IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: **COR 2017 2628**

FINDING INTO DEATH WITHOUT INQUEST

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

Findings of:	**MR PHILLIP BYRNE, CORONER**
Deceased:	**MR KONSTANTINOS ELEFTHERIOU-TRAGAKIS**
Date of birth:	**17 May 1981**
Date of death:	**5 June 2017**
Cause of death:	**I (a) Hanging**
Place of death:	**Wellington Reserve, Mulgrave, Victoria**

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

I, PHILLIP BYRNE, Coroner having investigated the death of
Konstantinos ELEFTHERIOU-TRAGAKIS
without holding an inquest:
find that the identity of the deceased was Konstantinos ELEFTHERIOU-TRAGAKIS
born on 17 May 1981
and the death occurred on 5 June 2017
at Wellington Reserve, Mulgrave, Victoria

from:

1 (a) HANGING

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

Background

1. Mr Eleftheriou-Tragakis, 36 years old at the time of his death, resided in Mulgrave, Victoria. He is survived by his brother Stelios.
2. Mr Eleftheriou-Tragakis and his brother were adopted by their paternal aunt, Mrs Kouzinia Eleftheriou-Tragakis (who, for the purposes of this finding I will refer to as Mrs Tragakis), and her husband after their parents passed away. Mr Eleftheriou-Tragakis was only 16-months-old at the time. He first learned about the details of his parents' death when he was sixteen years old and this was the first time he presented with any behavioural issues. A short time thereafter, those matters apparently resolved.
3. Mr Eleftheriou-Tragakis had a medical history of schizoaffective disorder, substance use disorder relating to amphetamines use, and drug induced psychosis. His first psychiatric admission occurred in 2006, with numerous voluntary and involuntary admissions occurring thereafter.

4. On 30 April 2017, and following various levels of contact with the Eastern Health Central East Crisis Assessment and Treatment Team (CECATT) throughout March and April 2017, Mr Eleftheriou-Tragakis was admitted to Upton House. He was reviewed by Assoc. Prof Dr Paul Katz and diagnosed with a psychotic relapse of his Schizoaffective Disorder and methamphetamine abuse. He was placed on an Inpatient Temporary Treatment Order (ITTO). He was initially admitted to the Low Dependency Unit (LDU).

5. On 1 May 2017, Mr Eleftheriou-Tragakis was reviewed by Dr Rebecca Fraser, Consultant Psychiatrist, a psychiatry registrar and an attending nurse. He presented with psychotic relapse and held delusional beliefs. He denied any recent suicidal thoughts. Mr Eleftheriou-Tragakis was prescribed regular risperidone and as required medications including diazepam and olanzapine.

6. By 3 May 2017, Mr Eleftheriou-Tragakis's mental state had deteriorated further. He was reviewed by Dr Fraser. Following an episode of agitation and aggression, Mr Eleftheriou-Tragakis was admitted to the Intensive Care Area (ICA) (which required and was facilitated by the calling of a 'Code Grey').[1] Mr Eleftheriou-Tragakis was extremely paranoid toward staff and admitted to purging his oral medication. He was administered an injection of antipsychotic medication. On 5 May 2017, Mr Eleftheriou-Tragakis was administered a further injection of antipsychotic medication.

7. On 9 May 2017 Mr Eleftheriou-Tragakis was treated with an 'extended release' risperidone depot injection and was subsequently transferred back to the LDU. Mr Eleftheriou-Tragakis absconded from the LDU on 9 May 2017 and was conveyed back to the ward by police and ambulance officers on 11 May 2017.

8. On 12 May 2017 Mr Eleftheriou-Tragakis again absconded from the ward. Mrs Tragakis called to advise that Mr Eleftheriou-Tragakis had returned home when she wasn't there, and further on 13 May 2017 that he was at home with her. Mr Eleftheriou-Tragakis was not 'found' within 48 hours of absconding and following protocol was subsequently discharged from Upton House.

9. On or about 17 May 2017 the ITTO was revoked and Mr Eleftheriou-Tragakis was referred back to CECATT after Dr Rebecca Fraser[2] spoke to Mrs Tragakis who asked if Mr Eleftheriou-Tragakis could have community treatment instead of being returned to the ward

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[1] A Code Grey is an organisation-level response to actual or potential violent, aggressive, abusive or threatening behaviour, exhibited by patients or visitors, towards others or themselves, which create a risk of health and safety.

[2] Consultant psychiatrist with Upton House, Box Hill Hospital.

by police. She was agreeable to a Crisis Assessment and Treatment Team (CATT) member visiting Mr Eleftheriou-Tragakis at home.

10. At approximately 7.48pm on 18 May 2017, CECATT clinicians attempted to review Mr Eleftheriou-Tragakis at home. He ran away from them. Mrs Tragakis reported that Mr Eleftheriou-Tragakis had not returned home the evening prior, and had been shouting at the neighbours, singing in the street, and acting bizarrely. Dr Melissa Lowe[3] issued an Inpatient Assessment Order (IAO). Mr Eleftheriou-Tragakis was apprehended by Victoria Police on the evening of 19 May 2017 and taken to Box Hill Hospital under the IAO and waited for an inpatient psychiatric bed to become available. He was subsequently admitted to St Vincent's Mental Health Service Inpatient Unit (SVMHS) on 20 May 2017 on a Temporary Treatment Order. At the time, his mood was elevated, and he was psychotic and aggressive.

11. On 21 May Mr Eleftheriou-Tragakis was reviewed by Dr Denis O'Loughlin[4]. He denied any psychotic symptoms and appeared to minimise his drug use. Mr Eleftheriou-Tragakis was again diagnosed with schizoaffective disorder and treated with another risperidone depot injection as well as oral risperidone, the side effects of which he complained about. Possible recent methamphetamine use was noted.

12. At approximately 11.00am on 22 May 2017, Mr Eleftheriou-Tragakis absconded from SVMHS. He was returned by the police at approximately 7.00pm that evening after having again been found at home.

13. On 23 May 2017, Mr Eleftheriou-Tragakis was seen by Dr Adam Mollinger, treating consultant psychiatrist. Mr Eleftheriou-Tragakis remained co-operative with staff on 23 and 24 May 2017. He was reviewed by the treating team again on 25 May 2017 at which time he denied suicidal thoughts. He also denied any psychotic symptoms. That evening Mr Eleftheriou-Tragakis requested to be transferred to Upton House to be closer to his family.

14. At approximately 12.30pm on 26 May 2017, Mr Eleftheriou-Tragakis absconded from the ward again. Fitzroy police and his next of kin were contacted as part of the AWOL procedure. Mrs Tragakis contacted SVMHS at approximately 12.30pm on 27 May 2017 and advised them that Mr Eleftheriou-Tragakis had returned home the evening prior. He had since left the house after telling her that he was returning to the ward. Associate Nurse Unit Manager (ANUM) Eastoe contacted Victoria Police and informed them of the conversation held with Mrs Tragakis. By 6.10pm on 27 May 2017, Mr Eleftheriou-Tragakis had not returned to the ward.

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[3] Consultant psychiatrist with the Eastern Health Central East Crisis Assessment and Treatment Team.
[4] On-call consultant psychiatrist with SVMHS

15. On 28 May 2017, attempts were made to contact Mrs Tragakis. At 2.10pm, she advised that Mr Eleftheriou-Tragakis was at home, that there was no problems, and that he was planning to attend church. ANUM Graham advised Mrs Tragakis that as Mr Eleftheriou-Tragakis was a compulsory patient she would need to inform the police of his whereabouts and then contacted Victoria Police to inform them of his whereabouts.

16. On 29 May 2017 Mr Eleftheriou-Tragakis was discharged from the SVMHS ward, and the ITTO revoked on the basis that he had been 'absent without leave' from the ward for 72 hours and that SVMHS were unable provide immediate treatments under the *Mental Health Act 2014 (Vic).*

17. On 29 May 2017, Dr Mollinger requested that the Box Hill CATT consultant be contacted to transfer care. The discharge documents were sent to Box Hill Hospital.

18. On 1 June 2017, CECATT reviewed Mr Eleftheriou-Tragakis at home. He was cooperative but had underlying irritability and denied any mental illness and the need for further depots. Mr Eleftheriou-Tragakis denied thoughts of harm to himself or others and said he would attend his general practitioner to obtain his next depot injection. CECATT contacted Dr Lowe with concerns that Mr Eleftheriou-Tragakis would not attend his GP for his treatment needs and were advised that he was a voluntary patient, but that CECATT could monitor him for the weekend to confirm his attendance with his GP for the depot. It was planned that if he did not attend that he was to be readmitted as a 'continuing care team' patient.

Circumstances of the death

19. On 4 June 2017 Mrs Tragakis, her husband, and Mr Eleftheriou-Tragakis were at home sitting in the family room. Mr Eleftheriou-Tragakis said "*I'm going to sleep here today, can you please stay with me Mumma please don't go.*" Mrs Tragakis responded "*okay, it's afternoon.*" Some time passed and Mr Eleftheriou-Tragakis lifted his head to check if Mrs Tragakis was still there. At approximately 5.00pm, Mr Eleftheriou-Tragakis arose and said "*I'm not feeling well*". Mrs Tragakis gave him two paracetamol tablets.

20. Mr Eleftheriou-Tragakis took a cigarette and went outside, but returned shortly thereafter telling Mrs Tragakis that he had "*left it.*" He then went outside again to have the cigarette before again returning shortly thereafter and saying "*No, I don't like the cigarette.*" Mr Eleftheriou-Tragakis returned to the couch and said "*Stay here mumma, don't go, don't go.*"

21. At approximately 6.00pm Mr Eleftheriou-Tragakis sat up and said "*I need help, I'm going to call them. I need help.*" He was pacing around the house. According to Mrs Tragakis, this was the first time Mr Eleftheriou-Tragakis actually wanted to call the CATT so she "*knew it was serious.*" Mrs Tragakis gave Mr Eleftheriou-Tragakis her telephone and he made a call. According to Mrs Tragakis, Mr Eleftheriou-Tragakis said "*Please come and get me, I need help. I have to come in.*" After the telephone call, Mr Eleftheriou-Tragakis said "*They're coming to take me, I'm going upstairs to wait*" before retreating upstairs with his cousin.

22. At about midnight, Mr Eleftheriou-Tragakis went outside for a cigarette. When he didn't return inside, his cousin went outside to the veranda to look for Mr Eleftheriou-Tragakis, but assumed he had gone on one of his late night walks, a common habit.

23. At approximately 6.15am on 5 June 2017, Mr Gordon McMillan attended Wellington Reserve, Mulgrave to run laps of the oval. It was still dark on his arrival. At approximately 7.20am, Mr McMillan observed what he believed to be a body hanging from a tree at the eastern end of the reserve and contacted Victoria Police.

24. Police officers arrived at the scene at approximately 7.45am and observed a male (later identified as Mr Eleftheriou-Tragakis) hanging from a blue and yellow rope tied to a tree. They located a white power cord also tied to the tree branch, which had a snapped end. Pieces of the power cord were on the ground. Muddy scuff marks were observed on the lowest tree branch. A Greek-Orthodox religious book, a half-consumed mandarin and apple, and a handwritten note that read "*I'm sorry guys*" were found in Mr Eleftheriou-Tragakis's pockets. Metropolitan Fire Brigade members arrived shortly thereafter and cut down Mr Eleftheriou-Tragakis.

The Role of the Coroner

25. The jurisdiction of the Coroners Court of Victoria is inquisitorial.[5] The Act provides for a system whereby reportable deaths are independently investigated to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.[6]

26. It is not the role of the coroner to lay or apportion blame, but to establish the facts.[7] It is not the coroner's role to determine criminal or civil liability arising from the death under investigation, or to determine disciplinary matters.

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[5] Section 89(4) *Coroners Act 2008.*
[6] See Preamble and s 67, *Coroners Act 2008.*
[7] *Keown v Khan* (1999) 1 VR 69.

27. The expression '*cause of death*' refers to the medical cause of death, incorporating where possible, the mode or mechanism of death.

28. For coronial purposes, the circumstances in which death occurred refers to the context or background and surrounding circumstances of the death. Rather than being a consideration of all circumstances which might form part of a narrative culminating in the death, it is confined to those circumstances which are sufficiently proximate to be considered relevant to the death.

29. The broader purpose of coronial investigations is to contribute to a reduction in the number of preventable deaths, both through the observations made in the investigation findings and by the making of recommendations by coroners. This is generally referred to as the '*prevention*' role.

30. Coroners are also empowered:

    (a) to report to the Attorney-General on a death;

    (b) to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and

    (c) to make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice. These powers are the vehicles by which the prevention role may be advanced.

31. All coronial findings must be made based on proof of relevant facts on the balance of probabilities. In determining these matters, I am guided by the principles enunciated in Briginshaw v Briginshaw.[8] 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 that they caused or contributed to the death.

Identity

32. On 7 June 2017, Dr Jeremy Graham of the Victorian Institute of Forensic Medicine (VIFM) opined, based on fingerprint identification and circumstantial evidence, that the identity of the deceased was Mr Konstantinos Eleftheriou-Tragakis born 17 May 1981.

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

[8] (1938) 60 CLR 336.

POST-MORTEM EXAMINATION AND REPORT

34. The matter was appropriately referred to the Coroner. Having regard to the circumstances, and having conferred with a forensic pathologist, I directed an external-only post-mortem examination and ancillary tests be conducted. A post-mortem examination was performed by Forensic Pathologist Dr Gregory Young of VIFM.

35. Dr Young's anatomical findings included a ligature abrasion around the neck and small abrasion at the front of the neck. There were no unexpected signs of trauma. The post mortem CT scan revealed no additional significant pathology.

36. Dr Young advised that the immediate cause of Mr Tragakis' death was

    I (a) HANGING.

37. Dr Young commented that hanging is a form of asphyxia due to compression of the neck structures by a ligature tightened by the weight of the body.

38. Toxicological analysis of post-mortem blood specimens detected the presence of risperidone[9] (~2 ng/mL); hydroxyrisperidone (~11ng/mL); and paracetamol[10] (trace detected < 5mg/L).

Further investigation

39. I directed a Coronial Brief of Evidence be prepared. Subsequently a Coronial Brief was submitted by Constable Danilo Caruso of Glen Waverley Police Station. No suspicious circumstances were identified surrounding Mr Eleftheriou-Tragakis' death.

Family Concerns

40. On 7 June 2017, Mr Eleftheriou-Tragakis' brother sent email correspondence to the Coronial Admissions and Enquiries (CA&E) team raising concerns that despite his brother contacting the CATT on 4 June 2017, nobody came to assist him. Attached to that email was an image of mobile telephone screen depicting the details of a telephone call made to 9895 3333 at 5.53pm on 4 June 2017. The telephone call is listed as having lasted 11 minutes and 27 seconds. The Court was also provided with photographs of a suitcase that Mr

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[9] Risperidone is an atypical antipsychotic and is a selective monoaminergic antagonist with high affinity for serotoninergic $5HT_2$- receptors and dopaminergic D_2-receptors, prescribed for schizophrenia and some behavioural disorders such as delusions and aggression.

[10] Paracetamol is an analgesic drug available in many proprietary products either by itself or in combination with other drugs such as codeine or propoxyphene.

Eleftheriou-Tragakis allegedly packed in anticipation of CATT members arriving at his home.

41. On 8 March 2018, in light of the concerns raised, I sought, through my legal officer Mr Darren McGee, that Eastern Health provide a statement from the person who took the telephone call addressing the detail of the response provided to Mr Eleftheriou-Tragakis, and the proposed course of action. Eastern Health was later provided a copy of the email correspondence received by CA&E, the photograph which depicted the telephone call details, and the details of the incoming telephone number. On 11 April 2018, I queried whether Eastern Health had, or intended to, undertake an internal investigation into the matter of the telephone call.

42. On 16 April 2018 I received a statement made by Ms Sue Allen, Chief Counsel at Eastern Health, accompanied by cover correspondence in which Ms Allen advised that she had undertaken an internal inquiry. In her statement, Ms Allen commented:

> *"I have been advised by the Eastern Health Information Communication Technology Department that a call from a mobile phone whose number was 0415 752 541 was received by the switchboard at Eastern Health at 17:53 hours on 4 June 2017. I have been advised that this call was then transferred to the Eastern Health Psychiatric Triage number and was answered by the Triage clinician, Rebecca Vucic. Ms Vucic has advised me that she transferred the call to the CATT mobile phone whose phone number was 0409 197 787. Ms Vucic advised me that she transferred the call to Ms Cukon.*
>
> *I have spoken to Ms Cukon about this call and she has advised me that she has no recollection of taking the call nor is there any record of the call content."*

43. I considered Ms Allen's statement insufficient for the purposes of my investigation into Mr Eleftheriou-Tragakis' death, and the concerns subsequently raised by his family. On 27 April 2018, Mr McGee again wrote to Eastern Health noting that I had anticipated specific details of an internal review by management, and that I wanted to understand what the process entailed, the conclusions reached, and the refinements to protocols and practice introduced, to ensure, as best one can, that a similar event did not re-occur. Mr McGee also advised that given the proximity of Mr Eleftheriou-Tragakis' telephone call to the CATT to his death, I may make an adverse comment or finding in relation to the absence of any detail of the call received, and a subsequent failure to respond.

44. I subsequently received a statement from Associate Professor Paul Katz, executive Clinical Director of the Mental Health Program and the Clinical Director of Adult Mental Health at Eastern Health, dated 5 June 2018. In that statement, Assoc. Prof Katz wrote:

> *"By way of background, in accordance with usual practice, Eastern Health conducted a clinical review into the death of Mr Eleftheriou-Tragakis when it was notified of his suicide in June 2017. At the time of this review Eastern Health was unaware of the phone call to the CAT Team. This review did not identify any systemic issues as it found that the care provided to Mr Eleftheriou-Tragakis was appropriate.*
>
> *In terms of His Honour's request for a review by management, as set out in the statement of Ms Sue Allen dated 16 April 2018 (which has been provided to me) Eastern Health's records show that the call was transferred to the CAT Team Clinician at approximately 6.00pm on 4 June 2017. The CAT team Clinician to whom the call was apparently transferred states that she did not take the call. The CAT Team Clinician was working with another clinician that evening and they were together for the entire shift. The shift was very busy and the staff spent most of the shift at the inpatient unit as there were two admissions. The staff member advises that if she had taken the call it would have been documented and appropriate action taken.*
>
> *In light of the above, a subsequent clinical review was undertaken by Eastern Health. The letter from His Honour Coroner Byrne to Ms Sue Allen dated 8 March 2017 was provided to the review team. The review team commented that the request made by the patient to "come and get me, I need help, I have to come in" would almost invariably trigger an assertive response from the CAT team. The response could include:*
>
> *(a) A home visit on the same day to re-assess the mental state of the patient;*
>
> *(b) A call to the family of the patient to gain collateral information;*
>
> *(c) Consideration of an admission to the Acute Psychiatric Unit;*
>
> *(d) A call to emergency services.*
>
> *Eastern Heath accepts the statement of the mother of the patient but as a matter of usual practice, CAT team members would almost never advise a patient that they were coming to transport him to a hospital as a process of further assessment would first be required and transport is not provided by CAT Team staff. If urgent transport*

to hospital is required because of a psychiatric emergency an ambulance would be called or the family would be asked to transport the patient if it was safe to do so.

As a result of the review I have issued a notice to all staff members reminding them of the importance of documenting interactions with patients. A copy of the notice is attached to this statement.

In terms of the staff member involved her performance will be monitored..."

45. The notice attached to Assoc. Prof Katz's statement was in the form of an email referencing 'Coronial hearing themes' dated 31 May 2018. The email provided did not include reference to any procedures to be undertaken by staff in relation to documenting interaction with clients. It could be argued that this initiative was an implied concession as to the records issue.

46. On 18 June 2018, I directed that a Form 4 Notice be served on Ms Allen which sought that she produce all Crisis Assessment and Treatment Team (CATT) records and all Psychiatric Triage records for 4 June 2017 from the hours of 3.00pm and 12.00pm. The documents requested were produced to the Court the following day. The records produced demonstrate the following:

    a. At 5.25pm, Ms Vucic undertook a telephone assessment regarding a male who had concerns for his mother. Ms Vucic telephoned the mother at 5.30pm and spoke with her;

    b. At 5.28pm Ms Cukon entered a file note regarding a patient under an ITO who was returned to Upton House at 5.25pm;

    c. At 5.44pm, Ms Cukon entered a retrospective file note regarding a home visit made to another patient earlier that afternoon;

    d. At 5.50pm, Nurse Practitioner Gareth Jones made a telephone call to another patient's mother (evidenced by a retrospective file note entered at 9.15pm);

    e. At 6.14pm, Ms Cukon entered a contemporaneous file note of a telephone call she made to another patient regarding a home-visit the following morning;

    f. At 6.30pm, Ms Cukon telephoned a patient who agreed to a home visit, and she subsequently attended at that patient's home with RPN Tracey Unsworth at 7.00pm; and

    g. There was no records of any interaction with Mr Eleftheriou-Tragakis.

47. The obvious inferences which are open to be drawn are that Mr Eleftheriou-Tragakis:

i. was not triaged by a triage clinician, who merely put the call through to the CATT clinician; and

ii. for whatever reason a CATT clinician did not take Mr Eleftheriou-Tragakis's call.

48. I am unable to determine whether Mr Eleftheriou-Tragakis merely hung up while waiting the approximate ten minutes for the transferred call to be answered. It is possible that Mr Eleftheriou-Tragakis concluded, mistakenly as it turned out, that in transferring his call to the CATT that he would be picked up, taken to Eastern Health, and admitted. In the absence of a record of events, I am left to speculate, which has somewhat compromised my investigation.

49. On 2 July 2018, Mr McGee put Eastern Health on notice that it was my tentative view that there was a real prospect that I would be required to make an adverse finding, or at least comment, in relation to the management of Mr Eleftheriou-Tragakis on the evening of 4 June 2017. On the face of it, I noted that his management was, at best, suboptimal on at least two bases:

i. a complete failure to record Eastern Health's interactions with Mr Eleftheriou-Tragakis; and

ii. a failure of the triage clinician, Ms Vucic, to undertake an assessment sufficient to determine the appropriate urgency of response.

Eastern Health was queried as to whether they would seek to resist or counter the adverse findings or comments I had foreshadowed, and if resisted, on what basis such resistance would be founded.

50. On 2 July 2018 in correspondence Ms Allen advised the following:

> "*Eastern Health appreciates the Coroner giving it an opportunity to respond to the adverse inferences that may be drawn by the Coroner...*
>
> *... it is normal practice at Eastern Health that if Psychiatric Triage receives a call from a current CATT client, the Triage clinician will put the client directly through to CATT for assessment and treatment if required. This is because CATT, as the current treatment service for the client, would have a better understanding of the client's background, current treatment and management plan, and would be better placed to meet the client's needs at that time. In these circumstances, the Triage clinician would not normally undertake an assessment of the client. I am instructed that this is also normal practice at other public mental health services.*

... I regret to advise that my enquiries did not elicit any further information about why the CATT clinician did not take the patient's call."

51. I note that in their response, Eastern Health did not explicitly respond to my query as to whether they would resist an adverse comment and if so on what basis.

52. On 5 July 2018, I requested through my legal officer that Eastern Health provide:

    a. a copy of it protocols/practices which cover the scenario involving a call being received at psychiatric triage from a current CAT client, and then being transferred directly through to a CATT member for assessment and treatment if required;

    b. whether there is a contingency plan in place if a call were to be transferred from the triage team to the CATT, and for whatever reason, not answered by a CATT member; and

    c. confirmation that their email dated 4 July 2018 represented their complete response to the Court's correspondence dated 2 July 2018, and that no additional response could be anticipated.

53. On 10 July 2018, Ms Allen responded as follows:

    "I am instructed that there is no particular written protocol or practice which covers the scenario involving a call being received by psychiatric triage from a current CATT client. I am instructed however that it is the usual practice for psychiatric triage to forward a call from a current CATT client to CATT.

    Similarly, there is no particular written protocol or practice for when a call is not answered by CATT. If a call is not answered by CATT, and the triage clinician does not deem the matter to be an emergency, the usual practice is as follows:

        1) During business hours, the call is forwarded to the administrative staff who will take a message and pass it on to CATT; and

        2) Outside business hours, the triage clinicians themselves will take a message and forward it to CATT during business hours the next day.

    I confirm that my email of 4 July 2018 represents Eastern Health's complete response to your correspondence of 2 July 2018."

54. I note that neither Assoc. Prof Katz nor Ms Allen explicitly responded to my foreshadowing that an adverse finding/comment may be made. I am satisfied that Eastern Health has been provided sufficient opportunity to put the Court on notice of any possible resistance to such a finding. On the basis of Ms Allen's confirmation in her email correspondence dated 10

July 2018 that her email of 4 July 2018 represented Eastern Health's complete response to our earlier correspondence, I propose to make the adverse comments that I foreshadowed.

55. The deficiencies identified in the management of Mr Eleftheriou-Tragakis on this occasion are in many ways interconnected.

56. Noting that Assoc. Prof Katz advised that at the time of Eastern Health's initial clinical review the reviewers were unaware of the phone call to the CATT and the failure to records details of the contact, which it is clear was indeed made that evening, means precise details of the interaction between Mr Eleftheriou-Tragakis and Eastern Health clinicians is unable to be determined, hence compromising my investigation.

57. In light of the fact that Mr Eleftheriou-Tragakis' call was not answered by a CATT clinician and the call was not redirected back to Ms Vucic, the triage clinician, as was "usual practice", no assessment was undertaken to determine the urgency of any response.

58. On the basis of the earlier correspondence and statements provided by Eastern Health, particularly the information provided in Eastern Health's email correspondence of 10 July 2018, even in the absence of a formal practice/protocol, Eastern Health's "usual practice" with respect to unanswered CATT calls was not followed when in contact with Mr Eleftheriou-Tragakis on 4 June 2017.

59. In his statement, Assoc. Prof Katz concluded by saying:

> *"By way of additional background which may assist the Coroner, the Eastern Health Psychiatric Triage Service received 25,455 incoming calls in the calendar year of 2017. The staff who work in Eastern Health's Mental Health Quality, Performance and Innovation Area (QPI) who monitors incidents have been contacted to advise if there have been reports or complaints of a similar nature in the last 12 months. The staff advise that they are unaware of any similar incidents."*

As to that claim, if, as happened here, no records of a contact were made, it leaves open that similar incidents may have occurred. This incident, in my view, clearly demonstrated that a formal protocol should be developed and implemented to address this issue.

60. While I take Assoc. Prof Katz's point, I note that Eastern Health has been on notice that there has been an issue with respect to a CATT clinician failing to answer a telephone call since 8 March 2018, when Mr McGee first wrote to them. Some four months have passed and during this time extensive correspondence has passed between the Court and Eastern Health. More recently Eastern Health have not confirmed that a written protocol or practice

with respect to telephone calls transferred to the CATT which are not answered has been implemented.

61. Furthermore, there has been no advice or indication from Eastern Health that an appropriate written protocol or procedure will be implemented to avoid a similar situation in the future.

62. I am satisfied, having considered all of the evidence before me, that no further investigation is required.

FINDING

63. I formally find that Mr Konstantinos Eleftheriou-Tragakis died at Wellington Reserve, Mulgrave, Victoria on 5 June 2017 as a result of hanging in circumstances where he intended to take his own life.

COMMENT

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

65. In passing it must be said that if there was an expectation that a CAT member would attend that evening in response to Mr Eleftheriou-Tragakis' telephone call, as no one had attended by midnight it was open to the family to make a further telephone call for assistance, or indeed if it was thought urgent enough to convey Mr Eleftheriou-Tragakis to hospital for further assessment.

RECOMMENDATION

66. Pursuant to section 72 (2) of the *Coroners Act 2008*, I make the following recommendation connected with the death.

67. I recommend Eastern Health, if it has not already done so, develop and implement a formal procedure/practice/protocol to the effect that if a call for assistance is put through to a CATT clinician and for whatever reason is not answered, then the call is automatically re-directed back to the initial call taker so that an initial risk assessment can be undertaken.

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

Mrs Kouzinia Tragakis, Senior Next of Kin;

Assoc. Prof Paul Katz, Executive Clinical Director Mental Health Program c/o Eastern Health;

Ms Melanie Kyezor, Clinical Risk Manager c/o St Vincent's Health;

Dr Neil Coventry, Chief Psychiatrist c/o Office of the Chief Psychiatrist; and

Constable Danilo (#41421) c/o Glen Waverley Police Station, Coroner's Investigator, Victoria Police.

Signature:

PHILLIP BYRNE
CORONER
Date: 13 July 2018