



**ST VINCENT'S  
HOSPITAL**  
MELBOURNE

A FACILITY OF ST VINCENT'S HEALTH AUSTRALIA

**St Vincent's Hospital  
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27 July 2023

Coroners Court of Victoria  
65 Kavanagh Street  
Southbank VIC 3006  
By email: [cpuresponses@coronerscourt.vic.gov.au](mailto:cpuresponses@coronerscourt.vic.gov.au)

Dear Ms Hajdari,

### **Investigation into the death of Justin Patrick Crome - COR 2020 000816**

I refer to the findings and recommendations made by His Honour Coroner Paul Lawrie into the death of Mr Justin Crome received by St Vincent's Hospital (Melbourne) Limited (**St Vincent's**) on 28 April 2023. St Vincent's response to the recommendations is detailed below.

**Recommendation** - *That St Vincent's Mental Health embed into its relevant policies and procedures a requirement for case managers to escalate to a psychiatrist when a patient in community care: misses multiple consecutive appointments; and has not been recently reviewed by their case manager, psychiatric registrar, or psychiatrist.*

St Vincent's accepts Coroner Lawrie's recommendation and can confirm that its policies and procedures include key actions for clinicians and multidisciplinary teams when consumers miss multiple consecutive appointments or have not had a face to face review by either their case manager, psychiatric registrar or consultant psychiatrist.

In 2021, St Vincent's first made changes to its policies to include escalation of missed appointments for case managed consumers. In June 2023 a comprehensive review of the Clinical Risk Assessment Policy was completed to strengthen and enhance the escalation of care requirements for all clinical teams, not only those providing case management services.

Thank you for the opportunity to provide a response to Coroner Lawrie's recommendation.

Should you, or Coroner Lawrie, require any further information please don't hesitate to contact me.

Nicole Tweddle  
Chief Executive Officer  
St Vincent's Hospital (Melbourne) Limited