IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: **COR 2017 3357**

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)
*Section 67 of the **Coroners Act 2008***

Findings of:	Sarah Gebert, Coroner
Deceased:	Mr O
Date of birth:	September 1969
Date of death:	12 July 2017
Cause of death:	*Hanging*
Place of death:	Dimboola, Victoria

INTRODUCTION

1. Mr O[1], born September 1969, was 47 years old at the time of his death. He is survived by his parents JO and KO, his older brother AO as well as his partner of 10 years, Ms L. His brother MO sadly passed away after Mr O's death.

2. July 2017, Mr O was located deceased in the backyard of MO's home.

THE CORONIAL INVESTIGATION

3. Mr O's death was reported to the coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.

4. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

5. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

6. Victoria Police assigned Detective Sergeant Stephen Walker (**DS Walker**) to be the Coroner's Investigator. DS Walker conducted inquiries on my behalf[2], including taking statements from witnesses and submitting a coronial brief of evidence. The coronial brief comprises statements from Mr O's parents, his partner, consultant psychiatrist Dr Nalaka Kolamunna, a number of Mr O's neighbours, the pathologist who examined him and investigating police as well as other relevant documentation.

7. The Court obtained Mr O's Medicare and Pharmaceutical Benefits Scheme (**PBS**) claims history for a period of 12 months prior to his death and copies of his medical

[1] Referred to as 'Mr O' unless more formality is required.
[2] The carriage of the investigation was transferred from Deputy State Coroner English.

records from Ballarat Health Services (**BHS**) and the Lister House Medical Clinic where Mr O had been a patient. Following receipt of the coronial brief, statements were provided by mental health clinician, Janine Launder and Director of Clinical Services, Grampians Area Mental Health Services, BHS, Dr Anoop Raveendran Nair Lalitha.

8. As part of the investigation, this case was also referred to the Coroners Prevention Unit (**CPU**).[3] The CPU were requested to review the care provided by BHS.

9. In addition, an expert opinion was obtained by the Court from Professor Richard Harvey, Consultant Psychiatrist who provided a report dated 15 December 2020.

10. This finding draws on the totality of the coronial investigation into Mr O's death, including evidence contained in the coronial brief and information provided by the Court's expert. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[4]

Background

11. Mr O was the middle of three boys. His parents separated when he was in year seven and he remained with his mother.

12. Mr O came to the attention of police and spent time in prison on drug-related offences in his early adult years. Both his brothers suffered brain injury – one following a motor vehicle accident and one as a victim of crime.

13. Mr O moved to Dimboola some years ago to help care for his brother MO. It appears he limited his use of illegal substances but continued to use intermittently and consumed alcohol to excess from time to time.

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[3] The Coroners Prevention Unit (CPU) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the Coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. The CPU also reviews medical care and treatment in cases referred by the coroner. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.

[4] Subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. 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 as to those matters taking into account the consequences of such findings or comments.

14. Mr O had been seeing General Practitioner (**GP**) Dr Philip Wimbury at the Lister House Medical Clinic in Horsham which was approximately 40 km from Dimboola. The Medicare records show that he saw Dr Wimbury on 12 September 2016, 6 October 2016, 28 November 2016 and 1 February 2017. Dr Wimbury held a Victorian DHHS[5] permit to prescribe Suboxone opiate substitution for Mr O.

15. Following his consultation with Dr Wimbury on 1 February 2017, Mr O was dispensed 30 x 40mg tablets of lurasidone[6] on 6 February 2017.

16. Mr O had also formed a stable relationship with his partner Ms L, who lived in Dimboola and worked in Horsham.

17. Approximately 18 months before his death, Mr O began to express concern that his neighbours and others (including bikies) were making derogatory comments about him and interfering in his life. He expressed anger and distress that these experiences were not believed by others. At his mother's request, Mr O was referred to the local mental health services by his father.

18. On 17 February 2017, BHS mental health service triage was contacted by KO, who indicated that he had received a series of phone calls from Mr O who was concerned that his neighbours were trying to attack and abuse him, despite his friends assuring him that none of it was real. The intake clinician phoned Mr O who, while initially "affronted" that he had been contacted by the mental health service, described the abnormal experiences that were occurring and agreed to attend the mental health service for an intake assessment. In the intake clinician's notes dated 17 February 2017, it was documented that Mr O had spoken to his GP and asked for a referral to a psychologist, but reported that instead he was given a prescription for lurasidone. Mr O was reported to state that he was "unhappy" with his GP and wanted to change doctors.

19. The intake clinician noted a previous history on the state-wide mental health database indicating contact with St Vincent's hospital in 2000 with issues relating to behavioural disturbance and acute intoxication of alcohol and other substances.

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[5] As it then was.

[6] Lurasidone (Latuda) is an antipsychotic medication used in the treatment of schizophrenia and other psychotic disorders. It is also used to treat low mood in people with bipolar affective disorder.

20. An intake assessment was booked for 23 February 2017. Mr O was rated triage category E indicating a low short-term risk and non-urgent mental health service response required.

21. On 23 February 2017 Mr O attended for an intake assessment which was undertaken by a mental health clinician. The assessment was comprehensive and noted that over the week since the triage referral, he had been staying with his partner and taking the prescribed lurasidone which had resulted in improved sleep.

22. A provisional diagnosis of schizophreniform disorder[7] and an additional diagnosis of sedative use disorder involving benzodiazepines was made, and Mr O was counselled in relation to coping strategies and sleep hygiene. Risk of deliberate self-harm was rated low as there was no previous history of self-harm and he identified his partner as a strong protective factor. However, it was noted that Mr O indicated he had vague thoughts of suicide with a plan to hang himself but with no specific intent. The clinician also noted that he was linked to his GP and that he was well connected with his partner, parents and siblings. All of these were given as protective factors.

23. On 24 February 2017, Mr O's case was discussed with consultant psychiatrist, Dr Nalaka Kolamunna who recommended a plan to reduce his use of benzodiazepines, to continue lurasidone and for him to be referred to alcohol and other drug (**AOD**) services. A psychiatrist review was booked for 7 March 2017.

24. Also on 24 February, a prescription for 28 duloxetine tablets (an antidepressant), prescribed by Dr Wimbury, was dispensed.

25. On 28 February 2017, the multidisciplinary team noted that Mr O did not have insight, but was of low risk, willing to receive treatment and that there was a plan for a psychiatrist review and links to AOD services.

26. On 3 March 2017, Mr O's mother phoned the mental health service expressing concern about her son's behaviours and that he was paranoid.

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[7] The characteristics of schizophreniform disorder are identical to those of schizophrenia but is differentiated by its difference in duration. Schizophreniform disorder has a duration (including prodromal, active and residual phases) of at least one month but less than six months, whereas schizophrenia has a duration of at least six months. Schizophreniform disorder also does not require an impairment in social and occupational functioning to make a diagnosis (though impairment may be present).

27. Mr O was seen by Dr Kolamunna on 7 March 2017 and a diagnosis of likely untreated schizophrenia was made[8] Dr Kolamunna recommended that he continue with the lurasidone but Mr O was unwilling to accept a higher dose. Dr Kolamunna prepared a letter for GP Dr Wimbury, requesting that the GP organise a CT head scan and forward the results of any investigations that had been undertaken recently.

28. Mr O was accepted for case management with a focus on engagement, developing insight and increasing medication compliance. It was noted that he lacked insight into the illness but was aware of legal repercussions if he harmed his neighbours and was denying intent to harm himself or others.

29. Dr Kolamunna's plan also directed that the treating clinician should review him fortnightly and that the psychiatrist would see him in three months' time or earlier at the treating clinician's discretion.

30. Also on 7 March, Mr O's mother received an email from her son indicating that he was rejecting the mental health service and would not be seeing them again.

31. On 22 March 2017, Mr O's mother phoned the treating clinician asking for an update and reporting that she was "fed up".

32. On 24 March 2017, the treating clinician scheduled a home visit for 27 March, which was 20 days after the initial intake assessment.

33. BHS mental health services visited Mr O at home on 27 March 2017. At this time Mr O took the staff outside and showed them where he had extended his fence for privacy from the neighbour he believed was harassing him. He also stated two other neighbours were now also harassing him, that his reputation was under attack and the community were talking about him when he walked down the street. He denied suicidal ideation but indicated that he would defend himself if he was attacked. He was noted to have halved the antipsychotic medication and had no insight into his illness but agreed to see BHS mental health services to talk but not for treatment, as there was nothing wrong with him. The notes indicate that Mr O was "delusional and

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[8] Schizophrenia refers to a group of disorders/spectrum characterized by positive psychotic symptoms at some stage of illness, where mania and major depression are not prominent or persistent features, and where negative and cognitive symptoms are likely to be prominent and associated with varying degrees of disability. Comorbidity is extremely common. In the paranoid type, paranoid delusions are prominent.

hallucinating", but denying suicide risk. The treating clinician made a plan for "regular reviews by TC".

34. The Lister House Medical Clinic records show Mr O's last face-to-face appointment was on 6 April 2017 when he consulted Yannick Roosje-Dol who recorded that he was interested in hepatitis C treatment and they discussed Mr O's belief that his neighbours wanted to kick him out of town. He was provided with scripts and the dose of the antipsychotic lurasidone 40mgs was changed from one daily to 0.5 – 1 tablet daily. A letter to a community nurse was also written.

35. On 7 April 2017, Mr O was dispensed 30 x 40mg tablets of lurasidone. This had previously been dispensed on 6 February 2017 indicating that he can only have been taking, at most, half the prescribed dose. The prescribed dose of 40 mg lurasidone daily is the generally accepted minimum effective dose.

36. There is a record of a telephone call made on 19 May 2017 and a message left for Mr O to make contact with BHS mental health services, which is almost 8 weeks after he was last seen or contacted. Mental health clinician, Janine Launder noted in her statement that,

At this time the service was continuing to experience longstanding difficulty recruiting staff members and I believe my lack of assertive follow-up was directly due to this factor.

37. Mr O's mother telephoned BHS mental health services on 25 May 2017 and informed them that her son had stopped his antipsychotic medication, was saying he was sick of life, that he was depressed, had been arguing with his brother and father and was hiding in his home during the day.

38. Also on this day, BHS mental health services called Lister House Medical Clinic to check if Mr O had attended for blood tests and CT scan as requested but this had not occurred. Dr Kolamunna stated that the treating clinician then planned an unscheduled home visit.

39. Mr O told BHS mental health services that he did not need them on 29 May 2017 when they went to his home for an unscheduled home visit. He had a visitor with him

at the time. The treating clinician noted a call to Mr O's mother indicating that the service would continue to try to engage with him.

40. Clinician Launder telephoned Mr O's mother on 31 May 2017, who told her the neighbour, who her son had accused of harassing him, had moved out and that she believed her son was psychotic. The Clinical Treatment Plan was developed that day and notes that Mr O had distressing psychotic symptoms, an absence of insight, and he was not taking the antipsychotic medications. This was 13 weeks after Mr O had been accepted for treatment. The BHS clinical treatment plan policy indicates that a Clinical Treatment Plan should be completed within 6 to 8 weeks of being accepted for treatment. The single action on the treatment plan was "continue to try to engage".

41. On 6 July 2017, a mental health clinician phoned Mr O's mother but was unable to get a call through.

42. On 9 July 2017, Mr O's partner, Ms L reported that she had an argument with Mr O after she became aware that he had used a "substance". She indicated that while she was aware that he was having *issues and struggling with certain mental health issues*...[she] *was not totally aware of the full problem or how bad it actually was.*

43. On 10 July 2017, Ms L said she received a text from Mr O which stated, *I'm going to check out for good don't know what else I can do.* She said that at no stage until this day *did she have any concerns that he would harm himself or try to take his own life.*

44. According to medical records, Mr O's mother contacted BHS mental health services on 10 July 2017 to express her concern that Mr O was still experiencing auditory hallucinations including yelling at people when there was no one there. JO said that she was told to ring Dimboola Police and ask for a welfare check.

45. Senior Constable Karyleen Hateley stated that at *approximately 5.00pm I received a job via police communications for a welfare check on a male at ... Street Dimboola. The details given were that the males* (sic) *mother JO was concerned that her son, 48 year old Mr O, had told her people were after him, but she didn't think that was actually happening.*

.... A further unit from Horsham was also called to attend the job as further details given were; the male is agitated and was heard yelling and screaming by neighbours.

46. Police noted that Mr O was willing to engage with them, that the house seemed neat and he was pleasant although concerned about the actions of his neighbours and angry about this. Police did not form a belief that he was mentally ill or at imminent risk and did not consider that apprehension under section 351 of the *Mental Health Act 2014 (Vic)* was indicated.[9]

47. Mr O's partner Ms L arrived while police were present and did not raise any concerns. She said that she stayed with Mr O for about 2 hours before leaving.

48. At 3.50pm on 11 July 2017, BHS mental health services returned Mr O's mother's phone call (she had left messages at reception). She informed them that Mr O had been expressing themes of hopelessness and talking about death. She stated that her son was expressing death wishes and she wanted him to have compulsory treatment, and she was so concerned she was repeatedly texting him to make sure he was safe. She also sent the service at 12.13pm copies of the content of her son's recent emails and text messages which included abuse directed to his mother, police, direct threats to kill others and that he had lost the will to go on. In her email, she requested they contact Mr O's friend who asked to speak with mental health services and provided a contact number.

49. After speaking with consultant psychiatrist Dr Kolamunna, the plan was to visit Mr O the following day at 2.00pm.

50. The medical records document:

JO stated that she organised a police welfare check yesterday and police has reported back to her saying "he was pissed but he was all right." .... E-mail depicts Mr O's

[9] Section 351 Mental Health Act includes the following criteria for its use by Victoria Police: (1) A police officer, or a protective services officer on duty at a designated place, may apprehend a person if the police officer or the protective services officer is satisfied that— (a) the person appears to have mental illness; and (b) because of the person's apparent mental illness, the person needs to be apprehended to prevent serious and imminent harm to the person or to another person. (2) A police officer or a protective services officer is not required for the purposes of subsection (1) to exercise any clinical judgement as to whether the person has mental illness. It also includes the following definition of a mental illness: Subject to subsection (2), mental illness is a medical condition that is characterised by a significant disturbance of thought, mood, perception or memory.

distressed mental state due to his psychotic symptoms. He has no insight into his delusional thoughts and hallucinations. There are expressions of death wishes but no plan or intent to self-harm or suicide. There were some threats to HTO. Discussed with CP, Dr Kolamunna regarding concerns expressed by his mother, JO. CP advised to review him tomorrow (12/07/2017) to ascertain his mental state and admission to AAU to be determined upon assessment.

51. Police who conducted the welfare check on 10 July 2017 discussed the outcome of the case with Leading Senior Constable (**LSC**) Cal Myers and, given Mr O's presentation (*hearing and seeing certain people*) that his case should be raised with *Psych service.*

52. LSC Myers called BHS mental health at 4.50pm on 11 July 2017 and said he was concerned that Mr O might act on his delusions and harm others[10] and was told that they planned a visit the following day. He then had a conversation with Mr O's mother, where he advised her that he would be attending with *Psych Services* to *ensure Mr O was assessed appropriately.*

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Circumstances in which the death occurred

53. At around 12.20pm on 11 July 2017, Ms L reported receiving a text from Mr O confirming plans for them to meet later that evening. She also reported receiving a further text at around 3.17pm asking what time she would be home and whether she wanted him to "feed the dogs".

54. On the evening of 11 July 2017, Mr O was at his brother's house in Dimboola where they talked and drank beer. Also present was MO's girlfriend.

55. Mr O had a yellow nylon rope with him which he said was to tow a car. No concerns were raised during this visit. Mr O left his brother's house at about 9.30pm.

56. Shortly after 11.20am on 12 July 2017, a person, later identified as Mr O was observed by a neighbour to be hanging in the rear of MO's home. Ambulance

[10] Noting that Mr O did not meet the criteria for compulsory apprehension by police on the previous evening.

services attended but unfortunately, Mr O was unable to be resuscitated and was declared deceased at 11.35am.

57. Police also attended the scene and commenced an investigation. Photographic evidence was collected and formed part of the coronial brief.

58. Following their investigation, police found no evidence of any suspicious circumstances and it was apparent that Mr O had taken his own life.

59. Following his death, Mr O's father located two notes which appeared to indicate this intention. He expressed love for those close to him but frustration about *constant threats* and not being believed.

60. Ms L who described Mr O as her partner, best friend and soulmate said, *suicide was never something I would have believed he was capable of.*

Identity of the deceased

61. On 12 July 2017, LSC Cal Myers visually identified Mr O born September 1969 who he had known for 9 years.

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

Medical cause of death

63. Specialist Forensic Pathologist Joanna Glengarry from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination on 13 July 2017 and provided a written report of her findings dated 10 August 2017.

64. Toxicological analysis of post mortem blood specimens detected oxycodone[11] (~ 0.1 mg/l), fentanyl[12] (~ 3 ng/ml), diazepam[13] (~ 0.05 mg/l), nordiazepam[14] (~0.07 mg/L) and mirtazapine[15] (~ 0.04 mg/L).

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[11] Oxycodone is a semi-synthetic opiate narcotic analgesic related to morphine used clinically to treat moderate to severe pain.

[12] Fentanyl (Actiq, Fenpatch, Durogesic) is an opioids analgesic indicated for the treatment and severe acute and chronic pain available in lozenge, an injectable and intranasal forms and in a patch. Like all opioid analgesics, it carries a high risk of dependency with continued use.

[13] Diazepam is a long acting benzodiazepine with anxiolytic, sedative, hypnotic, muscle relaxant and antiepileptic effects. It is indicated in the short-term management of anxiety, and agitation, acute alcohol withdrawal, muscle spasms, sedation, and status epilepticus. In addition, it is accepted for use in acute

65. Dr Glengarry provided an opinion that the medical cause of death was *Hanging*.

66. I accept Dr Glengarry's opinion.

CPU REVIEW

67. The CPU conducted a review of the available evidence including Mr O's medical records. They concluded that Mr O's initial engagement, assessment and diagnosis was appropriate and comprehensive, including the engagement with his family. It was also recognised that in response to Mr O's reluctance to be engaged with BHS mental health services, they did not discharge him, rather accepted him for treatment/case management with an allocated treating clinician.

68. However, when it became evident that there may be issues regarding the subsequent services provided, the Court engaged an independent expert, consultant psychiatrist Professor Richard Harvey, to advise on the following matters:

    a. The adequacy of the response to family concerns;

    b. The appropriateness of the community treatment plan; and

    c. The appropriateness of the frequency of contact by the case manager.

<u>The adequacy of the response to family concerns</u>

69. Professor Harvey noted that on each occasion that either of Mr O's parents contacted the mental health service, their interaction was recorded, discussed by clinicians and a reasonable response appeared to have been undertaken. However, he was concerned that the service response appeared to have been largely driven by contact from the family. He noted that there were extended periods between the intake assessment and follow-up visits when there was no contact between the mental health service and Mr O, and on each occasion, it was only when the family contacted the mental health service that more attempts were made to contact him.

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behavioural disturbance, night terrors, sleepwalking, panic disorder, sleep disorders, seizures and acute barbiturate or benzodiazepine withdrawal.

[14] Metabolite of diazepam.

[15] Mirtazapine is an antidepressant used in the treatment of major depression. Unlike many other antidepressants, it has sedating properties and is therefore chosen by some practitioners to treat patients for whom sleep disturbance is a feature of their depression.

70. Professor Harvey further noted an apparent failure of the mental health service to engage with Mr O's partner. Ms L was noted as a protective factor on the intake assessment and that he saw her daily, yet she was not mentioned in the Clinical Treatment Plan and there appeared to be no attempts to contact her at any time.

71. Professor Harvey observed,

It would seem to me somewhat unusual for a 47-year-old man with a partner who he sees daily, that all family member contact is directed to his parents. In my opinion, the lack of engagement with the partner (or explanation why they did not engage with the partner) was a missed opportunity.

72. Professor Harvey further noted that it was possible that engaging Mr O's partner early on in the process would have enabled a better therapeutic relationship with Mr O and a better and more immediate route for feedback to the treating clinician.

73. Professor Harvey was also concerned by the extended periods of time that passed without contact between the treating clinician and Mr O. He noted in this context that there was a very early indication from Mr O, shortly after the intake assessment, that he may be difficult to engage with, that over three weeks were allowed to pass before the next scheduled contact, particularly when the treating psychiatrist had directed that there should be contact within 14 days, and that even after this, engagement became even less frequent.

74. Professor Harvey also conducted a review of the service's policies and procedures and noted that there did not appear to be a specific policy or procedure addressing the importance of actively engaging family and responding to family concerns.

75. He referred in this context to the Victorian Chief Psychiatrist's guideline "Working together with families and carers" that promotes good practice. This guideline, which was published in August 2018[16], emphasises that:

- Families and carers should be recognised, respected and supported as partners in providing support and care to consumers.

[16] Available on the health.vic.gov.au website

- Families and carers should be identified and engaged as soon as possible in assessment, treatment, care and recovery.

- Services must have clear processes and practices that support open communication with consumers, families and carers regarding information sharing, privacy and confidentiality.

- Services are required to have regard for the impact of mental illness on family members and to assist families and carers to identify their needs, including in relation to the caring role.

- Families and carers should be engaged in organisational practice and governance.

The appropriateness of the community treatment plan

76. Professor Harvey raised concerns that the preparation of the community treatment plan took 13 weeks, when the relevant service policy states that a Community Treatment Plan (**CTP**) must be prepared within 6 to 8 weeks of initial contact.

77. He further noted that over the 13 weeks between the intake assessment and the preparation of the CTP, there was minimal contact with Mr O, with each contact indicating increasing reluctance on his behalf to engage with the mental health service.

78. It was Professor Harvey's opinion that as a result of this, the CTP had very limited, if any, value with the only action being "continue to try to engage". Further, that such a long delay, with such minimal contact with the patient would always inevitably make it exceedingly difficult to develop a patient-centred recovery-oriented CTP. He said that as a result, the document as it appeared in the medical record offered *very little*.

79. Professor Harvey further noted that the delay in the delivery and the very limited scope of the CTP should have been identified by the service management and clinical supervisor. He noted that the BHS "clinical supervision – mental health services" policy states that therapeutic intervention supervision and discipline specific supervision must occur monthly or as otherwise by negotiation with their clinical manager.

80. He noted that despite a direct request by the Court for the supervision records, only the comments of the multidisciplinary team were provided and therefore there is no evidence that any supervision (service management or clinical or discipline specific) of the treating clinician occurred during the period of Mr O's care. Professor Harvey said that potentially, if effective supervision were occurring on a monthly basis, this would have identified the ongoing difficulties of engagement, and the very limited scope of the CTP creating an opportunity for action.

81. Professor Harvey noted that the mental health service had subsequently published a procedure entitled "Recovery & Wellness Plan" which appeared to encourage a more patient-centred and recovery-oriented plan be developed within six weeks of engagement with the service, that is then reviewed every 91 days. He commented that it would be reassuring to see evidence of auditing of recovery and wellness plans, including content audits, procedural compliance audits and feedback from consumers.

82. It was also noted that the mental health service had published a procedure entitled "Persons who are difficult to engage". Professor Harvey commented that while this protocol sets out the steps that staff should undertake to attempt to engage with persons who are difficult to engage, it does not offer many clues about the important skills that are required in engaging such patients and it largely simply sets out a number of steps that need to be followed before a psychiatrist makes a decision to discharge the patient.

83. He considered that the procedure is a missed opportunity and more significant links need to be made with training and up-skilling staff to improve confidence and skills working with difficult-to-engage patients, and he commended much of the work undertaken by Orygen[17] in this area.

<u>The appropriateness of the frequency of contact by the case manager</u>

84. Professor Harvey noted from the case manager's statement that in her view, the service had significant staffing issues around this time and that she believes that this is the primary reason for the limited engagement with Mr O.

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[17] Orygen -Engaging Young People CPP – Clinical Practice Youth Mental Health – Addressing Barriers to engagement – Working with challenging behaviours

85. As already noted, the treating psychiatrist's review made a specific direction that Mr O should be seen fortnightly by the treating clinician, and that a further psychiatrist review should be scheduled in three months or earlier at the discretion of the treating clinician.

86. Professor Harvey would have expected the treating clinician to have formally reported back to the treating psychiatrist if they had been unable to deliver any part of the plan, specifically if they have been unable to maintain fortnightly contact with the patient. He commented that while there is some evidence from Dr Kolamunna's statement, and also some evidence from the medical records, that the psychiatrist was aware that the patient was difficult to engage, there appeared to be no formal attempt to document reported failed contact with the patient, or to highlight to the psychiatrist or multidisciplinary team that the prescribed treatment plan was not being adhered to.

87. The difficulties that the treating clinician experienced in delivering the fortnightly contact directed by the psychiatrist should have been identified in supervision, but as there is no evidence that this was occurring, the lack of supervision, possibly combined with staff shortages, allowed very extended periods of time to pass between attempts to contact Mr O.

88. Professor Harvey considered that these deficiencies are the responsibility of the mental health service and its management. If adequate and appropriate clinical and management supervision structures were in place, the failure of individual treatment plans could have been identified and management alerted to the need to put in place additional resources, or to direct further psychiatrist review to determine the need for the directed plan.

89. Professor Harvey also considered that a further missed opportunity in this case was that the mental health service clinicians were working in isolation from the GP, noting in particular that Mr O was attending his GP on a regular basis for Suboxone scripts.

90. Professor Harvey said that while the mental health service has a policy and procedure relating to shared care of patients with private psychiatrists, there is no policy or procedure regarding the shared care of patients with the general practitioner.

91. He went on to say that, *partly as a matter of simple courtesy, it can be very effective when a patient self refers or is referred by family member for triage staff or intake staff to contact the GP and seek a supporting referral. This ensures that the GP is engaged in the process and is then potentially more likely to respond to recommendations that follow that intake process. Similarly, whether or not the patient actively engages it is almost always helpful to keep the GP well-informed about progress of a case managed patient as the GP frequently has broader insights and a more holistic view of the patient's function within the community.*

Opportunity to respond[18]

92. Dr Wimbury noted in response that, at a distance of 40 km from a patient's residence, *review is difficult* and, *although not reflected in notes, telephone contact with Mr O was variable.* Further, in relation to the final consultation with Mr O on 6 April 2017, he said that *Mr O was interested only in getting treatment for Hepatitis C; Mr O was ... aggressive in demeanour during consultations so much so that at a prior occasion his consultation was cancelled and he was asked to leave; as a result we tended to view an occasion such as this referral for hepatitis C treatment as a therapeutic opportunity.*[19]

93. With respect to subsequent changes, Dr Wimbury noted improvements with the enlargement of Grampians Community Health, more drug and alcohol workers and local psychiatrists seeing patients despite *co-diagnosis of substance abuse.* He indicated that his procedure had changed to earlier psychiatrist referrals following mental health plans.

94. BHS indicated that recruitment to the Horsham mental health team is an ongoing concern and that at the time of Mr O's death, the service was down 4 full time workers.

95. BHS further indicated a number of changes including[20],

[18] BHS and Dr Wimbury were provided with a copy of Professor Harvey's report and given an opportunity to respond.
[19] Correspondence from Dr Wimbury dated 18 May 2021.
[20] Correspondence of Dr Lalitha dated 9 March 2021.

- A plan for the development of a Clinical Practice Guideline titled "Working with Families and Carers" which to reference the Victorian Chief Psychiatrist's guideline working together with families and carers;

- A plan to revisit their protocol on "Persons who are difficult to engage" to include clues in the skills required in engaging these patients.

- A further review and development of GP shared care and engagement practices;

- The development of new Clinical Review meeting guidelines for conducting clinical reviews on clinically appropriate times and for adhering with the policies guiding the provision of clinical care, noting that the Clinical Review meeting conducted will provide the governance to complete the treatment plans in a timely manner.

- The development of a recovery focused model of care with more involvement from the person, their families and lived experience work force, noting that they engaged a consultant to assist with the development of the model.

- A review of risk management procedures and the utilisation of the Clinical Risk Assessment and Management tool (**CRAAM**).

- A review of supervision practices to strengthen line supervision.

- The implementation of a clinical review guideline which sets out responsibilities of clinicians presenting in those review meetings.

Conclusion

96. It was recognised by Mr O's family and friends that he was unwell, and his parents had made considerable effort to have him assessed and treated. He was seen by the local mental health service and a diagnosis of schizophrenia was made. It is likely that he had been suffering from this for some time. Mr O did not wish to engage with mental health services and actively avoided their services. That is, he was not always willing to engage as a voluntary patient.

97. Significant issues were highlighted by independent expert Professor Harvey in relation to the care provided to Mr O. Those issues include that: the mental health

service's response was largely driven by contact from the family; there was a failure of the mental health service to engage with Mr O's partner; extended periods of time passed without contact between the treating clinician and Mr O; the preparation of the Community Treatment Plan took 13 weeks, where the relevant service policy stated that a Community Treatment Plan must be prepared within 6 to 8 weeks of initial contact; over the 13 weeks between the intake assessment and the preparation of the Community Treatment Plan, there was minimal contact with Mr O; the Community Treatment Plan had very limited, if any value, with the only action being "continue to try to engage; and that the delay in the delivery and the very limited scope of the Community Treatment Plan should have been identified by the service management and clinical supervisor which suggested a lack of adequate and appropriate clinical and management supervision structures.

98. This assessment appears to be consistent with JO's view regarding the care provided to her son, who she considers was 'let down'.

99. I note that the BHS have instituted or are instituting many changes, which are in direct response to those issues and concerns raised by Professor Harvey.

100. I also acknowledge the ongoing concerns regarding the recruitment and retention of staff which is experienced in rural areas.

RECOMMENDATIONS

Pursuant to section 72(2) of the Act, I make the following recommendations noting the changes already implemented by BHS:

101. *BHS develop a specific policy or procedure to address the importance of actively engaging family and responding to family concerns, consistent with the Victorian Chief Psychiatrist's guideline "Working together with families and carers", published in August 2018*[21].

102. *BHS ensure that their procedure entitled "Persons who are difficult to engage" incorporates information about the important skills that are required for these patients and ensure that staff are afforded training opportunities to improve their*

[21] Available on the health.vic.gov.au website

confidence and skills when working with difficult-to-engage patients, noting the work undertaken by Orygen[22] *in this area.*

FINDINGS AND CONCLUSION

103. Pursuant to section 67(1) of the Act I make the following findings:

(a) the identity of the Deceased was Mr O, born September 1969;

(b) the death occurred on 12 July 2017 at Dimboola, Victoria, from *Hanging*, and

(c) the death occurred in the circumstances described above.

104. I convey my sincere condolences to Mr O's family for their loss and acknowledge the tragic circumstances in which his death occurred.

105. Pursuant to section 73(1B) of the Act, I order that this finding (in a redacted format) be published on the Coroners Court of Victoria website in accordance with the rules.

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

JO, Senior Next of Kin

Ms L

Ballarat Health Services

Dr Philip Wimbury

Office of the Chief Psychiatrist

Detective Sergeant Stephen Walker, Victoria Police, Coroner's Investigator

[22] Orygen -Engaging Young People CPP – Clinical Practice Youth Mental Health – Addressing Barriers to engagement – Working with challenging behaviours.

Signature:

SARAH GEBERT

Date: 22 October 2021

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.