IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2019 4128

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Katherine Lorenz
Deceased:	Garry Mark Wise
Date of birth:	19 April 1972
Date of death:	5 August 2019
Cause of death:	1(a) Hanging
Place of death:	Hamer Court Accommodation, Room 17, 535 High Street, Kew, Victoria, 3101

INTRODUCTION

1. On 5 August 2019, Garry Mark Wise (**Mr Wise**) was 47 years of age when he was found deceased in his room at Hamer Court rooming house (**Hamer Court**) in Kew, Victoria.

2. Mr Wise had a medical history of chronic schizophrenia, first documented in 2007 when he sought help for auditory hallucinations and suicidality. Initially, his symptoms responded to treatment with antipsychotic medications, but he experienced many relapses associated with alcohol misuse, poor self-care and self-ceasing medications.

3. Mr Wise had a series of voluntary admissions to Alfred Health, several alcohol detoxification admissions and community case management. At the time of his death, he was prescribed diazepam, lurasidone, quetiapine and candesartan.

4. In addition to his mental health challengers, Mr Wise suffered multiple physical comorbidities including gastritis, hepatitis, chronic pancreatitis, hypercholesteremia, tachycardia and hypertension.

BACKGROUND

5. On 4 April 2019, a manager at Hamer Court contacted St Vincent's Hospital's (**SVH**) Psychiatric Triage Service (**SVHPTS**) seeking advice about Mr Wise having not taken his prescribed medication for multiple months. Mr Wise was not reported to be demonstrating any psychotic symptoms and no risks were identified by SVHPTS. The manager was advised to contact Mr Wise's general practitioner, Dr Mark Schulberg (**Dr Schulberg**) of Kew Junction Medical Clinic and contact SVHPTS again should Mr Wise start to display psychotic symptoms or odd or risky behaviours.

6. On 12 April 2019, while Mr Schulberg was visiting another patient at Hamer Court, staff alerted him that they had concerns about Mr Wise. He subsequently spoke with Mr Wise who informed him that he had not been compliant with his medication for three months because he felt "blunted". He also reported consuming about a bottle of spirits each day. Dr Schulberg contacted SVHPTS. It was documented by SVHPTS that there were no acute risks. SVHPTS reported being unclear as to what Dr Schulberg was seeking – whether it was a CATS[1] referral or information only. As such, no alert was made in their system.

[1] Stands for Crisis Assessment and Treatment Service

7. On 16 May 2019, Mr Wise, on referral by Hamer Court, was assessed and accepted into the Bolton Clarke Homeless Persons Program (**HPP**) which provided health assessment, monitoring and support, health education and promotion in the form of harm minimisation and referral for mental health support.

8. On 24 May 2019, HPP referred Mr Wise through the Eastern Melbourne Primary Health Network (**EMPHN**) to STEPS mental health program where he had an initial assessment on 14 June 2019. He was accompanied by a HPP community health nurse to this appointment. At this appointment, Mr Wise expressed suicidal thinking, saying that if he had gun, he would use it as his voices are so distressing. He also reported that he had a rope in his room and would use it if something significant were to happen. He was assessed and considered not an appropriate candidate for the STEPS program as he would not attend and eventually stated that he did not want to attend.

9. On 30 July 2019, HPP referred Mr Wise through EMPHN for the Psychological Support Service (**PSS**). The risk assessment completed by HPP as part of the referral noted that Mr Wise was currently experiencing suicidal thoughts and had a rope in his room. EMPHN considered the referral and determined that Mr Wise was not suitable for PSS due to his high-level clinical needs, high suicide risk with a plan and means, unstable mental health and vulnerability. The PSS referral was discontinued and EMPHN instead escalated the referral to SVHPTS for case management and services.

10. On 31 July 2019, an ENPHN worker spoke with a clinician at SVHPTS and a detailed referral was faxed through and included information about Mr Wise's prior engagement with SVH Hawthorn Clinic. SVHPTS proposed to make a referral to the Hawthorn Clinic that day for discussion on Thursday. The ENPHN worker planned to contact SVHPTS on 2 August 2019 to follow up the outcome of the referral.

11. On 2 August 2019, EMPHN contacted the Hawthorn Clinic to follow up the referral and was informed that Mr Wise had been allocated a case manager. Regrettably, Mr Wise did not have any contact with the case manager prior to his death.

THE CORONIAL INVESTIGATION

12. Mr Wise'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.

13. 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.

14. 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.

15. Victoria Police assigned Senior Constable Luke Pincott (**SC Pincott**) to be the Coroner's Investigator for the investigation of Mr Wise's death. SC Pincott conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

16. Coroner Paresa Spanos had carriage of this matter until my appointment as a Coroner on 8 February 2019.

17. This finding draws on the totality of the coronial investigation into Mr Wise's death, including evidence contained in the coronial brief. 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.[2]

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

Circumstances in which the death occurred

18. On 5 August 2019, Alan Morrison (**Mr Morrison**), the tenancy manager at Hamer Court, received information from staff that lived on site that a few of the residents reported that they had not seen Mr Wise for a few days and that he wasn't answering his door. Mr Wise was reported to be last seen on 2 August 2019 by his brother, who also lived a Hamer Court, another resident and Dr Schulberg, who had consulted with Mr Wise and noted him to be okay.

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[2] 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.

19. At 2:15pm, Mr Morrison attended Hamer Court and knocked on Mr Wise's door and yelled out to him. There was no response. He tried to open the door but it was locked, which Mr Morrison reported was unusual.

20. He used his master key to enter the room. He discovered Mr Wise hanging by red ligature tied around his neck, looped over the top of the bathroom door and attached to the door handle on the opposite side. Mr Wise was observed to have a blue complexion and was cold to the touch.

21. Mr Morrison immediately called emergency services. Ambulance Victoria paramedics arrived a short time later and confirmed Mr Wise deceased at 2:34pm.

22. Victoria Police commenced a coronial investigation and inspected the unit where they located an empty bottle of alcohol and numerous medications.

Identity of the deceased

23. On 5 August 2019, Garry Mark Wise, born 19 April 1972, was visually identified by Alan Morrison, tenancy manager at Hamer Court.

24. Identity was not in dispute and required no further investigation.

Medical cause of death

25. Forensic Pathologist Dr Paul Bedford from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an external examination on 6 August 2019 and provided a written report of his findings dated 8 August 2019.

26. The post-mortem examination revealed a ligature mark around the neck in keeping with the reported history.

27. A routine computed tomography (**CT**) scan showed a left hyoid fracture and pill residue in the stomach.

28. Toxicological analysis of post-mortem samples detected ethanol (alcohol) at a concentration in blood of 0.01 g/100ml as well as lurasidone[3] and nordiazepam[4] in lower than therapeutic levels.

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[3] Antipsychotic indicated for acute and chronic psychosis and bipolar disorder.
[4] Benzodiazepine derivative indicate for anxiety, muscle relaxation and seizures.

29. Dr Bedford noted that hanging causes death by obstruction of the airways and blockage of blood flow to and from the brain. He provided an opinion that the medical cause of death was 1 (a) *hanging*.

30. I accept Dr Bedford's opinion.

REVIEW BY THE CORONERS PREVENTION UNIT

31. Coroner Spanos referred this matter to the Mental Health Investigation team, a part of the Coroners Prevention Unit[5] (**CPU**) for review of Mr Wise's clinical management and care, particularly the intervention by services proximate to his death.

32. CPU reviewed available material[6] and provided the following advice:

    a) Mr Wise was high risk when he was not compliant with his medications and experienced extreme distress from auditory hallucinations that he over the long-term self-treated with large amounts of alcohol daily. EMPHN, SVH and HPP were all aware that he was high risk.

    b) Post-mortem alcohol levels suggested that he was not intoxicated when he died, suggesting his usual suppression of the hallucinations with alcohol was somehow either not available to him or he chose not to use it. In addition, post-mortem toxicology suggested Mr Wise had not been compliant with the prescribed psychoactive medications.

    c) The issue appears to be the assessment of acute risk for Mr Wise, especially as he had communicated increased distress, suicidal thinking and had a plan and access to means.

    d) The initial decisions made by the community health nurse at HPP appeared appropriate to the remit and expectations of the role in the HPP which is not a mental health service. Nonetheless, the community health nurse was aware Mr Wise had a rope in his room and that he had suicidal thinking and a plan as early as June 2019. This knowledge did not result in a recognition of acute risk or formal escalation to either Dr Schulberg, Mr Wise's family, Hamer Court, a mental health service or escalation within the HPP when it was

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[5] 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.

[6] Coronial brief of evidence; medical records of Eastern Health; Medical records of Alfred Health; Medical records of Box Hill Hospital; Medical records of Maroondah Hospital; Medical records of Kew Junction Medical Clinic and Eastern Melbourne Primary Health Network submission.

reasonable there was a response to this information that was separate to the referral to the non-acute mental health supports at EMPHN.

e) EMPHN completed an internal review into Mr Wise's death which appears detailed and addresses issues related to documentation and communication of critical patient information and escalation, and resulted in the following actions

   i. A procedure for documenting clinical pathways meetings;
   ii. A new template for documenting clinical pathway meetings that includes risks, treatment goals, other services involved, assessment and referral recommendations; and,
   iii. Improved documentation for increased collaborative decision-making for referrals out, and outreach service needs, including senior clinician/manager involvement.

   CPU were of the opinion that EMPHN's actions appear appropriate and will assist in addressing the identified issues.

f) St Vincent's Hospital conducted an internal review, the outcome of which found of there were gaps in 1) the review of the written referral by the Hawthorn Clinic, instead there was a reliance on the associated verbal handover, 2) a lack of escalation of key risks between Psychiatric Triage and the Hawthorn Clinic, 3) unclear Psychiatric Triage documentation in the assessment of Garry's status and risks, and 4) a delay in uploading of critical medical records to the electronic medical record by Hawthorn Clinic, with four resultant recommendations. The following actions were undertaken by St Vincent's Hospital as a result of Mr Wise's death:

   i. Development of a Psychiatric Triage assessment template to ensure standardized and consistent information at the point of referral and includes risk screening and escalation issues.
   ii. Development of a Community Mental Health Clinical Handover Guideline specific to effective communication between Psychiatric Triage, emergency departments and community mental health teams.
   iii. Development of a checklist to improve consistency of information to the duty worker at referral.
   iv. Amendment of the St Vincent's Hospital Clinical Case Management Policy to include detailed description of the duty worker at community mental health services

including reviewing all incoming communications, completion of tasks, risk identification and escalation and documentation requirements.

g) CPU considered the changes made by EMPHN and SVH to their internal processes to be appropriate and promote best practice in communication of critical clinical information and responses to it.

h) CPU considered that there may be opportunity for HPP to develop a safety plan with its clients that recognises the client group's risks and likely other involved agencies who can be contacted when there are concerns.

33. CPU's advice was considered by HPP who informed this Court that they have completed or commenced the following quality improvements:

i. A review of protocols to support all clients at risk of self-harm and develop clear individualised plans for escalation for all existing HPP clients at risk of suicide. This will include the recommendations to provide:

1. a documented list of contacts for situations where a client may feel unsafe or at increased risk;

2. identify in the plan people whom the client agrees to have contacted by a HPP nurse in case of an increase in concerns for the client's safety;

3. a system of regular review cycle where the plan is regularly assessed in consultation with the client.

ii. A Mental Health Guideline will incorporate the recommendations. Clear protocols will be developed with current individual clients at risk of suicide. The guideline has been drafted with assistance of the Bolton Clarke Senior Clinical Nurse Adviser - Aged Care and the Mental Health Clinical Nurse Consultants. This is expected to be finalised and published in September 2021.

iii. A Model of Care - Mental Health approach. This model of care was published in May 2021 and forms the basis for care of clients living with Mental Health issues.

iv. The existing Clinical Deterioration Guideline has been amended to provide improved instructions when clients deteriorate, and they have a documented Advanced Care Directive.

v. Review HPP training program to include training of culture and leadership, Bolton Clarke Client/Resident incident management, and client deterioration. Ensure HPP staff are familiar with all relevant Bolton Clarke procedures including the Clinical Deterioration Guidelines and Flowchart; and the Client/Resident Incident Management Guidelines.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Garry Mark Wise, born 19 April 1972;

    b) the death occurred on 5 August 2019 at Hamer Court Accommodation, Room 17, 535 High Street, Kew, Victoria, 3101, from *hanging*;

    c) the death occurred in the circumstances described above; and,

    d) having considered all of the circumstances, particularly the lethality of the means chosen and history of acute mental illness and associated suicidality, I am satisfied that Mr Wise intentionally ended own life.

RECOMMENDATIONS

35. Pursuant to section 72(2) of the Act, I make the following recommendation:

    a) To improve the safety of clients of the Bolton Clarke Homeless Persons Program and provide the program nurse clear and appropriate contact points for early escalation of concerns, the HPP develop and document a plan with clients as part of assessment that:

        i. provides the client with a documented list of contacts for situations in which they feel unsafe or at increased risk;

        ii. identify people the client agrees to have contacted by the Program nurse in case of an increase in concerns for the client's safety; and,

        iii. the plan is reviewed regularly and updated when circumstances change.

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

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

Karen Wise, Senior Next of Kin

Rachel Pritchard, Eastern Melbourne Primary Health Network

Donna Filippich, Legal Counsel, St Vincent's Health

Mary-Anne Rushford, Manager, Homeless Persons Program

Senior Constable Luke Pincott, Coroner's Investigator

Signature:

Coroner Katherine Lorenz

Date : 25 August 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.