IN THE CORONERS COURT

OF VICTORIA

AT MELBOURNE

Court Reference: COR 2015 5925

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)

*Section 67 of the **Coroners Act 2008***

Findings of:	Paresa Antoniadis Spanos, Coroner
Deceased:	Adrian Westropp Hamilton
Date of birth:	6 September 1954
Date of death:	On or about 20 November 2015
Cause of death:	Hanging
Place of death:	Hepburn Springs, Victoria

I, PARESA ANTONIADIS SPANOS, Coroner,

having investigated the death of ADRIAN WESTROPP HAMILTON

without holding an inquest:

find that the identity of the deceased was ADRIAN WESTROPP HAMILTON

born on 6 September 1954, aged 61

and that the death occurred on or about 20 November 2015

at 20 Forest Avenue, Hepburn Springs, Victoria, 3461

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 Hamilton was a 61-year old man who lived alone at the above address. At the time of his death he was unemployed. Mr Hamilton's long-time friend Toby Sime described him as a very friendly, warm and lovely person. He loved to swim and spent time outdoors and was very social but also enjoyed solitude.

Circumstances immediately proximate to death

2. Around early November 2015, Mr Hamilton was at the homee of his friends Anna Parsons and Mr Simes. Ms Parsons thought Ms Hamilton seemed clearly depressed and that something significant was worrying him. Mr Hamilton's presentation was somewhat erratic, and Ms Parsons found his speech hard to follow and tangential. He also seemed to harbour some delusions about Centrelink. Eventually, the pair established that Mr Hamilton was worried about not doing some mandatory volunteer work. Ms Parsons urged Mr Hamilton to see a doctor.

3. Mr Sime also saw a change in Mr Hamilton's demeanour. While he had observed lowered mood in Mr Hamilton in the past, he had never seen his friend so down. He was disturbed, silent and withdrawn and would not even look Mr Sime in the eye.

4. On 13 November 2015, Ms Parsons made an appointment for Mr Hamilton at Springs Medical Centre and took him there herself. Mr Hamilton saw general practitioner

(GP) Dr Gerard Ingham. Dr Ingham noted that Mr Hamilton did not have a Medicare card, which suggested to him that he had not sought medical attention for many decades. Mr Hamilton's medical history was difficult to elicit, and it was not immediately clear what prompted his attendance on this occasion. However, he reported low mood and described a recent realisation that he had not worked for some time and was a burden on society. A sense of guilt and shame pervaded his presentation.

5. Mr Hamilton told Dr Ingham that he thought he would be in trouble from Centrelink because he had not always been honest on his declarations and feared he might be taken to court and lose his house. It appeared to Dr Ingham that Mr Hamilton planned to make admissions along these lines to Centrelink and was not exhibiting delusional thoughts. Mr Hamilton reported recent weight loss but no sleep disturbance. He was currently abstinent from alcohol, whereas he had abused alcohol in the past, reported having supportive friends and described suicidal thoughts but no plans.

6. Dr Ingham found it difficult to discern Mr Hamilton's precise concerns but noted that he did not have ideas of flight and that his fear about Centrelink was not unreasonable. Dr Ingham had the impression that there was something else troubling Mr Hamilton, which might be revealed once trust and rapport had been established.

7. Mr Hamilton was diagnosed with depression of moderate severity and Dr Ingham wondered whether the cessation of alcohol had unmasked a latent depression. The offer of medication was refused by Mr Hamilton, who accepted a certificate for Centrelink so that he could continue to receive benefits without having to look for work. Mr Hamilton appeared somewhat reassured that Dr Ingham was willing to help him and that he had a diagnosis. An appointment was made for the following week.

8. A few days later, Mr Hamilton helped his long-time friend, Gary Thomas relocate his business. Afterwards, a barbeque was held for the 15-20 helpers, but Mr Thomas seemed somewhat withdrawn and did not seem to eat or drink anything. At about the same time, Mr Hamilton stopped playing volleyball with Mr Thomas which they had played together for years.

9. In the days leading to his death, Mr Hamilton went to Mr Sime's house and told him that he had disgraced himself and that everyone would soon find out and dislike him for it. Mr Sime felt that Mr Hamilton was very agitated and disturbed in his mind.

10. On 16 November 2015, Ms Parsons spoke to Mr Hamilton on the telephone. He sounded slow and was not his usual self with erratic speech patterns.

11. The next day, Ms Parsons took Mr Hamilton to Ballarat Centrelink where it was determined that there was no issue with his entitlements. After the appointment, Mr Hamilton told Ms Parsons that he was sure that the problem remained, but that Centrelink were not yet aware. The pair spent the day in Ballarat.

12. Afterwards, Ms Parsons telephoned the Ballarat Health Service mental health triage service (the triage service) and expressed concerns about Mr Hamilton. Mr Hamilton was assessed by the triage service as being at a low to moderate risk overall and there appeared to be an agreement that the situation would be reassessed once Mr Hamilton attended his appointment with Dr Ingham the next day.

13. However, Mr Hamilton did not attend the appointment with Dr Ingham on 18 November 2015.

14. Over the next two days, Ms Parsons telephoned the triage service expressing concerns about her friend and indicating he was amenable to engaging with the Ballarat Mental Health Service team (BMHS). Ms Parsons also informed them that Mr Hamilton had not attended his GP appointment. A multidisciplinary team meeting at BMHS (MDTM) took place that day concerning Mr Hamilton.

15. On 19 November 2015, a triage clinician spoke to Mr Hamilton on the telephone and offered him a home visit at 10am or a hospital visit at 1.30pm. Mr Hamilton declined the morning visit as he had a meeting at Centrelink that morning and he did not attend the hospital that afternoon. A further MDTM was held that day.

16. That evening, Ms Parsons telephoned triage after Mr Hamilton's non-attendance at hospital and asked for an assessment. The duty triage clinician told Ms Parsons that there were no acute concerns and no request for follow up had been made by the treating clinician.

17. On 20 November 2015, a MDTM was held and it was determined that a non-urgent appointment be offered for the following week. That afternoon, a triage clinician called Mr Hamilton without success.

18. On the evening of 20 November 2015, when Ms Parsons could not raise Mr Hamilton on the telephone, she called the triage service again. They reportedly indicated that

they did not consider that Mr Hamilton was at risk of imminent harm because he had been talking about plans for the next day and he had never specified the manner in which he would end his own life.

19. Mr Hamilton remained uncontactable and at about 9pm, Ms Parsons arranged for Mr Thomas to visit Mr Hamilton. Mr Thomas and his wife went to Mr Hamilton's house and found his car was in the yard and all lights off in the house. Mr Thomas entered the house through the unlocked front door and came upon Mr Hamilton hanging from a ligature attached to an unfinished wall frame near the bedroom. It was apparent that Mr Hamilton had been deceased for some time.

20. Mr Thomas called emergency services and Ambulance Victoria paramedics and Victoria Police members responded a short time later. Mr Hamilton was pronounced deceased by the paramedics.

21. Victoria Police members found nothing to suggest a struggle or that Mr Hamilton had died in suspicious circumstances or that drugs or alcohol were involved in his death. They noted that Mr Hamilton was naked and partially suspended, that is with his feet touching the ground. Police found a handwritten note that appeared to be concerned with the meaning of life and later ascertained that it was an extract from the book *"A Life Worth Living: Albert Camus and the Quest for Meaning"* written by Robert Zaretsky with an addendum saying *"I just did not understand"*.

22. This finding is largely based on the investigation and the coronial brief of evidence compiled by one of the attending police members Senior Constable Angela Bertocchini from Daylesford Police.

Medical cause of death

23. On 23 November 2015, Senior Forensic Pathologist Dr Matthew Lynch performed an external examination on the body of Mr Hamilton in the mortuary and reviewed the circumstances of the death as reported by police to the Coroner and post mortem computed tomography scans of the whole body (PMCT).

24. Dr Lynch advised that his findings on external examination were consistent with the circumstances as reported by police with no evidence of significant injury apart from a ligature mark about the neck with some associated abrasion and with dimensions approximating the belt which had been used as a ligature.

25. Routine toxicological analysis of post-mortem blood testing did not reveal ethanol (alcohol) or any other commonly encountered medications, drugs or poisons.

26. Dr Lynch advised that it would be reasonable to attribute Mr Hamilton's cause of death to *hanging,* without the need for an autopsy.

Mental Health Investigation

27. I asked a Mental Health Investigator (MHI) from the Coroners Prevention Unit to assess the management of Mr Hamilton following Ms Parson's referral to the triage Service on 17 November 2015. Their advice was based on the coronial brief, medical records and additional statements[1] collected over the course of the coronial investigation.

28. The MHI commented that according to the available documentation, there was only one telephone contact with Mr Hamilton on 19 November 2015 and no comprehensive mental health assessment made that day. This gave rise to concerns about the application of the Victorian Mental Health Triage Scale (VMHTS), the assessment and reassessment of risk and level of engagement and the MDTM review process as it pertained to Mr Hamilton.

29. The VMHTS mandates that a response category be assigned at each contact with the triage service and indicates the type and timeframe for response to a referral. It does not replace clinical judgment, but the selection of the appropriate triage category is informed by clinical judgment. The overarching purpose of the triage system is to decide whether a person needs further assessment by the mental health service or some other service, and the type and urgency of the response required from a service.

30. Ratings on the triage scale are made after an appropriately qualified and skilled mental health clinician has conducted a triage assessment via the collection of enough demographical, social, health and clinical information to determine whether there is a need for further assessment or intervention by a service. The response category should be assigned in accordance with the State-wide triage scale.[2]

[1] Comprising statements from involved clinicians, Ballarat Health Service and The Office of the Chief Psychiatrist

[2] Ballarat Health Service Clinical Practice Guideline Triage and Service Access – Mental Health Service

31. In the case of Mr Hamilton, the mental health clinician ascribed him a Category E response, which is a low risk of harm in the short-term or moderate risk with high supports and stabilising factors, indicating a non-urgent mental health assessment was recommended. The clinical rationale behind this decision was based on the likelihood that Mr Hamilton was experiencing symptoms of depression and paranoia that required further investigation via a mental health assessment, evidence of overall low to moderate risk factors with no acute risks requiring immediate intervention, an awareness that Mr Hamilton had seen his GP on 16 November 2015, made no referral to BMHS, and that a follow up GP appointment was booked for 18 November 2015.

32. The MHI commented that the initial response Category E[3] was not unreasonable based on the triage clinician's rationale and the plan for BMHS to make contact after the GP appointment to review the outcome of the appointment, the risks and Mr Hamilton's willingness to engage with a BMHS assessment.

33. However, Mr Hamilton did not attend his GP appointment. While BMHS offered him appointments, including on 19 November 2015 when they became aware that he had not seen his GP on 18 November 2015, he did not attend.

34. Ms Parsons placed follow up calls to BMHS on 18, 19 and 20 November 2015. While the State-Wide Triage Scale (SWTS) does not encourage revision of the initial response category, it does require new contacts in relation to an individual to be treated as a new contact episode, requiring reassessment in the context of the present circumstances. Each triage contact needs to be given a rating. The BHMS guidelines mirror the state-wide guidelines. However, BHMS did not appear to have considered the contacts made by Ms Parsons between 18 and 20 November 2015 as new contacts and accordingly, they did not trigger a reassessment in light of any changes or new information.

35. On 19 November 2015, Ms Parsons requested a home visit due to further concerns, but this was refused as the triage clinician had no acute concerns and had not requested follow up. The MHI noted that there was no documented assessment of risk for that contact, no apparent consideration of Mr Hamilton's failure to attend two

[3] Response Category E does not have a required response time

appointments, or evaluation of Ms Parson's continuing concerns and no evidence of the contact resulting in the assigning of a response category.

Risk and engagement

36. The SWTS acknowledges the issues with assessing mental state over the telephone as the triage clinician is unable to see the patient which can make it difficult to develop rapport and to provide an adequate mental state assessment. The MHI considered that a risk assessment completed via telephone and/or based on third party report is unreliable. In this instance, no escalation was triggered when there was a change in circumstances and it appeared that the triage clinicians relied on Ms Parsons to assess the risks for Mr Hamilton and to make a decision to contact BHMS, police or ambulance if she was concerned enough.

37. A comprehensive assessment was not completed, nor were efforts made to gather collateral information to inform an assessment of Mr Hamilton's risks between 17 and 20 November 2015. A follow-up plan was made on 20 November 2015, which included contacting Mr Hamilton's GP if he did not present over the weekend.

38. The MHI observed that the BMHS guidelines stipulate that there should be proactive engagement with a patient's GP, however that did not occur even after BHS were aware that Mr Hamilton missed his GP appointment on 18 November 2015. Mr Hamilton's lack of engagement did not appear to prompt a consideration that his risk may have changed. The MHI considered this to be unreasonable because the initial risk assessment was based on third party information, not formally repeated at the only telephone contact with Mr Hamilton and was predicated on the notion that he would engage with BHS and his GP.

39. The SWTS notes that poor engagement can increase risk to the individual or others, necessitating a higher-level triage disposition. The BMHS Guideline, *Clinical Risk Assessment and Management*, outlines the requirements for a comprehensive assessment of risk and requires a documented assessment of risk to be completed with each contact with a patient. Since no comprehensive assessment was conducted and only a single telephone contact was made with Mr Hamilton, the MHI considered that the reliability of any assessment of Mr Hamilton's mental state and risks was low and had limitations.

40. On 18 November 2015, Ms Parsons told the triage clinician on duty that Mr Hamilton was not sleeping, had superficial scratches on his arms and had turned himself in to police that morning. Ms Parsons requested an assessment as soon as possible. The triage clinician documented that she discussed options with Ms Parsons that comprised calling an ambulance to have Mr Hamilton transported to hospital or to have a friend stay overnight. It appeared to the MHI that the triage clinician considered Mr Hamilton's risk enough to warrant a response but left the decision of what was to happen up to Ms Parsons.

41. In response to a further call from Ms Parsons on 19 November 2015, the Triage Clinician on duty documented "Did not go to GP. Wanted home visit now. Due to there being nil acute concern's in the TC's (treating clinician's) note and TC not requesting follow-up from DW (duty worker) this did not appear required." The MHI observed that this decision was wholly based on what the team and especially the original triage clinician had recorded rather than the triage clinician on duty assessing the risk for herself in accordance with the SWTS that each contact is a new contact.

42. In this regard the SWTS advises that care must be taken to avoid making assumptions based on past behaviour and to ensure that appropriate consideration is given to any new behaviours and risks. Further, clinicians ought to be conservative in using the telephone to determine that a person does not have a mental illness or disorder that requires assessment and, when in doubt, a face-to-face (intake) assessment should be arranged.

43. The information provided by Ms Parsons to BMHS triage suggested that Mr Hamilton had considerable vulnerabilities hat do not appear to have been explored.

Multidisciplinary Team Meeting (MDTM) Review

44. MCTM reviews[4] in respect of Mr Hamilton were held on 18, 19 and 20 November 2015 at BMHS. The team consisted of registered nurses, registered and provisional psychologists, registered occupational therapists and social workers, of which six clinicians attended all three reviews and three attended two reviews. It can be inferred from this composition that the MDTM was aware of Ms Parson's escalating

[4] A daily meeting in which all clinical case work is reviewed and discussed with a Consultant Psychiatrist, Senior clinicians and mental health clinicians for the purpose of clinical governance and to provide improved outcomes for consumers by employing a multidisciplinary team approach to clinical care provisions.

concerns and Mr Hamilton's failure to attend either of his GP or BMHS appointments. It is also apparent Mr Hamilton's referral and contacts had not been discussed with any input from a psychiatrist.

45. There was also no evidence that staff considered Mr Hamilton's case outside of the MDTM. The MHI noted that the BHMS Clinical Practice Protocol[5] states that there is a low threshold for contact with a psychiatrist and the lack of psychiatric input was not in accordance with their own policy/guidelines.

Training for mental health triage clinicians

46. The Victorian State-Wide Mental Health Triage Scale (SWTS) was rolled-out in July 2010 and supported by a train the trainer model, but there was no reference to sustainable ongoing training. Currently, training for the SWTS is the responsibility of each public mental health service. There was no state-wide or otherwise, accessible Victorian Mental Health Triage Scale specific training, and in a sector of mental health services where staff turnover is usually higher than other areas of mental health, access to training is fundamental to triage clinicians understanding the principles and limitations for applying the scale.

47. The BHS protocol/guideline and policy document do not specify specific training for the scale but referred to a *suitably trained* mental health clinician.

48. The Department of Health and Human Services (DHHS) website includes the following: "Mental health services must ensure that well developed triage assessment protocols and tools are available, and that staff are trained in their use, such as risk assessment tools, functioning assessment tools and triage manuals/practice directions.

Conclusion

49. Based on the statements and information provided by BMHS, the MHI considered that the SWTS was not applied appropriately, resulting in an inadequate response to carer concerns for a patient they did not know and for whom no efforts were made to collect collateral information.

[5] Ballarat Health Service Policy Triage and Service Access – Mental Health Service, page 2

Ballarat Health Service Clinical Practice Protocol Triage and Service Access – Mental Health Service, page 2

50. The DHHS requires the use of the SWTS by all public mental health triage services. There appears to have been no baseline training requirements or program available to public mental health services since the initial roll-out[6] aimed at ensuring uniform skills in triage staff. There was no evidence of performance monitoring or assessment of the outcomes of the scale's use.

51. The absence of a psychiatric review of Mr Hamilton's referral is concerning, especially as BMHS policies and practices require their membership of the multidisciplinary team meeting, one of the service's safeguards in providing appropriate responses to referrals.

Response from Ballarat Health Service

52. Director of Clinical Services, Dr Anoop Raveendran Nair Lalitha provided a statement to the Court that outlined the changes that had been made since Mr Hamilton's death.

53. Over the course of 2018, changes to the triage and access services were implemented at BMHS in addition to the development of a specialist Access and Triage (A&T) service with highly trained clinicians undertaking all triage into the service around the clock.

54. As at December 2018, the centralised A&T service took triage calls for the Ballarat and Golden Plains areas for persons aged 16 to 64. Following staff recruitment, it was intended that Ararat, Horsham, the Infant and Child Mental Health Services and Aged Mental Health Services be brought into the centralised triage service.

55. All staff working in community settings within mental health attended a compulsory one-day training. The topics covered included the SWTS, risk assessment and planning, the *Mental Health Act 2014*, documentation and the role of the duty worker. New employees entering community roles must attend the same training. In addition, several stand-alone topics will be offered annually as stand-alone sessions, including risk assessment, SWTS and the *Mental Health Act 2014*.

56. Dr Lalitha also explained that more rigorous structures and processes around clinicians receiving clinical supervision were developed and implemented.

[6] In 2010

57. BHS have authored new access and triage service guidelines. They propose that for all Category E referrals, clinicians must speak directly with the consumer to complete a comprehensive mental health assessment and to discuss the referral with them unless exceptional circumstances intervene. All referrals to the community teams should be completed using the mandatory triage assessment template.

58. If the clinician determines that the consumer's needs would be best served by a non-urgent assessment, either for a secondary consult or medium to long term management with the community team, then the consumer should be referred to the duty triage clinician from the respective team as SWTS Category E, requiring a non-urgent mental health response within two weeks. Consumers must of course signify they are willing to engage with the community team.

Findings

59. I find that Adrian Westropp Hamilton late of Hepburn Springs, died at 20 Forest Avenue, Hepburn Springs, on or about 20 November 2015 from *hanging*. The available evidence, including the lethality of means chosen, supports a finding that Mr Hamilton intentionally took his own life.

60. The available evidence supports a finding that the state-wide Mental Health Triage Scale was not applied appropriately to Ms Parsons' contacts about Mr Hamilton beyond the initial contact, leading to an inadequate response to carer/friend concerns for a patient BMHS did not know and for whom, no efforts were made to collect collateral information.

Comments

Pursuant to section 67(3) of the Coroners Act 2008, I make the following comments on a matter connected with the death, including matters relating to public health and safety or the administration of justice:

1. Since 2010, it has been a DHHS requirement that the Victorian Mental Health Triage Scale be used by all public mental health triage systems. The concept of a uniform scale implies that it is applied routinely and with a baseline of training/skills in clinicians applying the scale. However, it appears to be no state-wide or otherwise accessible Victorian Mental Health Triage Scale specific training. In a sector of

mental health services where staff turnover is usually higher than other areas of the public mental health system, access to such training on an ongoing basis is fundamental to triage clinicians' understanding of the principles and the limitations for applying the scale.

2. A report by the Victorian Auditor General's Office,[7]concluded that the lack of sufficient and appropriate system-level planning, investment and monitoring over many years means the mental health system in Victoria lags behind the other jurisdictions in the available funding and infrastructure, and the percentage of the population supported.

3. In a statement dated 29 November 2017, the Chief Psychiatrist advised that there is to be a *"Project plan for review of triage in Victoria's area mental health services."* It is evident from that plan that there are concerns about the consistency of application and therefore fidelity of the triage scale across the different area mental health services.

4. This case also highlights the need to improve the reliability of and confidence in the triage scale. It is hoped that the project will review the accessibility and effectiveness of available training resources, as well as evaluate the effectiveness of each area mental health service's governance of clinician competency and their understanding of the triage scale and its limitations.

[7] *Access to Mental Health Services*, March 2019

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

The family of Mr Hamilton

Dr Anoop Raveendran Nair Lalitha, Ballarat Health Services – Mental Health Services

Dr Neil Coventry, The Office of the Chief Psychiatrist

Senior Constable Angela Bertocchini (#36598)

Signature:

PARESA ANTONIADIS SPANOS

Coroner

Date: 4 October 2019