IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2011 001852

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 RICHARD HILTON
without holding an inquest:
find that the identity of the deceased was RICHARD HILTON
born on 29 September 1983,
and that the death occurred on 22 May 2011
at 6 Buller Court, Hoppers Crossing Victoria 3029
from:

1 (a) HANGING.

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

1. Mr Hilton was a 27 year-old man who lived with his mother, Ms Robyn Hilton, at the above address and was employed as a bricklayer. He completed an apprenticeship, maintained employment, had travelled extensively overseas, supported himself and had a girlfriend.

2. Since 1997, when he was still a teenager, Mr Hilton had reported symptoms of a depressive illness. In 2004, he commenced receiving treatment from a private psychiatrist, including taking antidepressants. When this led to an elevation in his mood, he was diagnosed with hypomania and referred to the Orygen Youth Mental Health Service for treatment.

3. During his early twenties Mr Hilton had been prescribed benzodiazepines, specifically the anxiolytic Alprazolam, and had expressed concerns about their impact on his life, as he felt he had become dependant. According to his medical records, Mr Hilton was variously diagnosed with bipolar affective disorder, anxiety, chronic insomnia, dysthymia and more recently, antisocial personality disorder traits. In January 2010, Mr Hilton was seeing Dr Michael

Greenbaum, a private psychiatrist, and his regular treating GP was Dr Abdalla. Dr Greenbaum reported to Dr Abdalla that he considered that Mr Hilton had an underlying psychotic illness, as well as his drug dependence. Mr Hilton later consulted another private psychiatrist, Dr Carolyn Breadon, who considered that his main issues were drug dependence (on Alprazolam), anger issues and personality traits. Mr Hilton continued to seek treatment from private psychiatrists and his GP intermittently until March 2011.

4. On 1 March 2011, it appears that either Mr Hilton or a family member contacted Werribee Hospital Emergency Department (Werribee ED), stating that he was having suicidal thoughts. As a result, Mr Hilton was assessed by the Enhanced Crisis, Assessment and Treatment Team (ECATT) and provided with follow-up by them.

5. On 17 March 2011, Mr Hilton was admitted to the Werribee Mercy Mental Health unit following an attempted drug overdose and was diagnosed as having a depressive episode. At this time, Consultant Psychiatrist Dr Trjraj Tawde noted Mr Hilton had not been receiving treatment for depression and incorporated Mr Hilton re-engaging with his private psychiatrist and a medication review as part of the discharge plan.

6. Following this episode of care, Mr Hilton appears to have re-engaged with his private psychiatrist, his GP and with Reconnexion, a specialist service for people with anxiety disorders, depression and tranquilliser dependency. An assessment by Ms Biliana Dearly, counsellor and psychologist, resulted in Mr Hilton agreeing to undertake a withdrawal process. To this end, Ms Dearly provided Dr Abdalla with a recommended sliding scale for reducing the benzodiazepines. It is not clear whether Mr Hilton was offered counselling or any other ongoing involvement from Reconnexion.

7. On 1 April 2011, Ms Dearly contacted the CATT expressing concerns about Mr Hilton's suicidal thinking and advising that he had a large quantity of medication at home that he could use to overdose. The CATT responded by engaging with Mr Hilton and his treating practitioners at this time.

8. On 19 May 2011, Mr Hilton presented to the Werribee ED again after taking an overdose, and being found by his mother. Following medical clearance, he was assessed by the ECATT, discharged on 20 May 2011 to the care of his mother and his private practitioners, and encouraged to contact local drug and alcohol services.

9. Later in the evening on 20 May 2011, Mr Hilton told his mother that he was going to stay with his girlfriend, and Ms Hilton drove him to Hoppers Crossing Railway Station. She had no further contact with her son.

10. When Ms Hilton returned home after church at about 6.45pm on 22 May 2011, she found her son hanging from a rope tied to the pergola and immediately called 000.

11. Paramedics arrived a short time later and confirmed that Mr Hilton was deceased. Police also arrived and commenced their investigation of Mr Hilton's death. They found no evidence to suggest that he had died in suspicious circumstances and concluded that he had taken his own life.

12. An external examination of Mr Hilton's body was performed by Forensic Pathologist Dr Yeliena Fay Baber from the Victorian Institute of Forensic Medicine (VIFM). Dr Baber reviewed the circumstances as reported by the police to the coroner and provided a written report of her findings. She ascribed *hanging* as a reasonable cause of death, in the absence of performing a full post-mortem, and noted that toxicological analysis revealed the presence of aripiprazole (an anti-psychotic), diazepam (a sedative/hypnotic drug of the benzodiazepine class) and quinine, used to treat muscle cramps and (now less commonly) malaria.

Further investigation

13. In light of the circumstances in which Mr Hilton died, I asked a Mental Health Investigator (MHI) from within the Coroners Prevention Unit (CPU) to review the medical records and provide an appraisal of the clinical management and care provided to Mr Hilton by or through Werribee Mercy Hospital in the two months or so immediately before his death.

14. The MHI noted that Mr Hilton had both a substance abuse disorder and a mental illness, referred to as a 'dual diagnosis' and was seeking help for both. Optimal practice requires that dual diagnosis patients are treated at the same time for both diagnoses. Both Dr Greenbaum and Dr Tawde considered that Mr Hilton had an underlying psychiatric condition. Given that he presented to or had contact with Werribee Mercy Mental Health (WMMH) at least three times in the two months before his death, there was an opportunity for review by a consultant psychiatrist but it is not clear why one was not undertaken. In circumstances where a patient presents multiple times to the public mental health system, it seems an inadequate response to simply discharge the patient to the care of their private practitioner, in the absence of a shared care or agreed plan of care communicated between services.

15. In response to a request, WMMH provided additional information about –

(1) their policy/guidelines around review of patients who present multiple times with suicidal ideation and self-harm attempts; and

(2) why Mr Hilton was not offered mental health outpatient care or follow-up after his ED assessment on 19 May 2011.

16. WMMH advised that their usual procedure is that ECATT/triage clinicians facilitate medical or psychiatric review of patients who presents multiple times where they consider it appropriate. While this is reasonable enough as it is the ECATT clinician who completes the initial assessment, it does not address the particular exigencies of multiple presentations within a relatively short period of time with suicidal ideation and/or self-harm. In Mr Hilton's case, he had three presentations to the Werribee ED in about two months, was assessed by ECATT clinicians each time, and admitted twice, without review by a consultant psychiatrist.

17. The Department of Health's 2010 practice guideline titled *Working with the suicidal person: Clinical practice guidelines for emergency departments and mental health services* contains a summary of recommendations or main principles for staff to consider in the assessment and management of people at risk of suicide. These principles are information gathering, thorough assessment, secondary consultation/debriefing/supervision; and decision making that is clear and communicated to those involved. The suggested outcomes of any assessment of such patients are:

- a follow-up plan that is documented and communicated to the patient and their significant others;
- if the patient is currently known to mental health services, informing the relevant team of their attendance; and
- mental health team follow-up of all people within 48 hours of discharge, wherever possible.

18. At the time of Mr Hilton's death, these guidelines were available but relatively new and it was up to individual mental health services to decide on their service-specific requirements for follow-up of patients who presented multiple times to an ED with suicidal ideation and/or self-harm.

19. In relation to the second issue, WMMH advised that when Mr Hilton was reviewed in the ED on 19 May by ECATT, he was advised to contact Reconnexion to continue with his treatment

for benzodiazepine addiction. Furthermore, at his request, he was seen the day after discharge by way of follow-up.

20. The MHI advised that Mr Hilton received appropriate clinical management and care whilst he was in the ED, from both medical and psychiatric staff. The salient issue is that Mr Hilton had presented three times in less than three months following serious suicide attempts. He was vulnerable at the time because he was currently withdrawing from alprazolam, was not consulting with his private psychiatrist, nor receiving counselling from Reconnexion. Mr Hilton told ECATT that he believed he had an underlying psychiatric illness, in light of a lengthy prior history of bipolar affective disorder for which he had received treatment from WMMH and private practitioners.

21. The focus of ED staff was on Mr Hilton's withdrawal from alprazolam with no real recognition of his mental health issues as causative. Rather his self-harm was viewed as consequent to withdrawal from alprazolam, and not within the setting of mental illness. ECATT and ED staff asked about Mr Hilton's connections with services and assumed a level of engagement that was not there, especially with his general practitioner and private psychiatrist. Moreover, Mr Hilton had a history of disengaging from services without much provocation. As a patient with a 'dual diagnosis', optimal treatment should have been holistic in focus, having regard to his underlying mental health as well as his current attempts at withdrawal from alprazolam.

22. WMMH did review Mr Hilton appropriately on 19 and 20 May 2011 during his admission to the ED Short Stay Unit. However, it is reasonable to expect greater effort regarding follow-up from a mental health service that is organising a discharge plan, given Mr Hilton's mental health history, self-harm attempts, his demonstrated overuse of alprazolam when engaged in a withdrawal program, and his request for community-based WMMH support.

<u>Changes made at WMMH</u>

23. Following a Mortality and Morbidity Review undertaken by WMMH and, it appears the coronial investigation of Mr Hilton's death, WMMH has undertaken activities to improve the clinical governance of ECATT services and developed a draft procedure titled ECATT Assessment Review. The procedure proposes that:

- clients presenting three or more times within a fortnight for ECATT assessments and who have ongoing identified risk factors and/or present with diagnostic uncertainty must be

referred to the CATT for the purposes of a Medical Officer review and diagnostic clarification; and

- all psychiatric assessments conducted by the ECATT clinician in the ED are reviewed the following day by a senior clinician.

24. WMMH provided a copy of the *Werribee Mercy Mental Health Risk Assessment and Management Procedures* to the court that appears to address the requirements of the Department of Health's *Working with the suicidal person: Clinical practice guidelines for emergency departments and mental health services* guideline.

25. With the above changes, the processes at WMMH now match a best practice approach, and are appropriate to mitigate future risk to patients. I commend WMMH for the positive steps undertaken by Werribee Mercy in this respect.

RECOMMENDATION

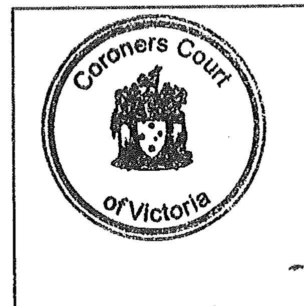
Pursuant to section 72(2) of the Coroners Act 2008, I make the following recommendation connected with the death:

1. That to increase the safety of patients presenting multiple times for ECATT assessments who have ongoing identified risk factors and/or present with diagnostic uncertainty, Werribee Mercy Mental Health (WMMH) endorses and incorporates its draft procedure titled *ECATT Assessment Review* into practice.

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

The family of Mr Hilton
Werribee Mercy Mental Health
Dr Mark Oakley Browne, Chief Psychiatrist
Constable Kevin Hooper, Werribee Police Station.

Signature:



PARESA ANTONIADIS SPANOS
CORONER
Date: **17 September 2013**