IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2020 000709

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Ingrid Giles
Deceased:	RCW[1]
Date of birth:	6 February 1977
Date of death:	6 February 2020
Cause of death:	1(a) exsanguination for incised wounds to the arms - self inflicted
Place of death:	Royal Melbourne Hospital, 300 Grattan Street, Parkville, Victoria, 3052

[1] This Finding has been de-identified by order of Coroner Ingrid Giles which includes an order to replace the name of the deceased with a pseudonym of a randomly generated three letter sequence. The original finding was published in a redacted (de-identified) manner on 13 December 2023 and a pseudonym was subsequently ordered. Relevant changes to reflect the pseudonym were made on 24 January 2024 pursuant to section 76A of the *Coroners Act 2008*.

INTRODUCTION

1. RCW was 43 years old when he died on 6 February 2020 in hospital from self-inflicted wounds. At the time of his death, RCW lived with his mother in Westmeadows.

2. As a child and young person, RCW was reportedly popular at school and was described as easy-going, funny, and well-liked. He left high school in Year 9 and commenced working in a number of odd jobs, including at a carnival, as a truck jockey, and in furniture removal.

3. In 2010, RCW was assaulted and sustained significant injuries. He heard someone yell out for help outside his home, and when he investigated, he was attacked by a group of men. RCW reportedly had multiple fractures, including skull fractures, and subsequently developed post-traumatic stress disorder (**PTSD**) as a result of the incident.

4. Initially, RCW's mother thought that he was improving following the incident, having completed treatment and therapy. However, about a year afterwards RCW showed signs of paranoia. He would stay up late at night listening to the front door, spent most of his time at home, and believed people were '*after him*'.

5. By 2015, RCW was reportedly drinking alcohol and using cannabis regularly. He was seeing a psychiatrist at NorthWestern Mental Health (**NWMH**), but his mother believed that he would only engage superficially and observed that he would often miss appointments.

6. According to RCW's brother, from around 2016-2017 RCW started using methamphetamine (commonly known as 'ice') about fortnightly. RCW showed increasing signs of paranoia from this time. He told his mother that he believed people were constantly listening in on their conversations around the house. He also started to experience auditory and visual hallucinations.

7. In 2018, RCW presented to his General Practitioner (**GP**) with symptoms of anxiety, suicidal ideation and schizophrenia. His GP commenced the antipsychotic risperidone and antidepressant mirtazapine. A few months later, RCW disclosed to his GP that his auditory hallucinations were worsening and described hearing voices that threatened his relatives. RCW also disclosed a deliberate overdose of oxazepam and ongoing suicidal ideation.

8. The GP referred RCW to NWMH for further assessment where he was seen intensively in the community between 20 September 2018 and 7 October 2018. After RCW missed two

appointments and stated that he no longer wished to engage with the service, he was discharged back into the care of his GP on 19 October 2018.

9. In the following months, RCW became increasingly reserved. According to his brother, by 2020, RCW spent most of his time in his bedroom and his family only saw him when he left his room to eat or use the bathroom. At some unknown time prior to 2020, RCW stopped taking his antipsychotic medication.

THE CORONIAL INVESTIGATION

10. RCW'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.

11. 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.

12. 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.

13. Coroner John Olle initially held carriage of this investigation. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of RCW's death. The Coroner's Investigator conducted inquiries on Coroner Olle's behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

14. I took carriage of this matter in July 2023 for the purposes of obtaining further statements, finalising the investigation and making findings.

15. This finding draws on the totality of the coronial investigation into the death of RCW, 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

Background Circumstances

16. On 16 January 2020, RCW was at home with his mother. RCW called out for a towel from the bathroom and said that he had cut himself. RCW's mother then called '000' and police and ambulance officers attended the address and conveyed RCW to the Northern Hospital Emergency Department pursuant to s.351 of the *Mental Health Act 2014* (**MHA**), as then applied.[3]

17. RCW was admitted to the Northern Psychiatric Unit (**NPU**) from 17 January 2020 to 1 February 2020. During his assessment, RCW stated that had used a serrated kitchen knife to cut his right forearm in a deliberate attempt to take his own life. He also disclosed that his auditory hallucinations sometimes told him to hurt other people and suggested to him that he was '*criminally insane*' and '*should be in prison for life*'.

18. The impression made by RCW's treating team was that of schizophrenia, with ongoing minimal low grade psychotic symptoms, and RCW was recommenced on antipsychotic medication. He was placed on a Temporary Treatment Order (**TTO**) and commenced on a monthly injectable antipsychotic to assist with compliance and to prevent relapse. There was evidence that his mental state improved throughout the admission. While his psychotic symptoms were still present, they were less frequent and less distressing. He denied suicidal ideation, and while he sometimes reported that auditory hallucinations told him to harm himself and others, he denied feeling as though he would act on this. Further, at a family meeting, RCW's family noted that he was requesting discharge and reported their view that RCW's mental state had improved and that he appeared relaxed.

19. RCW was discharged from the NPU on 1 February 2020 on a TTO, with a plan for further scheduled antipsychotic injectable medications, and referred to the Hume Community Team

[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.

[3] It is noted that a new *Mental Health and Wellbeing Act 2022* (Vic) commenced on 1 September 2023.

for follow up. On 3 February 2020, an interim case manager called RCW to offer an appointment with the consultant psychiatrist for 5 February 2020. RCW accepted the referral and reported that he had been '*alright*' since discharge, and the case manager documented that there were no obvious concerns.

20. RCW's mother reported that, during this period, RCW was very quiet and seemed angry and did not communicate much with her after discharge. He would often give one-word answers and displayed the same paranoid behaviours, just not as openly.

21. On 5 February 2020, the case manager contacted RCW as he had missed his scheduled appointment with the consultant psychiatrist. RCW reportedly got the dates mixed up and stated that he remained interested in attending this appointment, and the appointment was rescheduled for 10 February 2020.

Proximate Circumstances

22. On 6 February 2020 at about 1pm, RCW's mother had RCW's sister and nephew over to the family house to celebrate RCW's birthday, reportedly preparing '*a lot of food for him*'. However, RCW did not leave his bedroom the whole time. After everyone had left, RCW still refused to come out of his room. In the early evening, RCW's mother entered RCW's bedroom and saw blood, and when she asked RCW '*where he cut himself*', he became verbally aggressive, and she immediately left the room to call for assistance.

23. At 6.16pm, RCW's mother called '000' and informed the call-taker from ESTA[4] that her son would not come out of his room, that there was blood on the floor, and that she thought he had cut himself again. The ESTA call taker,[5] using the Computer Assisted Dispatch (**CAD**), listed the chief complaint as *'Psychiatric/Abnormal Behaviour/Suicide Attempt'* and commenced asking questions as per the relevant protocol script. Use of this script did not identify any obvious life threats.

[4] Emergency Services Telecommunications Authority (**ESTA**) was established as a statutory authority on 1 July 2005 under the *Emergency Services Telecommunications Authority Act 2004* (Vic). ESTA is vested with responsibility for the provision of multi-agency emergency services communications across Victoria; they operate the '000' phone service.

[5] ESTA call takers are not medically trained but use a computer program called 'Computer Assisted Dispatch' (**CAD**) system which contains 32 different scripts based on patient presenting complaint. These scripts have been designed by the International Academies of Emergency Medical Dispatch to rapidly assess the severity of the problem and dispatch an appropriately skilled response team to respond in a predetermined (algorithm driven) appropriate time-frame. This process, while delivered by ESTA was developed (and continues to be reviewed) in conjunction with Ambulance Victoria.

24. The CAD algorithm automatically dispatched an ambulance Code 3, Priority 3 (ambulance to arrive within 60 minutes but can be diverted if a more serious incident occurs). The algorithm also recommends that the call be transferred to AV Referral Service Communications (**REFCOMM**) team for secondary triage. REFCOMM's Secondary Triage Practitioners (**STP**) are paramedics and nurses employed by AV whose role is to reassess the situation to ensure that the dispatch code is appropriate.

25. At 6.17pm, the ESTA call taker tried to transfer the call to the STP, but they were occupied and so the call taker kept speaking to RCW's mother. The call taker determined via questions to RCW's mother that RCW was breathing but with a decreased conscious state, did not have a weapon, and that RCW's mother was unsure if he was still bleeding. RCW's mother reported that she could not move him to assess for further bleeding due to his height, and that he refused to let her look at him. With this additional information, the call taker changed the event type to *'psych: not alert'* which was still Code 3, Priority 3. The ESTA call taker gave advice about how to stop any bleeding before transferring the case to the REFCOMM STP at 6.24 pm.

26. The STP assessment, which lasted until 6.28pm, concurred with that of the CAD algorithm and the dispatch being kept as Code 3, Priority 3, adding that police should also be in attendance as there was a potential safety risk at the scene.

27. At 7.10pm, RCW's mother called '000' again to enquire when the ambulance would be arriving. The ESTA call taker, as per protocol, determined whether there had been any change in the patient's condition since the previous call. This line of questioning included whether RCW was breathing normally, was completely awake, and whether the bleeding had been controlled. RCW's mother stated that the situation had not changed. As per ESTA policy, the call taker advised *"Ambulances can be diverted to cases of a higher priority, so I cannot advise you how long it will take to arrive"*. The call taker advised to call back if there was any change in RCW's condition.

28. Two ambulances which had been dispatched to attend RCW were both diverted to attend higher priority cases.

29. At about 7.15pm, RCW's brother arrived. RCW's mother warned him that RCW was very angry and that he shouldn't go up to the room. He heard RCW call out for a drink and then heard a thump. He entered the room and found RCW on the floor of the bedroom between his bed and a cupboard. He noticed large cuts to RCW's arm but with no active bleeding and formed the belief that RCW had bled out.

30. At 7.31pm, RCW's mother, assisted by RCW's brother, called '000' to inform the ESTA call taker that he had *'gone downhill'* and that he was '*just'* breathing and that it was *'shallow'*. When this additional information was received and entered into the event type as *'cardiac or respiratory arrest/death'* with automated dispatch code up-triaged to Code 1, priority 0, instantly diverting two MICA[6] ambulances and the police and fire department in addition to the ALS[7] ambulance already dispatched.

31. At 7.44pm, the ALS paramedics arrived to find RCW lying between the floor and the bed, with *'altered conscious state, pre-arrest'* and proceeded to try and extricate him. Over the next few minutes, the MICA ambulances came to assist. Paramedics noted uncontrolled bleeding requiring tourniquets.

32. At 7.58pm, RCW arrested, paramedics commenced CPR and attached defibrillator pads. An ALS paramedic thought a wide complex rhythm was a shockable rhythm (ventricular tachycardia) and thus delivered a shock. After the shock was delivered, a MICA paramedic assessed the cardiac rhythm as a non-shockable rhythm and CPR continued without administering further shocks as per the life support algorithm. Paramedics applied a mechanical chest compression device and inserted intraosseous lines.

33. At 8.26pm, RCW arrived at the Emergency Department (**ED**) of the Royal Melbourne Hospital. The ED clinician's impression was cardiac arrest from blood loss, and the massive transfusion protocol was initiated. Unfortunately, despite extensive ongoing resuscitation including receiving six units of blood, RCW could not be revived.

Identity of the deceased

34. On 7 February 2020, RCW, born 6 February 1977, was visually identified by his mother who completed a statement of identification.

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

Medical cause of death

36. Forensic Pathologist Dr Paul Bedford (**Dr Bedford**) from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination on 10 February and provided a written

[6] Mobile Intensive Care Ambulance have critical care skilled paramedics.
[7] Advanced Life Support paramedic are the most common type of paramedic. Their scope of practice is less than that of a MICA skillset, for example, they cannot intubate patients, but can insert drips, give medications, and perform resuscitation until a MICA is available to assist.

report of the findings. Dr Bedford also considered the e-Medical Deposition, a post-mortem CT scan, and the Victoria Police Report of Death (**Form 83**).

37. The examination conducted by Dr Bedford showed incisions into both cubital fossae. There was an additional superficial linear incision more distally on the right upper limb. There were no other significant findings on examination or post-mortem radiology.

38. Toxicological analysis of post-mortem samples identified the presence of methylamphetamine, amphetamine, and hydroxyrisperidone.

39. Dr Bedford provided an opinion that the medical cause of death was *1(a) exsanguination for incised wounds to the arms - self inflicted.*

40. I accept Dr Bedford's opinion.

FURTHER INVESTIGATIONS

Coroners Prevention Unit review of Mental Health Treatment

41. As part of the coronial investigation, the Coroners Prevention Unit (**CPU**) undertook a review into the appropriateness of the care provided to RCW prior to his death and to identify any potential prevention opportunities.

42. The 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.

43. The CPU investigated the appropriateness of RCW's treatment and discharge from Northern Hospital Psychiatric Unit and subsequent follow up by the Hume Community Team. The CPU reviewed RCW's NorthWestern Mental Health medical record, coronial brief and additional statements obtained.

<u>Treatment and discharge from Northern Hospital Psychiatric Unit</u>

44. Following the CPU review of the management of RCW's care at Northern Hospital Psychiatric Unit (**NPU**), I am satisfied that his treatment and discharge from NPU was reasonable. I note that RCW was admitted as an in-patient to the IPU for a 14-day period, and

when the treating team assessed that his mental state had improved, and his acute symptoms had abated to baseline levels, it was decided that he could continue his treatment in the community in accordance with the requirement in the MHA (as then applied) to provide treatment in the least restrictive setting. I further note that, upon discharge, consideration was given to the possibility that RCW may not be adherent to oral anti-psychotic medications and accordingly he was prescribed and administered a long-acting injectable anti-psychotic medication.

45. Updates were provided to RCW's family on 22 and 30 January 2020, with discharge planning discussed on the latter date, and the Carer Peer Support Worker was engaged with RCW's family. While RCW's mother has expressed concerns about RCW being permitted to leave the hospital during his in-patient stay, it appears that he was approved for unescorted leave on 29 January 2020 upon the settling of his symptoms to a manageable level.

46. I do consider that, given RCW was known to use illicit substances and this usage was likely impacted his mental state, it would have been good practice to offer him a review by a specialist drug and alcohol clinician and to facilitate post-discharge referrals to addiction services on 1 February 2020 and following. However, I note that it is unlikely that RCW would have yet have the opportunity to engage with additional services in the brief period between his discharge and death and therefore it cannot be concluded that this would have resulted in an improved mental state or prevented his death.

47. I am satisfied that while RCW continued to experience some psychotic symptoms, these improved significantly with treatment and therefore, his discharge was appropriate.

Follow-up by Hume Community Team

48. Following discharge, RCW's case manager had phone contact with him on two occasions, both of which were for the purpose of arranging a psychiatrist review. There was no evidence that he was acutely psychotic or expressed concerns during either call, however the information obtained during a phone call is limited and one of the calls was documented to be brief. While RCW was asked how he was going, there was no documented evidence during either call that he was asked specifically about suicidal ideation or the presence of psychotic symptoms. Similarly, there was no evidence of enquiry into his use (if any) of illicit drugs which increased the risk of relapse. There was also no evidence that RCW's mother was informed of the scheduled psychiatrist review, which was a missed opportunity for her to support his attendance.

49. It has been well-established that the period immediately following discharge from an acute psychiatric facility can be high risk, especially for those with a history of suicide attempts, and when the person was admitted for self-harm. As such, the Department of Health '*Working with the Suicidal Person: Clinical Practice Guidelines for Emergency Departments and Mental Health Services*' notes that the evidence suggests that '*close monitoring through follow-up during the period of transition from hospital to the community'*, with face-to-face follow-up being the most effective. The significance of post-discharge contact by a public mental health service is supported by its inclusion in the Australian Institute of Health and Welfare Key Performance Indicators for Australian Public Mental Health Services indicators set that each state collects and reports quarterly. The rationale for the indicator is as follows:

> *A responsive community support system for persons who have experienced an acute psychiatric episode requiring hospitalisation is essential to maintain clinical and functional stability and to minimise the need for hospital readmission.*
>
> *Consumers leaving hospital after a psychiatric admission with a formal discharge plan, involving linkages with community services and supports, are less likely to need early readmission.*
>
> *Research indicates that consumers have increased vulnerability immediately following discharge, including higher risk for suicide.*[8]

50. While there was indeed a degree of follow-up by the Community Team following RCW's discharge from the NPU, this follow-up fell below RCW's level of needs in circumstances where he was in a high-risk period post discharge and he continued to experience psychotic symptoms at the time of discharge, although not at a level requiring acute admission. This was further impacted by RCW missing his psychiatrist appointment.

51. Given RCW's recent serious suicide attempt, recent command hallucinations, guarded mental state during admission and on discharge, and history of illicit drug use, it would have been reasonable for the Community Team clinician to seek additional information about RCW's mental state and risks when he did not attend the scheduled psychiatrist appointment on 5 February 2020. This could have occurred via a more thorough phone assessment with RCW, or ideally facilitating a face-to-face review while awaiting the psychiatrist review, along with

[8] Available: https://www.aihw.gov.au/getmedia/f9bb1a07-a43b-458a-9b73-64ef19d8aedd/key-performance-indicators-for-australian-public-mental-health-services-third-edition.pdf.aspx [Accessed: 11 October 2023].

seeking collateral information from RCW's mother, who had observed him upon discharge to be quiet, angry and communicating minimally.

52. It is unknown whether this would have altered the outcome, and there is insufficient evidence to suggest that RCW required readmission following his discharge. However, a more thorough assessment of RCW's mental state and concomitant risks may have identified an increase in those risks and resulted in more assertive community treatment.

Response from NWMH

53. NWMH was given an opportunity to respond to these comments and provided correspondence to the Court as such. NWMH stated that that RCW had been admitted as an involuntary patient under the MHA, had received a 14-day admission, and when his mental state had improved, and acute symptoms abated to baseline levels, then community treatment was appropriate and thus required to provide treatment in the least restrictive setting pursuant to the MHA. The NWMH also notes that the TTO remained in place in the community to counter the possibility that RCW may have chosen not to attend follow-up appointments, and he was prescribed and administered a long-acting injectable anti-psychotic medication to address medication compliance.

54. NWMH respectfully disagreed that RCW's follow-up care by the Community Team was suboptimal and outlined that RCW received contact via a telephone call from a case manager within two days of discharge, and there were no indications for concern on the part of the case manager during the telephone call. Further, after RCW failed to attend his scheduled review appointment on 5 February 2020 and was contacted by a case manager, he indicated that — he had simply got the appointment dates mixed up and noted he was '*keen to attend the service'*. NWMH also noted that, while speculative, the presence of methylamphetamine and amphetamine in RCW's toxicology report indicates that RCW's mental state before death may have been impacted and that his drug use likely increased the risk of impulsive and irrational behaviour.

55. The CPU reviewed this response and provided an opinion that it did not provide any new information and does not contradict the advice provided regarding RCW's discharge supports. In fact, the reference in the response to the potential impact of RCW's apparent recent drug use exemplifies that the Community Team should have enquired on this topic to inform its risk assessment and support planning.

56. I agree with the advice provided by the CPU and will make a pertinent comment in this regard.

Ambulance Victoria Response Times

57. It was noted in the course of the investigation that an ambulance took 92 minutes to arrive, and police were not requested for 83 minutes after the call was made to '000'. As such, statements from ESTA and Ambulance Victoria (**AV**) were also sought to comment on the case and outline the details of their own internal reviews, if any.

58. ESTA's review and AV's Observation Report of the three calls related to RCW's death concluded that their call takers acted in accordance with relevant procedures and systems.

59. AV conducted four reviews into RCW's death:

    a) A Minor Clinical Case Review ('clinical review') of the actions of the paramedics involved;

    b) A Minor Communications Case Review into the three '000' calls and dispatch management (i.e. ESTA's role);

    c) A Triage Services Review of the Secondary Triage Practitioner's (**STP**) role; and

    d) A Root Cause Analysis (**RCA**) – part of Safer Care Victoria's Sentinel Event Program reviewing all aspects of care.

60. The clinical review found that the paramedics involved had acted appropriately and within guidelines. The one exception was the defibrillation of a non-shockable rhythm[9] which was not of any clinical consequence.

61. The Communications Case Review did not identify any issues of concern with ESTA's management of the '000' calls.

62. The Triage Services Review identified inadequacies with the management of the '000' call and determined that:

[9] A 'junctional rhythm' is a wide complex slow rhythm that can occur as a consequence of the dying process – this is not a shockable rhythm. This was mistaken for Ventricular Tachycardia which is a wide complex fast rhythm that occurs as a consequence of underlying heart conduction abnormality – this is a shockable rhythm.

a) Clinical suspicion should have been raised when RCW's mother stated, '*He was making a peculiar noise and not making any sense, and I saw the blood on the floor so I phoned you immediately because he cut his wrists a few weeks ago*';

b) The role of an STP is to elicit further information from callers such as RCW's mother. For example, the STP could have further explored the nature of the peculiar noise that RCW was making, why RCW was not making sense and identified where the blood was coming from and how much blood there was; and

c) If further information had been gathered, it would have provided an opportunity to establish RCW's conscious state and bleeding status.

63. As a result, it appears that an assumption was made that RCW was predominantly facing a mental health issue rather than a medical emergency. The Triage Services Review concluded that, in the circumstances, the STP ought to have asked freelance questions, noting the possibility that RCW may have been in an altered conscious state, possibly had an airway compromise and/or a serious haemorrhage. Lack of clarification of these factors resulted in a lower probity dispatch code.

64. The RCA process identified one root cause, namely, there was no requirement for the STP to confirm or assess the potential for an immediate life threat, as this is presumed to be done at the initial '000'/ESTA stage. The RCA also found that STP communication scripts as then applied did not include a summary of the situation and plan being presented to the caller to provide the caller with an opportunity to identify anything that had been missed by the STP; and that more work may be required to support the STPs in eliciting accurate patient history. A final point was that the estimated time of arrival given to callers was not accurate.

<u>Recommendations from these reviews</u>

65. The Clinical Review recommended further ECG education to the ambulance officer who performed the defibrillation.

66. The Communications Case Review (ESTA) and Triage Services Review did not have any recommendations (however it is noted that a multidisciplinary team meeting discussion of the Triage Services Review led to an RCA being conducted, which included three recommendations).

67. The RCA recommended:

a) AV develop a baseline 'rapid assessment' workflow script for triage services (STP) in order to determine the patient's conscious state, breathing status and the presence of any uncontrolled bleeding.

b) AV improve the quality and consistency of the assessment summary used by a STP at call completion. This script should provide an additional opportunity for the caller to confirm the accuracy of the triage and provide any additional information; and

c) ESTA scripts for estimated time of arrival updates be reviewed to be more accurate.

68. In subsequent correspondence, both AV and ESTA confirmed that these recommendations have been implemented. This is reflected in the revised policy document 'Referral Service Application of Clinical Skills' and concomitant education provided to STPs, as well as the revised call closure scripts.

69. AV stated that implementation of this last recommendation involved:

a) Development of a procedure entitled 'Escalating Patient Care and Demand Subplan', which focuses on promoting effective communication, response and consequence management for people in life-threatening, time-critical emergencies;

b) Introduction of 'welfare call backs' to '000' callers, which provides AV staff with an opportunity to review the patient's condition and to advise the '000' caller of any potential delays with AV's attendance;

c) Developing revised call closure scripts to remove misleading timeframes. These scripts were endorsed by AV's Clinical Response Mode Improvement Standing Committee and went live with ESTA on 14 September 2021. The advice '*an ambulance has been arranged*' has been removed and an ETA is now to be provided to all '000' callers. This ETA is not to be a real time estimate, rather the aim is for it to provide '000' callers with pre-determined timeframes based on event priority and the level of escalation under AV's Emergency Response Plan; and

d) Updating AV's work instruction entitled 'Triage Services: Performing Secondary Triage' to include references to a Life-Threatening Emergency Check, which is to be undertaken by the Triage Practitioner in their introduction to a '000' caller, to screen for life-threatening emergency symptoms.

CPU Review

70. The CPU was also asked to review the ESTA and AV response times and the respective statements, reviews, and recommendations to identify any prevention opportunities.

71. The CPU explained that assessment of a clinical situation over the phone is difficult particularly when speaking to a third party who themselves are unable to assess events completely. This will continue to be the case as both callers and the situations they find themselves in will always be unique.

72. Additionally, whenever there is a transition of care (handover), the second party is faced with an *'efficiency-thoroughness-trade-off'*;[10] if they are to be maximally efficient, they accept everything the previous person has done as correct, if they are to be maximally thorough, they re-do the initial call-taker's work from scratch which in turn delays them in attending to the next call which can have its own safety consequences. There needs to be an appropriate balance of these two competing aims.

73. The CPU provided an opinion that the recommendations of the RCA strike the right balance in detecting missed life threats and ensuring that the situation has been accurately interpreted without significantly impacting efficiency. As such, the CPU had no further recommendations.

74. I accept and adopt the CPU's opinion. I am satisfied that the actions taken by ESTA and Ambulance Victoria subsequent to RCW's passing to address the delay in AV officers attending upon him, including the reported recommendations flowing from the RCA, negate the need for any further recommendations.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was RCW, born 6 February 1977;

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[10] Hollnagel, Erik (2009). *The ETTO principle: efficiency-thoroughness trade-off: why things that go right sometimes go wrong*. Aldershot, Hants, England: Ashgate.

b) the death occurred on 6 February 2020 at Royal Melbourne Hospital, 300 Grattan Street, Parkville, Victoria, 3052, from 1(a) exsanguination for incised wounds to the arms - self inflicted; and

c) the death occurred in the circumstances described above.

76. Having considered all the evidence, I find that RCW deliberately took his own life.

77. While an ambulance took 92 minutes to arrive at RCW's residence, I am satisfied that the subsequent actions taken by Ambulance Victoria, as detailed above in the extensive set of reviews conducted and the implementation of RCA recommendations, negate the need for any coronial recommendations to be made. Further, RCW's refusal to allow his family to adequately assess his injuries compromised his mother's, and consequently the call-taker's ability to recognise the specific features of his presentation. Thus, I am satisfied that the delay of the ambulance attending was a result of this incomplete clinical picture and that steps taken subsequent to RCW's passing adequately address the ways in which the best possible clinical picture can be obtained in future responses to '000' calls.

COMMENTS

Pursuant to section 67(3) of the Act I make the following comments:

1. As outlined above, I maintain that the follow-up care after discharge from NPU did not meet RCW's needs and that a more thorough assessment after RCW had missed his scheduled appointment with the consultant psychiatrist on 5 February 2020 may have identified an increase in risks and resulted in more assertive community treatment. In particular, given that RCW's family had been involved in discharge planning, it would have been prudent to seek collateral information to improve the reliability of the risk assessment conducted. However, it is unknown if this would have changed the outcome.

2. Accordingly, while it cannot be said that RCW's death was preventable, given the tragic outcome, any potential for improvement should be identified, considered, and pursued. As such, I make comment that NWMH consider revising any policies, guidelines, or call scripts for community-based staff tasked with supporting patients who have been discharged from an in-patient unit, particularly following a recent suicide attempt and with a history of illicit drug use, regarding:

(i) the utility of making direct enquiries regarding existing symptoms and regarding any illicit drug use; and

(ii) seeking collateral information from family, where they have been involved in treatment and discharge planning, to inform clinical decision making.

3. I note and endorse the recommendations made by AV and ESTA as part of the RCA following RCW's death, and make no further recommendations directed at either agency given that these recommendations have been identified and implemented.

I convey my sincere condolences to RCW's family for their loss.

Pursuant to section 73(1A) of the Act, I order that this finding be published (in de-identified form) on the Coroners Court of Victoria website in accordance with the Rules.

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

RCW's mother, Senior Next of Kin

Lander & Rogers, on behalf of the Emergency Services Telecommunications Authority

Ambulance Victoria

Royal Melbourne Hospital

NorthWestern Mental Health

Senior Constable Umut Kucuktepe, Coroner's Investigator

Signature:

Coroner Ingrid Giles
Date: 13 December 2023

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.