IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2010 000952

FINDING INTO DEATH WITHOUT INQUEST

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

I, PARESA ANTONIADIS SPANOS, Coroner,

having investigated the death of JEFFREY STUART WHITLING
without holding an inquest:
find that the identity of the deceased was JEFFREY STUART WHITLING
born on 8 October 1964,
and that the death occurred between 10 and 11 March 2010
at 45 Kingsley Road, Reservoir Victoria 3073
from:

1 (a) CONSISTENT WITH HANGING.

Pursuant to section 67(2) of the **Coroners Act 2008**, I make findings with respect to **the following circumstances**:

1. Mr Whitling was a 45 year-old unemployed man who lived with his brother, Trevor Whitling, and father, Frederick Whitling, at the above address. He had a daughter, Aimee Whitling from a previous relationship. Mr Whitling's family had a known history of mental illness. His own history commenced in 2004, and 2005 was a turbulent year in which his relationship with his partner ended and his mother died after a period of palliative care. There is a family history of psychiatric illness and Mr Whitling had a diagnosis of schizophrenia. According to Trevor, his brother had a diagnosed mental illness, but was not compliant with his medication regime.

2. On the evening of 10 March 2010, Mr Whitling was at home with his brother. He went to bed at about 9.00pm, and Trevor later stated that there was nothing unusual about his behaviour or mood. At about 4.40am on 11 March 2010, Trevor woke as usual and prepared for work. At about 5.20am he saw a note on the kitchen table in Mr Whitling's handwriting that stated *Check the*

garage Jeff x. Trevor went to the garage, found Mr Whitling hanging by a rope from a beam and called 000. When emergency services attended, they found that Mr Whitling was already deceased.

3. Police also attended and discovered pieces of paper near Mr Whitling's body in the garage with multiple names of people and organisations in the public profile including 'Reservoir cops', 'Christine Nixon', 'Simon Overland', 'Bob Hawke' and Darebin Mental Health consultants 'Dr Saateevan' and 'Dr Douglas'. The pieces of paper also referred to 'USA President Obama' and 'Nurses at Repat Hospital paid + fatal injection'. In making his statement to police, Trevor was adamant that Mr Whitling had uncovered high level corruption on the stock exchange, and that he could not provide further information about it to the investigating police member without putting her life in danger and damaging her career prospects. Police found no evidence to suggest that anyone else was involved in the death or that Mr Whitling died in suspicious circumstances.

4. An external examination of Mr Whitling's body was performed by Forensic Pathologist Dr Marian Wang from the Victorian Institute of Forensic Medicine (VIFM) who also reviewed the circumstances as reported by the police, and post-mortem CT scanning of the whole body. Dr Wang provided a written report of her findings concluding with advice that a reasonable cause of death would be *consistent with hanging,* without the need for a full post-mortem examination (autopsy).

5. Toxicological analysis of post-mortem samples did not reveal the presence of alcohol or any other common drugs or poisons, confirming that Mr Whitling had not been taking his prescription medication in the period leading up to his death, and increasing the likelihood that he was suffering the effects of his mental illness immediately before his death.

6. I find that Mr Whitling intentionally took his own life by hanging. I further find it probable that Mr Whitling's judgement was impaired at the time that he took his own life, although the available evidence does not enable me to determine the extent to which this was so.

Further investigation of Mr Whitling's psychiatric history

7. From 2005, Mr Whitling began writing to the Prime Minister and various federal government ministers stating that there was a conspiracy against him, that he had been offered a knighthood and that he could predict the winner of the Melbourne Cup. In February 2006, an intervention order was made on behalf of a senior office bearer of a company involved in the oil and gas industry, apparently related to actions taken by Mr Whitling in furtherance of his belief that he had uncovered high-level corruption in Bass Strait Oil Company Ltd. Mr Whitling's delusions in

this regard continued in 2006 when he began making abusive and threatening telephone calls to Korumburra Police station.

8. On 30 August 2006, Mr Whitling was admitted as an involuntary patient to the Northern Hospital Psychiatric Unit, and was case managed by Darebin Community Mental Health Centre (DCMHC). In October 2006, he was discharged from his Community Treatment Order (CTO) after a successful appeal to the Mental Health Review Board.

9. In February 2007, Mr Whitling was discharged from DCMHC, on the basis that he was a voluntary patient and had refused to engage. From March 2007, Mr Whitling began making further threatening phone calls to Korumburra Police Station. This lead to his arrest and bail for breaching intervention orders. After the charges were laid, Mr Whitling was readmitted to the Northern Hospital on 26 June 2007 where he remained an inpatient until 11 July 2007. His diagnosis was late onset schizophrenia. In a risk assessment and consultation undertaken during this admission, a *clear history of supervision failures* was documented.

10. Mr Whitling was discharged on a Community Treatment Order (CTO), case managed by DCMHC again, but refused to engage. This lead to revocation of the CTO in August 2007, as Mr Whitling could not be located for ongoing treatment.

11. The next significant occurrence in the chronology is on 11 June 2008, when Mr Whitling was admitted to Thomas Embling Hospital after being transferred from Melbourne Assessment Prison, where he had been on remand for failing to comply with bail conditions, breach of intervention order and stalking another person.

12. On 20 October 2008, Mr Whitling was discharged from Thomas Embling to the care of DCMHC on a CTO. He was treated with Risperdal Consta[1] injections, and later requested a change to oral medications. Although he appeared to be complying with his treatment regime, he still believed treatment was not necessary. A letter from Thomas Embling to Darebin Psychiatric Triage from Dr K Ong dated 15 October 2008 stated that *his main risk is non-compliance with treatment, though this is somewhat lessened by being on depot medication.*

13. On 27 January 2009, Mr Whitling was reviewed by Consultant Psychiatrist Dr Maxwell Gaynor, who prescribed a combination of oral and depot Risperidone. Mr Whitling was reviewed again on several occasions throughout 2009, and he appeared to be well engaged in treatment and compliant.

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[1] A slow-release form of the anti-psychotic medication Risperidone.

14. On 14 August 2009, Mr Whitling had an appointment with his case manager, David Chisolm. Mr Whitling reported feeling happy and had reunited with his daughter Aimee after a period of estrangement. He discussed possible discharge and said that he understood the need to continue engaging with DCMHC. On 11 September 2009 Mr Whitling was discharged from his CTO to his general practitioner, Dr Michael Conway.

15. Mr Whitling did not attend an appointment with his case manager scheduled for 9 October 2009. By way of follow-up, Mr Chisolm made several telephone calls to Mr Whitling's home but only ever spoke with Trevor and Frederick. Mr Chisolm escalated the matter to Consultant Psychiatrist Dr Sinnatamby Sujeevan and they decided to write to Mr Whitling offering an appointment, and to discharge him if he did not respond.

16. Mr Chisolm wrote to Mr Whitling on 24 November 2009 asking him to contact DCMHC. There is no record that Mr Whitling ever responded to that letter or made any further contact with DCMHC. Mr Chisolm tried telephoning again on 26 November 2009, but there was no answer. He sent another letter with an appointment time and service contact details again asking Mr Whitling to make contact.

17. On 16 December 2009, Mr Whitling was formally discharged from DCMHC. The reason for discharge was documented as *whereabouts not known; father and brother indicating that they have not seen Jeffrey for some time.* It was noted that no referral was made as a *clinical decision was made to discharge Jeffrey due to poor engagement and nil contact with DCMHC since October 2009 despite repeated attempts from CM.*

COMMENTS

Pursuant to section 67(3) of the **Coroners Act 2008**, I make the following comments connected with the death:

1. In investigating the circumstances surrounding the death of Mr Whitling, I asked the Coroners Prevention Unit (CPU) to review and provide advice on the adequacy of DCMHC's discharge planning and post-discharge follow-up prior to Mr Whitling's death.

2. DCMHC provided Mr Whitling with good care whilst he was engaged in treatment. The Centre had access to his psychiatric history, forensic history and history of service disengagement when his status under the *Mental Health Act 1986* (Vic) (MHA) was voluntary. Of particular relevance is his voluntary status being associated with increased risk of non-compliance and criminal offending.

3. The MHA requires that restrictions on the liberty of persons with a mental illness must be the minimum necessary to facilitate effective treatment, and to ensure protection of members of the public. In this case, the likelihood of Mr Whitling complying with the agreed plan was low. Whilst promoting Mr Whitling's self-determination in recovery is in line with the current approach to delivery of care in public mental health services in Victoria, the use of a CTO does not exclude a recovery-focused and collaborative approach by mental health services. There is limited evidence that DCMHC comprehensively assessed the risk to Mr Whitling and the community, or articulated the threshold at which it became reasonable to discharge Mr Whitling's CTO.

4. In light of Mr Whitling's previous forensic history and non-compliance, DCMHC's position that discharge was appropriate after a period of disengagement, and the reliance on re-presentation for re-engagement, was unreasonable. There is no evidence that the Centre contacted Dr Conway or notified him of the discharge plan, or that Mr Whitling attempted to engage with his doctor. At a minimum and in light of Mr Whitling's history of service disengagement if his *Mental Health Act* status was voluntary, it is reasonable to expect DCMHC to have made contact with Dr Conway prior to the change in status in September 2009. The change in status, current medication and plan to discharge a patient is basic information for a general practitioner.

5. NorthWestern Mental Health (NWMH) has responded by putting in place changes to policy and procedure that should improve the safety of clients who have a history of disengagement and deterioration once discharged off involuntary status under the MHA. The rapid disengagement and deterioration of this group of clients is, unfortunately, a theme from several deaths investigated by the Coroners Court of Victoria.

6. In December 2012 a Clinical Risk Management bulletin was issued by NWMH to its clinical staff. The bulletin, titled *Transfer of patient care from NorthWestern Mental Health to Primary Care and other providers*, has been tabled at the NWMH Continuous Improvement Committee and was distributed to all NWMH staff via email. It has also been placed in workplace Clinical Risk Management folders. The bulletin is a comprehensive and practical document that directly addresses the identified problem with people who have an extensive history of disengagement when discharged from involuntary status. However, these changes were not necessarily implemented in December 2012.

7. NWMH stated that it is in the process of reconfiguring its community teams, and the processes outlined in the bulletin have been incorporated into the NWMH Practice Guidelines and business rules associated with the redesigned service. It appears that the directions included in the

bulletin were not necessarily implemented in 2012, however I note that it is common for embedding changes in clinical practice to occur as part of a redesign process.

8. The NWMH *Continuity of Care in Transfer and Discharge* policy was updated in May 2012, but not uploaded until May 2013. The review of the policy does not include the rigour that is included in the *Transfer of patient care from NorthWestern Mental Health to Primary Care and other providers* bulletin, nor does it reference it.

9. The bulletin is a most helpful document, however, it was distributed in December 2012 and is yet to appear in or be referred to in the above policy. Whilst I acknowledge NWMH's clear articulation of the expected level of care required for this vulnerable group of clients, it is appropriate that the *Continuity of Care in Transfer and Discharge* policy be reviewed again and that the information in the bulletin either be inserted into the policy or be referred to, as has been the case for previous bulletins.

10. The work NWMH has done to date and its clear articulation of the vulnerabilities of this group of people sets a standard not commonly considered the responsibility of a mental health service. The Office of the Chief Psychiatrist guideline *Discharge Planning for Adult Community Mental Health Services* states that 'those who have not received services from AMHS within the previous three months' as one of five instances in which it is appropriate for discharge to occur. This guideline is the reference document for public mental health services' approaches to discharge planning in Victoria, and services rely on the Office of the Chief Psychiatrist to provide information about clinical standards. The guideline does not address the consideration that should be undertaken when dealing with the planned or precipitous discharge of people who have an extensive history of disengagement when discharged.

RECOMMENDATIONS

Pursuant to section 72(2) of the Coroners Act 2008, I make the following recommendations connected with the death:

1. That NWMH:

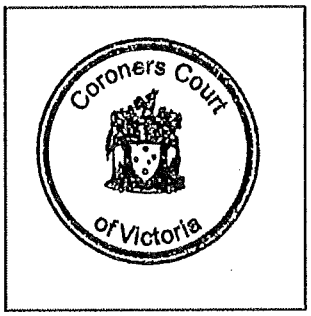
- implement the changes outlined in its *Transfer of patient care from NorthWestern Mental Health to Primary Care and other providers* bulletin; and
- update and upload its *Continuity of Care in Transfer and Discharge* policy to include the relevant information – or reference thereto – in the *Transfer of patient care from NorthWestern Mental Health to Primary Care and other providers* bulletin.

2. That to increase the safety of patients who have an extensive history of disengagement when discharged from involuntary status under the *Mental Health Act*, I recommend that NWMH and the Office of the Chief Psychiatrist work together to review the appropriateness of, and opportunities for, including information from NWMH's *Transfer of patient care from NorthWestern Mental Health to Primary Care and other providers* in the *Discharge Planning for Adult Community Mental Health Services* guidelines.

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

The family of Mr Whitling
Mr Peter Kelly, Director – Operations, NorthWestern Mental Health
Dr Mark Oakley Browne, Chief Psychiatrist
Darebin Community Mental Health Centre
Senior Constable Corinne Lowry, Reservoir Police Station.

Signature:



PARESA ANTONIADIS SPANOS
CORONER
Date: **23 September 2013**