IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2013 0273

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)
Section 67 of the ***Coroners Act 2008***

Inquest into the Death of: CHRIS PRAVIN PRASAD

Finding Of:	AUDREY JAMIESON, CORONER
Hearing Date:	19 April 2016
Counsel Assisting:	Leading Senior Constable Andrea Hibbins
Appearances:	Ms Alexandra Galanti, TressCox Lawyers on behalf of Monash Health
Delivered On:	20 April 2016
Delivered At:	Coroners Court of Victoria 65 Kavanagh Street, Southbank Melbourne VIC 3006

I, AUDREY JAMIESON, Coroner having investigated the death of **CHRIS PRAVIN PRASAD**

AND having held an inquest in relation to this death on 19 April 2016

at MELBOURNE

find that the identity of the deceased was **CHRIS PRAVIN PRASAD**

born on 15 December 1961

and the death occurred on 17 January 2013

at Clyde Road, Berwick VIC 3806

from:

1 (A) UNDETERMINED

in the following circumstances:

1. On 19 April 2016, a mandatory inquest under section 52(2)(b) of the *Coroners Act 2008* (Vic) ('the Act') was held into the death of Mr Chris Pravin Prasad, because immediately before his death, Mr Prasad was 'a person placed in....care' as it is defined in the Act. Mr Prasad was on day leave and had been an involuntary patient at Casey Hospital, part of Monash Health, since 1 January 2013, and was hence a patient detained in a designated mental health service within the meaning of the *Mental Health Act 2014* (Vic).[1]

BACKGROUND AND CIRCUMSTANCES

2. Mr Chris Pravin Prasad was 51 years of age at the time of his death. In recent years, he had primarily lived in Lynbrook with his wife and two daughters. Mr Prasad was born in Fiji, but had moved to Australia in 1988. His medical history included diagnoses of schizoaffective disorder, depression, hypertension, arthritis and diabetes mellitus type 2.

3. Mr Prasad had previously worked as a store manager for a computer company, but had suffered from depression in 2010, following reports of harassment. He was subsequently admitted to a psychiatric ward for treatment in October 2010 and July 2011. In 2012, Mr Prasad had a number of admissions to the psychiatric facilities, Dandenong Psychiatric Hospital and Springvale Prevention and Recovery Care (**PARC**). He was admitted for treatment in March 2012, following an attempt to take his own life. Mr Prasad had initial

[1] I note that at the time of Mr Prasad's death, the *Mental Health Act 1986* (Vic) applied. The *Mental Health Act 2014* (Vic) came into effect on 1 July 2014.

contact with the Casey Continuing Care Team (**CCT**) on 26 April 2012, and was treated by them throughout 2012 with case management and regular depot injections. In October 2012, Mr Prasad self-presented to the Dandenong Hospital Emergency Department (ED) with command hallucinations to take his own life. He was admitted for treatment and assessment. Following his discharge from hospital, Mr Prasad was reviewed by the Casey CCT on a number of occasions in December 2012.

4. On 1 January 2013, Mr Prasad was admitted to Ward E, an acute psychiatric inpatient unit at Casey Hospital. His Community Treatment Order (**CTO**) had been revoked, following assessment by a consultant psychiatrist and psychiatric registrar on 31 December 2012, in the context of presenting with delusions, suicidal ideation and auditory hallucinations. Mr Prasad presented with elevated corrected QT interval (**QTc**)[2] of 497ms,[3] and had been prescribed paliperidone 100mg four weekly and quetiapine 400mg daily. It had thus been decided that Mr Prasad would be admitted to hospital for close monitoring while his antipsychotic medication was changed.

5. While hospitalised, Mr Prasad was given daily electrocardiograms (**ECGs**) and blood tests on a regular basis. Consultant Psychiatrist Dr Melvin Pinto outlined that while Mr Prasad had been at Casey Hospital, all investigations had been within normal limits, except for mildly elevated erythrocyte sedimentation rate (**ESR**)[4] and C-reactive protein (**CRP**)[5], liver function tests with mildly elevated alkaline phosphatase (**ALP**)[6] and gamma-glutamyl transferase (**GGT**)[7], significant hyperglycaemia, elevated triglycerides and low vitamin D levels. All the ECG reports of QTc were persistently below 460.

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[2] Long QT interval is a condition in which there is an abnormality of the heart's electrical system that may cause an abnormal arrhythmia. Long QT refers to the changes in the pattern of an electrocardiogram. An ECG pattern from someone with long QT syndrome will have a longer than usual interval between the two points Q and T. A long QT interval results in a longer time for the heart muscle fibres to return to their normal electrical resting state between heart beats than in a normal heart. It is either congenital (genetic) or acquired through pharmaceuticals, cardiac pathology, electrolyte imbalance, heart disease, severe bradycardia and thyroid dysfunction.

[3] Dr Melvin Pinto reported that up to 450ms in males is considered to be the upper limit of normal, but a prolonged QTc interval is not considered unsafe until it is greater than 500ms.

[4] An erythrocyte sedimentation rate (ESR) test is used to help determine if a patient is experiencing inflammation; it does not diagnose a specific condition.

[5] C-reactive protein (CRP) is a marker of inflammation in the body. Its level in the blood increases in the presence of inflammation.

[6] Elevated alkaline phosphatase (ALP) levels can occur, inter alia, where bile ducts are obstructed.

[7] The gamma-glutamyl transferase (GGT) can be used to help detect liver disease and bile duct obstructions. It is often used in conjunction with alkaline phosphatase liver testing.

6. On 10 January 2013, Mr Prasad was assessed as fit to go on day leave. Mr Prasad's wife stated that she was not informed by the hospital, and was surprised when Mr Prasad turned up at her door, having travelled by taxi with a taxi pass provided by the hospital. Dr Pinto reported that following his assessment of Mr Prasad on this day, further day and overnight leave was approved over subsequent days, following risk assessment by his contact nurse on each occasion. Mr Prasad was also granted day leave on 13 and 15 January 2013.

7. Dr Pinto stated that as Mr Prasad had previously developed elevated QTc with paliperidone, an alternative depot antipsychotic, zuclopenthixol was gradually administered. Following daily administration of oral zuclopenthixol with daily ECG monitoring, and a test dose of Acuphase 50mg IM,[8] no adverse effects or QTc prolongation was found. Mr Prasad was then administered the long acting depot Zuclopenthixol decanoate 200mg IM on 16 January 2013.

8. On 17 January 2013, prior to Mr Prasad's leave, his QTc interval on ECG was 457ms, which Dr Pinto described as an acceptable level. Dr Pinto had planned to discharge Mr Prasad on 18 January 2013, on a CTO, for follow up with his case manager and the Casey CCT.

9. At approximately 4.00pm on 17 January 2013, Mr Prasad was again granted day leave by his contact nurse, on the proviso that he return to Casey Hospital at 7.00pm. Mr Prasad's wife was again not notified by the hospital. The temperature on this day reached a high of approximately 38°C.

10. Shortly after 7.00pm on 17 January 2013, a passer-by located Mr Prasad lying on his back on a grassed area on the side of Clyde Road, approximately 2.3km from Casey Hospital. After asking if Mr Prasad needed assistance, the passer-by noted that he did not appear able to speak, and was frothing at the mouth. Emergency services were called and ambulance paramedics attended, followed by a Mobile Intensive Care Ambulance, which arrived at 7.33pm. Mr Prasad's temperature was recorded as high. At 7.52pm, he went into cardiac arrest, and he was unable to be resuscitated. Mr Prasad was declared deceased at 8.30pm. Police arrived at 8.50pm and observed that Mr Prasad had a small lump on the back of his head, consistent with a fall.

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[8] Acuphase (or zuclopenthixol acetate) is for the initial treatment of acute psychoses, including mania and exacerbation of chronic psychoses, particularly where a rapid onset of action, and a duration of effect of two to three days is desirable.

11. At approximately 9.15pm on 17 January 2013, staff at Ward E had been about to inform police of Mr Prasad's absence without leave, when a police officer attended the ward and advised them of his death.

12. Mr Prasad's death was a reportable death under the Act. An extensive investigation into his death has been conducted.

FORENSIC PATHOLOGIST EXAMINATION AND EVIDENCE

13. Dr Linda Iles, Forensic Pathologist at the Victorian Institute of Forensic Medicine, performed a full post mortem examination on the body of Mr Prasad, reviewed Casey Hospital medical records and referred to the Victoria Police Report of Death, Form 83. The external examination showed Mr Prasad to have a Body Mass Index[9] of 30.8. At autopsy, Dr Iles found moderate to severe macrovesicular liver steatosis, moderate double vessel coronary artery atherosclerosis, asymmetrical calvarium and mild renal hyaline arteriosclerosis. However, Dr Iles opined that the post mortem examination did not demonstrate a clear cause of Mr Prasad's death.

14. Toxicological analysis of post mortem blood identified a number of substances, including venlafaxine,[10] risperidone, hydroxyrisperidone,[11] zuclopenthixol[12] and quetiapine.[13] Dr Iles reported that Ambulance Victoria records showed Mr Prasad's blood sugar level taken by attending ambulance paramedics on 17 January 2013, was 15.1mmol/L. Post mortem toxicological analysis of vitreous humour showed glucose at a level of 5.1mmol/L, but the report suggested no diagnostic value could be attributed to this finding, as concentrations may either increase or decrease after death.

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[9] Body Mass Index (BMI) is one of the anthropometric measures of body mass; it has the highest correlation with skinfold thickness or body density. BMI is determined by an individual's weight in kilograms, divided by their height in metres. It is designed for men and women over the age of 18. A healthy BMI is generally considered to be between 20 and 25. A result below 20 indicates that an individual may be underweight. A figure above 25 indicates that an individual may be overweight. If an individual has a BMI above 40, they are assessed as morbidly obese. Morbid obesity carries associated health risks, and is medically defined as an excess of body fat that threatens necessary body functions such as respiration.

[10] Venlafaxine is indicated for the treatment of depression.

[11] Risperidone is an atypical antipsychotic prescribed for schizophrenia and some behavioural disorders. While Mr Prasad was not known to be taking risperidone or its metabolite hydroxyrisperidone as an in-patient, Dr Iles noted from his GP medical record, that he had been previously prescribed paloperidone as an intramuscular injection, which can be given on a four weekly basis. Dr Iles opined that it was possible that the hydroxyrisperidone detected in Mr Prasad's blood was due to persistent effects of intramuscularly administered medication.

[12] Zuclopenthixol is an antipsychotic which can be used for the initial treatment of acute psychotic episodes or exacerbation of psychosis associated with schizophrenia.

[13] Quetiapine is an antipsychotic drug used in the treatment of schizophrenia.

15. While there were no physical findings that pointed to a cause of Mr Prasad's death, Dr Iles opined that some of the surrounding circumstances raised the possibility of neuroleptic malignant syndrome. This is a life threatening condition, characterised by mental state changes, rigidity, fever and dysautonomia in a setting of the use of antipsychotic medications. Both quetiapine and risperidone have been commonly associated with this syndrome, and case reports have also implicated zuclopenthixol. However, Dr Iles noted that consideration of neuroleptic malignant syndrome in Mr Prasad's case was based on circumstances alone, as there were no physical findings either to refute or confirm it as a possible cause of his death.

16. Dr Iles further noted that as Mr Prasad was recognised to have a prolonged QT interval, which can be exacerbated by anti-psychotic medications, he had been monitored as an in-patient with daily ECGs. Given Mr Prasad also had moderate double vessel coronary artery atherosclerosis, Dr Iles suggested it was possible that in a setting of acute onset neuroleptic malignant syndrome, he had a more rapid demise, given his underlying cardiac comorbidities.

17. Dr Iles reported to the Coroner that the cause of Mr Prasad's death was undetermined.

POLICE INVESTIGATION

18. The circumstances of Mr Prasad's death have been the subject of investigation by Victoria Police on my behalf. The police investigation did not identify evidence of third party involvement.

19. Police obtained statements from Mr Prasad's wife, Consultant Psychiatrist at Casey Hospital Dr Melvin Pinto, witness Justin Carroll, Ambulance Paramedic Adam Findley, Registered Psychiatric Nurse Haylee Brown, Registered Psychiatric Nurse and Case Manager Martin Munyimani, Registered Nurses Jerry and Prince Thomas, Associate Nurse Unit Manager (ANUM) Desmond Maruziva, Psychiatric Enrolled Nurse Beryl Palavikas, Enrolled Nurse Leanne Lasker, Psychiatric House Medical Officer (HMO) Dr Luiza Fernandez, General Practitioner Dr Deepa Nappally, Current Nurse Unit Manager of Ward E at Casey Hospital Kerrie La Roche and Head of Workplace Health, Safety and Risk at Monash Health Kim Flanagan.

FAMILY CONCERNS

20. I received letters from Mr Prasad's wife on 13 February 2013, 28 May 2013, 11 July 2013 and 26 November 2013, which outlined three main concerns, that:

a. Mr Prasad was a medicated, involuntary psychiatric inpatient at Casey Hospital and was allowed to go on day leave in 38°C heat.

b. Mr Prasad's wife was under the impression that Mr Prasad would be in hospital for two days, but had stayed for 17 days.

c. The Ambulance Paramedics made errors in treating Mr Prasad, and they had treated him at the scene, when the hospital was just five minutes away.

CORONER'S PREVENTION UNIT INVESTIGATION

21. In response to a number of concerns raised by the investigation, I asked the Coroner's Prevention Unit (CPU)[14] to investigate the circumstances of Mr Prasad's death on my behalf.

22. In relation to concerns raised by Mr Prasad's wife in regards to the treatment provided by Ambulance Victoria, the investigation did not identify any issues with the actions of the Ambulance Paramedics. In regards to the length of Mr Prasad's planned admission, it was identified that the slow and safe commencement of a new antipsychotic and close monitoring required in the context of his previous QT interval lengthening, would appropriately require his admission to be much longer than the two days understood by Mr Prasad's wife.

23. It was noted that Monash Health records show Mr Prasad had comprehensive physical and psychiatric assessments throughout his admission. The focus of his care was on changing over and starting a new antipsychotic safely, with frequent ECGs to monitor Mr Prasad's QTc interval in the context of a previous history of a long interval. This was completed with rigour. However, it was identified that there appeared to have been less focus on Mr Prasad's diabetes, or recognition of the combination of risk factors that might have suggested leave for Mr Prasad on 17 January 2013 be restricted, or other options such as a cab charge be utilised to enable his leave.

24. While the cause of Mr Prasad's death has not been determined, the investigation identified it is reasonable to assume any single component or combination of high blood sugar level,

[14] The Coroners Prevention Unit (CPU) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations, as well as assisting in monitoring and evaluating the effectiveness of the recommendations. The CPU comprises a team with training in medicine, nursing, law, public health and the social sciences.

being overweight, hypertension and high dose antipsychotics (quetiapine and zuclopenthixol) were contributing factors in his death, in combination with outside temperatures above the Department of Health's heat health temperatures threshold.

Diabetes

25. The investigation involved the review of Mr Prasad's digital medical records and identified that he had suffered from diabetes type 2, insulin dependent type. Mr Prasad was prescribed a twice daily injection of Novamix (biphasic combined long-acting and ultra-short acting insulin) and also took a daily oral hypoglycaemic metformin. Mr Prasad was also ordered a titrated pro re nata (prn)[15] dose of Actrapid (short-acting insulin) linked to his blood sugar (or glucose) levels (**BSL**). This appeared to have been ordered in response to a request by Mr Prasad on 6 January 2013 to "have a sliding scale of Novarapid in his med chart as he usually has it if BSL is > 10."

26. The medication chart in the digital medical records had nothing to suggest the following orders were ceased. The titration was as follows:

    a. Actrapid 2 units (glucose 10-12mmol)

    b. Actrapid 4 units (glucose 12-14mmol)

    c. Actrapid 6 units (glucose 14-16mmol).

27. The investigation showed that Mr Prasad had quite high blood sugar levels, compounded by the effects of antipsychotics, including zuclopenthixol, that can increase blood sugar levels. The last prn dose was given on 14 January 2013, when his blood sugar level was 14.4mmol.

28. After 14 January 2013, Mr Prasad's blood sugar levels were measured above 10.0mmol on three occasions:

    a. 16 January 2013, at 6.00pm pre-dinner, 13.1mmol, no titrated dose given

    b. 17 January 2013, at 8.50am pre-breakfast, 16.2mmol, no titrated dose given

    c. 17 January 2013, at 11.50am pre-lunch, 14.2mmol, no titrated dose given

29. The investigation noted that Psychiatric Enrolled Nurse Palavikas stated that on 17 January 2013, "I checked his BSL before his morning dose of insulin and subsequent breakfast and again before lunch. His morning blood sugar level was 16.3mmol/L, which although

[15] Pro re nata is a latin phrase meaning *in the circumstances* or *as the circumstance arises*. It is commonly used in medicine to mean 'as necessary'.

elevated, was within normal limits for him. His BSL when tested again before lunch was 14.2mmol/L."

30. In her statement dated 10 December 2015, Nurse Unit Manager of Ward E, Nurse La Roche (who was not employed in her position at the time of Mr Prasad's death), provided information confirming that enrolled nurses were not endorsed to administer medication at the time of Mr Prasad's death. In 2013, management and administration of medication was delegated to a registered nurse each shift. According to Nurse La Roche, an enrolled nurse's scope of practice in relation to medication was to monitor, assess and report the effects of medication administered by the registered medication nurse.

31. Nurse La Roche stated that regardless of the pre-lunch blood sugar reading of 14.2 mmol at midday on 17 January 2013, Mr Prasad would not have received a sliding scale dose because the sliding scale doses were given in conjunction with his routine twice-daily insulin doses.

32. Nurse La Roche noted that Mr Prasad did not have a diabetes management plan, the sliding scale of insulin was not reviewed daily, and the discharge plan did not include review of his insulin and diabetes management. The investigation showed there was also a lack of documentation of the blood glucose results having been reported to the dedicated medications nurse or any rationale for not following the sliding scale. In her statement, Nurse La Roche also identified deficiencies in the clinical handover of medication information to nursing staff across shifts, and that the sliding scale of insulin appeared inadequate in its content and format on the medication ordering form.

33. In his statement dated 10 December 2015, Consultant Psychiatrist Dr Pinto said that Mr Prasad was not reviewed by the medical team specific to his diabetes, because he had been reviewed in the outpatients' Monash Health Diabetes Chronic Disease Management Clinic on 20 December 2012, ten days prior to his admission to Ward E.

Social situation and family contact

34. Mr Prasad's wife stated that Mr Prasad was living at home with her and their two children at the time of his death. However, there is evidence that Mr Prasad had at times been living with other friends and people during his contact with Monash Health. In his initial assessment, after admission by the psychiatric registrar, it was noted Mr Prasad lived in shared accommodation with a "couple." When specifically asked about Dr Pinto's belief that Mr Prasad was divorced, Mr Prasad's wife told First Constable Scott Williams that she

was living with Mr Prasad at the time of his death and did not know why Dr Pinto thought otherwise. Evidence suggested Mr Prasad told Dr Pinto he did not have any children.

35. It was identified that the Casey CCT did have some record of contacting Mr Prasad's wife and Mr Prasad's brother Suresh Prasad, who was listed as the primary next of kin. It is not clear what information was in the statewide CMI database regarding address and next of kin information. There was no record of any family contact throughout the January 2013 admission. There was little family communication in the notes provided across any admission or community case management.

Department of Health heat health alerts

36. According to the Department of Health,[16] "in Victoria, a heatwave is generally defined as a period of unusual and uncomfortably hot weather that could impact on human health, community infrastructure and services."[17]

37. The Department of Health has an 'extreme heat and heatwaves' webpage[18] that is part of the 'Climate and Weather site', which provides information to the public and services about bushfires, dust storms, floods, heatwaves and wind farms. It was identified that Mr Prasad had a number of known risk factors in heatwave conditions, including a mental illness, taking an ACE inhibitor[19] and antipsychotics, and that he was overweight with a Body Mass Index of 30.8.

38. The Australian Government Bureau of Meteorology 'Annual Climate Statement 2013' stated that "an extended national heatwave began over the southwest of the continent late in December 2012, before moving into southern and eastern Australia. The heat was notable for its extent and duration, and was easily the longest continent-wide heatwave on record. Temperatures more than 10°C above average were recorded across extensive areas of Australia until 18 January 2013. A national daily average maximum temperature record was set on 7 January 2013."

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[16] I note that the Department of Health is now known as the Department of Health and Human Services. For consistency of reference, I have used the former term in this Finding.

[17] See: <https://www2.health.vic.gov.au/public-health/environmental-health/climate-weather-and-public-health/heatwaves-and-extreme-heat>

[18] See: <http://www.health.vic.gov.au/environment/heatwaves.htm>

[19] An ACE or angiotensin-converting-enzyme inhibitor is a pharmaceutical drug used primarily for the treatment of hypertension and congestive heart failure.

39. The investigation found that the minimum temperature threshold that is likely to impact on the health of a community, is known as the heat health temperature threshold, and these differ for different parts of the state. Once forecast average temperatures are predicted to reach or exceed the heat health temperature threshold for a specific weather forecast district, the Department of Health will issue a heat health alert for that district. The alert notifies hospitals, among other service providers. The heat health temperature for Central Districts (including the City of Casey and the suburb of Berwick) is 30°C, and the Department of Health issued a Heat Health Alert on 17 January 2013.[20]

40. In his statement signed 17 December 2015, Head of Workplace Health, Safety and Risk at Monash Health Mr Flanagan stated that Monash Health could not establish if they had received this Department of Health heat alert, because records of emails from 2013 have not been stored. Accordingly, Mr Flanagan provided the expected sequence of events should the Department of Health now issue a heat alert.

41. The process outlined by Mr Flanagan relies on the Chief Nursing Officer's Executive Assistant forwarding the alert via email to the site and program Directors of Nursing, including the Director of Nursing for Mental Health. It is assumed by Mr Flanagan that the Directors of Nursing will send the email to the operational staff, however the investigation identified no evidence that this system is reliable in getting the information to the clinical staff who are making decisions about consumer leave. For example, if the Nurse Unit Manager in Casey Unit is on leave, the email is likely to remain in the email box until his or her return, which may coincide with the Health Alert no longer applying. The information is not distributed as a memo or for information, but as a formal alert by the Department of Health and Human Services. Mr Flanagan could not state for sure that any of the information from the heat alert is communicated to patients and/or their carers or families.

Assessment of risk and implementation of policy documents

42. On the morning of 17 January 2013, Dr Fernandez stated that she assessed Mr Prasad's mental state had improved, he did not have any psychotic symptoms, and he reported he felt well to go home. Dr Fernandez said that Mr Prasad was suitable to go on day leave given his current mental state, and he was suitable to go home the next day as his mental state had improved with the commencement of medications.

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[20]<Department of Health. <http://www.health.vic.gov.au/chiefhealthofficer/alerts/alert-2013-0114-heathealth.htm>

43. Enrolled Nurse Palavikas was Mr Prasad's allocated contact nurse on the morning of 17 January 2013. She reported that Mr Prasad presented as settled and pleasant, and engaged easily upon approach at various times throughout her shift. Enrolled Nurse Palavikas conducted a routine risk assessment at 9.00am and assessed his overall risk to self and/or others as low.

44. Enrolled Nurse Lasker reported that on the afternoon of 17 January 2013, Mr Prasad was one of her allocated patients, and she had not nursed him previously on a day shift. Mr Prasad had asked for day leave and his bank card from the safe. Enrolled Nurse Lasker said that upon reading Mr Prasad's notes and risk management documents, she noted that his Leave of Absence for Involuntary Patients form MHA 21 had expired the day before. Mr Prasad had nil risks listed and she also noted that Mr Prasad had an ECG that morning and had been medically cleared.

45. Enrolled Nurse Lasker reported that she told Mr Prasad he needed a new MHA 21 form. She said that Mr Prasad then insisted that he had leave and said he was probably being discharged the next day and would like to get off the ward, and would wait at the nurses' station until he got his bank card and leave approved. Dr Pinto then walked into the office, and Enrolled Nurse Lasker asked for a new leave form to be completed. Dr Pinto signed the new MHA 21 form for Mr Prasad. Dr Pinto said that he had considered Mr Prasad to be fit for discharge on 17 January 2013. Enrolled Nurse Lasker subsequently retrieved his bank card from the safe.

46. Monash Health provided two policies to the Court that would have applied to Mr Prasad's leave on 17 January 2013, as well as four heatwave related Department of Health documents available on the Monash Health intranet. The first policy, 'Safe, Effective Patient Centred Care Background' (03/12/2010), was a contemporaneous organisational wide policy that included the care framework – patient centred care. It was a high level policy linked to organisational values. It was not specific to risk assessment or heatwaves but included principles that staff were expected to comply with, including treating people with respect and dignity, and involving patients, families and carers in decisions about care. The second policy, 'Mental Health – Leave from Inpatient Units Procedure' (08/12/2011) is a contemporaneous procedure that has at its focus the assessment of risk, especially suicidality and mental state examination, and does not include specific prompts for physical or environmental health issues. It was identified that the Inpatient Risk Assessment Continuation completed on 17 January 2013, by Enrolled Nurse Lasker, prior to Mr Prasad's

leave, rates other risks, including vulnerabilities as "low". This was the only prompt where environmental or physical health issues should be considered in the risk assessment.

47. It was noted that while the inclusion of Department of Health heatwave-related documents on the Monash Health intranet was appropriate, it relied on the motivation of staff to look at it, and their knowledge of a need to look at it. There was no evidence of awareness raising or education regarding the risk factors of heat on patients, specifically mental health, which often involves the prescription of medications that decrease thirst, increase body heat production and have risk implications regarding individual client insight and judgment.

48. Enrolled Nurse Lasker reported that she assessed Mr Prasad's mental state by asking relevant questions to him. Mr Prasad informed her that he had nil thoughts or intent to harm himself or anyone else. He stated that his mood was fine and denied any perceptual disturbances. Mr Prasad was dismissive and his affect restricted. He was very focused on day leave and it was Enrolled Nurse Lasker's impression that he did not want to talk to her. She asked the nurses if this was Mr Prasad's normal presentation and they informed her that he was normally dismissive and not very communicative. Enrolled Nurse Lasker added that she had asked her co-workers because she had not nursed Mr Prasad on a day shift previously and wanted to confirm his presentation.

49. Enrolled Nurse Lasker noted that Mr Prasad had no more medications scheduled until 6.00pm. She asked Mr Prasad to return to the hospital at 6.00pm for his medications and dinner, but he stated that he wanted to return at 8.00pm. Enrolled Nurse Lasker asked Mr Prasad to return by 7.00pm at the latest and he agreed, stating he might return earlier anyhow.

50. It was identified that according to her statement, Enrolled Nurse Lasker complied with the 'Mental Health – Leave from Inpatient Units Procedure' and the leave requirements under the *Mental Health Act 1986* (Vic). However, the progress notes detailing her actions and interactions with Mr Prasad for her shift are scant and contain no information to suggest that she recognised the significance of the heat or Mr Prasad's high blood sugar levels as areas of risk.

51. I note however, according to Enrolled Nurse Lasker's statement, she did discuss the hot weather with Mr Prasad at 4.15pm, before he left the ward. Enrolled Nurse Lasker reported that she mentioned to Mr Prasad that it was a hot day, and that he stated he planned to walk to Berwick and get a taxi back to the hospital, if needed and also get a taxi if he wanted to

go further. Dr Pinto noted that there was no formal policy of restricting leave in extreme weather conditions, and there were no specific rules imposed on Mr Prasad regarding his leave.

52. The investigation indicated that in relation to risk assessments, there is an assumption by Monash Health that the effects of heat are understood by the direct care clinicians who will be providing care. Mr Flanagan stated that 'the physiological effects of heat and its associated risks are addressed during the undergraduate education for health professionals. There is no specific organisational training on this issue'. In addition, the investigation suggested Monash Health assumed a level of knowledge in clinical staff that is unlikely to be reliable, including the implications of a heat alert on a person taking psychoactive anti-cholinergic medications.

53. Mr Flanagan did state that the discharge procedures in mental health have now been updated to include the assessment of environmental factors prior to a discharge. Consideration of weather conditions has been incorporated into three discharge procedures:

    a. Transfer and discharge in Mental Health. Procedure.

    b. Assessment, Care Planning and Discharge. Background document.

    c. Assessment, Care Planning and Discharge. Procedure.

54. It was also noted that including environmental conditions as a category in the clinical risk assessment procedures is under consideration.

DIRECTIONS HEARING ON 29 JANUARY 2016

55. A Directions Hearing was held on 29 January 2016, in order to progress the investigation and gain more information in relation to the diabetes management of Mr Prasad, heat risk assessment at Casey Hospital, and distribution of heatwave alerts on 17 January 2013.

56. Specifically, at the Directions Hearing, I sought clarification upon:

    a. How a patient's diabetes is treated when they are admitted to the mental health unit, and whether a diabetes management plan would be in place.

    b. Whether Monash Health could say with certainty that Department of Health (now Department of Health and Human Services) heat alerts are received by direct care clinicians, clients, carers and families.

c. Whether Monash Health had conducted a review of risk assessment in regard to heat alerts, specifically in regards to those people considered in the vulnerable group in the setting of mental illness associated patients on day release or day leave (as opposed to the updates made to discharge policies).

d. Whether Mr Flanagan's reference to 'the need to review current risk assessment procedures to include environmental conditions is under consideration' meant that environmental risk assessments will be included in the 'Mental Health Leave from Inpatient Units' document.

e. The level of understanding, beyond undergraduate training, by clinicians of heatwave related illnesses and risk associated with mental health patients, and in particular, how the hospital ensures staff are aware of the risks during extreme heat days in the setting of day leave.

57. Monash Health was asked to provide further information by way of written statements, in relation to the issues on which I sought clarification.

FURTHER INFORMATION PROVIDED TO THE COURT

Further statement of Dr Pinto

58. Monash Health provided an additional statement from Dr Pinto following the Directions Hearing.

59. Dr Pinto reported that he was aware of a number of patients who had been admitted to a mental health ward at Monash Health who also suffer from diabetes. He said they always have access to an on-call medical registrar to discuss any queries relating to diabetes management. The service is available on a 24 hour, seven day per week basis. If necessary, Dr Pinto said he could also speak to a consultant specialising in diabetes, or organise for the patient to be reviewed on the ward. Medical staff can also speak to a patient's general practitioner to obtain information about his or her diabetic management and previous history.

60. While Dr Pinto said that he receives emails containing information related to heat alerts on his Monash Health email account, he could not recall whether he received emails of this nature in January 2013.

61. Dr Pinto said that despite the high temperatures on 17 January 2013, he did not disagree with the risk assessment that was carried out in relation to Mr Prasad's request for day leave.

Dr Pinto noted that importantly, Mr Prasad was due to be discharged from hospital the next day, and on a number of previous occasions, Mr Prasad had returned to hospital from day leave on time and without any problems.

62. Dr Pinto added that even though Mr Prasad was an involuntary patient, Monash Health was required to treat him in the least restrictive way possible. In the circumstances, where Mr Prasad was due to be discharged the following day and considering his previous history of leave in January 2013, Dr Pinto did not believe it would have been appropriate to deny his request for day leave on 17 January 2013.

Further statement of Mr Flanagan

63. Following the Directions Hearing, Monash Health provided an additional statement from Mr Flanagan and documents relating to the heatwave policy and management of alerts.

64. Mr Flanagan was not able to provide a comment on heat policies and procedures prior to his commencement of employment at Monash Health in June 2015. However, Mr Flanagan provided current information about the distribution of heat alerts from the Department of Health at Monash Health. By providing an example of an email chain for a heat alert for 19 December 2015, Mr Flanagan explained that the emails in the chain involve:

    a. An email from the Department of Health to Adjunct Professor Cheyne Chalmers, the Chief Incident Commander at Monash Health.

    b. Email from A/Prof Chalmers to all Directors of Nursing at Monash Health, copied to Mr Flanagan, Cathryn Keenan (Manager of Emergency Management and Business Continuity at Monash Health) and Katie Durdin (Support Services at Monash Health).

    c. Email from Fiona Sutherland (Director of Nursing and Incident Commander at Dandenong Hospital) to all Deputy Directors of Nursing at Dandenong Hospital. This email was included as an example of the distribution of a heat alert beyond the Director of Nursing level.

65. Mr Flanagan noted that if a Director of Nursing was on leave, the practice was to send the alert to the relevant Deputy Director of Nursing, to ensure that a heat alert is distributed when one or more contacts are on leave. It was Mr Flanagan's understanding that Directors or Deputy Directors of Nursing then send a heat alert to staff members who report to them

and other staff in their department, who further distribute the alert to appropriate parties via email.

66. Further enquiries revealed that Mr Flanagan was unable to establish the exact time the heat wave alert policy came into being, because there was no email trail from his predecessor. As at 24 March 2016, enquiries were still being made. However, it was noted that information provided by Nurse La Roche included a December 2014 heat alert email to staff, which would infer the alert system had been operating since at least that time.

67. Mr Flanagan added that Monash Health uses a number of additional methods to inform staff members, patients and visitors about heatwave conditions, including distributing Department of Health pamphlets in multiple languages, displaying information on television screens throughout hospitals, and displaying posters in areas with a lot of foot traffic.

68. Mr Flanagan stated that the Workplace Health and Safety team at Monash Health begins discussions about planning for summer weather conditions including heatwaves during May each year. In his further statement, Mr Flanagan referred to an email dated 14 December 2015 from Ms Keenan, distributing the Department of Health's Heat Health Resources Pack to contacts at Monash Health.

69. Finally, Mr Flanagan also attached additional correspondence, general polices and Department of Health material in regard to summer preparedness, adverse weather conditions and working in the heat at Monash Health.

Further statement of Kerrie La Roche

70. Monash Health also provided an additional statement from Nurse La Roche following the Directions Hearing.

71. Nurse La Roche stated that as she began her position as Nurse Unit Manager of Ward E at Casey Hospital in February 2014, she was not in a position to comment on specific practices before this time. However, she did provide information about the current practice of diabetes assessment and management for mental health patients, the impact of heat and other environmental factors on decisions about day leave, and some information about heat alerts at Monash Health.

72. Nurse La Roche said a greater recognition amongst mental health practitioners of the need to proactively manage a patient's physical condition – often involving diabetes and obesity – as well as their mental health condition, is reflected in a number of documents and policies

that were attached to her statement. Nurse La Roche stated that upon admission to Ward E, all patients undergo a thorough physical examination, and daily monitoring of physical observations as a minimum.

73. Nurse La Roche referred to Monash Health's policy 'Management of diabetes in hospitalised adult patients >19yo'. This policy applies to all wards at Monash Health and sets out the criteria for a referral to the Diabetes Unit. Nurse La Roche added that while Casey Hospital does not have a Diabetes Unit on site, doctors and nursing staff on Ward E can contact an on-call medical registrar at any time.

74. Nurse La Roche said that on her request, nursing staff on Ward E are currently undertaking further training related to diabetes management. All staff who report to Nurse La Roche are required to complete Monash Health's Diabetes Online Education Module, which includes an online assessment. Successful completion of the Diabetes Online Education Module will be a requirement in the next performance appraisal for all of these staff members.

75. Nurse La Roche added that the handover process at the change of nursing shifts has been improved since she became the Nurse Unit Manager of Ward E in February 2014. She explained that nursing staff are now required to discuss each patient's physical issues and physical observations during handover. This is designed to ensure that clinical staff maintain a focus on a patient's physical condition, in addition to their mental health condition.

76. Nurse La Roche included reference to an email chain dated 30 December 2014, in which she had received a copy of a Department of Health heat alert via email from an Acting Director of Nursing for Mental Health at Monash Health. Nurse La Roche then sent this heat alert to staff members working on Ward E at Casey Hospital, including information that was specific to heat and environmental considerations for mental health patients.

77. Nurse La Roche also referred to an email sent to Ward E staff members dated 3 December 2015, which emphasised the importance of assessing weather conditions and heat factors when considering a patient's request for leave. The email was timed to coincide with the beginning of summer.

78. Nurse La Roche added that extreme heat can be a reason to deny a patient's request for day leave. For example, a patient may be denied leave if he or she shows very limited or no insight into the common risks of a very hot day, such as dehydration, heat stroke and sunburn. On very hot days, clinical staff on Ward E make every effort to grant leave either early in the morning or late in the afternoon to avoid the hottest part of the day. For all

patients, Nurse La Roche said risks associated with extreme heat form part of the risk assessment and a factor in the decision making process about whether to grant a patient's request for day leave.

79. However, I note that in Nurse La Roche's email to staff dated 30 December 2014, she added that "patients should be discouraged from taking leave for recreational purposes on these days." In addition, she said "check and ensure patients have satisfactory and safe transport plan i.e. with family/carers, taxi – discourage use of public transport and avoid excessive walking."

80. Nurse La Roche provided an updated current policy in regard to 'Mental Health – Leave from inpatient units', reviewed 20 February 2015. Although detailed in regard to planned day leave procedures, the document does not identify environmental risk factors such as extreme heat days and comorbidities of patients that may impact on the decision making or risk assessment for day leave. The version of this policy at the time of Mr Prasad's death, had included the need to meet with the patient and discuss the 'leave environment'. The current policy provided by Nurse La Roche includes this same requirement, but does not appear to include any additional consideration of environmental factors.

81. However, Nurse La Roche did provide a copy of an email dated 3 December 2015, 'Heat Wave Alerts – Patient Leave Assessments', that was circulated to all mental health clinicians on Ward E at Casey Hospital. The correspondence sets out environmental risk factors to be considered when assessing a patient for day leave in the mental health environment.

COMMENTS

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

1. In all the circumstances, I am satisfied that there would be no benefit from conducting a full inquest into Mr Prasad's death or obtaining any further medical or other evidence, as neither would assist me to further understand the medical issues before me or the cause of Mr Prasad's death.

2. I note that extreme weather is a factor that is customarily considered by institutions that have a responsibility to care for individuals. For example, schools cancel planned sporting commitments for students when temperatures are deemed very high. The community expects involuntary psychiatric patients to be cared for in a way that protects them from

dangerous external conditions. It seems that in Mr Prasad's case, this protection was not provided.

3. I note the Findings following an investigation into the deaths of Christopher John Dokos[21] and Katrina Ruth Baron[22] made by Coroner Phillip Byrne on 18 March 2015. This case involved complications of heat stroke in a man with schizophrenia, and I endorse His Honour's recommendation that the Chief Psychiatrist issue a directive requiring all public mental health services to develop and introduce an appropriate guideline that identifies, among other things, the clinical responsibilities for case managed and at-risk clients at times of extreme weather conditions.

4. I acknowledge the distress caused to Mr Prasad's wife by the circumstances of Mr Prasad's death and during the prolonged period of investigation. I also acknowledge the absence of clarity surrounding the reason for a lack of communication between Monash Health and Mr Prasad's family, in particular with Mr Prasad's wife.

Lack of contemporaneous evidence

5. Unfortunately, the passage of time has meant that there is a lack of evidence available to demonstrate Monash Health's policies and procedures that were in place at the time of Mr Prasad's death. I note that Mr Flanagan stated that the receipt and distribution of the Department of Health's Heat Health alert on 17 January 2013 could not be confirmed due to the lack of retention of previous correspondence and emails from 2013. In addition, Mr Flanagan was unable to comment on heat policies and procedures prior to his commencement of employment at Monash Health in June 2015. Similarly, Nurse La Roche noted that as she commenced her role of Nurse Unit Manager of Ward E at Casey Hospital in February 2014, she was not in a position to comment on specific practices relating to diabetes management or the impact of environmental factors on decisions about day leave, prior to this time. As a result, I note that the evidence provided by Mr Flanagan and Nurse La Roche largely relates to current practices only. It is disappointing to say the least that there is limited historical documentation to inform Nurse La Roche and Mr Flanagan.

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[21] COR 2014 000430

[22] COR 2014 000431

The management of Mr Prasad's diabetes

6. Mr Prasad's diabetes management while admitted at Casey Hospital appears to have been suboptimal. Contrary to the orders listed in Mr Prasad's medical chart, on the three occasions after 14 January 2013 when his blood sugar levels were measured above 10.0mmol, he was not administered prn titrated doses of the short-acting insulin, Actrapid. On 6 January 2013, Mr Prasad had requested a sliding scale dosage if his blood sugar level was above 10.0mmol. Subsequent efforts by Monash Health staff to explain the lack of an additional Actrapid dose on 17 January 2013, when Mr Prasad's blood sugar level was 16.2mmol, and then 14.2mmol, have been inadequate.

7. Dr Pinto's evidence that on admission Mr Prasad was treated with the same medication regimen for diabetes as he had as an outpatient, conflicted with his subsequent evidence that one of the doctors apparently acceded to Mr Prasad's request to prescribe a sliding scale of insulin according to his blood glucose level.

8. I note that Nurse La Roche subsequently confirmed that enrolled nurses were not administering medication at the time of Mr Prasad's death, but monitoring and assessing patients and reporting to the registered medication nurse. However, I note that Enrolled Nurse Palavikas' view that Mr Prasad's blood sugar levels were elevated on 17 January 2013, but within normal limits for him, were not substantiated by any evidence in the digital medical records of what Mr Prasad's normal levels were considered to be. Furthermore, it was not clear if it was in Nurse Palavikas' scope of practice to decide if the high level was normal for Mr Prasad and to ignore the titrated doses in the current medication chart that clearly stated if his blood sugar level was above a stated number, he was to receive additional units of insulin. I further note that there was a lack of documentation of blood sugar results having been reported to the dedicated medications nurse, or any further rationale for not following the sliding scale treatment order. It was also dismissive of Mr Prasad's knowledge of his own diabetes and how he manages it, specifically his requesting a sliding scale of insulin linked to his blood sugar level.

9. Nurse La Roche's assertion that regardless of Mr Prasad's pre-lunch reading of 14.2mmol, on 17 January 2013, he would not have received a sliding scale dose because they were given in conjunction with his routine twice-daily insulin doses, was reasonable. However, Nurse La Roche's statement failed to consider the effects of a conjunct dose of insulin in response to the pre-breakfast blood glucose of 16.2mmol on 17 January 2013.

10. I am satisfied the issues identified at the Directions Hearing, in relation to how a patient's diabetes is managed as an involuntary patient at the Mental Health Unit at Casey Hospital, and whether a diabetes management plan would be in place, have largely been answered by the implementation of current practices.

11. Both Dr Pinto and Nurse La Roche did state that Ward E clinicians always have access to an on-call medical registrar to discuss diabetes management. I welcome Nurse La Roche's reference to a greater recognition amongst mental health clinicians of the need to proactively manage a patient's physical condition, as well as their mental health condition, and that this was exemplified by policies such as the thorough physical examination undergone by patients upon their admission to Ward E. I similarly welcome Nurse La Roche's instigation of further diabetes education for Ward E nursing staff, and the inclusion of physical issues and observations during shift handovers.

Department of Health heat health alerts

12. I note that at the conclusion of the investigation into Mr Prasad's death, it is still unclear if the Department of Health's heat health alert that was issued on 17 January 2013, was disseminated to Ward E staff on that day, and it is also unclear precisely when the current heat alert communications approach was instated.

13. I acknowledge Mr Flanagan's elaboration in his further statement upon the current 'email chain' process of disseminating heat alerts at Monash Health. I also note the evidence provided by Nurse La Roche that she had received one of these alerts from an Acting Director of Nursing on 30 December 2014 and forwarded the email to Ward E staff. However, I note that this communications approach, involving the cascading of emails from the Department of Health to the Chief Incident Commander at Monash Health, to the Directors of Nursing, relies on the Directors of Nursing (or if they are absent, and this is known and they are sent the alert, their Deputy Director) to appropriately forward the heat alert to their teams. This cascading approach provides no certainty that the Department of Health's heat alerts are received by direct care clinicians, and there was no evidence provided that this communications method is regularly tested or audited.

14. I welcome the evidence that Monash Health uses other methods to disseminate information about heatwave conditions to staff, patients and visitors, and note the increased accessibility of these formats to patients and other non-clinicians. However, I note that the brochures,

posters and television screens throughout the hospital are not direct, all-encompassing communication tools.

Risk assessment and training of clinicians in regards to heat alerts

15. I note that Dr Pinto indicated that he considered Mr Prasad to be fit for discharge on 17 January 2013, and that he did not disagree with the risk assessment carried out in relation to his request for leave that day. In justifying the risk assessment, Dr Pinto pointed to the fact that Mr Prasad was due to be discharged the next day, and that on a number of previous occasions, Mr Prasad had returned to hospital from day leave and without problems. Dr Pinto also stated there was no formal policy of restricting leave in extreme weather conditions. In maintaining this view, it appears that Dr Pinto attributes little weight to the importance of heatwave considerations in the process of assessing risk for day leave requests.

16. Nurse La Roche's current position, that extreme heat can be a reason to deny a patient's request for day leave, seemed to contrast with Dr Pinto's statement relating to 17 January 2013. Nurse La Roche suggested that on very hot days, a patient may now be denied leave if they show limited insight into the common risks or a hot day. She added that efforts are made to grant leave in the morning or late afternoon to avoid the hottest part of the day. I further note Nurse La Roche's email to staff dated 30 December 2014 provides the advice that 'patients should be discouraged from taking leave for recreational purposes on these days.'

17. While I acknowledge Dr Pinto's statement, that Monash Health was required to treat Mr Prasad in the least restrictive way possible, they are not relieved of their overall responsibilities to a patient in their care, including performing adequate risk assessment, particularly incorporating all relevant factors including 38°C heat and Mr Prasad's comorbidities. Their obligation or responsibility extends to a holistic approach to a patient, and that duty cannot be discharged by simply stating they were managing Mr Prasad in the least restrictive manner.

18. I welcome the updating of Monash Health discharge procedures in mental health to include the assessment of environmental factors. While this change to discharge procedures is commendable, I note that Mr Prasad died whilst on day leave from the inpatient unit during extreme heat conditions. There was no suggestion that the same advice would be added to

the day leave policies. Expecting staff to routinely consider weather conditions as a risk factor prior to granting day leave is not in my view an overly onerous burden.

19. I welcome Nurse La Roche's statement that risks associated with extreme heat now form part of the risk assessment and a factor in the decision making process about whether to grant a patient's request for day leave. I also welcome Mr Flanagan's reference to the fact that 'the need to review current risk assessment procedures to include environmental conditions is under consideration.' However, I note that the updated, 2015 document provided by Nurse La Roche, 'Mental Health – Leave from inpatient units' still does not incorporate express consideration of environmental factors. It is unclear how these factors are practically implemented into risk assessments; the rating of 'other risks, including vulnerabilities' in the Inpatient Risk Assessment Continuation alone does not seem to be a very strong prompt to consider environmental issues.

20. I acknowledge Mr Flanagan's evidence that the Workplace Health and Safety team at Monash Health begin planning for summer weather conditions and heatwaves in May each year. I also note the documentation he provided included reference to the need for a heatwave action plan to include 'before summer' activities, such as staff awareness and training relating to heat and health. However, I note the documents provided by Mr Flanagan did not appear to cover any instance of risk assessment for day leave.

21. The email Nurse La Roche sent to Ward E staff members dated 3 December 2015, emphasised the importance of assessing weather conditions and heat factors when considering a patient's leave request. The email was timed to coincide with the beginning of summer and I welcome the direct highlighting of this issue to staff in the context of day leave.

22. Continuing education on the risks of extreme heat for staff is imperative; it not reasonable to expect clinicians to retain the information they learned as an undergraduate, assuming it was part of their course, and apply it to just a few days of extreme heat per year. A simple awareness raising activity could occur as part of a Summer Preparedness Plan or health promotion. The necessary information is readily available and updated by the Department of Health and Human Services.

RECOMMENDATIONS

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

1. I acknowledge the recommendation made by Coroner Phillip Byrne following the investigation into the deaths of Christopher John Dokos and Katrina Ruth Baron, and **I reiterate his recommendation** that the Chief Psychiatrist issue a directive requiring all public mental health services to develop and introduce an appropriate guideline that identifies, among other things, the clinical responsibilities for case managed and at-risk clients at times of extreme weather conditions.

2. It is still not apparent on the basis of the material provided to me that environmental factors have been formally incorporated into risk assessments for approving the day leave of psychiatric inpatients at Monash Health. With the aim of preventing like deaths, **I recommend** that Monash Health incorporate environmental and climate conditions into their policy 'Mental Health – Leave from inpatient units', that was last reviewed 20 February 2015.

FINDING

I accept and adopt Dr Linda Iles' report that the medical cause of Mr Chris Pravin Prasad's death was undetermined. There is no evidence of third party involvement and no suspicious circumstances. On the balance of probabilities, I find that Chris Pravin Prasad has died from undetermined natural causes.

AND I find that in light of the fact that the cause of Mr Prasad's death was undetermined, making any link between aspects of Mr Prasad's care and his cause of death is not possible. However, while I cannot definitively find that Mr Prasad's death was preventable, in the circumstances, where Mr Prasad was an involuntary psychiatric inpatient, diabetic with high blood sugar levels, overweight, with hypertension and a history of prolonged QTc, I find that the granting of day leave on a day of extreme, 38°C heat conditions failed to provide a holistic approach to his care.

Pursuant to section 73(1) of the **Coroners Act 2008**, I order that this finding be published on the internet.

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

- The Prasad family
- Office of the Chief Psychiatrist of Victoria
- Ms Kym Peake, Secretary of the Department of Health and Human Services
- Mrs Suzanne Lyttleton, Lyttletons Solicitors on behalf of Mr Prasad's wife
- Ms Susan Van Dyk, Monash Health
- TressCox Lawyers on behalf of Monash Health
- Casey Hospital
- Ambulance Victoria
- Senior Constable Tania Fox
- Senior Constable Scott Williams

Signature:

AUDREY JAMIESON
CORONER
Date: **20 April 2016**