FORM 37

Rule 60(1)

FINDING INTO DEATH WITH INQUEST

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

Court reference: 145/08

Inquest into the Death of CHRISTIAN GONZALO DIAZ

Hearing Date:	24 March 2010
Findings of:	AUDREY JAMIESON, Coroner
Delivered On:	3 May 2010
Delivered At:	436 Lonsdale Street, Melbourne
Representation:	Leading Senior Constable Greigory McFarlane, SCAU
	Mr John Snowden, Corporate Counsel, Southern Health

FORM 37

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FINDING INTO DEATH WITH INQUEST[1]

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

Court reference: 145/08

In the Coroners Court of Victoria at Melbourne,

I, AUDREY JAMIESON, Coroner

having investigated the death of:

Details of deceased:

Surname:	DIAZ
First name:	CHRISTIAN
Address:	2/44 Stud Road, Dandenong, Victoria, 3175

AND having held an inquest in relation to this death on 23 March 2010 at Melbourne Magistrates' Court

find that the identity of the deceased was CHRISTIAN GONZALO DIAZ

and death occurred on 9 January 2008

at St Vincent's Hospital, 44 Victoria Parade, Fitzroy

from:

1(a) HYPOXIC BRAIN INJURY
1(b) TOXICITY TO HEROIN (PRESUMED)

in the following circumstances:

1. Mr CHRISTIAN GONZALO DIAZ was born on 21 June 1979. He was 28 years old at the time of his death. He was born in Uruguay, South America and migrated to Australia with his family at the age of 8 years.

2. Mr Diaz had a history of substance abuse dating back to age of 15 years. By the age of 19 years he had progressed to illicit intravenous drug use including heroin. He was also drinking and abusing alcohol.

[1] The Finding does not purport to refer to all aspects of the evidence obtained in the course of the Investigation. The material relied upon included statements and documents tendered in evidence together with the Transcript of proceedings and submissions of legal representatives including the Coroner's Assistant. The absence of reference to any particular aspect of the evidence, either obtained through a witness or tendered in evidence does not infer that it has not been considered.

3. Mr Diaz' substance abuse appears to correlate with a history of offending and violence. At the age of 15 years he spent 3 months on a Youth Training Order and subsequently served twenty (20) periods of imprisonment. In 2005 he spent a period of time in Thomas Embling Hospital.

4. Mr Diaz also had a history of severe mental illness which proved difficult to treat. He was diagnosed with Schizophrenia, Polysubstance abuse, Acquired Brain Injury (ABI) and Antisocial personality traits. He had a history of self harm and had numerous admissions to acute inpatient units since 2002. He was treated on different medications including Olanzapine, Risperidone tablets and Depot, Zuclopentixol Depot.

5. In November 2007, Mr Diaz was referred by Thomas Embling Hospital to Dandenong Community Care Team for case management. He was on a Community Treatment Order (CTO). His insight and compliance with his mental health treatment was limited.

6. On 10 December 2007, after the revocation of his CTO, Mr Diaz was admitted to the Acacia Ward[2] of Dandenong Area Mental Health Services, Southern Health[3]. His Mother, Elda Torres, reported that he had been using drugs for 1-2 weeks, that his behaviour was becoming increasingly bizarre and unpredictable and as a consequence, she was fearful of her son. He was brought directly into the ward by Police due to the risk of violence towards staff and his family. On admission he was noted to be agitated, unsettled and suspicious. He denied illicit drug use but a Urine Drug Screen (UDS) tested positive for opiate.

7. At family meetings held on 13 December 2007 and 17 December 2007, Mr Diaz' progress and future plans for discharge were discussed. Mrs Torres informed the treating team that her son would be living with her on discharge. She was also agreeable to leave being granted to him.

8. From 17 December 2007, Mr Diaz had escorted leave with nursing staff, his Eastern Region Mental Health Association (ERHMA) Key Worker and his Mother. He had overnight leave at his mother's house, attended Centrelink matters, other appointments and attended a Christmas party, all without issue or incident.

9. On 31 December 2007, the plans for Mr Diaz' discharge to his Mother's home were postponed when Mrs Torres informed staff that she could no longer accommodate her son because of recent aggressive outbursts. Later the same day, Mr Diaz absconded from Acacia Ward.

10. On 1 January 2008, Mrs Torres brought her son back to the ward. He denied any drug or alcohol consumption stating that he had caught the train to the city for New Year's Eve and later stayed with a friend. His UDS was positive for opiates.

11. On 4 January 2008, Psychiatrist, Dr Marcelo Rosenstein, reviewed Mr Diaz, performing a risk assessment. Dr Rosenstein reported that Mr Diaz denied desires, intentions or plans to abscond[4] or use illicit substances. He was co-operative and did not present with psychotic or depressive symptoms. He also denied any suicidal or homicidal thoughts. According to Dr Rosenstein, Mr Diaz' insight remained poor and his judgement impaired. Dr Rosenstein had no particular concerns about granting leave to Mr Diaz. A Leave Form - MHA21, was completed.

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[2] Acacia Ward is a secure ward located within Dandenong Hospital.

[3] Southern Health has three acute inpatient psychiatric units at Casey Hospital, Dandenong Hospital and Monash Medical Centre.

[4] Transcript of Proceedings @ p.17

12. On 5 January 2008, Mr Diaz asked Nurse Siew Fong if he could go to the hospital kiosk to buy some food. Nurse Fong checked the Leave Form[5] and negotiated with Mr Diaz terms of the leave which included direct questioning about his preparedness to co-operate with her.[6] Nurse Fong escorted Mr Diaz to the kiosk and back to the ward without incident.

13. At approximately 2.00pm, Mr Diaz asked Nurse Fong if could have leave to his Mother's home. The request was refused. Mr Diaz asked if he could go to McDonald's but this request was also refused. After further negotiation, Nurse Fong agreed to take Mr Diaz back to the hospital kiosk. As Mr Diaz and Nurse Fong were returning to the ward, walking along an enclosed walkway, Mr Diaz absconded through an automatic sensor sliding door that exited the building into the staff carpark. Nurse Fong was not able to stop Mr Diaz as he ran off. She returned to the ward, reported the incident and obtained assistance performing a search of the hospital grounds. At approximately 2.35pm, unable to locate Mr Diaz, Mrs Torres and the Police were notified of his absconding.

14. At 3.48pm, the Metropolitan Ambulance Service received a request to attend the corner of Lennox Street and Elizabeth Street, Richmond. On arrival at the location at 3.51pm, Ambulance paramedics found Mr Diaz slumped against a wall in a collapsed and unconscious state. He was pulseless and not breathing. He had a syringe in his hand. With the assistance of Metropolitan Fire Brigade (MFB) personnel, resuscitation measures were implemented. He was intubated and cardiac compressions initiated. A Mobile Intensive Care Ambulance (MICA) paramedic arrived soon after and took over the management of the resuscitation process. Cardiac output was restored.

15. At approximately 4.17pm, Mr Diaz was loaded into the ambulance and transported to St. Vincent's Hospital. Artificial ventilations continued en-route. The ambulance arrived at the Accident and Emergency (A&E) department at approximately 4.24pm.

16. Following initial assessment and undergoing a CT scan in the A&E, Mr Diaz was transferred to the Intensive Care Unit (ICU). He was noted to be unresponsive and to have fixed and dilated pupils. There was evidence of recent venipuncture and an abrasion on his sacral area. A UDS taken in the A&E was positive for opiates and benzodiazepines. Treatment involved cooling and sedation and subsequently paralysing after he developed myoclonic jerking.

17. On 7 January 2008, sedation was ceased.

18. On 9 January 2008, there was no neurological change. There was an absence of all brain stem reflexes apart from some weak respiratory effort. Mr Diaz' prognosis was assessed as poor. Following discussion with Mrs Torres a decision was made to withdraw ventilatory support. Mr Diaz was extubated at 10.25pm. He was pronounced dead at 10.40pm. The cause of his death was attributed to irreversible hypoxic brain injury.

[5] Transcript of proceedings @ p.31

[6] Transcript of Proceedings @ p.31

19. Immediately before death, Mr Diaz was *a person held in care*[7] as it is defined in section 3 *Coroners Act 1985 and* as a consequence, his death was *reportable*[8].

Investigation:

20. Dr Michael Burke, Forensic Pathologist, at the Victorian Institute of Forensic Medicine, performed an autopsy. Dr Burke reported that the post mortem examination showed no evidence of any injury that could have contributed to or led to death but that the anatomical findings were consistent with hypoxic brain injury being the cause of death. Toxicological analysis of serum specimens taken on 6 January 2008, at St. Vincent's Hospital showed only the presence of therapeutic medications. Dr Burke commented in his report that *illicit drugs may well have been cleared from the deceased's bloodstream prior to this blood sample being taken.* The urine sample (UDS) performed in the A&E does not appear to have been re-tested however, Dr Burke attributed the cause of death, hypoxic brain injury, to have been presumably caused by toxicity to heroin.

21. Section 17(1) *Coroners Act 1985*[9] mandates the holding of an Inquest in circumstances where a person immediately before death, was a person held in care. Immediately before the circumstances leading to Mr Diaz' death, he was a person held in care by virtue of his involuntary status in an approved mental health service.

22. The *Coroners Act 2008* became operational on 1 November 2009, that is, before Mr Diaz' Inquest commenced. Provisions of the 2008 Act also mandate the holding of an Inquest[10] for a person who immediately before death, was *a person placed in custody or care.*[11] The 2008 Act

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[7] "person held in care" means-
(a) a person under the control, care or custody of the Secretary to the Department of Human Services; or
(ab) a person-
(i) in the legal custody of the Secretary to the Department of Justice or the Chief Commissioner of Police; or
(ii) in the custody of a member of the police force; or
(iii) in the custody of a protective services officer appointed under the Police Regulation Act 1958; or
(b) a patient in an assessment or treatment centre under the Alcoholics and Drug-dependent Persons Act 1968; or
(c) a patient in an approved mental health service within the meaning of the Mental Health Act 1986...

[8] "reportable death" means a death-
(a) where the body is in Victoria; or
(b) that occurred in Victoria; or
(c) the cause of which occurred in Victoria; or
(d) of a person who ordinarily resided in Victoria at the time of death-
being a death-
(e) that appears to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from accident or injury; or....

(i) of a person who immediately before death was a person held in care; or.....

[9] s.17(1) A coroner who has jurisdiction to investigate a death must hold an inquest if the body is in Victoria or it appears to the coroner that the death, or the cause of death, occurred in Victoria and -
(a) the coroner suspects homicide; or
(b) the deceased was immediately before death a person held in care; or.....

[10] See section 52(2)(b) *Coroners Act 2008*

[11] See section 3 *Coroners Act 2008*

became the applicable Act for the remainder of this investigation. The preamble to the *Coroners Act 2008* identifies that a purpose of the coronial system is to contribute to the reduction in the number of preventable deaths and fires and the promotion of public health and safety. The Coroners Court is a specialist inquisitorial court in contrast to criminal and civil proceedings in Victoria, which are adversarial in nature. A Coroner investigating a death is required to find if possible, the identity of the deceased, the cause of death and the circumstances in which the death occurred[12]. Mr Diaz' identity was not in issue and required no additional formal investigation. Similarly, the cause of his death required no additional investigation beyond Dr Burke's post mortem examination.

23. The investigation into Mr Diaz' death found no evidence to indicate that anyone else contributed to his death. The person who contacted Emergency Services could not subsequently be located to provide a statement. The investigation did identify a number of issues requiring further exploration. These included security for psychiatric patients in the Acacia Ward and Dandenong Hospital *per se*, the policies and practices in place at Dandenong Hospital in relation to the authorising/granting of escorted and unescorted leave to psychiatric patients and specifically whether a risk assessment was performed before allowing Mr Diaz to have escorted leave including his suitability to have escorted leave with one carer.

The Inquest:

24. The Inquest heard *Viva voce* evidence from Dr Marcelo Rosenstein, Psychiatrist, Registered Nurse Siew Hong Yip Chee Fong, and Associate Professor Saji Damodaran, Program Medical Director, Mental Health Program, Southern Health. I was also assisted by the provision of the Chief Psychiatrist's Guideline on *Patient Leave of absence* issued in September 2009[13]. Mrs Elda Torres was present in court and assisted by a Spanish Interpreter.

25. Dr Rosenstein was of the view that he had a good therapeutic relationship[14] with Mr Diaz. When he last saw Mr Diaz on 4 January 2008, he recorded that his judgement remained impaired, meaning that he had poor insight into his condition. Mr Diaz had consistently denied having any psychiatric condition or any problem with substance abuse and as such, this impaired his judgement[15]. Nevertheless, Dr Rosenstein believed Mr Diaz had improved and the reason he was still an inpatient was because there was not any accommodation currently available to him[16]. Leave is seen as part of a transitional period to the community and Mr Diaz had several leave periods as part of a plan to release and treat him in the community in a less restrictive manner[17]. Several of his leave periods were outside the hospital, including after 31 December 2007, and were without incident.[18] There was also the opportunity at the time to easily abscond from Acacia Ward due to the presence of a low fence in one of the backyards. Although readily

[12] See section 67(1) *Coroners Act 2008*

[13] See Exhibit 4

[14] Transcript of Proceedings @ p.18

[15] Transcript of proceedings @ pp13-14

[16] Transcript of Proceedings @ p.15

[17] Transcript of proceedings pp 11-12

[18] Transcript of proceedings @ pp 24 -25

accessible to Mr Diaz, he never attempted to abscond.[19] Dr Rosenstein stated it was not uncommon for people with schizophrenia and acquired brain injury to make decisions impulsively but Mr Diaz did not display any impulsiveness throughout his admission[20]. Dr Rosenstein considered that the episode of absconding on 31 December 2007, was more likely to have been a plan that subsequently involved him volunteering to return to the ward. Dr Rosenstein felt that Mr Diaz' decision to abscond on 5 January 2008, was likely to have been a similar type plan.

26. Nurse Siew Fong was familiar with Mr Diaz. She had made approximately 12 entries in his Nursing Progress notes from 14 December 2007 to 5 January 2008 when he absconded under her supervision. She was not threatened by him although she was aware of his history of violence. He had never been violent to her or anyone else in Acacia Ward. He had become a bit irritable after being told that he could not go to his Mother's for leave or to live but this was not of itself, unusual behaviour as he did often become irritable if he did not get things his own way. His irritability was not to such a level that Nurse Fong felt at personal risk or thought that he might try to abscond.

27. Associate Professor Saji Damodaran reported on the security provisions for involuntary patients at Dandenong Hospital. Although he had no personal involvement with Mr Diaz he had reviewed his file and had formed the view that he had been cared for professionally and in accordance with recognised standards at the time. He too would have approved the escorted leave to the kiosk on 5 January 2008. Mr Diaz' absconding and death had not been the subject on an internal review by the hospital and no policies or protocols changed in response to his death but the absconding incident had been accounted for in a more wider review of such incidents within the whole of the Southern Health network. Arising from the review structural changes had occurred including increasing the height of the external wall in the outdoor area of Acacia Ward. Currently a new Psychiatric Inpatient Unit is under construction. The release in September 2009, of the Chief Psychiatrist's Guidelines on leave of absence for inpatients has also been implemented although the Chief Psychiatrist's Guidelines are not markedly different[21] from what Southern Health's own protocols were at the time of Mr Diaz' death.

COMMENTS:

Pursuant to section 67(3) of the *Coroners Act 2008*, I make the following comment(s) connected with the death:

1. There is no evidence which links the management of Mr Diaz in Acacia Ward at Dandenong Hospital to his reason(s) for absconding. He may have been influenced by the refusal to allow him leave to his mother's home or leave to attend McDonald's or he may have been influenced by the realisation that his mother was no longer able to accommodate him on his discharge. According to Dr Rosenstein, Mr Diaz was probably disappointed about the change to his accommodation plans as he had a very close relationship with his Mother who had been very supportive of her son[22]. Nurse Fong also recorded that Mr Diaz looked disappointed and

[19] Transcript of proceedings @ pp 17 - 18

[20] Transcript of proceedings @ p.18

[21] Transcript of Proceedings @ p.44

[22] Transcript of Proceedings @ p.24

unhappy[23] when he was given this news. However, the extent of any such influence on his decision to abscond is speculative only and cannot be substantiated.

2. There is no evidence to suggest that Mr Diaz was suicidal at the time he absconded from Dandenong Hospital. There is no evidence that he accessed illicit drugs with the intention of taking his own life. His behaviour on 5 January 2008, was not inconsistent with his behaviour on 31 December 2007, when he also absconded and accessed illicit drugs; confirmed by the positive UDS on his return to the ward. The lack of evidence of an intention to take his own life supports a conclusion that his death was the unintentional consequence of his illicit drug taking.

3. Mr Diaz' ability to abscond from the hospital was made easier by being outside Acacia Ward at the time, being escorted by one carer/nurse and made easier by an automated door that provided an exit into the grounds of the hospital. He did not abscond on his way to the kiosk despite walking past the same automated door but waited until he and Nurse Fong walked past on their return to the ward.

4. Mr Diaz was outside Acacia Ward because he had been granted leave by Nurse Fong to attend the kiosk. The leave had previously been authorised by Dr Rosenstein. The leave was conditional that she escort him. Nurse Fong made a clinical risk assessment before granting the leave. She knew Mr Diaz well. She had granted him leave with the same conditions earlier in the day and there had been no deviation of expected negotiated behaviour by Mr Diaz. There were no clinical indicators which might have alerted Nurse Fong to some additional risk on the second occasion.

5. I accept that the granting of leave of absence for inpatients is a balancing and potentially problematic process. According to the *Key Principles* in the Chief Psychiatrist's Guidelines:

> *The decision to grant leave of absence must be made within the context of the treatment objectives and strategies of the patient's treatment plan.*

I am satisfied that this was done for Mr Diaz. The principles contained within section 4(2) *Mental Health Act 1986* about providing appropriate care and treatment *in the least possible restrictive environment and the least possible intrusive manner* is consistent with the management of Mr Diaz in the Acacia Ward.

6. The evidence supports a conclusion that Mr Diaz was appropriately managed in Acacia Ward at Dandenong Hospital. I accept that appropriate risk assessments were performed before the granting of leave to Mr Diaz and that the escorted leave granted to him by Nurse Fong on the afternoon of 5 January 2008, was reasonable and appropriate in the circumstances. I also accept that once Mr Diaz absconded from Nurse Fong and the hospital, all reasonable steps were taken to locate him and notify his Mother and the Police.

7. I make no recommendations pursuant to section 72(2) *Coroners Act 2008* in this matter.

[23] Transcript of proceedings @ p.38

FINDINGS:

Pursuant to section 67 (1) *Coroners Act 2008,* I make the following findings:

- **I find** that the identity of the deceased is CHRISTIAN GONZALO DIAZ; and
- **I find** that the cause of death is hypoxic brain injury presumed to have occurred as a direct result from toxicity to heroin; and
- **I find** that Mr Diaz' death was the unintended consequences of the intentional act of injecting heroin; and further
- **I find** that there is no relationship between the cause of his death and the fact that immediately before his death, he was a person placed in care.

Signature:

AUDREY JAMIESON
CORONER
3 May 2010

Coroners Court of Victoria

Distribution of Finding:

Mrs Elda Torres

Mr John Snowden, Corporate Counsel, Southern Heath

Dr Ruth Vine, Chief Psychiatrist, Department of Human Services