IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2010 002621

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 ROBERT GLAISHER
without holding an inquest:
find that the identity of the deceased was ROBERT GLAISHER
born on 15 July 1953
and that the death occurred on 8 July 2010
at Rosebud Hospital, 1527 Nepean Highway, Rosebud West Victoria 3940

from:

I (a) HYPOTHERMIA.

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

1. Mr Glaisher was a 56-year-old man who had separated from his wife, Rosemary Glaisher, and was living alone in the family beach house in Rye. Mr Glaisher had previously lived in the family home with his wife and their two daughters, and had been driving from Bendigo to Melbourne for work for many years, before changing his workplace to Ballarat. Although employed as a Professor of Physics at a university, he had been unable to work for some time and was on extended sick leave.

2. Mr Glaisher reported suffering depression, which he preferred to refer to as a chemical imbalance in the brain, since early 1973, with his most difficult period being the six years immediately before his death, which he had tried to manage with a combination of yoga, meditation and exercise.

3. In late 2008, Mr Glaisher began to seek medical treatment. He saw Consultant Psychiatrist Dr Erihana Ryan and general practitioner (GP) Dr Moli Tamanika in Bendigo. Mr Glaisher was

prescribed the antidepressant Venlafaxine, which was later changed to Escitalopram, which he was still taking at the time of his death.

4. Mr Glaisher's symptoms included high levels of anxiety, marked weight loss over the year prior to his death, sleeplessness, loss of concentration and lapses in memory. He reported multiple stressors in his life; the dissolution of his marriage, inability to be with his daughters, inability to work, especially guilt about letting down his PhD students, his sister's serious illness, the loss of his driver's licence and the sale of the family home.

5. On 26 July 2009, Victoria Police completed a welfare check at the request of Ms Rosemary Glaisher who was concerned because she had not heard from Mr Glaisher in three days. After locating him, police transported Mr Glaisher to the Frankston Hospital Emergency Department (ED) where he was assessed by medical staff before being assessed by the Consultation Liaison Inpatient Psychiatry Service (CLIPS), and referred to the Peninsula Health Port Philip Community Mental Health Team.

6. Mr Glaisher was allocated a case manager, Registered Nurse Mr Tony Flynn. Between 27 July 2009 and 1 March 2010, Mr Glaisher received comprehensive and multidisciplinary harm minimisation-focused care, combined with treatment of his depression, from Mr Flynn and the Port Philip Community Mental Health Team (Port Philip Team).

7. In December 2009, an inpatient stay at the Rosebud Hospital Walker Unit was arranged because Mr Glaisher developed elevated Liver Function Test results, and expressed a desire to stop drinking alcohol. Mr Glaisher reported a 12-year history of alcohol abuse and more recently heavy and uncontrolled drinking. Although he completed the five-day acute withdrawal program during admission, but he re-commenced drinking soon after discharge.

8. Throughout the period of care by the Port Philip Team, and with Mr Glaisher's consent, the team liaised with and involved Mr Glaisher's private medical practitioners Dr Ryan and Dr Tamanika, and Rosemary Glaisher in his care.

9. A feature of his engagement with the Port Philip Team was his insistence on what he saw as a logical approach when discussing his illness with staff, refusing to use the term depression, preferring instead to refer to his illness as a chemical imbalance in the brain. When staff provided information about possible treatments for his substance abuse such as Cognitive Behavioural Therapy, Mr Glaisher required scientific evidence of its effectiveness and remained resistive to therapies and engagement with the local drug and alcohol services. He

consequently did not participate in any therapies, and on referral to the Peninsula Health Drug and Alcohol Program (PenDAP), he would not engage with the service.

10. On several occasions, Mr Glaisher did not attend appointments, despite proactive reminders from staff. On other occasions, Mr Glaisher cancelled appointments reporting to staff that he was either returning to Bendigo for a few days, or that he was ill. On each of these occasions, staff were alerted by Rosemary Glaisher to the fact that Mr Glaisher remained at home in Rye and could be uncontactable on the whole. Staff attempted telephone contact on each occasion, which was not always successful, as Mr Glaisher would unplug his home telephone. On occasions, staff would undertake or attempt home visits or request police conduct a welfare check.

11. Mr Glaisher reported a reduction in his drinking and wanted to return to work for brief periods, however, it appears that the decision to discharge him from the Port Phillip Team was based on his continued drinking and non-engagement with services. Mr Glaisher appears not to have engaged with his GP or PenDAP, even though a referral had been made and Mr Glaisher was involved in the discharge planning process and aware of the referral. A medical certificate was issued by Peninsula Health Consultant Psychiatrist Dr O'Loughlin, for Mr Glaisher dated 5 March 2010, citing an emotional illness as the reason for his unfitness of employment for eight months from 27 July 2009 until 31 March 2010 for an emotional illness.

12. Mr Glaisher had no involvement with Peninsula Health in April or May 2010. However, on 25 June 2010, CLIPS received a telephone call from Rosemary Glaisher who said that she had been unable to contact Mr Glaisher for three days. The matter was reported to Victoria Police who conducted a welfare check at his home but could not find him.

13. Two days later on 27 June 2010, Mr Glaisher was found at home, and said that he had gone for a long walk. He was assessed as physically run down but not mentally unwell, and agreed to see his GP, but it is not clear whether he did so. Dr Stephanie Ryan, GP, had provided services as part of the Port Philip Team service at Bayview House whilst he was a patient and offered to see Mr Glaisher privately in her rooms in Mornington after his discharge, but he did not make an appointment with her. It is not clear if he returned to his GP in Bendigo at this time.

14. On 4 July 2010 Mr Glaisher's sister, Ms Susan Glaisher, contacted her brother by telephone and noted that he seemed agitated and paranoid. She asked him to stop leaving his telephone off the hook, as he had been known to do, so that he was at least contactable.

15. On 5 July 2010, after finding him at his home in Rye acting strangely, Victoria Police escorted Mr Glaisher to the Rosebud Hospital from where he was then taken by ambulance to Frankston Hospital ED for assessment. Mr Glaisher was confused, agitated, disorientated, and at times incoherent, and reported seeing four children in his home who had escaped through the vents. He did not appear to be affected by alcohol at the time these observations were made.

16. Mr Glaisher was triaged at Frankston Hospital at 5.23pm, given some food and drink and assessed by Medical Officer Dr Jonan Woo, who found him to be suffering from delusions and then referred him to CLIPS. Registered Nurse Mr Stephen Blowfield who saw Mr Glaisher between this medical assessment and before he was discharged home from the ED alone in a taxi at 7.30pm, assessed his mental state as 'reasonably good'. The medical records document that Rosemary Glaisher was contacted about his discharge by telephone, but do not indicate by whom, at what time or what was discussed.

17. The following day, 6 July 2010, Mr Blowfield faxed a copy of his assessment documentation to the Port Phillip Team at Bayview House at 12.03pm.

18. Some time after the day shift commenced on 6 July 2010, Registered Nurse and Port Phillip Team Manager Mr Paul Blakely reviewed the faxed information provided in the assessment from Mr Blowfield. In response to the lack of information in the referral, Mr Flynn attempted to telephone Mr Glaisher without success, before conducting a home visit and finding the house locked and no response to his knocking. With the aim of gleaning more information about Mr Glaisher's current state, Mr Flynn requested a copy of the Frankston Hospital ED notes, but they provided no additional information. Mr Flynn documented a decision to discuss the non-urgent referral on 7 July 2010, and from 4.01pm, another clinician made several attempts to contact Mr Glaisher and Rosemary Glaisher over the afternoon and into the following day.

19. On 7 July 2010, Mr Blakely contacted Registered Nurse and CLIPS Team Leader Ms Margaret O'Donnell and refused the referral from CLIPS based on the information contained in the assessment document, and requested CLIPS to complete a re-triage.

20. On the morning of 8 July 2010, the deceased's sister Susan Glaisher, who had frequent contact with her brother, became concerned when she could not reach him by telephone. Susan Glaisher contacted Victoria Police at Rye and requested a welfare check. The Peninsula

Health medical records indicate that CLIPS also requested police to conduct a welfare check on 8 July 2010.

21. At 10.40am on 8 July 2010, Rosebud Police found Mr Glaisher naked, alive but unconscious on the floor of his home. The back door was open, the heater was off and there was no evidence of alcohol or empty alcohol in the premises. Police called an ambulance, including a MICA unit, who attended and attempted resuscitation before conveying Mr Glaisher to Rosebud Hospital ED. Unfortunately, Mr Glaisher could not be revived and died at 1.20pm.

22. An autopsy of Mr Glaisher's body was performed by Forensic Pathology Registrar Dr Julie Teague from the Victorian Institute of Forensic Medicine (VIFM) who reviewed the circumstances as reported by the police to the coroner and post mortem CT scanning of Mr Glaisher's body, and provided a detailed written report of her findings. Having done so, Dr Teague attributed Mr Glaisher's death to *hypothermia*, and advised that the autopsy revealed significant natural disease consistent with hypothermia. Dr Teague noted police observations that the house was cold, and medical notes that documented that Mr Glaisher had an antemortem temperature of 25 degrees Celsius. Dr Teague advised that there is a phenomenon of *paradoxical undressing*, where a cold person removes their clothes and is often found scantily clad or naked.

23. Dr Teague further commented that *to become hypothermic a person needs to be either unaware that they are severely cold (intoxicated, unconscious, unwell etc) or unable to warm themselves (lost in a cold environment etc).* She also made findings of natural disease processes, consistent with Mr Glaisher's history of alcohol misuse, including hepatic steatosis and fibrosis, testicular atrophy and Purkinje cell dropout and gliosis of the cerebellum.

24. Toxicological analysis of antemortem samples revealed acetone in blood at ~390mg/L and in vitreous humour at ~490mg/L. Glucose was not detected in vitreous humour. Dr Teague advised that acetone concentrations can increase in fasting, which was the likely mechanism in this case. Ethanol (alcohol) was not detected, and Dr Teague noted that the presence of a fasting state could imply that there was a time delay from becoming hypothermic and death. This length of time makes it possible that alcohol may have been present (even at quite significant levels) at the time of onset of hypothermia, but had been metabolised by the time of death. Dr Teague further stated that the absence of alcohol does not exclude it as the cause of Mr Glaisher's episode of hypothermia.

25. Microbiological studies revealed *Streptococcus viridans* isolated from blood. This organism normally exists in the mouth and can be a cause of endocarditis. Dr Teague commented that sepsis may have caused confusion, thereby making it possible for Mr Glaisher to become hypothermic, or that having become hypothermic Mr Glaisher may have been susceptible to septic infection.

26. I find the cause of Mr Glaisher's death to be hypothermia.

27. In light of the circumstances in which he died, I asked a Mental Health Investigator from the Coroners Prevention Unit (CPU)[1] to review the adequacy of the clinical management and care provided to Mr Glaisher at the Frankston Hospital ED, specifically the psychiatric and medical assessments conducted proximate to his death, and any discharge planning.

PSYCHIATRIC AND MEDICAL ASSESSMENTS

28. The CPU advised that when Mr Glaisher was assessed at the Frankston Hospital on 5 July 2010, basic observations/vital signs were taken on arrival. According to the medical records, Dr Woo did not complete any other form of physical assessment of Mr Glaisher. Victoria Police and the triage clinician described Mr Glaisher as shaking, trembling, confused, very anxious, at times incoherent and claiming to be at the ED because he hit a dog and broke its leg and the vet wanted a medical clearance.

29. According to the CPU, little effort was made to ensure there were no medical issues contributing to Mr Glaisher's presentation before referring him to CLIPS. Whilst it is apparent that Dr Woo was aware of Mr Glaisher's history of alcohol abuse, in his assessment he did not consider a possible withdrawal syndrome as a possible explanation for his presentation. In the medical records there is also a reference to possible epilepsy, yet there is no documented effort to assess Mr Glaisher for the after effects of a seizure, nor to indicate that possible epilepsy was being investigated.

30. The CPU also found that the documentation of the psychiatric assessment completed by Mr Blowfield was poor, and noted that it appeared that Peninsula Health had an electronic record system that appeared to allow for the cutting and pasting of clinical information from one document to another. The assessment documentation faxed to the Port Phillip Team regarding

[1] The Coroners Prevention Unit (CPU) is a specialist service comprising a team of investigators and health clinicians. The CPU assists coroners fulfil their prevention role and contribute to a reduction in preventable deaths.

the ED assessment on 5 July 2010 was incomplete and contained inaccurate information.[2] The content appears to largely replicate the Clinical Assessment Documentation completed by the Port Phillip Team when Mr Glaisher was still a current patient prior to 3 March 2010.

31. Mr Blowfield had access to Mr Glaisher's history and did not record any assessment of Mr Glaisher's recent consumption of alcohol. The fax covering letter from Mr Blowfield to the Port Philip Team indicates a predominantly physical problem, and the presenting problem section of the assessment states that Mr Glaisher was not depressed, but was very shaky and that this required a full medical investigation. This is at odds with a decision to discharge and re-refer Mr Glaisher to the Port Philip Team, and more in keeping with a re-referral to the medical staff in the ED for a full medical assessment.

DISCHARGE PLANNING

32. The CPU advised that the discharge planning from the ED was entirely reliant on the outcome of the CLIPS assessment, with Mr Glaisher being discharged home alone by taxi. Mr Glaisher was given food and drink before discharge, and it is unclear what prompted the offer of food and drink, as patients are not routinely fed while waiting for less than two hours in an ED in Victoria.

33. Mr Glaisher was discharged home from the ED with an expectation the Port Phillip Team provide follow-up and arrange a full medical review. It is not clear why Mr Blowfield thought it appropriate for the community mental health team to do this, if it was the sole presenting problem. Further, the CPU noted that the request for follow-up in the community conveyed no sense of urgency or recognition that withdrawal from alcohol was a possible explanation for Mr Glaisher's presentation.

PENINSULA HEALTH RESPONSE

34. Peninsula Health has reviewed the circumstances surrounding Mr Glaisher's death and has implemented five changes to improve the safety of patients who present to the ED for assessment. Associate Professor Sean Jespersen, Clinical Director, Peninsula Health Mental Health Service provided a statement advising of the following changes:

    i. All assessments conducted by ED mental health clinicians on patients that are subsequently discharged home from the ED are now subject to a clinical review process

[2] For example, there were references to Mr Glaisher still being well engaged with Dr O'Loughlin in one section, and no professional supports apart from Peninsula Health in another. Mr Glaisher had been discharged from the Port Phillip Team in March 2010, therefore neither statement is accurate.

lead by a consultant psychiatrist and the team manager. The monitoring and clinical review of telephone triage contacts has also been improved.

ii. A number of clinical practice guidelines relevant to Mr Glaisher's case have been developed and updated. These include joint clinical practice guidelines between the mental health service and the ED that clarifies the assessment and management of substance-related presentations, as well as the need for mental health patients presenting to the ED to be medically assessed.

iii. The in-service training and education program for triage and ED mental health clinicians, particularly with regard to standards of practice and the new clinical practice guidelines, have been considerably enhanced. The performance of the individual ED mental health clinician involved in this case has been thoroughly addressed.

iv. Regular meetings of senior ED and mental health service staff take place in order to facilitate improved clinical practice, communication and joint education across both areas.

v. The referral process between triage and ED mental health clinicians and community mental health teams has been improved and checks are in place to ensure that unnecessary delays do not occur. The duty triage clinician contacts each community team every morning to ensure that all referrals from the preceding day have been received and to clarify any missing information. Community teams are expected to take responsibility for promptly following up referrals even if they consider them to have been inappropriate.

COMMENTS

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

1. I am unable to determine the events that led to Mr Glaisher lying naked on the floor in his home with the back door open, leading to the development of hypothermia and his death. However, Mr Glaisher had a lengthy history of deterioration over the two years prior to his death, and the available evidence indicates that, although he baulked at the description, he did have a depressive disorder and a significant problem with alcohol abuse.

2. Mr Glaisher may well have decided to reduce his alcohol intake, or to cease it all together as he had on several occasions prior, with the belief he was ready to make changes to his

lifestyle. This case highlights that withdrawal from alcohol is a significant medical event, with many possible complications including shaking, trembling, delirium tremens, hallucinations, seizures, black outs, fatigue and loss of appetite.

3. There was an opportunity for intervention with Mr Glaisher on 5 July 2010. The medical and the psychiatric assessments undertaken in the Frankston ED on that day were suboptimal, and the clinical response deficient to the extent that it did not address the possibility of an acute alcohol withdrawal.

4. I am unable to determine what happened to Mr Glaisher over the following two days, but it is entirely possible that he experienced the complications of acute withdrawal from ceasing his heavy alcohol intake. It is also possible, although less likely in my view, that he was drinking heavily.

5. During the two days following Mr Glaisher's last ED presentation, there was also opportunity for the Port Phillip Team, CLIPS or Mr Glaisher's family to ask police to conduct an earlier welfare check as had occurred on previous occasions, with the possibility of a different outcome.

6. I acknowledge that Peninsula Health has reviewed the circumstances of Mr Glaisher's death and implemented significant changes, and I recognise that these changes have the potential to improve patient safety, and minimise the risk of deaths in similar circumstances in the future.

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

Ms Susan Glaisher

Ms Rosemary Glaisher

Ms Janet Pugh, Peninsula Health

Dr Mark Oakley Browne, Chief Psychiatrist

Leading Senior Constable Colin Barber, Rosebud Police Station.

Signature:

PARESA ANTONIADIS SPANOS
CORONER
Date: **25 March 2014**

Cc: Manager, Coroners Prevention Unit