FORM 37

Rule 60(1)

FINDING INTO DEATH WITH INQUEST

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

Court reference: 4204/06

Inquest into the Death of LIONEL RAYMOND PERRY

Place of death:	St Vincent's Hospital, 41 Victoria Parade, Fitzroy 3065
Hearing Dates:	9 December 2008 @ Coronial Services Centre, Southbank 23 March 2009 @Melbourne Magistrates' Court
Appearances:	Leading Senior Constable King Taylor, SCAU[1] - Assisting the Coroner Ms Sharon Moore of Counsel - on behalf of Ms Ella Griffin (Pearsons) Mr John Goetz of Counsel - on behalf of St. Vincent's Hospital (Lucy Cordone)
Findings of:	AUDREY JAMIESON, Coroner
Delivered On:	22 July 2011
Delivered At:	Melbourne

[1] SCAU = State Coroners Assistant Unit. In 2010 the SCAU changed its name to Police Coronial Support Unit (PCSU)

FORM 37

Rule 60(1)

FINDING INTO DEATH WITH INQUEST[2]

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

Court reference: 4204/06

In the Coroners Court of Victoria at Melbourne

I, AUDREY JAMIESON, Coroner

having investigated the death of:

Details of deceased:

Surname: PERRY
First name: LIONEL
Address: 6/11 Rutland Street, Clifton Hill, Victoria 3068

AND having held an inquest in relation to this death on 9 December 2008, at the Coronial Services Centre, Southbank and on 23 March, 2009 at the Melbourne Magistrates' Court, Melbourne

find that the identity of the deceased was LIONEL RAYMOND PERRY

and death occurred on 3 November 2006

at St. Vincent's Hospital, 41 Victoria Parade, Fitzroy 3065

from:

1a. CARDIOMEGALY

in the following summary of circumstances:

1. Lionel Raymond Perry died in the Psychiatric Inpatient Unit at St. Vincent's Hospital (St. Vincent's Mental Health Service - SVMHS), a division of St. Vincent's Hospital (Melbourne)

[2] 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/Counsel. 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.

Limited (SVHML). Lionel was deemed to be *a person held in care*[3] as he was an involuntary patient at the time. Lionel's death was *reportable*.[4]

2. An Inquest was held in accordance with section 17(1)[5] *Coroners Act* 1985.

JURISDICTION:

3. At the time of Lionel Perry's death, the *Coroners Act* 1985 (the Old Act) applied. From 1 November 2009, the *Coroners Act* 2008 (the new Act) has applied to the finalisation of investigations into deaths that occurred prior to the new Act commencement.[6]

4. In the preamble to the new Act, the role of the coronial system in Victoria is stated to involve the independent investigation of deaths for the purpose of finding the causes of those deaths and to contribute to the reduction of the number of preventable deaths and the promotion of public health and safety and the administration of justice. Reference to preventable deaths and public health and safety are referred to in other sections of the Act.[7]

5. Section 67 of the new Act describes the ambit of the coroner's findings in relation to a death investigation. A coroner is required to find, if possible, the identity of the deceased, the cause of death and, in some cases, the circumstances in which the death occurred.[8] The 'cause of death' generally relates to the *medical cause of death* and the 'circumstances' relates to the *context* in which the death occurred.

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[3] "person held in care" means-

(a) a person under the control, care or custody of the Secretary to the Department of Human Services; or....

(c) a patient in an approved mental health service within the meaning of the Mental Health Act 1986;

[4] "reportable death" means a death-

(a) where the body is in Victoria; or....

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

(iaa) of a person who immediately before death was a patient within the meaning of the Mental Health Act 1986 but was not a person held in care; or....

[5] s17. **Jurisdiction of coroner to hold inquest into a death**

(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....

[6] Section 119 and Schedule 1 - Coroners Act 2008.

[7] See for example, sections 67(3) & 72 (1) & (2)

[8] Section 67(1)

6. A coroner may also comment on any matter connected with the death, including matters relating to public health and safety and the administration of justice.[9]

7. A coroner may also report to the Attorney General and may make recommendations to any Minister, public statutory authority or entity, on any matter connected with a death which the coroner has investigated, including recommendations relating to public health and safety or the administration of justice.[10]

- **Standard of Proof**

8. The civil standard of balance of probabilities applies in coronial proceedings. In determining whether a matter is proven to that standard, the court should consider the nature of the facts in issue[11] and give effect to the principles explained by Dixon CJ in *Briginshaw v Briginshaw.*[12] In other words, the coroner must consider the seriousness of the matters alleged and may consider the consequences of an adverse finding for particular witnesses.[13]

BACKGROUND CIRCUMSTANCES:

9. Mr Lionel Perry[14] was born on 25 December 1961. He was 44 years old at the time of his death. He lived at Flat 6, 11 Rutland Street, Clifton Hill, with his wife of approximately one (1) month, Toni Kilby. Lionel was of Aboriginal descent. He was unemployed at the time of his death.

10. Lionel had a medical history which included asthma, arthritis, hypertension and Hepatitis C. He also had a long history of schizoaffective disorder and polysubstance abuse including heroin, amphetamines, marijuana and alcohol. His first admission to SVMHS was in 2001. He had a number of hospital admissions thereafter, often on a background of non-compliance with oral medication and increased illicit substance use/intoxication. Lionel had also been diagnosed with Antisocial Personality Disorder and had an extensive forensic history.

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[9] Section 67(3)

[10] Section 72(1) & (2)

[11] *Anderson v Blashki* [1993] 2 VR 89 at 95

[12] (1938) 60 CLR 336 at 362-363

[13] See also *Secretary to the Department of Health and Community Services v Gurvich* [1995] 2 VR 69 at 73 - 74

[14] Ms Griffin indicated that she preferred for her brother to be referred to as "Lionel" during the course of the Inquest. For the purposes of consistency I have, in the most part, adhered to Ms Griffin's request in the writing of the Finding.

11. On 31 July 2006, following a period of approximately six (6) months of incarceration for Theft and numerous charges for Failing to Appear for Court, Lionel was released from HM Loddon Prison. On 1 August 2006, he was assessed by Dr Kah-Seong Loke and Dr Wallace of the Psychiatric Unit and placed on a Community Treatment Order (CTO) pursuant to the provisions of the *Mental Health Act 1986.* Lionel's CTO was to be monitored and supervised by SVMHS. His medication included the depot antipsychotic, zuclopenthixol 400mg intra-muscular injection (IMI) fortnightly and oral medication, sodium valproate 1gm daily and benztropine 2mg daily. Lionel also remained subject to an Intervention Order held by Clarendon Clinic (SVMHS) which prohibited Lionel from attending the clinic outside of his scheduled appointments.

12. On 6 September 2006, Lionel was reviewed by Dr Vicki Shephard, Consultant Psychiatrist. His mental state was assessed as stable with no psychotic symptoms. Lionel admitted to Dr Shephard that he had ceased taking his oral medication, sodium valproate and to smoking 1 gram of marijuana each day. His CTO was extended to 5 April 2007, to coincide with his annual medical assessment.

13. Lionel reported that he was looking forward to his impending marriage in October 2006.

14. On 2 October 2006, Lionel admitted to recent heroin use.

SURROUNDING CIRCUMSTANCES:

15. On Tuesday 24 October 2006, Lionel presented at his Community Mental Health Clinic (Clarendon Clinic) with multiple bruises and pain following a physical altercation with his brother-in-law. His brother-in-law was residing with Lionel and his wife in their one bedroom flat. Lionel was assessed by Dr Shephard as having lowered mood and was expressing suicidal ideation. He did not want to return to his residence and was requesting hospitalisation. Dr Shephard revoked his CTO and admitted Lionel to the Psychiatric Inpatient Unit (PS1) at St. Vincent's Hospital as an involuntary patient. He had a physical examination performed by Dr Joshua White, Psychiatric Registrar. He was recommenced on his oral medication and commenced on methadone at 30mg/day after revealing to Dr White that he had been using heroin daily since his release from prison. Dr White did not record any unusual chest or heart sounds.

16. Lionel was assessed as moderate risk and placed on general observations on a daily basis. He was reluctant to return to his marital home while his brother-in-law remained there. Accommodation options were discussed.

17. On Wednesday 25 October 2006, Lionel was complaining of agitation, nausea, vomiting, diarrhoea and cramping. His symptoms were believed to be related to opiate withdrawal. He was noted to be hypertensive at 180/120. He was treated with Clonidine and Diazepam but when his blood pressure rose to 210/125, and he failed to respond to a further dose of Clonidine, he was later transferred to the Emergency Department for monitoring. He was treated with a 25mg GTN patch resulting in a prompt reduction in his blood pressure to 114/70. He was monitored overnight in a general medical ward (8 West) and returned to the Psychiatric Unit the following day as his blood pressure had normalised. Medical examination failed to identify a cause for his complaints. Blood tests were ordered to exclude possible organ damage as a secondary cause of his hypertension. An Electrocardiogram (ECG) was ordered and the plan was to continue with the GTN patch. Lionel's recent withdrawal from heroin was noted in the Progress Notes. He provided information to the medical registrar that he used between $50 - $100 of heroin per day.

18. On 26 October 2006, Lionel was transferred back to the Psychiatric Unit. Lionel's blood pressure (lying and standing) and other vital signs were recorded on a daily basis from 28 October 2006 to 2 November 2006.

19. On 27 October 2006, Lionel was reviewed by Dr Shephard in the presence of his contact nurse. He appeared both medically and psychiatrically well - his mood was lifted and was no longer feeling suicidal.

20. On Monday 30 October 2006, Dr Shephard granted escorted leave of absence from the ward, for up to 2 hours, in accordance with the provisions of sections 40 & 41 *Mental Health Act* 1986.

21. On 31 October 2006, Lionel's mental health team agreed that he was medically stable, his mental state was greatly improved and that discharge was appropriate pending the availability of suitable short-term accommodation and with arrangements to be put in place for access to prescription methadone.

22. On Thursday 2 November 2006, Lionel's dosage of methadone was increased to 40mg/day by St. Vincent's Drug and Alcohol Service Registrar, Dr Zarifpour, because of complaints of ongoing withdrawal symptoms. Dr White performed Lionel's Annual Medical Examination under section 87 *Mental Health Act* 1986, noting that Lionel's blood pressure was 130/100 and his heart rate was normal and in a regular rhythm. Lionel reported some nausea, vomiting and lethargy which he attributed to eating a large amount of take-away food and smoking marijuana the previous evening. Dr White found no signs of major or acute physical illness.

23. On Friday 3 November 2006, the hospital planned to discharge Lionel. At approximately 0930 hours, Dr Shephard gave permission to Lionel to leave the ward on the grounds that he return by 1200 hours, which he complied with. At approximately 1130 hours Registered Psychiatric Nurse (RPN) Ben Gilbert, who was Lionel's contact nurse on the AM shift, reported to Dr White that he was concerned that Lionel was apprehensive about discharge and was displaying physical symptoms of stress. At approximately 1200 hours RPN Gilbert observed Lionel watching television in the dining room of the ward. He had a discussion with Lionel. There were no issues of concern noted.

24. RPN Rayner Balfour was working the AM shift in PS1 as the medication nurse. At approximately 1200 hours, RPN Balfour received a telephone call from the ground floor section of the psychiatric ward advising that Lionel was slumped over a table in the court yard. RPN Balfour used a wheelchair to retrieve Lionel and convey him back to the 1st floor and into bed. Lionel told RPN Balfour that he did not feel well. RPN Balfour reported the incident to the Nurse Unit Manager (NUM) RPN Ruth Whitely, but did not record the incident or his observations of Lionel at the time. Dr White was temporarily out of the hospital but being covered for by another Registrar, Dr Schultz. Attempts were made to page Dr Schultz. On his return to the hospital at approximately 1415 hours, Dr White was not informed of any incident or of any concerns about Lionel by either Dr Schultz or nursing staff.

25. At or around 1400 hours, RPN Gilbert was informed by RPN Whitely that Lionel had been merely returned to his bed and observations had been taken and the Registrar had been paged. No specific issues of concern were communicated to him. During the course of the afternoon RPN Gilbert observed Lionel on a number of occasions to be asleep and breathing normally with his usual snoring pattern. No vital signs were recorded.

26. At approximately 1700 hours, Dr Alegiers-Lara, Psychiatric Resident, informed RPN Pierre Baume, Associate Nurse Unit Manager (NUM) that Lionel would not be discharged until the following week because the hospital had been unable to organise for the provision of community/outpatient methadone.

27. At approximately 1744 hours Dr White returned to the Unit. RPN Grant Wooten primary nurse for this admission and contact nurse[15] for the PM shift, approached Dr White and expressed some concern about Lionel. At approximately 1745 hours, Dr White and RPN Wooten located Lionel lying on his bed absent of a pulse and respirations (cardio-respiratory arrest). Resuscitation attempts were immediately implemented and a Code Blue was called.

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[15] *The contact nurse is the term that we use for the nurse who is given responsibility for that patient on the day but the primary nurse has overall responsibility for the treatment and again the care.* Transcript of Proceedings @ p.199 (Ms Anna Love)

28. Despite active resuscitation attempts, Lionel was unable to be revived. He was declared deceased at approximately 1800 hours

INVESTIGATION:

29. The identity of Lionel Perry and the place and date of death were without dispute and required no additional formal coronial investigation.

- **The medical investigation:**

30. Dr Shelley Robertson, Forensic Pathologist, at the Victorian Institute of Forensic Medicine, performed an autopsy. Post mortem findings included cardiomegaly, mild coronary artery atherosclerosis, splenomegaly and cholelithiasis. A positive Hepatitis C serology along with inflammatory changes in the liver were also noted.

31. Toxicological analysis showed the presence of a number of drugs including methadone, codeine, benzodiazepines and paracetamol - all at levels consistent with therapeutic usage. There was no evidence of recent exposure to intravenous heroin.

32. Dr Robertson reported the heart weight to be 690 grams and that the heart was *considerably enlarged due predominantly to concentric ventricular hypertrophy.* She commented that the cause of Lionel's cardiac enlargement was not clear but possibly related to hypertension. Dr Robertson attributed the cause of death to cardiomegaly.

- **Clinical Liaison Service:**

33. The Clinical Liaison Service (CLS)[16] reviewed the medical management of Lionel at St. Vincent's Hospital on behalf of the coroner. Following a Case Review Meeting on 30 May 2007, statements were sought from hospital personnel in an attempt to clarify the circumstances in the 24 hours preceding Lionel's death. At a final Case Review Meeting on 25 June 2008, CLS discussed the statements obtained and commented that communication between hospital staff could have been better however, the cause of death had been attributed to natural causes.

[16] The Clinical Liaison Service (CLS) assisted the State Coroner's Office in ensuring that the true nature and extent of deaths caused during specialised clinical care provision were fully elucidated and that any remediable factors were identified to prevent any future occurrences. The CLS drew on the distinct experiences and expertise of medical, nursing and research personnel to evaluate clinical evidence for the investigation of healthcare deaths reported to the State Coroner's Office. The CLS was replaced with the Health and Medical Investigation Team (HMIT) in 2010. HMIT sits within the Coroners Prevention Unit (CPU), which was established in 2008 to strengthen the prevention role of the coroner. The unit assists the coroner in relation to the formulation of prevention recommendations, as well as assisting in monitoring and evaluating the effectiveness of the recommendations.

INQUEST:

34. *Viva voce* evidence was obtained from the following witnesses:

- Dr Vicki Robyn Shephard - Consultant Psychiatrist, St. Vincent's Mental Health
- Mr Pierre Baume - Associate Nurse Unit Manager (NUM)
- Mr Rayner Balfour - Registered Psychiatric Nurse (RPN1)
- Dr Joshua White - Psychiatric Registrar
- Mr Ben Gilbert - Registered Psychiatric Nurse (RPN1)
- Ms Anna Love - Manager Acute Inpatient Services Mental Health

FINDINGS, COMMENTS and RECOMMENDATIONS:

- **Revocation and Admission:**

1. The revocation of Lionel's CTO by Dr Shephard was done in response to a crisis situation. Lionel was assessed at risk. The intention was that he would remain an inpatient for a short period and then be discharged back into the community under supervision on a CTO. Assisting him in obtaining alternative short-term accommodation was an integral part of the overall plan.

I find that this was an appropriate response to the escalation of Lionel's mental health issues and the psychosocial problems confronting him.

- **Response to hypertension:**

2. There were reasonable grounds for assumptions to be made that Lionel's initial complaints of feeling unwell and his hypertension were related to opiate withdrawal. He had a long history of illicit drug abuse and had made admission of regular drug use since his release from prison. When he failed to respond to the administration of Diazepam and two (2) doses of Clonidine, a medical review was initiated and Lionel was transferred.

I find that the transfer of Lionel from the Psychiatric Unit to the Emergency Department was an appropriate response by his mental health team. The subsequent management of his hypertension appears appropriate in the circumstances. He was monitored overnight in a medical ward and returned to the Psychiatric Unit when his blood pressure had returned to within normal limits. The absence of the ECG taken during that medical review was not available/unable to be located, at the time of the Inquest however, the tenacity of the medical review was not of itself challenged.

I find that the medical review and management of Lionel's documented complaints and detected hypertension was reasonable and appropriate in the circumstances.

- **Ongoing monitoring of Lionel in the Psychiatric Unit (PS1):**

3. Dr White was aware of Lionel's hypertension but considered it under control with Methadone implementation and the introduction of Clonidine. Blood test results identified no concerns warranting further investigation. The medical team had not identified any need for ongoing medical management having transferred Lionel back to the Psychiatric Unit on 26 October 2006.

4. Lionel's blood pressure continued to be monitored by RPNs on a daily basis from 28 October 2006, save for the day of his death. By all accounts there were no ongoing medical concerns about Lionel and his mental health also appeared to be improving. Active measures were underway for his discharge. By the morning of 3 November 2006, it was anticipated that Lionel would be discharged on that day.

5. The events of 3 November 2006, that is, the contemporaneous circumstances of Lionel's death, required the examination of a number of witnesses because his medical records and in particular, the Nursing Progress Notes, lacked details of the events of that day. The failure of nursing and medical professionals to make contemporaneous entries in the records consequentially deny themselves the benefit of an *aide memoir,* when called upon to account for their involvement in a patient's care. They also deny families/loved ones and investigators such as myself, certainty about the delivery of appropriate care. An absence of appropriate contemporaneous notes reflects a failure to appreciate the importance documentation plays in the delivery of health services. The medical file is a legal document and in addition to the role documentation plays as an *aide memoir*, contemporaneous notes are also intended to act as a means of communication to other professionals involved in a patient's care.

6. RPN Gilbert was Lionel's contact nurse between the hours of 0700 hours and 1500 hours - the AM shift. He made no entry into the Progress Notes at the conclusion of his shift. He was supervising a student nurse throughout the day and although there is an entry from a student nurse, Mr Gilbert could not recall if this was his student. It was not his signature countersigning the student's entry. RPN Gilbert could recall that when he came out of handover at approximately 1330 hours, Nurse Whitely told him there had been an *incident* involving Lionel and that she had taken his observations and *his vital signs were within normal range* and that he was now resting. RPN Gilbert could not recall being given any details of the incident and did not question Nurse Whitely because *he believed her to be a reliable source.* He stated that he had subsequently visually checked Lionel but did not record any observations and did not look at

Lionel's Observation Chart to inform himself of the observations allegedly taken by Nurse Whitely. There is no record of any "incident" involving Lionel on that day. No notes made by RPN Balfour. There are no recorded observations to support RPN Gilbert's recollection of the events.

7. RPN Gilbert could also not recall advising the PM shift Associate NUM, Mr Pierre Baume, that Lionel appeared *unsteady on his feet*[17] when he had returned to PS1 around the middle of the day. RPN Gilbert could not recall advising the PM shift contact nurse, RPN Grant Wooton, that Lionel had experienced *cardiac symptoms* or that Lionel was *feigning symptoms to prolong admission* - a *behaviour pattern displayed on previous admissions.* Re-reading RPN Wooten's contemporaneous notes in the medical records did not assist RPN Gilbert's recollection.[18]

8. The absence of contemporaneous notes by RPN Gilbert for the AM shift on 3 November 2006, reflects negatively on his professionalism. He was an unimpressive witness who was guarded in his responses and left me with the impression that his recollection was selective. He only reluctantly acknowledged the importance of contemporaneous documentation. Nevertheless, my comments about RPN Gilbert should however be read in the context of my overall findings.

9. RPN Balfour similarly made no entry in the Progress Notes despite the fact the he was the nurse that retrieved Lionel from the ground floor in what can only be described as unusual circumstances. Despite the speculation of some about recent drug use or the feigning symptoms to prolong admission, this incident warranted a formalised means of communication to others in Lionel's treating team. Furthermore, no vital signs were recorded for 3 November 2006, either from before, during or after Lionel was retrieved by wheelchair from the ground floor.

10. Dr White was not informed that Lionel had been found slumped over a table and was observed unsteady on his feet until after his death. He was absent from the hospital between 1230 hours and 1415 hours but received no urgent requests to attend to Mr Perry upon his return. Dr White had returned to PS1 around 1744 hours and was at the Nurses Station when RPN Wooten approached him, expressing concern about Lionel's physical state. Dr White accompanied RPN Wooten to Lionel's room and it was then that they discovered Lionel in cardio-respiratory arrest.

11. The paucity of relevant documentation by those that cared for Lionel on the day reflects on the individual health care provider and the facility as a whole. It has occupied a significant part of the *viva voce* evidence and its absence makes an assessment of the standard of delivery of

[17] Exhibit 4 - p.1 of the Statement of Mr Baume

[18] Transcript of Proceedings @ pp 186 & 189

healthcare difficult, but of more significance to this inquiry is whether the absence of appropriate documentation was in any way causative to Lionel's death.

12. It is not possible to be definitive that the communication about Lionel's "symptoms" and the incident on the ground floor, done in a timely manner and formally in the Progress Notes, would have altered the outcome. There was a potential opportunity lost for an early medical assessment. An opportunity that should have been followed through by the mental health team when Lionel was returned to the Unit by RPN Balfour. However, to attach any significant weight to this opportunity lost, a number of speculative propositions would also be necessary. For example, if a timely medical examination had occurred it would be necessary to assume that a cardiac problem would have been identified and effective life saving treatment could have been implemented. In the circumstances **it is not possible to find** to the requisite standard, that the opportunity lost for a medical examination/intervention was causative to Lionel's death or that his death could have in fact been prevented. As Dr White stated:

> *....it's still uncertain to me whether knowing earlier,...knowing about his symptoms earlier in the day and responding to those at the time would have led to an intervention by me that could have prevented his death. I'm not confident that that would have changed the outcome.*[19]

- **St. Vincent's Root Cause Analysis (RCA):**

13. Ms Anna Love addressed the hospital's response to Lionel's death. A Root Cause Analysis was conducted to ascertain any causal factors and with a view to guide solutions if any system failures were identified. The RCA examined and made findings in relation to:

- Illicit substances policy;
- Documentation, communication and quality of care;
- Methadone policy and documentation in the Drugs of Addiction Register; and
- Emergency response.

14. A review of the Drugs of Addiction Register was included in the RCA because, according to Ms Love, it was the hospital's original belief that Lionel had accessed opiates when he left the ward on approved leave on 3 November 2006. The RCA identified incomplete compliance with the recording requirements in the Register and although it decided that no amendment to the Hospital's Medication Policy was required, additional education sessions for nursing staff were undertaken. Ms Love stated that the Hospital would not have done the RCA if they had known that the cause of death was attributable to natural causes.

[19] Transcript of Proceedings @ p.153

15. In relation to documentation, communication and quality of care, Ms Love stated that the hospital's Medical Record Documentation Policy at the time of Lionel's death *made it clear that documentation in the patient record is to be timely, accurate and comprehensive with sufficient detail to allow care delivery, communication and monitoring of the patient's condition.*[20] Mental health nursing staff were also required to make such a record at the end of every shift, that is, a minimum of three entries every day and to document additional notes if an *extraordinary event* should happen and this included such an event as the discovery of Lionel slumped over a table on the ground floor. [21]

16. Ms Love stated that no change in the Hospital's Medical Record Documentation Policy was required however, education sessions were initiated for medical, nursing and allied health staff to ensure compliance with the policy and these included the nursing staff involved in Lionel's care on 3 November 2006.

17. In relation to the issue of communication to medical staff about Lionel's changed condition on 3 November 2006, the RCA identified that staff were not clear about what to do if the Registrar or Consultant did not respond to their call for assistance. The Hospital actioned this finding by inserting a flow chart into the Primary Nursing Manual which aimed to clarify that it is the primary nurse's responsibility (or the contact nurse's responsibility if the primary nurse is not on duty) to liaise with the treating registrar or consultant *and bring to their attention any issues regarding a patient's treatment or any concerns about the physical wellbeing of the patient.*[22]

18. The RCA also identified the need for the hospital to make improvements to its clinical file audits to ensure clinical notes accorded with the Documentation Policy. These audits are now undertaken on a routine annual basis. According to Ms Love, the overall effects of the education sessions and routine file audits appear to have reduced the incidence of inadequate documentation practices .

19. I commend the Hospital for its review and the matters actioned as a result however, policies and guidelines of any organisation are only likely to be effective and followed if they are complemented by continuous periodic education/professional development sessions.

[20] Exhibit 9 - Statement of Anna Love dated 16 March 2009, Transcript of Proceedings @ p 197

[21] Transcript of Proceedings @ pp197-198

[22] Exhibit 9 @ p.2 and Transcript of Proceedings @ pp199-200

I recommend that St. Vincent's Hospital (Melbourne) Limited continue to implement all the matters actioned from the findings of the RCA with particular regard to:

- the provision of periodic education sessions for staff involved in mental health care with emphasis on the importance of timely, accurate, contemporaneous and comprehensive documentation in accordance with the Medical Record Documentation Policy;
- and the provision of periodic education sessions on the roles and responsibilities of nurses who undertake the role of primary nurse or contact nurse as outlined in the Primary Nursing Manual; and
- the continuation of the annual file audits of clinical files from the mental health service for the purposes of monitoring and ensuring continued compliance with the Documentation Policy.

CONCLUDING COMMENTS:

1. At the time of Lionel's admission to St. Vincent's Psychiatric Inpatient Unit it was not known that he had a life threatening medical condition - *a considerably enlarged heart due predominantly to concentric ventricular hypertrophy.*[23]

2. **I accept** that Lionel did not demonstrate typical symptoms of a person with a failing heart. To the contrary, on the morning of 3 November 2006, he was seen by Dr Shephard and assessed as being fit for discharge. I accept that *he was not symptomatic of somebody with a failing heart.*[24] The weight of the evidence indicates that Lionel's death was not predictable but sudden and unexpected.

3. The investigation into Lionel's death identified shortcomings in the documentation of observations including observations of significant events, recordings of vital signs and shortcomings in communication between health professionals however, **I find** that there is no causative relationship between these shortcomings and Lionel's death on 3 November 2006.

4. The making of adverse comment or adverse findings of individuals working in their professional capacity is not to be done lightly. The consequences for the individual's professional status and position can be grave and far reaching.[25]

[23] Autopsy Report - Dr Shelley Robertson - contained within Exhibit 10 (balance of the brief of Evidence)

[24] Transcript of Proceedings @ p.57

[25] *Briginshaw v Briginshaw* (1938) 60 CLR 336

5. Save for the comments I have made about the importance of documentation *per se,* I make **no adverse finding** against individuals involved in the care of Lionel during his admission to St. Vincent's Hospital Psychiatric Inpatient Unit.

I accept and adopt the medical cause of death as identified by Dr Shelley Robertson and **I find** that Lionel Raymond Perry died from natural causes being cardiomegaly.

And **I further find** that there is no evidence of contribution to his own death by the contemporaneous use of illicit drugs. Toxicological analysis supports a conclusion that Lionel had not obtained and taken heroin or other illicit drugs on the morning of 3 November 2006, during the time he was on approved leave from the ward.

Pursuant to Section 73(1) *Coroners Act* 2008, this finding will be published on the Internet in accordance with the Rules.

Signature:

AUDREY JAMIESON
CORONER
Date: 22 July 2011

Distribution of Findings:

Ms Ella Griffin - (sister of Lionel)
Director of Mental Health Services, St.Vincent's Hospital (Melbourne) Limited
Office of the Chief Psychiatrist - Department of Human Services