IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2014 3350

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)
Section 67 of the Coroners Act 2008

Findings of:	**JUDGE JOHN CAIN, STATE CORONER**
Deceased:	**PAUL PETERSON**
Date of birth:	4 May 1960
Date of death:	Between 1 and 2 July 2014
Cause of death:	1(a) NECK COMPRESSION
Place of death:	Burwood Reserve, 282 Warrigal Road, Glen Iris, 3146 Victoria

HIS HONOUR:

Background:

1. Paul Peterson was born on 4 May 1960. He was 54 years old when he took his own life between 1 to 2 July 2014.

2. Mr Peterson lived in Warragul with his partner, Ms Robyn Begelhole, and their daughter.

3. Mr Peterson was diagnosed with depression during his 30s, which was subsequently treated with Citalopram (an antidepressant). When that drug started to become less effective, he began self-medicating with painkillers.

4. In 2013, Mr Peterson underwent minor surgery, after which he was prescribed OxyContin. He continued taking this medication until it also lost its effect, and he turned to other painkillers. According to Ms Begelhole, Mr Peterson began acting out of character, making silly decisions, was unable to concentrate, and became angry and snappy.

The Coronial Investigation:

5. Mr Peterson's death 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.

6. Coroners independently investigate reportable deaths to find, if possible, identity, medical cause of death and with some exceptions, surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. Coroners make findings on the balance of probabilities, not proof beyond reasonable doubt.[1]

7. The law is clear that Coroners establish facts; they do not cast blame or determine criminal or civil liability.

8. 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

[1] In the coronial jurisdiction facts must be established on the balance of probabilities 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.

comments or recommendations in appropriate cases about any matter connected to the death under investigation.

9. Coroner Carlin and Coroner Hodgson had prior conduct of this investigation and I have been greatly assisted by their earlier work. As of December 2019, I took conduct of this investigation as both Coroner Carlin and Coroner Hodgson were leaving the Court.

10. Victoria Police assigned Constable Amelia Hanvey to be the Coroner's Investigator for the investigation into Mr Peterson's death. Constable Hanvey submitted a coronial brief of evidence and I also requested additional statements from Delmont Private Hospital and Mr Peterson's treating psychiatrist.

11. With the assistance from the Coroners Prevention Unit (**CPU**),[2] Mr Peterson's medical records from Delmont Private Hospital, the medical examiner's report, toxicology report, the coronial brief, and additional statements have all been reviewed.

12. After considering all the material obtained during the coronial investigation, I determined that I had sufficient information to complete my task as Coroner and that further investigation in the form of an inquest was not required.

13. 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.

Identity of the deceased:

14. Mr Peterson was visually identified by his friend, Mr Michael Bridges, on 3 July 2014. Identity was not in issue and required no further investigation.

Medical cause of death:

15. On 3 July 2014, Dr Paul Bedford, Forensic Pathologist at the Victorian Institute of Forensic Medicine, conducted an external examination of the body of Mr Peterson and reviewed a post-mortem computed tomography scan. The examination revealed injuries which were consistent with hanging.

[2] The role of the CPU is to assist coroners investigating deaths, particularly deaths that occur in a healthcare setting. It is staffed by healthcare professionals, including practising physicians and nurses, who are independent of the health professionals and institutions under consideration.

16. Toxicological analysis of post-mortem specimens taken from Mr Peterson identified nortriptyline,[3] oxazepam,[4] and chlorpromazine.[5]

17. After reviewing the toxicology results, Dr Bedford completed a report, dated 14 July 2014, in which he formulated the cause of death as "***1(a) Hanging.***"

18. In July and September 2014, Ms Begelhole and her legal representative separately contacted the Court to request that the cause of death be amended in the interests of Mr Peterson's child. Following consultation with Dr Bedford, this request was granted, and the cause of death was amended to ***"1(a) Neck compression."***

Circumstances in which the death occurred:

19. In February 2014, Mr Peterson disclosed to his sister that he was planning to go to a motel and overdose on a stockpile of OxyContin. He was admitted overnight to Royal Melbourne Hospital as an involuntary[6] patient and subsequently referred to Dr Jill Hosking, Psychiatrist. He was weaned off OxyContin.

20. Dr Hosking referred Mr Peterson to Delmont Private Hospital (**Delmont**). He was admitted as a voluntary patient on 6 May 2014, where he was treated by Dr Barry Williamson, Psychiatrist. According to Dr Williamson, he assessed Mr Peterson as suffering from major depressive disorder with melancholic features.

21. Initially, Mr Peterson was weaned off citalopram and started on desvenlafaxine, however, his mental state continued to deteriorate. Mr Peterson also continued to suffer severe agitation. According to Dr Williamson, Mr Peterson's thinking and sense of hopelessness was very intense at times. During these periods, he was observed very carefully on the ward and leave was not permitted.

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[3] Nortriptyline is used to treat depression.
[4] Oxazepam is a sedative/ hypnotic drug of the benzodiazepine class.
[5] Chlorpromazine is a phenothiazine tranquilliser used in the treatment of psychotic disorders.
[6] Section 8 of the *Mental Health Act 1986* (Vic) set out the criteria for involuntary treatment as follows: (a) the person appears to be mentally ill; and (b) the person's mental illness requires immediate treatment and that treatment can be obtained by the person being subject to an involuntary treatment order; and (c) because of the person's mental illness, involuntary treatment of the person is necessary for his or her health or safety (whether to prevent a deterioration in the person's physical or mental condition or otherwise) or for the protection of members of the public; and (d) the person has refused or is unable to consent to the necessary treatment for the mental illness; and (e) the person cannot receive adequate treatment for the mental illness in a manner less restrictive of his or her freedom of decision and action. The *Mental Health Act 1986* has since been repealed and replaced by the *Mental Health Act 2014* (Vic) (effective 1 July 2014).

22. Treatment with antidepressants was augmented with atypical antipsychotic medication (quetiapine and olanzapine). However, Mr Peterson developed involuntary movements, which complicated pharmacological management. He was treated with several other medications to help reduce the anxiety and agitation.

23. Mr Peterson was subsequently treated with electroconvulsive treatment (**ECT**). After four treatments, he decided to discontinue that type of treatment.

24. Ms Begelhole visited Mr Peterson almost every day during his admission. During her visits, and if Mr Peterson was granted leave, they would walk to the park or shops.

25. On 24 June 2014, Mr Peterson was placed on close observations, which required that he be visually sighted every hour.

26. On 29 June 2014, Mr Peterson expressed his intent to leave Delmont. A meeting with his treating practitioners and family was convened to discuss his treatment. According to Dr Williamson, at that time, he explained Mr Peterson's serious risk of suicide and the likelihood of it worsening if he was not adequately treated. Mr Peterson subsequently agreed to continue treatment at Delmont.

27. The next day, Mr Peterson again expressed his wish to leave to Dr Williamson. Dr Williamson's progress note of 30 June 2014 at 4.15pm describes Mr Peterson's plans as *"vague."* Dr Williamson spoke to Ms Begelhole and they discussed referral to another doctor or clinic. He planned to speak to Dr Hosking and seek further clarification from Mr Peterson's family. He noted:

> *Factors I insist on are that he must be not left alone, that prefer handover to CATT* [Crisis Assessment and Treatment Team] *or another psychiatrist occur and that the process be orderly.*
> *He may have leave with family this evening.*
> *Suicidal ideation not evident.*
> *He is <u>not</u> agitated.*

28. Mr Peterson subsequently exercised accompanied leave with Ms Begelhole that evening.

29. The progress notes of the morning of 1 July 2014 record Mr Peterson asking about resuming ECT. He had been speaking to co-patients who had received positive outcomes from the

treatment. However, he remained *"low in mood,"* but not anxious or agitated with no overt risk identified.[7]

30. According to Ms Begelhole, Mr Peterson telephoned her in the morning, and they discussed him resuming ECT. He seemed *"good"* on the telephone and she could hear that he was thinking clearly and was having a good day. Mr Peterson subsequently agreed to resume ECT.

31. At about 1.30pm, Mr Peterson requested to go to the gym to swim. As he was still on hourly observations, his treating doctor was contacted, and the leave was approved. Mr Peterson was accompanied to the gym.

32. According to Dr Williamson, he assessed Mr Peterson as less anxious but still quite depressed that day.[8] Mr Peterson still expressed feelings of sadness but did not express any suicidal thoughts during their interview. According to Dr Williamson, this fluctuation in intensity of symptoms was a characteristic of the course of his illness during his stay in hospital.

33. In preparation for ECT, Mr Peterson ceased taking his anti-anxiety medication at approximately 5.00pm.[9] Later that evening, Ms Begelhole and their daughter arrived at Delmont to have dinner with Mr Peterson.

34. According to Ms Begelhole, when she arrived, Mr Peterson said he was *"not very good"* and was noticeably trembling and agitated due to having stopped the medication. They tried to have dinner in the hospital cafeteria, but Mr Peterson was struggling with his tremors and was concerned that he could not hide them from their daughter. At this time, Mr Peterson disclosed to his partner that he felt suicidal. Ms Begelhole stated that he had regularly expressed thoughts of suicide over the preceding years and that this was nothing out of the ordinary. She believed he was worried and upset about his anxious state and tremors. Ms Begelhole stated that she was not sure whether Mr Peterson told staff of his suicidal thoughts, but he was often open to staff when he had thoughts of that nature.

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[7] Progress note of 1 July 2014 at 11.35am.
[8] Dr Williamson's progress note of 1 July 2014 does not refer to leave. The time of the review is not recorded, but it is apparent it occurred sometime between 1.30pm and 7.45pm.
[9] Diazepam is a benzodiazepine and prevents seizures, which defeats the purpose of ECT.

35. While they were in the cafeteria, a nurse requested Mr Peterson sign a consent form for the next day's ECT. According to Ms Begelhole, Mr Peterson expressed concern about getting through the night due to his tremors and she asked the nurse to keep an extra eye on him that night. The nurse suggested that she try to distract him, and they decided to go for a walk.

36. Nurse Gemma Johnston stated that she could not recall suggesting that Mr Peterson go for a walk. Ms Johnston stated that she was not told Mr Peterson was feeling suicidal at that time as she would have advised him not to the leave the hospital and would have contacted Dr Williamson.

37. The progress notes from 7.45pm that evening state:

> *Paul has presented as much more settled this afternoon, chatting with co-patients in the lounge. No overt agitation observed. Paul appeared sedated, dry mouth but calmer. However, when his wife arrived Paul presented as agitated, wringing his hands, rocking back and forth. Very poor self-soothing, dismissive of mindfulness techniques. Wife very concerned so took him for a walk. Initially Paul was reluctant to sign ECT consent but approached writer later and signed his agreement. 60/60 obs continue. No S/I* [suicidal ideation] *reported and he denied any overt risk. Settled in the lounge ATOR* [at time of report].

38. According to Raveeni Srikanthan, Acting Director of Nursing at the time of her statement, prior to leaving the hospital at 7.45pm on 1 July 2014, the contact nurse performed a risk assessment of Mr Peterson and assessed him as calm and not agitated. Other than the above quote, there is no other evidence of a risk assessment being performed.

39. On leaving the hospital at 7.45pm, Mr Peterson signed out of the patient leave book, recording the time he left and an estimated time of return (one hour later). Ms Begelhole stated that they only managed to walk two blocks, approximately five minutes, before they had to turn back due to the severity of Mr Peterson's tremors.

40. At approximately 8.00pm, they returned to Delmont and Ms Begelhole walked him to near the front entrance, where her vehicle was parked facing the front door. They said their goodbyes and Ms Begelhole observed Mr Peterson walking to the front steps, at which time she took her eyes off him to start the car. He was gone when she looked back up.

Ms Begelhole assumed that Mr Peterson had gone inside through the reception area as he usually did.

41. According to Ms Srikanthan, at 8.45pm the contact nurse checked the leave register and determined that Mr Peterson had not returned from leave. It was decided to allow some extra time in case he had been delayed. At 9.00pm, staff had still not observed Mr Peterson return to the hospital. Staff conducted a search of the hospital. At 9.25pm, staff recorded in Mr Peterson's file that he had not returned from leave. Attempts were made to contact Ms Begelhole, which were delayed as she had a long drive home during which she was out of telephone contact.

42. According to Dr Williamson and Ms Srikanthan, Delmont's CCTV recorded Mr Peterson re-entering the hospital after being dropped off by Ms Begelhole and then leave the hospital again shortly thereafter. At no time during his brief return was he seen by hospital staff.

43. At approximately 10.00pm, Ms Begelhole returned Delmont's calls. Staff asked whether she was still with Mr Peterson; she confirmed he was not.

44. Following discussion with Dr Williamson, staff contacted Victoria Police at approximately 10.27pm to report Mr Peterson as a missing person. Police members subsequently conducted a search of nearby Burwood Reserve following information from Ms Begelhole that Mr Peterson had previously mentioned hiding a knife in the Reserve's toilet block. Mr Peterson's friends and family also searched the park. Mr Peterson was not located at this time.

45. The next morning, police members searched Burwood Reserve again. At 8.20am, Mr Peterson was located deceased beside the front gate to Burwood Bowls Club in the Reserve. He was hanging by a bag strap which was connected to a cyclone fence concealed by bushes. Police members did not identify any suspicious circumstances.

Delmont's leave procedures and policies in place at the time of Mr Peterson's death:

46. As part of the coronial investigation, evidence was sought as to Delmont's leave procedures in effect at the time of Mr Peterson's admission.

47. According to the Director of Nursing at Delmont, Peter Randell, therapeutic leave was granted and operated in accordance with the *Therapeutic Leave Procedure* and *Therapeutic Leave Policy.*

Therapeutic Leave Policy

48. The *Therapeutic Leave Policy* in effect at the time of Mr Peterson's admission was dated August 2012. The overriding policy statement stated as follows:

> *All patients admitted to Delmont Private Hospital as inpatients are required to remain in Hospital for the duration of their stay. It is recognised that during admission, exceptional circumstances can arise which may necessitate the granting of leave. In general, leave is not permitted as part of inpatient care, due to consideration for safety and risk.*

49. Despite the statement that leave is generally *not* permitted and may be granted in exceptional circumstances, the remainder of the policy details when leave may be granted in circumstances that do *not* appear exceptional. The policy outlines overnight and day leave. Overnight leave may be granted in exceptional circumstances, such as the death of a relative or sudden illness. However, day leave may be granted if it is considered an important component of treatment, such as to maintain the patient's independence and coping skills. It is unclear whether a walk to the shops or down the road is considered 'day' leave.

50. All leave was to be determined in advance by the patient's treating doctor in consultation with the treating team and the patient's carer/family where appropriate. Patients were required to return from leave by no later than 9.00pm. The leave approval was required to be documented in the patient's clinical file and ward leave book by the treating doctor and verbally relayed to nursing staff. The policy also set out criteria for determining suitability for leave, which was to be determined by the patient's treating doctor. Therapeutic leave was only to occur under the guidelines of *"this policy"*.

Therapeutic Leave Procedure

51. The *Therapeutic Leave Procedure* in effect at the relevant time was dated August 2012. The procedure set out the following requirements for therapeutic leave:

(a) all leave must be approved and relayed to the clinical team verbally via the leave permission form and in the patient's clinical file by the patient's treating doctor following a risk assessment;

(b) the treating doctor is to use a stamp for this purpose prior to leave occurring;

(c) strategies for safety whilst on leave must be discussed with the patient and their carer and agreed to and documented in the patient's clinical file by the treating doctor;

(d) an individual leave form is to be completed and given to the patient, outlining medication instructions, by nursing staff immediately prior to the leave commencing;

(e) patients returning from leave are requested to be back at the hospital by 9.00pm; and

(f) on return from leave, a review is required to occur as soon as practicable by a member of the clinical team with the patient and carer. This review is required to be documented in the patient's clinical file.

52. Notably, when a person was on 'close observations,' all previous leave entitlements were ceased until they were determined safe to no longer require a higher level of intervention by the treating doctor.[10]

53. According to Mr Randell, this procedure required therapeutic leave to be recorded in the leave register. When leaving the hospital, patients were required to discuss with nursing staff what time they planned to return from leave. Provided that staff considered the nominated time appropriate, the time of the patient's return would be recorded in the leave register. The patient would then sign the leave register when they returned. The staff member allocated to the patient (the contact nurse) was required to check the leave register throughout the shift to ensure that the patient has returned at the nominated time. The patient's nominated time of return was also written on the whiteboard to alert staff.

54. On return from leave, a patient was required to undertake a review with their contact nurse or another member of the clinical team if that nurse was not available. Any relevant information from this review was required to be documented in the patient's clinical file.

[10] This was echoed in the *Specialling and Close Observations Procedure* (August 2012), which similarly stated that if a patient has been placed on close observation, all previous leave entitlements are ceased until they are determined safe to no longer require a higher level of intervention by the treating doctor.

55. Mr Randell further stated that in the event that the patient did not return from leave at the nominated and documented time, the clinical team was required to make efforts to contact the patient and the responsible accompanying adult to ascertain the patient's whereabouts. Staff were also required to conduct a search of the hospital premises. If the patient could not be located, staff would contact the treating psychiatrist for further direction (such as contacting Victoria Police).

Mr Peterson's leave:

56. According to Mr Randell, Mr Peterson undertook leave on 16 occasions during his admission, excluding the times he went to the gym and swim therapy at an external venue that was organised and supervised by staff. Mr Randell stated that in order to obtain this information, he had to interview relevant nursing staff about their recollection of the number of times that Mr Peterson had taken leave. He also perused hospital records. Delmont noted that consultation of Mr Peterson's progress notes alone would not give an accurate record of leave approvals, because in accordance with the procedure and practice, daily recording of a patient's leave status was recorded on the leave whiteboard located in the nurses' station. This is despite the *Therapeutic Leave Procedure* requiring leave to be recorded in the leave register, clinical file, medication chart, and the whiteboard in the unit office, and a post-leave review having to be documented in the patient's clinical file.

57. According to Ms Srikanthan, Mr Peterson was on 'close observations' at the time of his death. Staff were required to sight Mr Peterson on an hourly basis and record this in the 'Close Observations Record.'

58. Dr Williamson stated that the decision to allow Mr Peterson to have brief periods of accompanied leave with family was a considered one. Earlier during his admission, Mr Peterson had taken leave with his wife to visit family. At this time, Mr Peterson had told his partner that he had felt like jumping off a bridge. It was subsequently agreed that he should not have long periods of leave and that he should not be left alone for safety reasons. Dr Williamson and Mr Peterson's family agreed that Mr Peterson should not have leave as a matter of course, but that suitability for leave should be reviewed beforehand.

59. On the other hand, Mr Peterson often expressed a desire to be discharged and it was difficult for family members to see him in hospital. Therefore, they organised for supervised brief

periods of leave when Mr Peterson seemed to be in a less distressed state. His family had subsequently taken him out of the hospital for short periods of time on several occasions.

60. According to Dr Williamson, he explained to Mr Peterson's family, including Ms Begelhole, that hospital leave needed to be undertaken carefully and Mr Peterson needed to be carefully supervised. He emphasised that the risk of suicidal behaviour was present and fluctuated in intensity. Mr Peterson expressed a wish to be discharged at times, however, Dr Williamson strongly advised against discharge and told his family that he required inpatient treatment until his condition was significantly improved.

61. According to Ms Begelhole, when they went out together, she would always leave Mr Peterson at the front door or he would walk her to her car before returning on his own. She was never told to return Mr Peterson to the ward or to sign him back in during their short outings. When she was worried about him, she would call the nurses five minutes later to check whether he was ok. On the night he went missing, she did not call.

62. In order to take Mr Peterson on day leave, Ms Begelhole stated that she spoke to the nurses who then sought approval from Dr Williamson, who would authorise the leave if appropriate. When she had taken Mr Peterson out on *day* leave, staff discussed the requirements with her. She was provided with a handover as well as medications. However, she recalled that the discussion was more about medication rather than safety. She could not recall discussing safety strategies, including what to do in an emergency, with staff.

63. Ms Begelhole did not recall whether there was an expectation to see a nurse when returning to the hospital. She stated that she was never provided with any documentation about leave or the procedures.

64. Ms Begelhole also stated that at times, (when he was not on 'suicide watch') Mr Peterson had gone on leave unaccompanied to the coffee shop. She stated that staff would not question Mr Peterson if he signed the leave book.

Were relevant policies and procedures followed when Mr Peterson had leave?

65. Delmont submitted to the Court that all applicable policies and procedures, including the unwritten '*Close Observation Practice,*' were adhered to by Dr Williamson and nursing staff on 1 July 2014. It was submitted that Dr Williamson had approved Mr Peterson's

accompanied leave with family on 30 Jun 2014 and that this approval remained in force at the time of Mr Peterson's death.

66. Dr Williamson was asked whether he was familiar with Delmont's *Therapeutic Leave Policy, Therapeutic Leave Procedure* or the *Specialling and Close Observations Procedure* at the time of Mr Peterson's death. He confirmed that he was not familiar with these documents.

67. From the outset, I must say that both the August 2012 *Therapeutic Leave Policy* and *Therapeutic Leave Procedure* were unclear as to whether they applied to shorter periods of leave, for example, one hour of leave to have a coffee with a family member or to attend the gym. I accept they set out requirements for both day leave (an extended period) and overnight leave. Without any evidence to the contrary, I have interpreted both documents as applying to shorter periods of leave, such as the period of leave exercised by Mr Peterson immediately before his death.

The significance of Mr Peterson being placed on close observations:

68. Mr Peterson was placed on close observations on 24 June 2014, which continued until his death. As set out above, the August 2012 *Therapeutic Leave Procedure* specified that if a patient had been placed on close observations, all previous leave entitlements were ceased until the treating doctor determined that the patient is safe to no longer require a higher level of intervention. The procedure was unclear as to whether a patient who was *already* on close observations was allowed leave. To my mind, it would be incongruent if one patient were allowed leave and the other not, merely by reason of the date they are made subject to close observations. It therefore appears that Mr Peterson should **not** have been granted leave while on close observations.

69. Dr Williamson stated that he understood 'close observations' to mean that he could grant leave as long as the patient was under the supervision of a responsible adult *"nominated by me."* I am unclear as to the source of Dr Williamson's understanding as the procedure clearly does not refer to a 'responsible adult' (or one nominated by the treating doctor), nor does his progress note of 30 June 2014, which merely refers to leave with 'family.' On my interpretation of the procedure, Mr Peterson was not entitled to be granted nor exercise leave.

Grant of leave

70. Putting that issue to one side, I am satisfied that Dr Williamson conducted a risk assessment on 30 June 2014, at which time he was satisfied that suicidal ideation was not evident and Mr Peterson was not agitated. The approval for leave that day was appropriately documented in the clinical file. I have not received any evidence as to whether the approval was relayed to the clinical team verbally or via the leave permission form.

71. Delmont submitted that once leave is granted by the treating doctor, that approval remains in force until it is reviewed or cancelled or there is a change in the patient's status. In this regard, the medical and nursing staff work together to ensure that patients that are granted an approved level of leave are assessed by nursing staff before each specific period of leave to ensure that the patient's condition is stable and it is appropriate for that patient to take leave. If the nursing staff assess a change in a patient's status, leave is discouraged, and a note is made in the clinical record for the treating doctor to review the patient's leave status.

72. Delmont submitted that the leave approval granted by Dr Williamson on 30 June 2014 continued to remain in force until 1 July, because there was no record on Mr Peterson's clinical file of suicidal ideation or acute risk and his condition had not deteriorated. Delmont submitted that the progress notes over 30 June and 1 July 2014 repeatedly record that Mr Peterson does not have any suicidal thoughts and is not at overt risk.

73. Despite the note stating that Mr Peterson could have leave *"with his family this evening,"* Dr Williamson confirmed that that approval was intended to stay in place until there was a reason for him to vary or revoke it, such as further clinical information from the nursing staff or family or his assessment. He assessed Mr Peterson on 1 July 2014 and saw no reason to change the leave status.

74. I do not accept the submission that the grant of leave on 30 June 2014 continued to remain in force. The opening paragraph of the procedure clearly states that *"[a]ll leave must be approved."* Leave must then be relayed verbally and in writing via a leave permission form and in the patient's clinical file *following* the treating doctor completing a risk assessment. A stamp must be used before the leave is to occur. In addition, the procedure refers to individual leave forms. The language of these instructions imply that a number of steps must be taken prior to *each* individual leave occurring.

75. More significantly, the treating doctor must conduct a risk assessment before granting leave. This is appropriate as inpatients may often experience varying levels of risk in relatively short periods of time. Dr Williamson appears to acknowledge this in his statement that he and Ms Begelhole agreed that, "[Mr Peterson] *should not have leave as a matter of course but that suitability for leave should be reviewed beforehand ... we organised for supervised, brief periods of leave* ***when*** *he seemed to be in a less distressed state"* [my emphasis].

76. Mr Peterson's fluctuation is evident in the progress notes in the days before his death, which record him as experiencing suicidal thoughts, varying levels of agitation, and then settling before his partner's visit on 1 July 2014.[11]

77. Mr Peterson's risk is also plain by the fact he was on hourly observations at the time of his death. The *Specialling and Close Observations Procedure* states that, *"close visual observations occur where specialling is not warranted, but the patient is still at risk of self-harm, absconding, etc ...".*[12]

78. This interpretation is also supported by staff practice. On 1 July 2014, Mr Peterson requested to attend the gym. The nursing notes state at 1.30pm, *"... as he was on 60/60 visual obs treating Dr contacted and he allowed him to go."* If the leave granted the night before was intended to continue until revoked, why did the nurse seek Dr Williamson's permission for Mr Peterson to attend the gym with staff?

79. I am satisfied that Dr Williamson reviewed Mr Peterson on 1 July 2014. This may have included a risk assessment, although his notes in the clinical file do not make that clear. However, I am not satisfied that Dr Williamson granted leave on that day (other than leave to attend the gym). I am also not satisfied that the leave granted on 30 June 2014 remained in force until revoked as there is nothing in the procedure that allows such a practice.

80. Delmont submitted that approval of leave by a patient's treating doctor prior to every specific period of leave is a practical impossibility given the number of patients at the hospital and the schedules of consulting psychiatrists. That may be so, but I do not make comment on whether a treating doctor *should* approve every period of leave. That is a matter that should be addressed by *clear* hospital procedure and policy.

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[11] Between 24 June and 1 July 2014.
[12] Dated August 2012.

81. The procedure in place at the time of Mr Peterson's death implied that the treating doctor must approve each instance of leave and as such, I am satisfied that leave was not approved on 1 July 2014.

82. The *Therapeutic Leave Policy* in effect at the time of Mr Peterson's death required leave approval to be documented in the patient's clinical file and ward leave book by the treating doctor and verbally relayed to nursing staff. As above, I do not accept Dr Williamson's submission that he complied with the policy by documenting leave approval in Mr Peterson's clinical file as I have found there is no evidence in Mr Peterson's clinical file to suggest that leave was granted on 1 July 2014. I have received no evidence as to whether Dr Williamson's leave approval was documented in the ward leave book or verbally relayed to nursing staff.

Safety strategies

83. The procedure required that strategies for safety whilst on leave must be discussed with the patient and their carer, agreed to, and documented in the patient's clinical file by the treating doctor.

84. Delmont submitted that Dr Williamson had a number of discussions with Ms Begelhole about the hospital's requirements of a 'responsible adult' and her obligations when accompanying Mr Peterson on leave, including the requirements of the unwritten 'close observations' practice. Dr Williamson stated that throughout Mr Peterson's admission, he had many conversations with Ms Begelhole (and as recently as two days before his leave of 1 July 2014) that Mr Peterson was unsafe to leave alone, and he needed to be supervised closely whilst on leave. Dr Williamson outlined the education and discussions he had with Mr Peterson's family and stated, *"We agreed that he should not have leave as a matter of course but that suitability for leave should be reviewed beforehand."*

85. However, Ms Begelhole could not recall discussing safety strategies with staff, including what to do in an emergency. I am therefore unable to be satisfied whether the necessary safety strategies were discussed with Ms Begelhole before she accompanied Mr Peterson on leave.

86. The progress notes proximate to Mr Peterson's leave on 1 July 2014 do not refer to a discussion about safety strategies with Ms Begelhole. I am satisfied that this omission was in

breach of the August 2012 *Therapeutic Leave Procedure*. Whilst Dr Williamson's progress note of 30 June 2014 states, *"... [Mr Peterson] must not be left alone,"* it is unclear whether this is a direction to Ms Begelhole during their telephone conversation, his thoughts on Mr Peterson's possible discharge/transfer, or a direction to nursing staff.

Delmont's unwritten policies and procedures

87. Delmont submitted that their written policy and procedure regarding therapeutic leave could not be relied upon as the sole source of information upon which an understanding of the therapeutic leave procedure should be gained. This is despite the *Therapeutic Leave Policy* clearly stating *"[t]herapeutic leave will only occur under the guidelines of this policy."* Delmont submitted that there was a 'practice' in place that filled the gaps in the applicable written policy and procedure. According to Delmont, *"learnings"* had arisen during the implementation of the 2012 policy and procedures that resulted in the adoption of a *"complementary practice, which effected improvements upon the written policy and procedure documents."*

88. The 2012 *Therapeutic Leave Procedure* stated that leave entitlements would be ceased upon a patient being placed on close observations. This procedure was *"shaped and more specifically articulated by the Practice for Patients Under Close Observations as at 1 July 2014,"* which seems to be an unwritten policy or procedure. This 'practice,' which informed the 2014 amendment, allowed a patient on close observations to be granted leave if a discussion (which is to be documented in the patient's clinical file) occurred between the treating doctor and the nursing team to determine risk and safety considerations. A patient must then be accompanied by a *"responsible adult"* who must bring the patient back to the hospital and hand over the patient back to the nursing team.

89. Delmont submitted that Dr Williamson assessed Mr Peterson's suitability for leave on 30 June 2014 whilst he was under close observations. The progress notes for that day at 2.15pm by a registered nurse, relevantly stated:

> *[Mr Peterson] then proceeded to ask for day leave, advised that Dr Williamson would like to review him before approving day leave.*

90. Delmont submitted that this progress note demonstrated a discussion between Dr Williamson and nursing staff as required by the unwritten close observations practice to

determine risk and safety considerations before Mr Peterson took leave. I do not agree. That progress notes record what the nursing staff told Mr Peterson. It does not in any way record a conversation between nursing staff and Dr Williamson. I accept that the next entry, which is by Dr Williamson, grants leave. However, the unwritten close observations practice, later incorporated into the 2014 procedure/policy, required the nursing staff and the treating doctor to have a conversation before the patient exercised leave. There is no evidence on Mr Peterson's clinical file that this conversation took place.

91. There is evidence of a discussion between Dr Williamson and nursing staff on the afternoon of 1 July 2014, at which time Dr Williamson granted Mr Peterson leave to attend the gym. There is no evidence in the clinical file that Dr Williamson granted Mr Peterson leave with Ms Begelhole that evening and there is no evidence recording a staff discussion regarding that leave.

92. Mr Randell stated that when leaving hospital, patients were required to discuss with nursing staff what time they planned to return from leave. The 7.45pm progress note recorded that Mr Peterson's wife took him for a walk and a later note stated that he signed out at 7.45pm with the intention of returning in one hour. Although the progress note does not specify whether Mr Peterson discussed what time he would return, I accept that this discussion likely took place.

93. Delmont submitted that Mr Peterson left the hospital on 1 July 2014 in the care of his partner, who was a *"responsible adult"* for the purpose of relevant policies and procedures. She was required to hand Mr Peterson over to nursing staff at the nominated time of return (8.45pm), which did not occur. However, the written policies and procedures in effect at the time of Mr Peterson's death do not refer to the role of 'responsible adult' nor the requirement that the responsible adult hand the patient back to nursing staff when returning to the hospital. I therefore assume that this role and practice was part of the unwritten practice.

94. According to the unwritten close observations practice, Ms Begelhole was required to hand over Mr Peterson to nursing staff on his return to the hospital, which did not occur, and nursing staff were not aware of his return (before he quickly left again).

Changes to Delmont's leave procedures and policies following Mr Peterson's death:

95. According to Mr Randell, after Mr Peterson's death several changes were made to the 2012 *Therapeutic Leave Procedure* in relation to patients on close observations. The August 2014 procedure[13] relevantly states as follows:

> *It is preferable that patients are not given leave whilst on close observations and that they only be granted leave when considered to be safe enough to leave the hospital without risk and no longer require more intensive nursing care.*
>
> *Where a patient on close observations is given leave, a discussion between the treating Doctor and the nursing team must occur before the patient takes that leave to determine risk and safety considerations. This discussion may take place in person or via a phone call and must be documented in the patient's clinical file. If a Doctor has not communicated with the nursing team on this matter, the Doctor is to be contacted by the nursing team before a patient can leave the hospital.*
>
> *All patients granted leave whilst on close observations must be accompanied by a responsible adult. This person must be informed prior to accompanying the patient, that they are accepting full responsibility for the safety and care of the patient, and that they must bring the patient back to the hospital and hand over the patient in person to the nursing team. It is the treating Doctor's responsibility to have this conversation with the responsible adult.*
> *Nursing staff will check that this has occurred prior to the patient and responsible adult leaving the hospital. If it has not occurred, they will contact the Doctor to undertake the discussion, which must take place before the patient can leave the hospital. This conversation and any relevant information, on return from leave, must also be documented in the patient's clinical file.*
>
> *All patients (or the responsible person on the patient's behalf) taking leave must sign out, completing all sections of the leave form including the date, their departure time, destination and expected time of return. They must sign again once back in the hospital, including their time of return.*

[13] The *Specialling and Close Observations Procedure* was reviewed in November 2014. The procedure refers the reader to the *Therapeutic Leave Procedure* for leave entitlements for patients placed on close observations.

Leave is to be recorded in the:-

- *Leave Register*
- *Clinical File*
- *Medication Chart*
- *Whiteboard in Unit Office*

Patients returning from leave are requested to be back at Delmont by 9.00pm. On return from leave, a review must occur as soon as practicable by a member of the Clinical team with the patient and carer/s. This must be documented in the patient's Clinical file.

96. According to Mr Randell, the changes to the procedure merely captured and formalised what was already in practice at Delmont in relation to leave of patients under close observations prior to August 2014 in order to ensure the process was clear and applied consistently by all nursing and medical staff. Mr Randell also stated that the changes were designed to address a range of concerns about leave and issues raised by staff, including the circumstances surrounding Mr Peterson's death. The changes were designed to enhance communication between the psychiatrist, the patient, the responsible accompanying adult, and nursing staff regarding the conditions of therapeutic leave. The changes were also aimed at ensuring that patients on close observations who are granted therapeutic leave by the treating psychiatrist return to the hospital in accordance with the stipulated conditions.

97. Ms Srikanthan agreed that these changes largely reflected the existing practice in relation to therapeutic leave and it was decided to formalise the existing practices in procedure at the time of review.

98. The *Therapeutic Leave Procedure* was amended again in October 2017.[14] Changes included:

(a) allowing for unaccompanied leave, to be determined by the treating Doctor and clinical team;

(b) allocated nurses were required to assess the patient's mental state and conduct a risk assessment immediately prior to commencing leave;

[14] The *Specialling and Close Observations Procedure* was reviewed again in October 2017. The procedure refers the reader to the *Therapeutic Leave Procedure* for leave entitlements for patients placed on close observations.

(c) strategies for safety whilst on leave must be discussed with the patient and carer prior to leave, however, there is no longer a requirement to document this conversation in the patient's clinical file;

(d) patients on close visual observations should not be granted leave, however, the treating doctor may cease close observations and approve leave as long as a responsible adult is present to accept their care/safety and ensure the patient's safe return to the hospital; and

(e) it is no longer stipulated that patients must be reviewed by a member of the clinical team upon their return from leave (and that this review be documented).

99. The *Therapeutic Leave Policy* was reviewed in November 2014 and October 2016. Much of the 2012 policy remained unchanged as a result of these amendments, which were largely insignificant.

Further questions for Delmont:

100. In December 2019, Delmont were invited to respond to further questions in relation to their current *Therapeutic Leave Policy* and *Therapeutic Leave Procedure*. These questions arose from submissions made by Delmont in May 2015 and December 2018.

The questions are set out in full below:

Therapeutic Leave Policy and Procedure:

101. Please advise whether the October 2016 *Therapeutic Leave Policy* and October 2017 *Therapeutic Leave Procedure* are the most up to date policies in force at Delmont. If not, please provide the most relevant policies as a matter of priority.

- How do these policies differentiate between a patient who is on day leave and a patient taking leave for say a half hour accompanied/unaccompanied walk?

- The current policy states *"All leave will be determined in advance by the patient's treating doctor, in consultation with the treating team and the patient's carer/family when appropriate."* Is it the intention that this be interpreted to mean every occasion that a patient leaves the hospital?

- Is it still practice at Delmont that a treating doctor's approval for leave remains in force until it is reviewed or cancelled or there is a change in the person's status? If so, please advise where this can be located in the current policy or procedure.

- How does Delmont say that extant leave approval is addressed by the current policy and procedure?

- The current procedure states *"All leave must be approved and relayed to the clinical team verbally and written in the patient's clinical file by the patient's treating doctor, following a risk assessment."* Is it the intention that this be interpreted to mean every occasion that a patient leaves the hospital?

- What is the nature of the risk assessment that takes place by nursing staff before a patient is granted leave?

- Submissions on behalf of Delmont state *"The close observations practice required that Mr Peterson's partner hand over Mr Peterson to nursing staff on his return to Delmont."* This appeared to be the requirement in the 2014 procedure, however, seems to have been removed from the 2017 procedure. Please outline the current requirements for when a patient returns from leave. Are they required to be handed over to nursing staff by their family/carer?

- What is the current procedure for when a patient does not return from leave?

- Do the current policy and procedure take into account all the unwritten practices that have previously been referred to by Delmont as taking place?

Training and Awareness

- Dr Williamson indicated previously that he was not aware of the therapeutic leave policy and procedures in place at Delmont at the time of Mr Peterson's death. How are the current policy and procedures introduced to new employees, including consultants?

- How are the policy and procedures reinforced to employees, including consultants?

- Is there any training in relation to the policy and procedure? And if so, how frequently?

- When the policy and/or procedure are updated, are employees and consultants made aware? If so, how?

- Where can employees and consultants access the policy and procedure? Is it available on an intranet page, for example?

- Is the location of the policies and procedures told to employees?

Response from Delmont:

102. Delmont responded to each of the questions and described in some detail the current procedures in place dealing with therapeutic leave. The response addressed each of the questions raised. I have summarised the key parts of the current policies:

103. Delmont advised that their most up to date leave policies are the;

January 2020 Therapeutic Leave Policy; and

January 2020 Therapeutic Leave Procedure.

Leave

104. There are two types of therapeutic leave- accompanied leave and unaccompanied leave. These are defined in the 2020 Policy as follows:

> *"Accompanied Leave is leave, taken by an in-patient away from Delmont Private Hospital that is not planned or scheduled by the Hospital. In this instance the patient is to be accompanied by another individual over the age of 18 years"*
>
> *"Unaccompanied leave is leave taken by an in-patient away from Delmont Private Hospital that is not planned or scheduled by the Hospital. In this instance the patient has leave without the need for another individual to accompany them."*

Treating Doctors

105. The role of the patient's treating doctor is:

- Upon admission, the doctor is to assess the patient and determine whether they are suitable for therapeutic leave and identify whether this leave is accompanied or unaccompanied. If

the patient has not deemed suitable for therapeutic leave on admission, the treating doctor must come and review a patient who is requesting leave prior to any leave being taken.

- If the patient has been deemed suitable for accompanied leave, and is now requesting unaccompanied leave, the patient must be assessed by the treating doctor prior to unaccompanied leave being taken.

- If a patient has been assessed as suitable for unaccompanied leave, and their condition changes, the doctor must review and make changes to the patients leave requirements.

- On each occasion that the patient takes accompanied leave, the patient must be assessed by the treating doctor who must complete an accompanied leave form.

Clinical Staff

- Clinical staff are to complete a risk assessment for every patient on **every**[15]occasion that the patient takes leave (where accompanied or unaccompanied). The risk assessment conducted by clinical staff involves taking into account the patient's mental state and level of risk with reference to several risk factors, by deriving information from and interacting with the patient.

- When conducting the risk assessment, clinical staff often ask direct questions regarding the patient's mood and thought processes and refer to the patient's medical history and background information obtained from the patient upon admission and supplied by the patient's referring doctor. Clinical staff may also seek information from third parties, such as the patient's relatives or carers, if appropriate.

- The risk factors to be considered are set out in the *January 2020 Therapeutic Leave Procedure* and include;

    a. the patient's risk of harm to self and others;
    b. likelihood of substance use;
    c. risk of absconding/taking unauthorised leave;
    d. their vulnerability and ability to drive/use public transport.

[15] My emphasis

- Clinical staff are required to document the results of their assessment in the patient's clinical file.

What is the current procedure when a patient does not return from leave?

- The *January 2020 Therapeutic Leave Procedure* requires clinical staff to attempt to contact the patient and their carer via telephone, and if the patient is not responding, notify the patient's treating doctor. Clinical staff must also notify the Hospital Co-ordinator or the Director of Clinical Services who, in conjunction with the patient's treating doctor, must decide whether it is appropriate to notify police with reference to several criteria, namely the patient's goal, the duration of leave, their mental state, the risk assessment undertaken prior to leave and any previous concerns.

Training

- New employees are informed of the existence of Delmont's policies and procedures including its *January 2020 Therapeutic Leave Policy and January 2020 Therapeutic Leave Procedure* during orientation and are instructed that they are expected to review and familiarise themselves with these policies. They are shown where to find them on Delmont's Intranet.
- New employees are also alerted to any recent changes to Delmont's policies and procedures.
- Delmont provides an 'orientation pack' to all consultants upon their commencement. This pack includes instructions on where Delmont's policies and procedures can be located on its Intranet.
- New employees and consultants are also provided with briefings by an experienced member of Delmont's clinical staff regarding the requirements of the *January 2020 Therapeutic Leave Policy and January 2020 Therapeutic Leave Procedure*, including those requirements pertaining to accompanied therapeutic leave, and the completion of Delmont's Accompanied Therapeutic Leave Form.

How are the policy and procedures reinforced to employees, including consultants?

- Both employees and consultants are strongly encouraged to review and familiarise themselves with Delmont's policies and procedures on a regular basis.
- Delmont is currently creating 'reminder' signs, which state that all staff are expected to be aware of and familiarise themselves with Delmont's policies and procedures. It is intended that these signs be displayed on every computer in each of the wards and consulting suites, and on the noticeboard outside the staff room on each of the wards, and so are visible to both clinical staff and consultants.
- In addition, Delmont's current Director of Clinical Services **(DCS)** regularly attends each ward to discuss aspects of Delmont's *Therapeutic Leave Procedure* with clinical staff and, to obtain any feedback or discuss any concerns they may have;
    a. The DCS has attended Medical Advisory Board **(MAB)** meetings, which are held monthly, and presented to Delmont's consultants about their obligations under Delmont's *Therapeutic Leave Policy* and *Procedure*, including any changes to these obligations. A memorandum containing a summary of this information is then circulated by the Chairman of the MAB to Delmont's consultants via email (including those who may have not attended the MAB meeting).
- The existence and location of Delmont's policies and procedures is reinforced in the annual mandatory training it provides to its consultants.
- Delmont is amending its processes so that an email will be forwarded to consultants on the first Monday of each month reminding them that Delmont's policies and procedures are located on the Intranet, and that they are expected to review and familiarise themselves with them. It will also provide consultants with refresher training on the contents of its policies and procedures as part of the annual mandatory training it provides to consultants.
- Delmont is also considering the possibility of creating an on-line training module accessed via a portal on Delmont's Intranet, to be completed by clinical staff and consultants, and which is directed to their respective obligations as set out in Delmont's policies and procedures. The concept is that the completion of this module be confirmed and recorded, either by having the module configured in such a way that it is possible to track who has and has not accessed the portal, and/or by requiring its employees and consultants to sign a

training register confirming they have completed the module (which would be maintained by a member of Delmont's administrative staff).

Information for Patients and Carers

- Delmont has prepared a one-page document to provide to patients and carers setting out their responsibilities regarding accompanied therapeutic leave. The document is to be provided to patients and carers prior to accompanied leave occurring.

Comments:

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

106. Delmont is an open, unlocked and voluntary facility. It is therefore possible for patients to leave the hospital if they wish to do so and to be discharged if they so desire. I accept Dr Williamson's submission that if he formed the opinion that Mr Peterson required involuntary admission pursuant to the *Mental Health Act 1986* (as it was at the time), he would have arranged his transfer to an appropriate psychiatric hospital.

107. Delmont submitted that the granting of leave to patients undergoing voluntary psychiatric care is therapeutic and an important part of the treatment process, especially for long-term patients such as Mr Peterson. I agree. Allowing patients to leave hospital premises with family gives them respite from the hospital setting and assists with maintaining their social skills. However, it is essential that leave is granted in line with applicable policies and procedures. Written policies and procedures help reinforce particular steps that need to be taken, clearly delineates staff responsibilities linked to particular actions, and, in short, ensures everyone is 'on the same page'.

108. It is clear that the August 2012 *Therapeutic Leave Policy* and *Therapeutic Leave Procedure* and even the unwritten practice were not followed when Mr Peterson was allowed to leave Delmont on 1 July 2014. By his own admission, Dr Williamson was not familiar with written policy and procedure at the time of his death. Given he was not familiar with the written documents, it is likely he was also not familiar with the unwritten practice also in place at the time of Mr Peterson's death.

109. I therefore do not accept Delmont's submission that all applicable policies and procedures were followed on 1 July 2014.

110. Delmont admitted that all of the applicable policies and procedures were not in writing. An unwritten practice had apparently evolved to fill in gaps. When practice deviates from policy, it means that the written policies and procedures are outdated or incomplete. It appears that in this case, Delmont's written therapeutic leave policy and procedure were incomplete.

111. It is concerning that until Mr Peterson's death, Delmont did not consider it necessary to formalise existing unwritten practice. Delmont's submission that amendments to the *Therapeutic Leave Procedure* largely reflected what was in practice suggests there was recognition that the practice was not always in place or followed.

112. For the reasons I have outlined above, I find that the written policy and procedure nor the unwritten practice were followed. I cannot be satisfied that it was part of Delmont's policy that, once granted, a leave entitlement would continue until it was revoked by the treating doctor. That is not the meaning derived from the language used in the written policies. Despite Delmont's submission, it clearly was not an unwritten practice as there would have been no need for staff to seek permission for Mr Peterson to attend the gym on 1 July 2014. This interpretation is supported by the August 2014 amendment to the *Therapeutic Leave Procedure,* which required the treating doctor and the nursing team to discuss risk and safety considerations *"... before the patient takes **that** leave ..."* [my emphasis]. If that discussion does not occur, the nursing team must contact the treating doctor before the patient can leave the hospital. The language of the amendment refers to leave as a singular period of leave.

113. Putting the fact that Delmont staff did not follow their own policy and procedure to one side, I turn to whether Mr Peterson should have been allowed to leave hospital on the evening of 1 July 2014.

114. After an unsuccessful attempt at day leave, Dr Williamson organised for brief periods of supervised leave when Mr Peterson seemed to be in a *"less distressed state."* Dr Williamson referred to the discussion with Mr Peterson and his family during the weekend before his death. At that time, he explained Mr Peterson's serious risk of suicide and the likelihood of it worsening if he was not adequately treated.

115. In their submission that the grant of leave of 30 June 2014 continued to remain in force until reviewed or cancelled or there was a change in the patient's status, Delmont submitted:

> *In this regard, the medical and nursing staff at the hospital work together to ensure that patients who are granted an approved level of leave are assessed by nursing staff before each specific period of leave to ensure that the patient's condition is stable and it is appropriate for that patient to take leave. If the nursing staff assess a change in a patient's status, leave is discouraged, and a note is made in the clinical record for the treating doctor to review the patient's leave status.*

116. Delmont submitted that there was no record in Mr Peterson's clinical file of suicidal ideation or acute risk and that on 1 July 2014, his condition had not deteriorated since the previous day. Although there is no evidence that he was suffering from suicidal ideation and he denied overt risk, I do not agree that Mr Peterson's condition had not deteriorated since the preceding day.

117. The progress notes of 30 June 2014 record Mr Peterson as less agitated and more settled in behaviour. His settled mood continued into the next afternoon. However, his mood dramatically changed at 7.45pm on 1 July 2014 after Ms Begelhole arrived. At this time, the progress notes record Mr Peterson as:

> *... agitated, wringing his hands, rocking back and forth. Very poor self-soothing, dismissive of mindfulness techniques. Wife very concerned ... No S/I* [suicidal ideation] *reported and he denied any overt risk. Settled in lounge ATOR.*

118. If his mood had remained settled as it had the previous day and on the morning of 1 July 2014, leave would have remained appropriate. However, Mr Peterson's mood deteriorated, and Ms Begelhole became concerned. I note that at this time Mr Peterson expressed suicidal thoughts to his partner, however, Ms Begelhole did not believe he was suicidal but appeared more worried and upset about his anxious state and tremors. I am not satisfied that Mr Peterson exhibited or expressed suicidal ideation to anyone other than Ms Begelhole at this time. However, his mental state had clearly deteriorated to a point where he was clearly agitated and could not self-soothe. This was on the background of ceasing diazepam in preparation for ECT the next day. It is unclear as to what *"settled in lounge"* refers to.

119. On review of the progress note of 7.45pm, it appears that Mr Peterson's mental state is not stable and that it was not appropriate for him to exercise leave at this time. I am satisfied that the contact nurse, upon observing Mr Peterson's deterioration, should have taken action to discourage Mr Peterson from exercising leave in line with Delmont's submission above. It may have also been appropriate to contact Dr Williamson. I acknowledge that Ms Begelhole stated that a nurse suggested they go for a walk at this time. However, Nurse Johnston could not recall suggesting they go for a walk. I do not make any finding as to whether it was a nurse who suggested Mr Peterson go for a walk.

120. I also acknowledge the discrepancy in the evidence as to what information Ms Begelhole received when accompanying Mr Peterson on leave. Dr Williamson stated that he told Ms Begelhole that Mr Peterson needed to be carefully supervised. Delmont submitted that Dr Williamson had several discussions with Ms Begelhole and other family members about Delmont's requirements of a 'responsible adult'. Ms Begelhole stated that she was never told to return Mr Peterson directly back to the ward and could not recall discussing safety strategies.

121. Delmont submitted that Ms Begelhole was a 'responsible adult' for the purpose of the applicable written therapeutic leave procedure and the unwritten close observations practice. The unwritten close observations practice apparently required that the responsible adult hand over the patient to nursing staff upon their return to the hospital.

122. A review of the *Therapeutic Leave Procedure, Therapeutic Leave Policy* and the *Specialling and Close Observations Procedure* in effect at the time of Mr Peterson's death does not identify the term 'responsible adult.' That term is not defined and none of those documents refer to the responsibilities of a 'responsible adult' or 'carer,' which is a term that is used in those documents. Those documents merely state that a patient must return to the hospital by no later than 9.00pm. There is no written requirement that the patient be handed back to nursing staff. I accept that this information *may* have been part of the unwritten practice, which was subsequently captured by the August 2014 amendment to the *Therapeutic Leave Procedure.*

123. To apply an undocumented and inaccessible practice or procedure to a patient and their family members strikes me as patently unfair. It is also unfair to allow a family member to

take responsibility for a patient without them fully knowing and appreciating the requirements and procedures.

124. I am unable to determine how staff, patients, and carers became aware of these requirements. The inherent problem with applying undocumented practices is that you never know whether they are applied or, if applied, whether they are applied in a standard manner. How does a new staff member know to tell a carer to bring a patient back directly to nursing staff? How do other staff members know that these requirements have been previously explained to the carer? Mr Randell appears to have acknowledged this problem when he stated that leave procedures were amended in 2014 to capture the unwritten practice to ensure processes were clear and applied consistently by all medical and nursing staff.

125. Although Ms Begelhole may have been told that Mr Peterson needed to be closely supervised and/or not be left alone, I am not satisfied that Ms Begelhole was told she was required to hand Mr Peterson back to nursing staff upon returning from leave. She stated that she was never told to return him to the ward door and sign him back in and she was never provided any documentation about leave or leave procedures. Ms Begelhole stated that when she visited Mr Peterson, she sometimes left him at the door, or he would walk her back to her car in the carpark. This appears to have occurred on more than one occasion, but Ms Begelhole did not report being reprimanded by staff for not adhering to procedures. It therefore appears that not only did Delmont staff not follow their written and unwritten leave practices, but they also did not reinforce them when Ms Begelhole to not adhere to them.

126. The *January 2020 Therapeutic Leave Policy and January 2020 Therapeutic Leave Procedure* adopted by Delmont are a more comprehensive and complete approach to leave arrangements for patients. They address many of the shortcomings and inadequacies of the earlier versions of these policies. The documents are an improvement on earlier versions and removes reliance on unwritten procedure and practice.

127. However, in order to be effective, compliance will need to be managed and enforced. Comprehensive induction and training for new staff and consultants should be implemented by management at Delmont. Continuing training and information for existing staff and consultants will also be required to ensure that all staff and consultants are familiar with the

policies and procedure for Therapeutic Leave. Delmont in their written submissions have acknowledged this.

Findings:

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

(a) the identity of the deceased was Paul Peterson, born 4 May 1960;

(b) that Mr Peterson died between 1 and 2 July 2014 at Burwood Reserve, 282 Warrigal Road, Glen Iris, 3146 Victoria, from neck compression;

(c) that Mr Peterson intentionally took his own life; and

(d) the death occurred in the circumstances described above.

Recommendations:

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

I recommend that Delmont Private Hospital:

(a) Conduct a comprehensive review of the operation of and compliance with the *January 2020 Therapeutic Leave Policy* and *Therapeutic Leave Procedure*. The review should be conducted by and independent person and be completed no later than September 2021.

(b) Consider developing an e-learning or online training module for staff and consultants directed at obligations and compliance with the *Therapeutic Leave Policy* and *Procedure*.

Publication:

Given that I have made recommendations, I direct that this finding be published on the internet pursuant to section 73(1A) of the *Coroners Act 2008*.

I convey my sincere condolences to Mr Peterson's family.

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

Mrs Robyn Begelhole, Senior Next of Kin (copy to Kevin Davine & Sons)

Dr Barry Williamson (c/- Avant Law Pty Ltd)

Delmont Private Hospital (c/- Norton Rose Fulbright)

The Australian Health Practitioner Regulation Agency

Constable Amelia Hanvey, Coroner's Investigator, Victoria Police

Signature:

JUDGE JOHN CAIN
STATE CORONER
Date: 17 March 2020