcript p 28

the premises there was an appointment made in two days' time. However there is no other evidence of that being the case. Dr Britz did not seek to contact the psychologist involved in the treatment of Sabrina or the Mental Health Service.

43. That same day (12 July) Sabrina saw the psychologist at EASA. It was recorded that she was "very distressed no longer able to push self to get done – trauma of identity".

44. Also on that afternoon at 2.19pm a mental health clinician from the Mental Health Service called. Sabrina told the clinician that she had "seen Dr Britz and they have decided to cease the medication". She said the psychologist had been very helpful. The clinician made the following note about that phone call:

> "No pressure or poverty of speech and normal rate and volume. Polite and engaging. States that she has been working on being clearer in her thinking and mood improved. Future focused and says that she has improved since cessation of medication."

45. The plan by the mental health clinician was to close the file. The clinician did not communicate with Dr Britz or the psychologist. Dr Chapman confirmed the closure of the file six days later.

46. There was one more contact with the psychologist on 26 July 2017. Sabrina seemed to be improving at that consultation although it was recorded: "a lot of philosophising and past regretting and then fear of future".

47. Sabrina said to her father:

> "I've got this for life … if I can crumble over two stupid exams, what about when I get married and I have kids, you're going to be worried for me for the rest of your life".

48. To her parents, Sabrina seemed to improve somewhat. Her mother continued to sleep in her room, but Sabrina was making some effort to

reconnect with friends, she was going to the gym and she made arrangements to go with her friends to the Darwin Cup on 7 August 2017.

49. The night before the Cup Sabrina was concerned about what she would wear, particularly the fascinator. She was still trying different fascinators at midnight.

50. At 1.30am her mother went to Sabrina's room. Sabrina was sitting at her desk. When her mother entered her room she jumped up as if she didn't want her mother to see what she was doing. She put on another fascinator. She told her mother to go to bed, that she was fine. Her mother said goodnight. Sabrina hugged her and told her she loved her. It was the first time in over two months her mother did not sleep in her room.

51. By 10.00am Sabrina hadn't been seen. Her bathroom door was locked. When her mother opened the door she found Sabrina hanging from the fan by a length of rope. There was a note in her daily journal. It said in part:

> "It all makes sense to me. It's better that I am a memory to move on from than a constant worry for the rest of their lives. I have to go and hope one day I will be forgiven … it's all my fault everyone has done the best they can".

Issues

52. A number of expert reports were obtained and tendered in evidence during the inquest. The issues raised included:

    a. The failure of the Mental Health Service to take a detailed history and undertake a proper assessment, including a face to face assessment with Sabrina;

    b. The failure of the psychiatrist to speak with Mrs Di Lembo;

    c. The failure of the GPs to take a detailed history and undertake a proper assessment;

d. The failure to use assessment tools such as K10, GAD7, DASS to assist in gauging the severity of the symptoms and to assist with diagnosis;

e. The failure to make a diagnosis;

f. The failure to take appropriate notes;

g. The failure to prescribe a therapeutic dose of Efexor;

h. The failure to undertake a review of Sabrina after her stopping taking the anti-despressant;

i. The failure of both GPs to refer Sabrina to a psychiatrist; and

j. The failure to coordinate the care of Sabrina.

53. During the last nine weeks of her life Sabrina had seen or spoken to medical providers over the phone on 17 occasions. Her mother had more than 20 interactions with the medical providers.

54. During that period no adequate detailed history was taken. At no time was she properly assessed. At no time was she asked to undertake formal testing to assist in determining the severity of her symptoms or diagnosis. At no time was she appropriately diagnosed.

55. After her death expert psychiatrists suggested possible diagnoses. Two experts were of the opinion that she suffered from melancholic depression. A third psychiatrist thought she had an anxiety disorder. However they did not have the benefit of an adequate history or assessment in forming those opinions.

56. What is abundantly clear is that during the course of those nine weeks no person at the Mental Health Service set eyes on either Sabrina or her mother and the General Practitioners did not take the time to make an

appropriate assessment or refer her to the Mental Health Service or a private psychiatrist for that purpose.

Notetaking

57. The notetaking by the health practitioners was and was conceded to be very poor.

58. Dr Britz said:

> "I concede that my note-taking, note-keeping is quite poor. It's not up to the standard that you would expect for a written psychological assessment and it is something that I have endeavoured to improve on".[10]

59. Dr Westley didn't think the notes of Dr Britz were adequate.[11] He conceded his own notes were also lacking:

> "… unfortunately and clearly, I should have written much more regarding the nature of the consultation"[12].

60. When asked about the level of detail (specifically whether he should have recorded the dosage of Efexor Sabrina was on prior to the consultation), Dr Westley said:

> "If I sought to get that level of information on every single patient I would only be able to see five patients a day".[13]

61. If that is the case, I encourage Dr Westley to reconsider his priorities and the manner in which he conducts his practice.

[10] Transcript p 14
[11] Transcript p 41
[12] Transcript p 42
[13] Transcript p 47

Lack of Transparency about Level of Training

62. Any person can look up the status of Health Practitioners on the Australian Health Practitioners Regulation Agency (AHPRA) website. The entry for Dr Britz next to "Registration type" is "General".

63. What is not so intuitive is that to have a provider number to access Medicare a General Practitioner needs to be a specialist General Practitioner or part of a training scheme to obtain that specialty. If that specialty is obtained the AHPRA website will list a further "Registration type" as "Specialist".

64. That in effect indicates that the doctor has successfully completed their examinations to become a fellow of either the Royal Australian College of General Practitioners (RACGP) or the Australian College of Rural and Remote Medicine (ACRRM).

65. There is no readily available information of the status of a doctor's progression in training prior to obtaining the specialisation. There are, it seems, a considerable number of pathways and programs to assist doctors in completing that specialisation. They form a maze that is not easy to navigate.

66. The relevance is that it was not until the first day of the inquest that the parents of Sabrina were aware that Dr Britz did not have fellowship of either of the Colleges. It was the first time that they were aware that Dr Britz had not been able to pass her examinations on at least five occasions to obtain the "Specialist" label.

67. Doctor Britz indicated that she was a "Registrar GP" and has been since 2009. That she was a "Registrar" rather than a specialist General Practitioner was not known to Mr and Mrs Di Lembo when they accepted the recommendation of the Mental Health Service to change their GP and

consult Dr Britz. It was not known to them during the consultations with Dr Britz.

The Responses

Dr Kara Britz

68. Doctor Britz indicated that she is a "General Practitioner in training". She entered the training program in 2009 and said that she is a "GP registrar in the Rural Locum Relief Program". She said she no longer needed direct supervision but had a mentor with whom she spoke. Doctor Britz said she had an interest in mental health.

69. Dr Britz conceded that she should have taken a detailed history, that she should have used common assessment tools such as the K10 or DASS and that her consultation notes were very poor. She said most of the information she provided was from her memory.

70. She said that had she known that when Sabrina saw her on 7 June 2017 she had already seen another GP about her mental health on two occasions she would have referred her to the Access Team of the Mental Health Service (MHAT). She said that was preferable because in her experience patients are seen a lot sooner that way than if referred to a private psychiatrist. She said that she accepted that the dose of Efexor prescribed was sub-therapeutic.

71. Dr Britz said she had made significant changes to her practice since the death of Sabrina.

Dr Bernard Westley

72. The only medical provider that didn't provide a response prior to the inquest was Dr Westley. Nor did he attend the inquest in response to the Summons served upon him until after I provided him with the invitation to either attend of his own volition or be brought in by the Police.

73. One of the experts, Dr James Lynch, was of the opinion that Sabrina "required treatment which was outside the scope that a general practitioner could have provided. She required urgent specialist intervention by a psychiatrist." Dr Westley was asked about that opinion:

> Q. I think what this witness [Dr Lynch] is suggesting is that you should have referred her to a psychiatrist?
>
> A. In urban Melbourne that would be excellent advice. I would disagree with that advice in Darwin or in any NT area.

74. That was in contrast to the evidence of Dr Britz who conceded that she should have referred Sabrina to the Mental Health Team after the first consultation.

75. However in later correspondence Dr Westley wrote about his attendance on Sabrina on 6 July 2017 in these terms:

> "I did not see a need to refer Sabrina back to the MHAT that day as I confirmed that she intended to again see her psychologist the following week. However, with hindsight it would have been wise for me to contact the MHAT that day for guidance."[14]

Dr David Chapman

76. Dr Chapman provided two statements. The first was filed on 15 October 2018. In that there were few concessions made. However, having listened to the evidence on 23 October 2018, Dr Chapman provided a supplementary statement. In the second paragraph of that statement he said:

> "I regret that my refusal to speak to Lidia has caused her and her family distress. I apologise. I acknowledge I should have made the

[14] Submission dated 31 October 2018, paragraph 7

effort to find the time to speak to Lidia or more particularly Sabrina."

77. Dr Chapman agreed that there should have been more engagement of the Mental Health Service Access Team after contact was made on 7 June 2017. He said he was away on that day but that a clinician should have seen Sabrina face-to-face. He considered that depending on the recommendation of the clinician he could then have personally seen Sabrina on his return. Dr Chapman apologised to the family of Sabrina for that not happening.[15]

78. He accepted that given the interactions of the Mental Health Service with the Di Lembo family that it was reasonable for them to have the view that the Mental Health Service was assisting in the care and treatment of Sabrina.[16]

79. Dr Chapman agreed that there was no coordination of Sabrina's care. He thought that the primary responsibility lay with the General Practitioners however he accepted that the involvement of the Mental Health Service should not have been terminated without obtaining notes of at least the last attendances by Sabrina on the other providers.

80. He accepted that if that had occurred the file would not have been closed and it is likely that a face-to-face consultation would have been had with Sabrina at that point. He said that he would institute a procedure to ensure that happened in all cases prior to closure.

Top End Health Service

81. The response for the Top End Health Service was provided by Mr Richard Campion the General Manager for Top End Mental Health and Alcohol and Other Drugs.

[15] Supplementary statement, paragraph 3
[16] Transcript p 112

82. Mr Campion indicated in his response that opportunities were missed for Sabrina to be provided with a face-to-face assessment. He was of the opinion that if the opportunities had not been missed the family would have "experienced much easier pathways to the relevant support and advice". He believed that with the changes made since the death of Sabrina, a person in similar circumstances would now receive a face-to-face assessment.

83. He indicated that there were a plethora of policy reviews and changes. On that point the following exchange took place:

> Coroner: Policies are worth nothing unless they're enforced, aren't they?
>
> Campion: That's right, your Honour, I agree fully.
>
> Coroner: And one of the ways to get them enforced is to do regular audits so you can slap people who aren't following the policies?
>
> Campion: That's right, your Honour.
>
> Coroner: And you're going to be doing that, aren't you?
>
> Campion: We are, your Honour, yes.

84. There were some changes made that are particularly relevant to the circumstances surrounding the difficulties Sabrina and her family experienced. For instance, from August 2018 there has been a mandated requirement to use a pro forma triage form for the initial assessment, whether that be by telephone or face-to-face.

85. There has been a revision of the procedures that ensure that clients are routinely asked about consent to share information with family members. That is hoped to overcome the reservations that may have in part contributed to the refusal of Dr Chapman to speak to Mrs Di Lembo.

86. Mr Campion indicated that the referring of patients to particular GP's would cease.

87. The Top End Health Service provided a number of undertakings in the following terms:

a. "The Top End Mental Health Service will expressly confirm with the consumer and referrers whether it is the primary health care provider.

b. If the Top End Mental Health Service is not acting as a primary health care provider then it will not adjust or make recommendations to adjust medications without a request or a referral from the primary health care provider, or that a face-to-face assessment with the consumer.

c. If Top End Mental Health Service assumes the role of the primary health care provider for a consumer it will communicate that fact to all known stakeholders.

d. A case will not be closed until all known stakeholders have been communicated with and Top End Mental Health Service is satisfied that it's appropriate to do so.

All of the above undertakings will be embedded in procedures and audited to ensure compliance."

Suggestions by family

88. Counsel for the family made impassioned submissions in relation to changes that should be made to the Mental Health Service. It is clear that the Di Lembo family have put a great deal of thought and consideration into those submissions. For that reason I have annexed the bulk of those to these findings.

89. However, the Coroner's role is not to determine matters of policy, the preferred model for care or the best allocation for the resources. Those are matters for Government.

90. Section 34(2) Coroners Act does provide that I may comment however:

> "A coroner may comment on a matter, including public health or safety or the administration of justice, connected with the death or disaster being investigated".

Comment

Top End Mental Health Service

91. As indicated during the course of the inquest, the NT is not and never has been well serviced by private psychiatrists and those that are in the NT are very busy. That provides challenges particularly for the Mental Health Service that shoulders a relatively larger proportion of the cases compared to other jurisdictions.

92. That appears to have been managed to some extent by deflecting clients from the service to General Practitioners. That is what happened in this case. The Mental Health Service on receiving the telephone call from the very concerned mother told her to take her daughter to a GP and gave her the name of one they recommended. They did so without seeing either Sabrina or her mother.

93. Having done that however they maintained some minimal involvement. They called to check how things were going. They even corresponded with the GP Practice about increasing the dose of the anti-depressant. The level of their involvement however was at best confused. So much so that there was no agreement within the Mental Health Service as to whether Sabrina was a client or not.

94. The most crucial aspect however, was the expectations their involvement gave to Sabrina and her mother. Mrs Di Lembo was given ample reason to

believe that the expertise of the Mental Health Service was being utilised to oversee the care and treatment of Sabrina.

95. But for that belief there is little doubt that Mr and Mrs Di Lembo would have taken other action to obtain expert assistance for Sabrina. However, despite their many contacts with Sabrina and her family the Mental Health Service did not oversee her care and treatment.

96. The Top End Mental Health Service provided undertakings at the end of the inquest. They are primarily aimed at ensuring those aspects are remedied:

    a. Any referral to a GP is made on an appropriate basis. That would require an appropriate and comprehensive assessment that may well include a face-to-face assessment;

    b. There is a proper and considered decision about the role that the Mental Health Service will play;

    c. The decision about that role is communicated to everyone concerned, including other providers and the family; and

    d. The involvement does not cease without first taking appropriate steps to check with other providers involved in the care and treatment of the client.

97. If that had happened in the case of Sabrina's care there were a number of critical points at which there would have been an opportunity for the care and treatment to have taken a different path.

General Practitioners

98. Having referred Mrs Di Lembo and Sabrina to a GP the care and treatment provided was significantly below the level that Sabrina and her family were entitled to expect.

99. No detailed history was taken. Common sense would suggest that as a first step. It is a necessary precursor to assessment. It was also an expectation of the Medicare scheme. The explanation to Medicare item 44(a) is “taking an extensive patient history”. The explanation to Medicare item 36(a) is “taking a detailed patient history”. The explanation to Medicare item 2713 in part involves “taking relevant history and identifying the presenting problem”.

100. No proper assessment of Sabrina was undertaken. That is surely a necessary precursor to treatment. As it turned out the chosen treatment, prescribing an anti-depressant, was ineffective because it was half the therapeutic dose. Her continuing deterioration was then thought by her family and both the GPs to be at least in part related to the anti-depressant. In those circumstances neither GP saw the need to contact the Mental Health Service for either referral or guidance when Sabrina stopped taking the anti-depressant.

101. It is possible that the anti-depressant was having an effect upon Sabrina. However, whether that was the case or not there was an urgent need for some other form of treatment. She was significantly worse than when she had first been seen a month before. She had experienced suicidal ideation. A week later she appeared to have given up and no longer cared about her education.

102. However, neither GP advocated any other treatment. They left her with the same plan she was on while deteriorating, excepting that they agreed that the anti-depressant medication could cease. Neither saw the need to contact the Mental Health Service in the context that but a week or so before that service had recommended increasing the anti-depressant.

103. The question of course is what system needs to change to ensure that GPs take an extensive history, undertake a proper assessment, understand

appropriate drug dosage[17] and recognise when referral to a specialist mental health service is required.

104. Training or experience of the GPs appeared to be lacking. That was most plainly displayed in the failure to appreciate that the 37.5mg Efexor was a sub-therapeutic dose. That led to Sabrina and her mother waiting for a change they were told would come after the medication had time to take effect. They waited and Sabrina deteriorated. That was attributed to the medication. They lost faith in the medication. That may have been able to be restored if it had been recognised that Sabrina had not been provided the correct dose.

105. Crucially in waiting for something that was not going to happen, Sabrina lost hope of ever being able to function without the severe levels of anxiety she was experiencing.

106. There also seemed a less than satisfactory understanding of their role in the coordination of care. There was none. That was particularly evident on 12 July 2017 when she saw or spoke to the three providers involved in her care and treatment: Dr Britz, EASA and the Mental Health Service. She gave a different account of herself on each occasion.

107. It was urged upon me by Counsel for the family during the course of submissions that I refer the GPs to the Medical Board. As I commented at the time. It is not necessary that I do so as that can be done by anyone including the family and their counsel.

108. The care and treatment of Sabrina was a heart wrenching story of missed opportunity after missed opportunity. Her parents involved themselves in her care to the point of becoming a nuisance to the health practitioners in their attempt to convey the severity of their daughter's condition. Dr

[17] Those comments should not be taken as an endorsement of the use of anti-depressants in this case. However, having chosen that course it was incumbent upon the GPs to ensure that the dose was appropriate to bring about the desired effect.

Chapman even instructed that Mrs Di Lembo be told to "stop trying to be a doctor". Perhaps it is too easy to criticise that remark. But in circumstances where neither Dr Chapman, nor any other doctor or clinician employed by the Mental Health Service had seen Sabrina or her mother it was breathtaking.

109. Pursuant to section 34 of the Coroner's Act, I find as follows:

(i) The identity of the deceased was Sabrina Josephine Di Lembo born on 5 May 1998, in Darwin, Northern Territory, Australia.

(ii) The time of death was prior to 10.00 am on 7 August 2017. The place of death was 40 Charlotte Street, Parap in the Northern Territory.

(iii) The cause of death was self-inflicted hanging.

(iv) The particulars required to register the death:

1. The deceased was Sabrina Josephine Di Lembo.

2. The deceased was of Caucasian descent.

3. The deceased was a student at law at the time of her death.

4. The death was reported to the Coroner by the deceased's brother.

5. The cause of death was confirmed by Forensic Pathologist, Dr John Rutherford.

6. The deceased's mother was Lidia Maria Di Lembo and her father was Michael Di Lembo.

Recommendations

110. I recommend that the Top End Mental Health Service ensure that all clients are properly assessed before making a decision to refer their care and treatment to a General Practitioner.

111. I recommend that the role of the Top End Mental Health Service in the care and treatment of clients is explicitly stated to the client and if applicable the client's family or significant other person.

112. I recommend that the Top End Mental Health Service have a specific procedure to ensure that where any responsibility is retained by the Service for care and treatment, or the monitoring of care and treatment, that there be a proper coordination with all relevant providers.

113. I recommend that before the involvement of the Top End Health Service ceases that it ensures that that all other relevant providers are contacted and copies of their last consultations obtained.

114. I recommend that the Medical Board remind all General Practitioners of the care and attention required and the obligation to take a detailed history, undertake an appropriate assessment and take proper notes when dealing with clients presenting with mental health concerns.

Dated this 3rd day of December 2018.

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GREG CAVANAGH
TERRITORY CORONER

Annexure

Your Honour, Sabrina's family based on a lived experience as survivors of a family impacted by suicide, have suggested the following be read on to the record as their official suggestions for improvement.

That a one-stop shop be established for adolescents up to the age of 25, experiencing any form of mental condition or illness. All should be seen face to face for a period of at least four to six weeks, particularly if medication is prescribed. This service can then refer or recommend other qualified professionals to continue the care of the patient.

However, the service ultimately should be responsible for monitoring progress and the coordination of treatment. We suggest this for adolescents specifically because they are the most vulnerable in our society and do not have the life experience to deal with anxiety, depression and other mental illnesses without careful and clear treatment pathways.

Next, that general practitioners should not be allowed to prescribe antidepressant medication to adolescents without consulting a psychiatrist, albeit even interstate or on the phone if necessary. There has to be communication.

Next, that general practitioners should not change medication dosage for adolescents without the consulting of a psychiatrist.

That the Northern Territory Public Health Network, the AMA, and the Northern Territory Government create the opportunity and incentive for interested GPs to attend intensive ongoing professional training in mental health and treatment planning. They would then be identified on a publicly available list to any member of the public who wishes to source a general practitioner with specialisation in mental illness and treatment. The public need this.

That the Department of Health explore how to incentivise the Commonwealth to increase remuneration or fees for general practitioners who treat patients with mental illness so that proper time and care can be dedicated to patients to ensure appropriate clinical pathways and an integrated continuity of care.

That patients on antidepressants be asked to give consent for their general practitioner to discuss and share information with psychiatrists and a psychologist if one is engaged.

That the Northern Territory Government approach and fund headspace to expand its current model of service delivery for adolescents experiencing mental illness.

That a family support group be funded and established for those caring and supporting family members with a mental illness. Families are really left to fend for themselves and navigate the system at a critical time without clear

understanding, knowledge and pathways to help loved ones experiencing mental illness.

That the Department of Education should introduce mental health awareness in schools for teachers and students from at least year 10 to prepare students on how to deal with anxiety and depression and to build resilience. This should be continued into university with resources allocated. The counselling service at Charles Darwin University is underfunded. When Sabrina's mother called them to request a counsellor she received a call back two weeks later. She was then told they didn't have the capacity anyway.

The Department of Education and the Department of Health should collaborate and develop information for parents in understanding mental illness. How to care for children who may experience anxiety and depression, understanding antidepressant medication and the management of this and referral pathways should they need additional support.

That all health professionals treating young people with anxiety and depression should be asking young people different questions to "are you suicidal" to assess risk. A young person doesn't understand what that means. Are they in pain? Can they describe it? Do you want it to stop? Young people do not think the same way adults do and language should be tailored accordingly.

That there should be a coordinated, collaborative and joined up mental health model of care developed in the Northern Territory for adolescents and adults suffering from mental illness. Most professionals are currently working in isolation and no one is taking accountability or responsibility to holistically manage a patient. This could result in better clinical services and outcomes.

The risk assessment by the Mental Health Service to provide clinical care should be reviewed and it's acknowledged that this has been a central focus and has already begun. A focus on risk, your Honour, does not appear to indicate who may or may not be suicidal and diverse services from high quality clinical care, genuine engagement with an individual and with their circumstances.

That the Department of Health develop guidelines and policy for staff on how to effectively engage and communicate with private GPs and psychologists so that community and continuity of care is clear and delineated, including escalation strategy and joint supervision to ensure the best possible outcome for patients.

That evidence-based mental health training should be regularly offered to help professionals, educators, counsellors, to increase awareness and reduce the stigma of mental illness. The family recommends that the Black Dog Institute be considered for this.

That the Department of Health take a leading role in coordinating reform across all services in suicide prevention and intervention that are delivered by government, private and non-government sectors.

That calls by patients and carers to inform the Mental Health Service be recorded so that other practitioners involved can listen to the calls and hear information first-hand. This also ensures, your Honour, that there will be an accurate record of all phone calls for the service.

And finally, that the Coroner's Office, your Honour, in collaboration with the relevant agencies should closely audit and monitor the progress of the key findings and recommendations in a meaningful way to ensure that identified gaps and improvements are not lost in translation.