FORM 37

Rule 60(1)

FINDING INTO DEATH WITH INQUEST

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

Court reference: 129/07

Inquest into the Death of STUART FRASER RONALDSON

Delivered On:	4 March 2010
Delivered At:	Coroners Court of Victoria, 436 Lonsdale Street, Melbourne
Hearing Dates:	18 February 2010
Findings of:	JOHN OLLE
Representation:	Paul Halley for the Alfred Hospital
	Bill O'Shea Alfred Health 55 Commercial Road, Melbourne
	Ms Jessica Fisher Fisher Cartwright Beriman Lawyers Level 11, 83 Mount Street, North Sydney for the family

Place of death/Suspected death: Darebin Creek, Sparks Reserve, Ivanhoe 3079

SCAU: Senior Constable King Taylor

FORM 37

Rule 60(1)

FINDING INTO DEATH WITH INQUEST

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

Court reference: 129/07

In the Coroners Court of Victoria at Melbourne

I, JOHN OLLE, Coroner

having investigated the death of:

Details of deceased:

Surname: RONALDSON
First name: STUART
Address: 24 Little Grey Street, St Kilda 3182

AND having held an inquest in relation to this death on 18 February 2010
at Melbourne
find that the identity of the deceased was STUART FRASER RONALDSON
and death occurred between 27 December, 2006 and 12th January, 2007

at Darebin Creek, Sparks Reserve, Ivanhoe 3079

from

1a. UNASCERTAINED

in the following circumstances:

1. Stuart Ronaldson was aged 46 years at the time of his death. He lived at 2 Little Grey Street, St Kilda.

2. A comprehensive coronial brief has been prepared by the coronial investigator, Senior Constable Roy, Heidelberg Police Station.

3. Mrs Ronaldson detailed Stuart's formative years:

> "Stuart was one of four children and despite being born with a bad liver, lived a normal life. My husband was a university lecturer and his work took us to America to live. It was while we were living there, when Stuart was about 13 to 15 years old, that he began smoking marijuana and ran away from home to live with a neighbour. It was around this time we

decided to head back to Australia to live. It was when we returned, and Stuart was 17 to 18 years old that he began to show signs of mental illness and had his first episode of bi polar."

Mental Health Issues

4. Dr Mark Jeanes, Consultant Psychiatrist, prepared detailed statements in respect to Stuart's mental health history. Dr Jeanes gave evidence before at the inquest.

5. Dr Jeanes' summation thoroughly details the complexity of Stuart's mental health issues. Stuart suffered schizoaffective disorder and substance abuse.

Final admission at the Alfred Hospital

6. Stuart was admitted as an involuntary patient, to the Alfred Hospital on the 23rd November, 2006. At the time of his admission, Stuart was assessed unable to safely accept treatment in the community, resulting in the revocation of his Community Treatment Order.

7. Dr Jeanes assessed Stuart in the High Dependency Unit (HDU) of the Psychiatric Unit on the 24th November. He had previously treated Stuart.

8. Stuart remained in HDU and underwent daily review initially by the on-call consultant psychiatrist.

9. Following adjustments to medication regime, on the 19th December, Dr Jeanes noted significant improved in Stuart's mental state. He explained:

> "He was more oriented to his surroundings and his behaviour demonstrated a clearer understanding of his circumstances. He was able to be moved to the Low Dependence Area of the ward on 22nd December, 2006. At this stage he was mobilizing around the unit independently and had returned to eating his usual diet following a speech pathology review."

Escorted Leave

10. On the 23rd December, Stuart was granted escorted leave from the ward. Staff reports were positive.

11. Dr Jeanes was aware Stuart underwent several escorted leaves without incident.

Unescorted Leave

12. On the 27th December, Stuart was granted unescorted leave. The decision was made by the treating team, including the consultant psychiatrist.

13. On the morning of the 27th December, the medical registrar, Dr Bourke, in company with Stuart's allocated nurse assessed Stuart. According to Dr Jeanes:

> "...his mental state findings were discussed with me prior to a decision being made regarding further leave.
>
> It was considered that the most appropriate treatment options for Mr Ronaldson included treating him in the least restricted manner possible. Therefore, as he had been successfully trialled on escorted leave with staff, it was considered appropriate for him to be trialled on a short period of unescorted leave."

Significant Improvement

14. Dr Jeanes noted the significant improvement in Stuart's mental state. Mrs Ronaldson also noted the improvement.

15. Derek Ronaldson, Stuart's brother, visited him on the 27th December and did not consider Stuart's mental state had stabilized. His observation is at odds with the assessment of the treating team and Mrs Ronaldson.

Decision to grant unescorted leave appropriate

16. I am satisfied that the decision to grant Stuart unescorted leave was appropriate in all respects.

17. I found the evidence of Jean Yinson compelling. Ms Yinson was the manager of Stuart's Boarding House and knew him well.

18. Following his release on unescorted leave, Stuart visited Ms Yinson. They walked some distance to his Boarding Home to obtain footwear. Stuart spoke of his plan to visit his father at the Austin Hospital.

19. Ms Yinson noted nothing untoward. She was a woman with vast experience of people who suffer mental illness. There was nothing in his speech or demeanour which indicated to her that he was either mentally unwell or at risk.

20. Importantly, Ms Yinson's observations corroborated the assessment of medical and nursing staff in respect to Stuart's mental state.

The 12th January, 2007

21. Stuart was located facedown in the Darebin Creek on the 12th January, 2007. He had been in the creek for some lengthy period.

Medical Cause of Death

22. On the 12th January, 2007 Dr Malcolm Dodd, Forensic Pathologist at the Victorian Institute of Forensic Medicine, performed an autopsy. He was unable to ascertain a cause of death.

23. Dr Dodd noted Stuart's body was located in Darebin Creek. Further, Dr Dodd noted that Stuart's body was facedown, wedged on rocks; his head completely submerged below the water line.

24. Dr Dodd could find no evidence of trauma to the external surface of Stuart's body. At autopsy, there was no evidence of significant naturally occurring disease or trauma.

25. Post mortem toxicological analysis disclosed alcohol at a concentration of .07 gram/100mL. Dr Dodd explained the reading may be explained on the basis of endogenous production via decomposition.

26. Dr Dodd could not provide a definitive cause of death. He considered it possible that Stuart may have suffered a convulsion and drowned in the creek. He explained Stuart may have:

> "... slipped, fallen, possibly struck his head, lost consciousness and then drowned. The cause of death may be epilepsy in its own right.
>
> Either scenario is beyond absolute proof."

27. Dr Dodd noted that there are no diagnostic findings in cases of drowning and almost all cases:

> "... the autopsy examination of an epileptic victim is generally a negative one.
>
> There were no apparent offensive or defensive type injuries that may implicate the involvement of other persons in this event."

Cause of Death

28. In Dr Dodd's opinion, the cause of death could not be ascertained.

Circumstances of his death

29. The evidence does not permit a finding to explain the circumstances in which Stuart died. Dr Dodd has suggested the above possibilities. Dr Jeanes explained that Stuart did not suffer from epilepsy.

30. Stuart had a history of fainting.

31. There is no evidence to suggest foul play.

The clinical management was reasonable

32. There is no basis to criticise the medical or nursing management during Stuart's final admission at the Alfred Hospital. Further, the decision to grant Stuart unescorted leave was appropriate.

33. Stuart's death was the result of either a tragic accident or a medical event, neither or which could have been reasonably foreseen.

Lessons Learnt

34. Dr Jeanes gave impressive evidence. He frankly acknowledged that in hindsight the family should have been advised of the decision to offer Stuart unescorted leave. Since Stuart's death, Dr Jeanes ensures it is his practise to consult families in respect to decisions relating to leave.

35. The Alfred Hospital has provided a letter dated 11 February 2010 from the Director of Psychiatry, Dr Simon Stafrace.[1]

36. Dr Stafrace sets out a policy which is in the process of being implemented by the Alfred Hospital, Department of Psychiatry, addressing "inpatient leave from wards" with a particular focus on risk assessment and processes which specifically delineate the levels of leave to be granted to a patient.

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[1] Exhibit 2.

37. Further, Dr Stafrace refers to a patient brochure/flyer which is being developed to be provided to patients prior to commencing leave advising them of the expectations around leave and phone numbers to ring if they require assistance or are in distress.

38. Finally, and importantly, Dr Stafrace sets out the requirement to, inter alia, consult family and carers regarding the leave plan:

> "....a pre-leave checklist and a post leave review process. This includes confirmation of consultant approval of leave, education of the patient, rigorous assessment of mental state prior to leave, and family and carer consultation regarding the leave plan. It also includes a requirement for consultation with family carers and upon a patient returning from leave, and assessment of mental state on return from leave."

39. I have been provided with a copy of a document prepared by the Office of The Chief Psychiatrist, entitled "Inpatient Leave of Absence". I attach a copy to this finding.

40. The focus of Dr Vine's guideline is Section 40 of the Mental Health Act (the legislative requirement relating to Leave of Absence for involuntary patients).

41. I have reviewed the guideline and am satisfied it represents a comprehensive and accurate overview of the relevant legislation. It has a heavy focus on the key principles which govern the decision to grant leave of absence and practice procedures in respect of risk assessment and, importantly, communication documentation and clinical self-assessment.

RECOMMENDATION:
Pursuant to section 72(2) of the **Coroners Act 2008**, I make the following recommendation connected with the death:

> I recommend that the Chief Psychiatrist guideline entitled "Inpatient Leave of Absence" be distributed to approved mental heath services.

42. I find the cause of death of Stuart Fraser Ronaldson is unascertained.

Signature:

John Olle
Coroner

4th March, 2010

Distribution:

Office of The Chief Psychiatrist
The Alfred Hospital
All approved Mental Health Services in Victoria

Inpatient leave of absence

Chief Psychiatrist's Guideline

Key message

Leave from an approved mental health service is regulated by the *Mental Health Act* 1986 (the Act). All mental health services must ensure that appropriate clinical decision making occurs with regard to inpatient leave decisions; this includes the development and review of policies and procedures to guide clinical risk assessment and risk management. Leave decisions must include consideration of the risks and anticipated benefits, and of the rights of the patient, their family and carers.

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Background

Recent coronial findings have highlighted the importance of having robust systems for the management of patient leave to ensure patient safety. Particular emphasis has been given to:

- risk assessment prior to the granting of leave
- communication with patients and carers regarding leave arrangements
- documentation of leave approval and arrangements

Purpose and scope

The purpose of this guideline is to provide a framework to enable services to develop and review their existing policies and procedures regarding the management of inpatient leave.

1) For the purpose of this guideline *patient* refers to all persons admitted to an inpatient unit irrespective of their legal status.
2) Specific provisions exist under the Act in relation to leave of absence for Security Patients (s.51 & 52) and Forensic Patients (s.53 AC). Discussion of these is outside the scope of this guideline.

Relevant Legislation

The legislative requirements relating to leave of absence for involuntary patients are articulated in s.40, of the Act and, in essence, permit the authorised psychiatrist or his or her delegate to grant involuntary patients leave from a gazetted facility for such periods and subject to any conditions that the authorised psychiatrist considers appropriate.

Mental Health Act 1986

s. 40 Leave of absence

(1) The authorised psychiatrist may allow an involuntary patient to be absent from the approved mental health service in which the involuntary patient is detained –

(a) for such period; and

(b) subject to any conditions – that the authorised psychiatrist considers appropriate.

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(2) The authorised psychiatrist may from time to time extend the period of absence allowed under subsection (1).

(3) The authorised psychiatrist may revoke the leave of absence allowed to an involuntary patient and require the involuntary patient to return to the approved mental health service.

s. 41 Absence of involuntary patient with permission

The authorised psychiatrist may allow an involuntary patient to be absent from the approved mental health service for the purpose of receiving medical treatment-

(a) for the period: and

(b) subject to any conditions- that the authorised psychiatrist considers appropriate

Key principles

- 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.
- The granting of leave to any patient whether they are involuntary or informal, requires the treating psychiatrist to give due consideration to the reasons why the patient has requested leave and the likely associated benefits and risks. Such risks include, but are not limited to, the risk of harm to self or others (including any child protection issues), the likelihood and consequences of substance use, absconding from care, and vulnerability. These risks need to be balanced against the benefits of leave such as maintenance of social contacts, attending to family responsibilities, maintaining education/employment or other structured activity.
- A decision to grant leave should include consideration of anticipated activity while on leave, such as use of public transport or private vehicle
- When deciding whether to grant leave under s.40 of the Act, the authorised psychiatrist or his or her delegate should be mindful of the following principles set out in s.4(2) of the Act which are intended to guide the making of all decisions under the Act:
  - that people with a mental disorder are to be given the best possible care and treatment appropriate to their needs in the least possible restrictive environment and the least possible intrusive manner consistent with the effective giving of that care and treatment; and
  - that any restrictions upon the liberty of patients and other people with a mental disorder and any interference with their rights are to be kept to the minimum necessary in the circumstances.
- Where possible, leave should be planned well in advance and should occur as a result of discussion and routine treatment planning within the treating clinical team, in consultation with the patient and carers where this is indicated. If a leave request is made after hours at short notice, or on weekends when the usual treating team is absent, the person responsible should ensure they are familiar with all aspects of the treatment and care provided, and are able to adequately weigh up the risks and anticipated benefits of the requested leave. Where adequate information is not available, a decision should generally be deferred until clinicians familiar with the full clinical picture of the patient are available.
- Decision making about the purpose and granting of leave should be clearly documented and communicated to the patient, their primary carer (where appropriate), and relevant clinical staff.
- Newly admitted patients should generally not be granted leave until the treating team has developed sufficient familiarity with the patient to allow a valid mental state and risk assessment to be made.

Practice procedures

Risk Assessment

- A patient's mental state and risk assessments should be reviewed immediately prior to commencing leave. It is not appropriate to automatically allow a decision to grant leave that has been made some days previously without consideration of the patient's current mental state
- Due care must be exercised in the granting of leave to voluntary patients. Voluntary patients have the right to discharge themselves from hospital at any time, and in theory may leave the hospital at any time. If staff are concerned that a voluntary patient's safety may be at risk if he or she takes leave, a staff member should try to persuade the patient to stay in the hospital. If the patient insists on leaving, it will be necessary to consider whether an involuntary treatment order should be made with respect to the patient.
- Where a patient insists on leaving immediately and staff believe there is an imminent risk of harm to self or others, the person should be detained pending further assessment.
- If a patient fails to return as expected from leave, the senior nurse and consultant on call should be notified as soon as possible. Attempts should be made to contact the patient by phone and next of kin consulted and contacted. The decision to notify police is made by senior staff and depends on the pre-leave risk assessment, legal status of the patient and duration of leave.

Communication

- The purpose of the leave, its duration and any special conditions such as whether the patient should refrain from driving, should be discussed with the patient, prior to leave being granted. Where appropriate, the patient's carer should also be involved in these discussions. The discussion should be guided by a senior clinician of the treating team, ideally the treating psychiatrist, and should include the provision of a crisis plan in the event that difficulties are encountered by the patient or their carer during the leave period.
- Where expectations are placed upon the carer as part of the leave plan, this must be clearly communicated to both patient and carer.
- Conditions of leave may include the proviso "accompanied by a responsible adult". When granting such leave to any patient, if the expectation is that the patient is to remain under the effective supervision of a responsible adult at all times whilst absent from the ward, this must be clearly discussed with both patient and carer. If the carer is unable or unwilling to exercise this responsibility, any decisions regarding leave should be reviewed. This should be clearly documented. The clinical responsibility for the patient at all times remains with the authorised psychiatrist.
- Consideration should be given to the appropriateness of the "accompanying adult" in terms of their capacity to exercise appropriate responsibility and effective supervision of the patient whilst on leave.
- Consideration should be given to the use of a leave register that the patient should sign (specifying the time of departure and an agreed return time) in the presence of a nurse prior to departing on leave. The "accompanying adult" and carer should be contacted without delay if the patient does not return on time.
- Patients and carers should provide contact numbers for the duration of the leave granted and also be provided with after hours contact numbers to assist with any concerns they may have during the leave period.
- Upon return from leave, an assessment of the patient should occur and the carer should be consulted to ensure any issues arising during leave are noted.
- Consideration should be given to locking the room of a patient absent on leave from the ward where this is practicable and does not infringe upon the rights of other patients. This not only helps safeguard the personal property of absent patients, but provides a mechanism whereby if a patient returns early or unexpectedly from leave, or their return is not noticed by staff, a need is created for the patient to contact staff in order to gain access to their room.

Documentation

- All patients should have clearly documented risk assessment and risk management plans which are considered and referenced in the documentation of all leave decisions.
- The leave plan, approval of the leave by the authorised psychiatrist or his or her delegate, communication of this plan with patient and carer, and the departure and return times of the patient, should be clearly documented.
- Any issues arising in the course of the patient's leave should be noted.
- A Leave of Absence form (MHA21) should be completed for all involuntary patients granted leave. This form is be used whenever an involuntary patient is to be absent overnight or longer periods, and at other times at the discretion of the authorised psychiatrist or his or her delegate.

Clinical Self Assessment

Standard 1: Each service has an established policy and procedure concerning inpatient leave

Indicators:

1.1 There is a written policy and procedure for inpatient leave which is informed by this clinical guideline.

1.2 Clinical staff are able to articulate a sound knowledge of the key principles, legal requirements, guidelines, and local policy and procedures relating to inpatient leave.

Standard 2: All inpatient leave is clearly documented.

Indicators:

2.1 Clinical record documentation of inpatient leave meets the requirements of relevant policies and procedures.

2.2 Regular clinical audits are conducted

Standard 3: Adverse events relating to inpatient leave are comprehensively reviewed

Indicators:

3.1 Practice improvements are made in response of review of adverse events via the health service clinical governance framework.

About Chief Psychiatrist's Guidelines

The information provided in this guideline is intended as general information and not as legal advice. If mental health staff have queries about individual cases or their obligations under the *Mental Health Act 1986*, service providers should obtain independent legal advice.

Acknowledgements

Published by the Mental Health and Drugs Division, Victorian Government Department of Health.
Also published on www.health.vic.gov.au/mentalhealth/cpg.
Document number: CPG090801

Document review cycle

Scheduled for review: September 2014
Guidelines issued: September 2009

Further information

For further information about inpatient leave of absence, contact the Chief Psychiatrist on 9096 7571 or 1300 767 299 (toll free).

Information is also available on the Department of Health's website at www.health.vic.gov.au/mentalhealth/cpg.

Dr Ruth Vine
Chief Psychiatrist

State Government Victoria Department of Human Services