IN THE CORONERS COURT OF VICTORIA AT MELBOURNE	**COR 2020 000816**

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Paul Lawrie
Deceased:	Justin Patrick Crome
Date of birth:	24 April 1980
Date of death:	13 February 2020
Cause of death:	*Injuries sustained in a fall from the Camberwell train station bridge*
Place of death:	Alfred Health, the Alfred Hospital, 55 Commercial Road, Melbourne, Victoria

INTRODUCTION

1. Justin Patrick Crome (**Justin**), born 24 April 1980, was 39 years old at the time of his death. He is survived by his parents Robin and Ritsuko Crome and younger brother Adrian. He graduated from Monash University with qualifications in business and throughout his life he was employed at the National Australia Bank and Cooper Investors. He was described as having a very active social life and often spent weekends with friends in bars and clubs. At the time of his death, he was living with his mother and brother in Camberwell.

2. From 2016, Justin struggled with his mental health and he was later diagnosed with delusional disorder and schizophrenia. He was treated at St Vincent's Mental Health (**SVMH**) and Hawthorn Community Mental Health (**HCMH**).

3. On 13 February 2020, Justin jumped from a bridge near the Camberwell railway station and died from the injuries he sustained on impact.

THE CORONIAL INVESTIGATION

4. Justin'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.

5. 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.

6. 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.

7. Victoria Police assigned Senior Constable Andrew Manning (**SC Manning**) to be the Coroner's Investigator for the investigation of Justin's death. SC Manning conducted inquiries on my behalf and compiled a coronial brief of evidence. The brief comprises statements from Justin's family members, the pathologist who examined him, investigating officers, witnesses from the scene, treating medical practitioners, as well as other relevant material.

8. The Court obtained copies of Justin's medical records from SVMH and a statement from Andrew Green, Case Manager at HCMH.

9. As part of the coronial investigation, the Coroners Prevention Unit (**CPU**) was also asked to review the appropriateness of the care provided to Justin proximate to his death. The CPU is staffed by healthcare professionals, including practising physicians and nurses, who are not associated with the health professionals and institutions under consideration and are therefore able to give independent advice to coroners.

10. This finding draws on the totality of the coronial investigation into Justin'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.[1]

Background

11. The evidence suggests Justin struggled with his mental health in the years preceding his death. In July and December 2016, Justin sent emails and Facebook messages to his former employer, Peter Cooper, and other former colleagues saying he planned to suicide, resulting in police and ambulance transporting him to St Vincent's Hospital emergency department. In December 2016, the Mental Health Hospital Admission Risk Program (**MH-HARP**) attempted to engage with Justin but he did not respond to messages.

12. In August 2016, police called SVMH psychiatric triage service seeking advice as Justin had sent Mr Cooper several disturbing emails. However, the triage service did not believe that Justin would satisfy the criteria to be detained under section 351 of the *Mental Health Act 2014* (Vic). Police were advised to utilise the Police, Ambulance and Clinical Early Response[2] clinician, however there is no evidence that this occurred.

13. In 2017, Justin was convicted of stalking and assaulting Mr Cooper and he was sentenced to two months' imprisonment. Whilst in prison he was assessed by two forensic psychiatrists who formed the impression that Justin was experiencing a psychotic illness. Upon release, he was placed on an inpatient assessment order under the *Mental Health Act* and underwent another

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[1] 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.

[2] An established inter-agency program known as 'PACER'.

mental health assessment and was diagnosed with delusional disorder. Medical records from St Vincent's Hospital indicate Justin was also diagnosed with schizophrenia, however the precise timing of that diagnosis is unknown.

14. Justin was placed on a treatment order at the Northern Hospital for two weeks and his care was overseen by treating psychiatrist, Dr Ajit Selvendra, who noted Justin's history of anxiety, depression and illicit drug use. Justin was commenced on the antipsychotic paliperidone, by injection.

15. Justin's care was transferred to the HCMH branch of SVMH and he continued his treatment for the next three years. He was admitted to St Vincent's Hospital on two occasions, in October 2017 and June 2018. Both admissions concerned a deterioration in his mental health marked by Justin's fixation on the idea that Mr Cooper and his brother were conspiring against him.

16. Throughout his treatment at SVMH, Justin's care was overseen by clinician Andrew Green. Mr Green said that his sessions with Justin were characterised by Justin fixating on Mr Cooper and believing him to be a psychopath. He voiced beliefs that strangers had been sent by Mr Cooper to watch him and became obsessed with this idea.

17. Progress notes from SVMH record that Justin was often verbally abusive to SVMH staff and other treatment providers such as the men's behaviour change program and his general practitioner. It was noted that the aggression occurred both with, and without, accompanying psychotic symptoms.

18. In October 2019, Justin was referred to a community recovery mental health service, MIND, to facilitate his NDIS application. However, this engagement was ended in December 2019 after Justin sent abusive messages and emails to his MIND worker.

19. Between November 2018 and February 2020, Justin twice breached a personal safety intervention order (**PSIO**) that Mr Cooper had taken out against him. He also assaulted his brother Adrian, resulting in a family violence intervention order (**FVIO**) with Justin as the respondent. He was admitted to SVMH as an inpatient on the first two of these occasions in October 2017 and June 2018, during which his paliperidone injection was ceased and he was commenced on the antipsychotic lurasidone.

20. On 9 January 2020 Justin called Mr Green to confirm the details of his next appointment. During the call he admitted to feeling flat but was not psychotic. He requested a psychiatric review to explore the options of being prescribed diazepam, being admitted to the mental health

ward, or being admitted to the Prevention and Recovery Care Unit (**PARC**). He missed the scheduled psychiatric review on 14 January 2020 at HCMH and this was rescheduled for 20 January 2020, but he subsequently missed that appointment as well.

21. When being interviewed by police on 5 February 2020 in relation to breaching the PSIO, Justin said that he had attempted suicide in the past and that he 'may as well not be here and be dead'. An ambulance was called early on 6 February 2020 and Justin denied suicidal ideation to paramedics. He was detained under section 351 of the *Mental Health Act* and taken to St Vincent's Hospital.

22. Ambulance Victoria records and St Vincent's Hospital medical records consistently document that Justin was arrested over a dispute with his neighbour, though there was initially some confusion in the brief whether he was arrested over a neighbour dispute or due to a breach of the PSIO with Mr Cooper as the protected person. Clarification was sought from Victoria Police which revealed that police attended in response to a neighbourhood dispute. No new offences were disclosed at the time but Justin was arrested for an outstanding breach of the PSIO.

23. On his mental health assessment at St Vincent's Hospital, Justin was reported to have engaged well and was polite and cooperative. He denied suicidal ideation, stating that he was 'absolutely and definitely not suicidal'. He denied beliefs that his brother had recent contact with Mr Cooper and further denied recently thinking about Mr Cooper or thoughts of harming him. He reported compliance with medications and stated that he never missed a dose. He reported that he was tired because he had taken temazepam an hour before being arrested and reported that he believed that his current treatment was working. He also reported feeling the best he had in a long time. He denied recent drug or alcohol use and was proud of the length of time he had been abstinent. He said that he wanted to go home and was happy to continue community treatment.

24. Collateral information was sought from Justin's mother, who stated that she did not have concerns about his mental state. She also did not believe there were any acute risks and was very happy for him to return home. Justin was discharged on 6 February 2020.

25. On 10 February 2020, Justin missed a scheduled psychiatrist appointment. He did not respond to a phone call and text message the following day. Mr Green spoke with Justin's mother, who advised that he had not come home two nights earlier and said that she would ask Justin to contact Mr Green. Mr Green also contacted Justin's Assessment and Referral Court worker to

advise of his missed appointment, ED presentation and recent delusions about his MIND worker.

26. On 12 February 2020, Mr Green made several attempts to phone Justin and spoke with his mother each time. Mrs Crome advised that Justin was asleep, and she believed that he had been in a fight because his face was swollen. During the final phone call, she asked Justin to take the call and Justin was heard in the background angrily telling her to say that he was not home. Mr Green advised Mrs Crome that he would write to Justin offering another medical review.

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

Circumstances in which the death occurred

27. As to the details of what occurred in the days leading up to Justin's death, there is little available information. Justin's father noticed Justin giving away his possessions in the weeks preceding his death, which Mr Crome thought was unusual because these items included Justin's school textbooks, which he loved.

28. On 13 February 2020, Adrian heard Justin leave the house around 6.00am, which was not unusual. At about 7.20am, Justin was observed by a witness, Emily Mellor, walk past her at the pedestrian crossing on Stanhope Grove in Camberwell headed from East Camberwell railway station. He crossed the road diagonally and then jumped over the bridge railing, landing on the tracks below.

29. Ms Mellor and another witness, Kirsty Lane, provided first aid to Justin. Ms Mellor commenced CPR and Ms Lane contacted emergency services.

30. At about 7.30am, police arrived at the scene and were joined shortly after by paramedics. They attended to Justin for two hours before he was transported to the Alfred Hospital. He could not be saved and was later pronounced deceased.

31. Police commenced an investigation and collected photographic evidence, which formed part of the coronial brief. On examination of the scene, they estimated the height from the bridge to the train tracks was approximately 11.5 metres. There were no suspicious circumstances evident to the investigators.

Identity of the deceased

32. On 17 February 2020 Justin Patrick Crome, born 24 April 1980, was visually identified by his family. He was also identified via fingerprint identification by Dr Lyndall Smythe.

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

Medical cause of death

34. Forensic Pathologist Dr Victoria Francis from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination on 14 February 2020 and provided a written report of her findings dated 26 February 2020.

35. The post-mortem examination revealed injuries over his head, face, torso and the lower limbs. A post-mortem CT scan showed skull and facial fractures including a base of skull fracture with cerebral oedema and subarachnoid haemorrhage. There was a complete fracture of the right femoral shaft. There was fluid in the pleural cavities and drains. No definite rib fractures were identified.

36. Toxicological analysis of post-mortem blood samples identified the presence of Citalopram, Promethazine and Ketamine. Analysis of post-mortem plasma samples identified the presence of Citalopram and Promethazine. Justin was prescribed the antipsychotic medication aripiprazole, but this was not present on toxicological analysis.

37. Dr Francis provided an opinion that the medical cause of death was *1(a) Injuries sustained in a fall from the Camberwell train station bridge*. I accept Dr Francis' opinion.

FURTHER INVESTIGATIONS

38. A review was conducted by the CPU to consider whether any prevention opportunities were available.

Discharge from ED on 6 February 2020

39. The CPU considered that Justin's discharge from St Vincent's Hospital ED was reasonable, however noted that that handover of critical information from Victoria Police may have had an impact upon the treatment provided. In this respect, the CPU noted that Justin's treatment plan identified that signs of being 'well' included being 'less preoccupied with his ex-boss', signs of becoming 'unwell' included, 'sending unwanted emails' and signs that he was 'acutely

unwell’ included ‘making threats to kill’. His October 2017 admission was precipitated by Justin being charged with breaching the PSIO protecting Mr Cooper. The available evidence indicated that police members (from Camberwell Police Station) were diligent in liaising with HCMH when they had contact with Justin in the context of his beliefs around Mr Cooper.

40. However, when Justin was arrested on 5 February 2020, the attending members were from Box Hill Police Station, who were likely less familiar with his mental illness and its impact on his offending behaviour. Police attended because Justin was banging on a neighbour’s front door, but the reason he was arrested was for a previous breach of the intervention order protecting Mr Cooper. It seems that the actual reason for Justin’s arrest was not effectively communicated to paramedics and St Vincent’s Hospital staff. The need to do so is clear. The medical staff assessing Justin should have as complete a picture as possible when undertaking this task, including a proper account of his recent behaviour.

Post-discharge follow up

41. In circumstances where: (1) Justin’s most recent contacts indicated that he was feeling flat; (2) medical reviews had been scheduled to consider treatment options including voluntary admission to PARC or the acute unit; (3) Justin had missed two medical appointments prior to his presentation to ED; and (4) Justin had contact with police, which he was known to do when becoming unwell, the CPU considered that it would have been reasonable to attempt to contact Justin prior to 10 February 2020 and, if unable to do so, seek collateral information from his mother about his mental state in the days following discharge.

42. The CPU noted that when Justin missed the appointment on 10 February 2020, this was his third missed medical review in four weeks. By this time, he had not been seen by HCMH for over 6 weeks and had not been in contact in 4 weeks. His only known contact with health professionals during that time was the presentation to ED in the context of possible suicide risk. Based on the evidence, it did not appear that any contact was made with Justin or his mother in the seven days between his presentation to ED and his death.

43. The CPU considered that, based on Justin’s presentation and poor engagement both leading up to and after his ED presentation, simply providing a letter with another medical review appointment in a week hence was not consistent with his recent presentation and risks.

44. Based on this advice, further inquiries were made of HCMH. In response, the Court received a supplementary statement from Mr Green dated 31 May 2021.

45. Mr Green stated that he left a letter in Justin’s mailbox offering an appointment for 18 February 2020 as based on Justin angrily telling his mother to say that he was not home, a home visit may have damaged the therapeutic relationship. Mr Green further stated that it was not the usual practice for case managers to inform the treating psychiatrist on every occasion when a client had not attended a medical review.

46. Mr Green did not refer to the appropriateness of escalating the matter when Justin missed three medical reviews over four weeks, was assessed in ED after expressing suicidal ideation (and had not been reviewed since) and his most recent mental state review via phone on 9 January 2020 indicated that he felt flat and wanted additional medication and/or admission. In such circumstances, and particularly after discovering Justin’s mother’s concerns about him being out all night and possibly having been in a fight, the CPU considered it would have been reasonable for Mr Green to escalate to a psychiatrist.

47. St Vincent’s Health conducted an internal investigation into Justin’s death and found that follow up of any ‘consumer’ the day after presenting to ED should be routine practice, including discussion with a psychiatrist or psychiatric registrar. This was implemented into the Case Management Policy and the process for a daily automatically generated report is now in place. Although brief contact was made with Justin to offer an appointment, this likely would not have met the standard for follow up according to the new procedure.

48. While the lack of follow up after Justin’s ED presentation was acknowledged in the St Vincent’s Health internal investigation, the lack of escalation of multiple missed appointments and a sustained period without review was not acknowledged or addressed.

49. The CPU considered that the changes made to the SVMH Case Management Policy are good practice. I agree that there was a lack of escalation when Justin: (1) missed three medical appointments in four weeks; (2) had not been seen for more than 6 weeks and had not been reviewed via telephone in 4 weeks; (3) at his last mental state review he voiced concerns about his mental state; (4) was taken to ED by police due to concerns about his suicidality; (5) was identified by his mother has having been out all night and having been in a fight: and (6) was heard to be angry in the background of a phone call and not wanting to engage with mental health services. The lack of escalation was not addressed during the SVMH internal investigation and Mr Green stated that it is not usual practice to escalate to a psychiatrist when patients miss their appointments, though he did not comment on the cumulative effect of multiple missed appointments.

50. In the circumstances, I consider it appropriate 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. The recency or otherwise of a review should remain a matter to be determined by the service based on their assessment of the individual patient.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Justin Patrick Crome, born 24 April 1980;

    b) the death occurred on 13 February 2020 at Alfred Health, the Alfred Hospital, 55 Commercial Road, Melbourne, Victoria, 3004, from *Injuries sustained in a fall from the Camberwell train station bridge*; and

    c) the death occurred in the circumstances described above.

52. Having considered all the circumstances, I am satisfied that Justin intentionally took his own life.

RECOMMENDATIONS

53. Pursuant to section 72(2) of the Act, I make the following 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.

54. I convey my sincere condolences to Justin's family.

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

    a) Ritsuko Crome, Senior Next of Kin

    b) Senior Constable Andrew Manning, Coroner's Investigator

Signature:

Coroner Paul Lawrie

Date: 24 February 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.