IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2015 1685

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)
Section 67 of the ***Coroners Act 2008***

I, PETER WHITE, Coroner having investigated the death of ALISON RAE WOLINSKI
without holding an inquest:
find that the identity of the deceased was ALISON RAE WOLINSKI
born on 3 August 1978
and the death occurred between 5 March 2015 and 7 April 2015
at 4/33 Gordon Street, Balwyn, Victoria
from:

1 (a) HANGING

Pursuant to section 67(1) of the *Coroners Act 2008* I make findings with respect to the following circumstances:

1. Alison Rae Wolinski was a 36 year old woman who was found deceased in her apartment on 7 April 2015 by police performing a welfare check. Ms Wolinksi's death was reported to the Court and I conducted an investigation into the circumstances of her death.

Coronial Investigation

2. Senior Constable Rebekah Mater provided me with a coronial brief of evidence (the brief). The brief contains statement from Ms Wolinski's father, Jeffrey, her private psychiatrist and general practitioners along with Dr Tessa Reimers, Psychiatrist at St Vincent's Hospital. The brief also contains statements from the police members who performed welfare checks in the lead up to Ms Wolinksi being found deceased. I have also been provided with medical records, scene photographs, photographs of notes found at the scene and a letter from Jeffrey Wolinski expressing concerns about the circumstances surrounding his daughter's death. I caused those concerns to be provided to St Vincent's Hospital for comment. I also sought further information from Victoria Police in relation to its welfare check policies and information from the Chief Psychiatrist about the development of the updated version of the Department of Health and Victoria Police Protocol for Mental Health. I have relied on the totality of the material before me in setting out this finding.

Medical Investigation

3. Senior Forensic Pathologist Dr Matthew Lynch of the Victorian Institute of Forensic Medicine performed a post mortem medical inspection. Dr Lynch provided me with a report of his findings. Dr Lynch noted that the external examination showed marked post mortem change and a ligature mark around the neck. Toxicology testing showed the presence of alcohol, venlafazine and desmethyvenlafaxine, diazepam and nordiazepam. Dr Lynch concluded that the cause of Ms Wolinski's death was 1(a) hanging. I adopt Dr Lynch's findings in relation to the cause of death.

Mental health treatment and admission to St Vincent's Hospital

4. Ms Wolinski had been diagnosed with borderline personality disorder (BPD) and alcohol use disorder. Ms Wolinski had experienced mental health problems from her teenage years after she was the victim of a sexual assault. Jeffrey Wolinski reported that Ms Wolinski's depression intensified over the years. She completed an accounting course at RMIT University and obtained employment however she stopped working in 2010 as her depression made it difficult for her to attend work every day.

5. In June 2014, Ms Wolinski's mother passed away. They were very close and the death of her mother affected her greatly and had a detrimental effect on her mental health. Ms Wolinski was subsequently referred to Dr Kamal Sanghvi, consultant psychiatrist. At the initial appointment she requested urgent admission for further Electro-convulsant Therapy (ECT). She was admitted to the Delmont Private Hospital the following day under the care of Dr Sanghvi. Following six ECT treatments, she was assessed by the Director of ECT Dr Barry Williamson. Dr Williamson assessed her on 30 August 2014 and concluded that Ms Wolinski remained significantly depressed although she appeared to have made some gains. Dr Williamson recommended continuing ECT treatment as well as psychotherapy. She consented to ongoing ECT and she received a further seven treatments. Her mental state improved and she was discharged on 19 September 2014.

6. Ms Wolinski, her father and her son went on a holiday to Perth and on her return, she attended weekly day patient ECT at Delmont Hospital. On review on 19 November 2014, she reported a further improvement in her mood. She had decided to cease maintenance ECT due to memory impairment but agreed to continue with Venlafaxine 150mg daily.

7. On 28 January 2015, Ms Wolinski attended an appointment with Dr Sanghvi and reported that she had been away with her father and son in Perth but returned abruptly. She reported drinking two bottles of wine daily and had taken an overdose of medication on one occasion. Dr Sanghvi offered to admit her to Delmont Private Hospital but she refused this. She was given a prescription for Diazepam and she was to continue to take her Venlafaxine.

8. On 25 February 2015, Ms Wolinski again saw Dr Sanghvi and she reported having taken two significant overdoses. He offered to admit her to Delmont immediately and she rejected this offer. He refused her request for diazepam and sleeping tablets. She stated that she would not attempt self-harm again. Following this appointment, he contacted the St Vincent's Hospital Crisis Assessment and Treatment Team (CATT) and requested an urgent home assessment and admission to their service.

9. On 26 February 2015, CATT attended her apartment after multiple unsuccessful telephone attempts to arrange an assessment. Ms Wolinski reluctantly opened the door but did not release the chain. She appeared intoxicated, denied risks and refused CATT clinicians entry inside. She did agree to an assessment the following morning. She then contacted Triage

and complained about CATT doing a home visit and stated that she did not want any further contact with them. She ultimately agreed to being contacted by telephone the next day.

10. On 27 February 2015, CATT telephoned Ms Wolinski in the morning. CATT documented her mental state as stable and that she denied any risk behaviours or thoughts. Ms Wolinski was placed on the CATT Alert List and follow-up was made with Dr Sanghvi. Later that day, they again contacted Ms Wolinski and became concerned about her presentation so they arranged a home visit.

11. At 3.20pm, CATT attended at Ms Wolinski's apartment. They assessed her as at risk of self-harm and noted that she was consuming at least two bottles of wine daily. At first she agreed to a voluntary admission however she became agitated and threatened staff with a knife. Police members attended and she was transported as an involuntary patient to St Vincent's Hospital Emergency Department.

12. On admission, she was reviewed by psychiatry registrar Dr Sousan Zarifpour who arranged a physical work up including blood tests and ECG given her reported quetiapine overdose four days earlier.

13. On review by the on call psychiatrist Dr Vicky Sheppherd on 28 February 2015, Ms Wolinski disagreed with the CATT assessment that she was not safe at home and stated that she wanted to go home. Her risks to self were deemed to be at a moderate level, her risk to others was assessed as low and her risk of absconding was high. Ms Wolinksi was then placed on a Temporary Treatment Order (TTO) under the *Mental Health Act 2014* (Vic). The TTO was to continue with the admission with no leave and 15 minutely observations by nursing staff.

14. On 2 March 2015, she was reviewed at length by Consultant Psychiatrist Dr Tessa Reimers. After this review, he was granted escorted leave but tended to keep to her herself. She was settled in her behaviour and was often seen with her large teddy bear. On 4 March 2015, her TTO was revoked after an improvement in her presentation and seemingly lessening acute risk. I note that Ms Wolinski would not allow the treating team to involve her father.

15. On 4 March 2015, Dr Reimers attempted to speak with Dr Sanghvi but he was unavailable. Dr Reimers met with Ms Wolinksi and documented a complete assessment and treatment plan which included approved leave to see Dr Sanghvi and some unescorted leave and discharge on 5 March 2015.

16. On 4 March 2015 Ms Wolinski had an appointment with Dr Sanghvi and was given leave from the inpatient unit to attend. She did not return to the inpatient unit, nor did she attend her appointment with Dr Sanghvi. According to the medical records, she told staff she had unsuccessfully telephoned Dr Sanghvi but it is not clear if this was instead of attending the appointment.

17. St Vincent's staff contacted Ms Wolinski after she failed to return to the unit at 7pm. She reported that she could not contact her doctor and she was eating a meal with her son. They requested that she return to the unit but she failed to do so.

18. At this time, the paperwork that recorded her change in status as agreed during her meeting that day with Dr Reimers could not be found and Nurse Mike Golding notified the treating team and manager. Without the correct paperwork, staff considered that Ms Wolinski was still subject to the *Mental Health Act 2014* (MHA) and absent without leave. Consequently, Victoria Police Fitzroy Station was notified and faxed a MHA 124 Apprehension of patient absence without leave and missing person forms.

19. Psychiatric Registrar Dr Marc Jurblum discussed follow-up for Ms Wolinski in the community with CATT Consultant Psychiatrist Dr James Leahey but she was deemed inappropriate for CATT follow-up because of her previous knife threats to the team.

20. At 10.56pm on 4 March 2015, Constable Nicole Finter and Senior Constable Ferdi Cokelek attended at Ms Wolinksi's home address. There was no response to their knocking and the neighbour reported that they had not seen her that day. Victoria Police informed St Vincent's Hospital that they had been to Ms Wolinski's house but that she was not there.

21. Overnight on 4-5 March 2015, the medical record shows the missing Revocation of Temporary Order signed at 11.15am on 4 March 2015 by Dr Reimers was found and Ms Wolinski was now a missing person as opposed to absent without leave and was therefore not subject to the MHA.

22. On 5 March 2015, St Vincent's Hospital staff telephoned Ms Wolinski on three occasions leaving messages requesting that she contact the ward. Dr Jurblum noted further attempts to contact Ms Wolinski and that these were unsuccessful. Ms Wolinski was formally discharged from St Vincent's Hospital after two day of no contact on 6 March 2015.

23. St Vincent's Hospital notified Victoria Police that Ms Wolinski may have gone to her father's house following discharge and staff were trying to get her to give permission for contact to be made with her father. Ms Wolinski had refused to provide any family or carer details.

24. At 5.05pm on 6 March 2015, Constables David Field and Benjamin Mahon attended at Mr Wolinski's home and spoke to Ms Wolinski's son who told them that his mother was possibly at her home address. They then attended Ms Wolinski's home address for a further welfare check. There was no response to their knocking or ringing her mobile phone. They noted her car was there and it was cold. Victoria Police informed St Vincent's Hospital of this.

25. According to the discharge summary, on 10 March 2015, a staff member contacted Victoria Police again because of the service's concerns regarding a lack of contact with Ms Wolinksi. Also on 10 March 2015, the discharge summary was completed by psychiatric registrar Dr Jurblum. The discharge plan included preparation of a mental health care plan, encouraging psychological follow up and referral back to the private psychiatrist.

26. On 17 March 2015, Clinician Fran Timmins documented that she contacted Dr Sanghvi's office and spoke with the receptionist who stated the Ms Wolinski had deferred one appointment but had made two more and that the receptionist was confident that she would attend.

27. On 7 April 2015, Mr Wolinski called police to perform a welfare check as he was concerned about his daughter. Police entered the home and found Ms Wolinski hanging in the kitchen.

Appropriateness of the decision to discharge Ms Wolinski

28. On the basis of the material before me, I consider that the decision by Dr Reimers to discharge Ms Wolinski from the ward two days after she had failed to return from leave was reasonable. Ms Wolinksi had been settled on the ward. At the time Dr Reimers changed her status to voluntary, the medical records support that she would not have met the criteria under the MHA for compulsory treatment. Ms Wolinski had agreed to treatment and had been compliant and engaged with her treating team in the days prior.

29. St Vincent's Hospital reported Ms Wolinski as a missing person to Victoria Police and requested a welfare check. In the two days that she failed to return from leave they notified

the police of possible other address and staff contacted numbers in previous medical records without success. Multiple staff members repeatedly telephoned Ms Wolinksi and left messages asking her to return to the unit.

Department of Health and Victoria Police Protocol for Mental Health

30. I note that the Department of Health and Victoria Police Protocol for Mental Health is currently being revised through the Office of the Chief Psychiatrist. The Chief Psychiatrist has informed the court that the draft includes guidance about performing welfare checks. It is hoped that this updated protocol will clarify roles and feedback between Victoria Police and mental health services. I also encourage the Department of Health and Victoria police to include guidance in the protocol in circumstances where the person is not located.

Finding

31. Ms Wolinski was identified through the use of DNA testing. I formally find that the identity of the deceased was Alison Rae Wolinski.
32. There is no evidence before me of any third party involvement in Ms Wolinski's death. Accordingly I find that Ms Wolinski intentionally took her own life by way of hanging.

Pursuant to section 73(1A) of the Coroners Act 2008, I order that this finding be published on the internet in accordance with the rules.

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

Ms Wolinski's family

Chief Psychiatrist

St Vincent's Hospital

Senior Constable Rebekah, coroner's investigator

Signature:

PETER WHITE
CORONER
Date: **22 August 2016**