IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2011 4320

FINDING INTO DEATH WITH INQUEST[1]

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

Inquest into the Death of: MOUFID SAWAN

Delivered On:	28 August 2015
Delivered At:	Coroners Court of Victoria 65 Kavanagh Street Southbank VIC 3006
Hearing Date:	11 – 12 March 2014
Finding Of:	AUDREY JAMIESON, CORONER
Appearances:	Mr John Snowdon on behalf of Monash Health
Counsel Assisting	Leading Senior Constable Amanda Maybury, Police Coronial Support Unit

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

I, AUDREY JAMIESON, Coroner having investigated the death of **MOUFID SAWAN**

AND having held an inquest in relation to this death on 11 – 12 March 2014

at the Coroner's Court of Victoria sitting at MELBOURNE

find that the identity of the deceased was **MOUFID SAWAN**

born on 5 February 1950

and the death occurred on 16 November 2011

at the Alfred Hospital, 55 Commercial Road, Melbourne 3004

from:

1(a) COMPLICATIONS OF CUTANEOUS BURNS

in the following summary of circumstances:

2. On 11 March 2014, a mandatory inquest under section 52(2)(b) of the *Coroners Act 2008* (Vic) (the Act) began into the death of Moufid Sawan, because immediately before his death, Mr Sawan was "a person placed in....care" as it is defined in the Act.[2] Prior to his death, Mr Sawan was a patient in an approved mental health service within the meaning of the *Mental Health Act 1986* (Vic)[3] (the Mental Health Act).

3. On 4 November 2011, Mr Sawan was admitted as a voluntary patient to the psychiatric inpatient unit, 'P-block', at the Monash Medical Centre, Clayton (MMC). It was documented that Mr Sawan was refusing medications, abusive, aggressive and had disorganised behaviour and sleep disturbance. On 8 November 2011, Mr Sawan commenced unaccompanied leave. Dr Dong Xu, Hospital Medical Officer, spoke to Registered Nurse (RN) Vera Parker, Mr Sawan's community case manager at the Dandenong Continuing Care Team (DCCT), to discuss overnight leave and discharge. RN Parker reported Mr Sawan's mental state continued to be elevated, disorganised and that he was demanding. On 11 November 2011, Consultant

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2 *Coroners Act 2008* (Vic) s 3(i).

3 The *Mental Health Act 1986* (Vic) has been repealed and replaced by the *Mental Health Act 2014* (Vic).

Psychiatrist Associate Professor Michael Wong reviewed Mr Sawan and determined that he should be made an involuntary patient under the Mental Health Act. Mr Sawan continued to have unaccompanied leave as an involuntary patient between 11 November 2011 and 15 November 2011, some days taking leave during the morning and afternoon shifts.

4. On 15 November 2011 at approximately 3.45pm, Mr Sawan left P-block on unaccompanied leave. Mr Sawan attended the Caltex Service Station at the intersection of Clayton Road and Centre Road, Clayton and purchased two litres of petrol. He walked down Centre Road to the corner of Cooke Street where he was observed to pour petrol over himself and set himself alight with a cigarette lighter. Witnesses rendered assistance and called emergency services. Mr Sawan was transported by ambulance to the Alfred Hospital with extensive burns. On arrival at the Emergency Department it was estimated Mr Sawan had sustained full-thickness burns to approximately 90% of his body. It was determined his injuries were not survivable and he was treated palliatively. Mr Sawan was pronounced deceased at 2.13am on 16 November 2011.

BACKGROUND CIRCUMSTANCES

5. Mr Sawan was born on 5 February 1950. He was 61 years old at the time of his death. He resided in a Supported Residential Service (SRS) in Dandenong. He received a Centrelink Disability Support Pension and his finances were managed by the State Trustees.

6. Mr Sawan had a long history of severe psychiatric illness, having been diagnosed with schizophrenia and schizoaffective disorder in 1984. In the five years before his death, Mr Sawan had multiple mental health related admissions to Monash Health[4] facilities. His past history included arson, suicidal ideation and he had previously attempted to take his own life on numerous occasions.[5]

7. RN Parker had a longstanding clinical relationship with Mr Sawan and reported that when Mr Sawan was unwell he was erratic or completely non compliant with medication, suffered from paranoia and auditory hallucinations and had delusional and disordered thoughts with elevated, grandiose affect and pressured speech.[6] In about late September 2011, Mr Sawan became erratically compliant with medication. On 13 October 2011, Mr Sawan was referred to

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4 Previously known as Southern Health.

5 Southern Health Medical Records, 'Major Clinical Alerts', page 2; Mr Sawan's previous suicide attempts included putting metal into power points, breaking a window and cutting himself with broken glass and drinking bleach. On occasions these attempts were made while an inpatient.

6 Exhibit 12 – Statement of Vera Parker, dated 10 January 2012, page 3.

the Prevention and Recovery Care Service (PARCS),[7] however there were no beds available. On 14 October 2011, Mr Sawan agreed to have his prescribed Risperidal Consta[8] intramuscular 'depot' injection. A PARCS bed became available, however as Mr Sawan's mental health had deteriorated his admission was no longer appropriate.[9]

8. On 28 October 2011, Mr Sawan refused his depot injection. RN Parker reported he was unsettled, verbally aggressive, irritable and angry. Staff at the SRS called emergency services as a result of his escalating behaviour and he was transported to the Dandenong Hospital Emergency Department. Mr Sawan was referred to the Dandenong Crisis and Assessment Treatment (CAT) team who referred him back to DCCT on 31 October 2011. On the same day, DCCT conducted a clinical review of Mr Sawan's case and the decision was made to refer his care back to the CAT team for stabilisation of his mental state and medication compliance. On 4 November 2011, the CAT team admitted Mr Sawan to P-block as a voluntary patient.

SURROUNDING CIRCUMSTANCES

9. On 5 November 2011, Mr Sawan was assessed by the on-call Psychiatrist Dr Vivienne Mak. She believed Mr Sawan was either suffering from a manic episode or a deterioration of his chronic schizophrenia. Mr Sawan agreed to stay as a voluntary inpatient.[10] At this time, Dr Mak made a note in Mr Sawan's medical records for "old files please."[11] On 7 November 2011, Associate Professor (A/Prof) Wong reviewed Mr Sawan with Dr Xu and assessed his mood as mildly elevated. He was prescribed oral medications including risperidone, sodium valproate and mirtazapine and agreed to take them, although reported he did not think they helped.[12] He was also prescribed Risperidal Consta depot injection which was administered. Mr Sawan's level of nursing observation was reduced from once every 15 minutes to once every 30 minutes.[13] At this review he requested leave and A/Prof Wong determined leave would not be granted.

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7 A short term recovery focused residential service for people who are either leaving acute mental health care, or who would benefit from 24 hour support to avoid a hospital admission.

8 Risperidone

9 Ibid.

10 Southern Health Inpatient Progress Notes, dated 5 November 2011 at 11.30am, page 223.

11 Ibid, page 224.

12 Exhibit 7 – Statement of Michael Wong, dated 22 February 2012, page 2.

13 Ibid.

10. On 8 November 2011, Mr Sawan had a multidisciplinary team review. Dr Xu rated Mr Sawan as having no apparent risk across nine out of 10 mental health related safety risk elements.[14] As a result of this review it was decided to increase medication and contact his case manager for follow up. Dr Xu called RN Parker and entered notes of his conversation into Mr Sawan's medical records. These notes reflect a very brief recent history; Dr Xu was informed that Mr Sawan's last admission was to Dandenong Hospital in February 2011.[15] RN Parker reported that Dr Xu telephoned her informing her that Mr Sawan would be discharged soon. She voiced her concerns that he needed time to stabilise.[16]

11. On the same day, Mr Sawan was approved for leave. A risk assessment was conducted by nursing staff at 9.30am[17] which determined Mr Sawan's overall level of risk was medium. He was deemed to have low risk for suicidality and self harm and low to medium risk for absconding.[18] Mr Sawan attended the hospital kiosk unaccompanied between 11.47am and 12.18pm.

12. Medical records indicate that on 9 November 2011, Dr Xu again had contact with RN Parker and told her that A/Prof Wong had decided to trial Mr Sawan on overnight leave. Dr Xu noted RN Parker: "*is very concerned...she spoke with him on the phone. He is elevated, disorganised, demanding. She believed that [Mr Sawan] should be kept in hospital longer.*"[19] A/Prof Wong reported that as a result of Dr Xu's conversation with RN Parker, "*Mr Sawan should have more leave, including extended leave outside of the hospital, before he had [a] further assessment for discharge to the community on a Community Treatment Order (CTO).*"[20]

13. Mr Sawan had uneventful, unaccompanied leave on 9 November and 10 November 2011; both days taking leave twice. Risk assessments were conducted by nursing staff three times on these days; twice his overall risk was determined to be low, twice rated medium and at two assessments his overall risk was not rated. Risk of suicidality, self harm and absconding were consistently determined to be low, apart from on 9 November 2011 at 9.25am, where Mr Sawan's risk of absconding was determined to be medium.[21] Nursing observations and risk

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[14] Southern Health Adult Clinical Review, dated 8 November 2011, page 216; harm from others was rated as low risk

[15] Southern Health Inpatient Progress Notes, dated 8 November 2011, page 228.

[16] Exhibit 12, page 4.

[17] The risk asessment states Mr Sawan was assessed at 9.30am – however results were documented at 2.15pm.

[18] Southern Health Adult Inpatient Risk Assessment, dated 8 November 2011, page 198.

[19] Southern Health Inpatient Progress Notes, dated 9 November 2011, page 230.

[20] Exhibit 7, page 3.

[21] Southern Health Adult Inpatient Risk Assessment, dated 9 November 2011, page 199.

assessments often noted Mr Sawan was irritable, loud, mildly elevated but generally pleasant and polite.[22]

14. On 11 November 2011, Mr Sawan was reviewed by A/Prof Wong and Dr Xu. Mr Sawan's mood was noted to be mildly elevated, similar to his assessment on 7 November 2011. Giving consideration to RN Parker's concerns and Mr Sawan's lack of insight for his need for medication, A/Prof Wong made him an involuntary patient under the Mental Health Act. He reported "*I was of the opinion that involuntary status would allow a discharge on [a] CTO in order to address his non-compliance.*"[23] He assessed Mr Sawan as having chronic schizophrenia, limited insight, was being non-compliant and unfit to consent.[24] He also noted Mr Sawan's continued agitation, irritability and mild mood elevation and referred him to the inpatient social worker for assistance regarding State Trustees.[25] Pursuant to section 40 of the Mental Health Act, A/Prof Wong assessed Mr Sawan as suitable for unaccompanied leave from 11 November 2011 to 17 November 2011. The condition of Mr Sawan's leave was noted as "unaccompanied day leave".[26]

15. On 11 November 2011, Mr Sawan had uneventful unaccompanied leave twice. Risk assessments completed by nursing staff at 8.30am and 8.20pm observed Mr Sawan's overall risk to be medium and on both occasions his risk of suicidality, self harm and absconding was determined to be low. Over the next two days, Mr Sawan continued to have uneventful unaccompanied leave on five separate occasions.[27] In line with previous risk assessments, Mr Sawan's overall risk was assessed to be medium.[28]

16. On 14 November 2011, A/Prof Wong and Dr Tynu Thomas, Hospital Medical Officer, reviewed Mr Sawan who reported that his leave had been going well and acknowledged that he is easily upset but is able to settle soon after.[29] It was noted again that Mr Sawan was irritable and in order to better control this and his mood elevation, he was prescribed another dose of Risperidal Consta which was administered. A/Prof Wong determined there was no significant improvement or deterioration compared to his previous review on 11 November

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22 Southern Health Adult Inpatient Risk Assessments, dates between 9 November and 11 November 2011, pages 199-201; Southern Health Inpatient Progress Notes, dates between 9 November and 11 November 2011, pages 230-235.

23 Exhibit 7, page 3.

24 Examination of Involuntary Patient by Authorised Psychiatrist MHA 1 Form, dated 11 November 2011 at 9.15am, page 6.

25 Exhibit 7, page 3.

26 Exhibit 6 - Leave of Absence for an Involuntary Patient form

27 On 12 November 2011, Mr Sawan returned from leave 30 minutes late (expected return 10.00am – actual return 10.30am);

28 A risk assessment conducted at 3.30am on 12 November 2011, documented Mr Sawan's overall risk to be low.

29 Southern Health Inpatient Progress Notes, dated 14 November 2011; Exhibit 7, page 4.

2011. Mr Sawan had one episode of unaccompanied uneventful leave and the one risk assessment completed on this day[30] documented that Mr Sawan's overall risk remained medium.[31]

17. On 15 November 2011, a multidisciplinary review determined Mr Sawan to have a medium risk for cognitive impairment, non-compliance and harm to others and a low risk of suicidality, self harm, absconding and harm from others.[32] A/Prof Wong reported that "*we decided Mr Sawan should remain an involuntary patient and that he should continue to have injectable, long acting antipsychotic medication in view of his limited insight [and] non-compliance.*"[33] It was determined that RN Parker should be contacted for assistance in assessing Mr Sawan's readiness to return to the community. The multidisciplinary team confirmed that his risk of "*self harm, suicide and absconding continued to be low and that his unaccompanied leave should continue if his risk assessment remained low.*"[34] Risk assessments completed by morning shift nursing staff determined Mr Sawan's overall risk was low at 5.30am and medium at 10.45am.[35] At both assessments, his risk of suicidality, self harm and absconding was determined to be low. Mr Sawan went on unaccompanied uneventful leave at 10.45am.

18. At approximately 3.00pm, Dr Thomas spoke to RN Parker. Dr Thomas documented that she remained concerned with Mr Sawan's mental state; he was "*not back to baseline*".[36] RN Parker had received a phone call from him recently and he was abusive, irritable and demanding whereas she stated that Mr Sawan was usually polite when well.[37]

19. RN Gagandeep Singh[38] was Mr Sawan's allocated contact nurse[39] during the afternoon shift. He observed Mr Sawan to be asleep in the television room; waking up at approximately 3.00pm. At this time, RN Singh talked with Mr Sawan and introduced himself. During the interaction RN Singh conducted a risk assessment and Mr Sawan presented as "*somewhat elevated, evidenced by his loud speech during our interaction.*"[40] He denied having thoughts

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30 Completed at 2.30pm.

31 Southern Health Adult Inpatient Risk Assessment, dated 14 November 2011, page 204.

32 Southern Health Adult Clinical Review, dated 15 November 2011, page 214.

33 Exhibit 7, page 4.

34 Ibid.

35 Southern Health Adult Inpatient Risk Assessment, dated 15 November 2011, pages 205 and 206.

36 Southern Health Inpatient Progress Notes, dated 15 November 2011, page 242

37 Ibid; Exhibit 12, page 4.

38 RN Singh was employed as a Graduate Nurse in 2011.

39 RN Singh had previously been Mr Sawan's allocated contact nurse on 6 November 2011.

40 Exhibit 4 – Statement of Gagandeep Singh, dated 19 March 2012, page 1.

of suicide, self harm, and harm to others. RN Singh therefore determined that Mr Sawan had a low risk of suicidality, self harm and absconding.[41] He determined Mr Sawan's overall risk was medium.[42]

20. At approximately 3.30pm, Mr Sawan asked RN Singh if he could go on leave, saying he wanted to buy food and drink from the local shops. RN Singh checked Mr Sawan's 'Leave of Absence for an Involuntary Patient' form, which documented he had approved unaccompanied leave. He reported he confirmed the leave with the nurse in charge of the afternoon shift, RN Vanessa Vuat.[43] He further reported:

> *"there was nothing different in his presentation on 15 November [2011], compared with the assessments of other staff in the previous few days, to raise my concerns...or to stop his planned leave."*[44]

21. Mr Sawan left P-block sometime after the morning shift staff left the ward and was documented as due to "return to the ward around 5pm."[45] RN Singh reported that when Mr Sawan did not return from leave, he called[46] his SRS in an attempt to locate him, however was told he had not been there. RN Singh's meal break was scheduled at 6.00pm. RN Vuat reported she was unable to locate Mr Sawan whilst doing her scheduled Nursing Care Level (NCL) observations between 5.30pm and 6.30pm. Upon checking his records, she observed that he had been granted day leave and had not returned despite it being after his documented return time.[47] RN Vuat planned to speak to RN Singh about Mr Sawan's whereabouts when he finished his meal break. At approximately 6.45pm, RN Singh received a phone call from Victoria Police informing him that Mr Sawan had been involved in an incident, was badly burnt and had been admitted to the Alfred Hospital Emergency Department.[48]

22. RN Singh informed Nurse Unit Manager RN Kerrie La Roche and RN Vuat notified the on call executive, Psychiatrist and the on duty Hospital Medical Officer with the information

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41 Exhibit 5 – Statement of Gagandeep Singh, dated 25 February 2014, page 1.

42 Southern Health Adult Inpatient Risk Assessment, dated 15 November 2011, page 206.

43 Exhibit 4, page 2; Exhibit 5, page 1.

44 Exhibit 5, page 1.

45 Southern Health Inpatient Progress Notes, dated 15 November 2011, page 243; RN Singh stated two different departure times; "at around 4pm" and "after the departure of morning shift nursing staff at 3.30pm." Medical records state Mr Sawan departed at 4.05pm. Please see heading below 'response to Mr Sawan failing to return on time' for further discussion of Mr Sawan's documented return time.

46 It is unclear, based on RN Singh's statements, the actual time he called the SRS. He reports that he called the SRS and "shortly after at 6.45pm" he was informed by Victoria Police that Mr Sawan was at the Alfred Hospital Emergency Department.

47 Exhibit 2 – Statement of Vanessa Vuat, dated 7 February 2012, page 1.

48 Exhibit 4, page 2.

known at the time; Mr Sawan had received significant burns that were probably life ending, which were likely self inflicted.[49]

23. The police investigation identified Mr Sawan's movements after leaving P-block. At approximately 3.55pm, he attended the Caltex Service Station on the corner of Clayton Road and Centre Road, Clayton and filled a two litre plastic bottle with petrol. The service station attendant informed Mr Sawan he must only fill approved containers. Mr Sawan reportedly became "quite upset" and told the attendant his car had run out of petrol and was blocking traffic.[50] He left the service station and walked down Centre Road to the corner of Cooke Street. At approximately 4.00pm, witnesses observed Mr Sawan pour the contents of the plastic bottle over himself and use a cigarette lighter to light his t-shirt on fire. They called emergency services and attended to Mr Sawan, using clothing and blankets to put out the flames and then rendered what first aid they could.

24. Attending paramedics found Mr Sawan sitting on the footpath leaning against a wall, he was conscious, talking and was not in obvious distress. Mobile Intensive Care Ambulance (MICA) paramedic Andrew Fraser spoke to Mr Sawan. Mr Fraser questioned Mr Sawan who responded that he purposefully lit himself on fire in an attempt to take his own life and he had previously made attempts to take his own life.[51] Mr Sawan was given intravenous pain relief and moved into the ambulance. On examination, he was found to have approximately 90% full thickness burns. Due to the extent of his injuries, Mr Sawan was placed in a medically induced coma. He was transported to the Alfred Hospital Emergency Department. On arrival, the severity of Mr Sawan's injuries were confirmed and they were deemed to be not survivable. He was treated palliatively and passed away on 16 November 2011 at 2.13am.

25. On 16 November 2011, at the end of P-block morning handover, RN Vuat informed nursing staff of Mr Sawan's death and the surrounding circumstances. She reported that at this time, RN Phoebe South told all staff members present that Mr Sawan had been asking people for petrol.[52] RN Vuat spoke to RN South at the end of handover. She reported RN South told her that on 15 November 2011, a patient's visitor informed her that Mr Sawan had been asking patients if they could get him petrol.[53] RN South reported the visitor spoke to her in the courtyard at approximately 2.30pm and she informed the nurse in charge at the nurse's station,

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[49] Exhibit 2, page 1.
[50] Exhibit 14 – Remainder of Coronial Brief of Evidence, page 13.
[51] Ibid, page 51.
[52] Exhibit 2, page 2.
[53] Ibid.

about the information she received.[54] RN Vuat reported RN South could not remember who she spoke to in the nurse's station. RN South reported that she could not recall whether she spoke to the morning or afternoon shift nurse in charge.[55]

26. On the night of 16 November 2011, RN Sandra Haselgrove was given a letter by a patient. The patient reported they found it on 15 November 2011. The letter was written in a foreign language. RN Vuat spoke to the patient on 17 November 2011. At that time, the patient reported they found the letter on the night of 14 November 2011, in the corridor, near where they had seen Mr Sawan sitting earlier that day.

POST MORTEM EXAMINATION AND REPORT

27. Dr Matthew Lynch, Forensic Pathologist at the Victorian Institute of Forensic Medicine performed an external examination on the body of Mr Sawan and reviewed a post mortem CT scan, medical records and the Form 83 Victorian Police Report of Death. Dr Lynch reported[56] that the external examination and the findings were consistent with the history. The post mortem CT scan revealed no evidence of occult injury or natural disease. Dr Lynch ascribed the cause of Mr Sawan's death as complications of cutaneous burns.

PURPOSE OF THE CORONIAL INVESTIGATION

28. The primary purpose of the coronial investigation of a reportable death[57] is to ascertain, if possible, the identity of the deceased, the cause of death (interpreted as the medical cause of death) and the circumstances in which the death occurred.[58]

29. Coroners are also empowered to report to the Attorney-General on a death they have investigated. Coroners can comment on any matter connected with the death, including matters relating to public health and safety or the administration of justice; and the power to make recommendations to any Minister, public statutory or entity on any matter connected with the death, including recommendations relating to public health and safety or the administration of justice.[59] This is referred to as the 'prevention role' of the coroner.

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[54] Exhibit 1 – Statement of Phoebe South, dated 9 May 2012.

[55] Ibid.

[56] Medical Examiner's Report of Dr Matthew Lynch dated 22 November 2011.

[57] Section 4 of the *Coroners Act 2008* (Vic) requires certain deaths to be reported to the coroner for investigation. Apart from a jurisdictional nexus with the State of Victoria, the definition of a reportable death includes all deaths that appear 'to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from accident or injury. Mr Sawan's death falls within this definition.

[58] *Coroners Act 2008* (Vic) s 67.

[59] *Coroners Act 2008* (Vic) ss 72(1), 72(2) and 67(3).

30. I note that historically, under the *Coroners Act 1985* (Vic), a Coroner was obliged to make a finding regarding person/s or other entities who had "contributed" to the death. In 1999, the 1985 Act was amended to remove this obligation. The absence of this obligation was preserved in the *Coroners Act 2008* (Vic), and is supported by the common law, which maintains that it is not part of a Coroner's role to lay or apportion blame.[60] However, the removal of this obligation does not preclude a Coroner from making a finding of contribution, in appropriate cases. The *Briginshaw*[61] standard of proof is applicable to findings of fact in this Court. As Dixon J espoused:

> The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding are considerations which must affect the answer to the question whether the issue has been proved to the reasonable satisfaction of the tribunal. In such matters 'reasonable satisfaction' should not be produced by inexact proof, indefinite testimony or indirect inferences.[62]

THE EVIDENCE

31. This finding is based on all the investigation material comprising the inquest brief of evidence, all material obtained after the provision of the brief, the statements and evidence of those witnesses who appeared at the Inquest and any documents tendered through them, other documents tendered through counsel, and submissions made by counsel.

32. *Viva voce* evidence was obtained from the following witnesses at the Inquest:

a. Phoebe South, Registered Nurse

a. Vanessa Vuat, Registered Nurse, Associate Nurse Unit Manager

b. Dr Tynu Thomas, Hospital Medical Officer

c. Gagandeep Singh, Registered Nurse

d. Associate Professor Michael Wong, Consultant Psychiatrist

e. Lalrambuatsaihi Zahau, Registered Nurse, Associate Nurse Unit Manager

f. Kerrie La Roche, Registered Nurse, Nurse Unit Manager; and

g. Vera Parker, Registered Nurse

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[60] *Keown v Kahn* (1999) VR 69:, 76 per Calloway JA.
[61] *Briginshaw v Briginshaw* [1938] 60 CLR 33.
[62] Ibid, at [362]-[363].

ISSUES INVESTIGATED AT INQUEST

33. At the commencement of the Inquest, it was evident that most of the facts surrounding Mr Sawan's death were known and without dispute, including his identity, the medical cause of his death and aspects of the circumstances of his death, including the place of his death.

34. Issues were identified regarding the care provided to Mr Sawan that required further exploration at Inquest, including:

    a. communication between treating clinicians

    b. the availability of Mr Sawan's medical records to P-block staff

    c. risk assessments

    d. Mr Sawan's unescorted leave on the afternoon of 15 November 2011; and

    e. response to Mr Sawan failing to return on time

Communication between treating clinicians

35. RN South was employed as a graduate nurse in 2011. She gave evidence at Inquest that when she received the information from a patient's visitor that Mr Sawan had been asking patients to buy petrol on 15 November 2011, she went directly to the nurse in charge.[63] RN South stated she took this action because Mr Sawan was not her allocated patient and thought the best thing to do was to inform someone higher up.[64] RN South could not recall if she spoke to the nurse in charge of the morning or afternoon shift.[65] She stated that when she reported the information to the nurse they "*just sort of looked at me and didn't really respond.*"[66] She does not recall making any notes, or the nurse she informed making any notes.[67]

36. RN Vuat gave evidence that she could not recall having a conversation with RN South in the nurses station on 15 November 2011. She stated that sort of information would have raised alarm bells and changed Mr Sawan's presentation.[68] RN Lalrambuatsaihi Zahau was the nurse in charge of the morning shift on 15 November 2011. At Inquest, she stated she could not recall RN South approaching her in the nurse's station.[69] She gave evidence she was therefore not aware Mr Sawan was asking visitors and patients to purchase petrol for him. RN Zahau

[63] Transcript, page 21, 28, 32 and 33.
[64] Transcript, page 19.
[65] Transcript, page 18.
[66] Transcript, page 20.
[67] Transcript, page 19 and 20.
[68] Transcript, page 39.
[69] Transcript, page 166.

stated she would expect a staff member to speak to her, if they had heard such information.[70] She could not however categorically say RN South did not come up to the nurse's station on 15 November 2011.[71] She could also not comment on whether RN South may have said a general comment in nurse's station about Mr Sawan asking for petrol.[72]

37. RN Singh gave evidence he was not aware that Mr Sawan had asked other patients to purchase petrol for him. He stated and if he had known he would have told the nurse in charge and also spoken to the doctor.[73] RN Singh could not recall seeing RN South on the afternoon of 15 November 2011.[74]

38. RN Vuat, RN Zahau and RN Singh all gave evidence they first heard about Mr Sawan asking for petrol on 16 November 2011, at the morning handover, when RN South told the assembled group.[75] As soon as handover concluded, RN Vuat took RN South out of the nurse's station, spoke to her in private about where she heard the information and asked whom she told.[76] RN South could not tell her whom she had told and this surprised RN Vuat.[77] She stated she did not make any notes of their conversation.[78]

39. RN Vuat informed RN La Roche and the graduate nurse co-ordinator. RN La Roche then spoke to RN South. RN La Roche gave evidence that she was left with the impression that RN South did not understand the significance of the information. At the time, RN South did not convince her that she conveyed the information, as one would have done, if it were considered significant.[79] She stated the information seemed to ring some alarm bells for RN South but given her inexperience, she was mindful that she perhaps did not think in the way a more experienced clinician may have. RN South reported to RN La Roche that on hearing the information from the visitor, she checked on Mr Sawan and found him in the courtyard.[80] RN La Roche stated that after speaking with RN South she was not left with the impression that RN South communicated the information on 15 November 2011.[81] She said it appeared that

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70 Transcript, page 162.
71 Transcript, page 176.
72 Transcript, page 174.
73 Transcript, page 101.
74 Transcript, page 109.
75 Transcript, pages 44, 167 and 104.
76 Transcript, page 44.
77 Transcript, page 57.
78 Transcript, page 44.
79 Transcript, page 199.
80 Transcript, page 214.
81 Transcript, page 199.

RN South did not follow procedure that day.[82] RN South was counselled about what she should have done and the director of nursing was informed as well as her clinical supervisor and the graduate nurse coordinator.[83]

40. RN South gave evidence she did not ask either nurse in charge on 16 November 2011, why they did not act on the information she relayed because she was a junior nurse and did not have the confidence to question someone with more experience than her.[84]

The availability of Mr Sawan's medical records to P-block staff

41. At Inquest, Counsel for Monash Health conceded that documentation was not managed effectively and efficiently.[85] Clinicians at P-block were not provided with the past records or detailed alerts which contained reference to Mr Sawan's extensive psychiatric history.[86] Staff only had access to a scanned medical record (SMR) which covered the year 2011; no other records were available to them, therefore no background clinical information was known by the staff at P-block.[87] Clinicians had no knowledge Mr Sawan had a criminal record for arson, with multiple fire issues involving a SRS and his ex-wife's home, a history of aggression towards staff and a significant history of suicide attempts.[88]

42. RN Vuat gave evidence she had no knowledge of Mr Sawan's history.[89] RN Singh stated he knew Mr Sawan had a chronic history but did not know details of this; he agreed there was a history to be found if someone made the enquiry.[90] He did not attempt to locate Mr Sawan's history on 6 November 2011, nor did he discuss with anyone the availability of any records.[91] It was his understanding that a patient's history was chased up by doctors.[92] He gave evidence that with the benefit of hindsight, it would have been good to have known Mr Sawan's history; stating, "*he wouldn't have been going on unaccompanied leave. He would.have been going on accompanied leave with someone to start with.*"[93] Mr Sawan's history of arson,

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82 Transcript, page 201.
83 Transcript, page 221.
84 Transcript, page 30.
85 Transcript, page 4.
86 Transcript, pages 88 and 90.
87 Transcript, pages 5 – 8.
88 Transcript, page 92.
89 Transcript, page 39.
90 Transcript, page 121-122.
91 Transcript, page 111.
92 Transcript, page 95.
93 Transcript. Page 113.

assault and previous suicide attempts was significant and RN Singh stated a patient with this sort of history would not have had access to a cigarette lighter.[94]

43. A/Prof Wong gave evidence that reviewing a patient's history and medical records is standard practice; it is also standard to request them when they are not available.[95] A/Prof Wong had general background knowledge that Mr Sawan had a history of arson and self harm, however, later said he was not 100% sure he was aware of the arson history when he was treating him.[96] A/Prof Wong stated this general history was known from interactions with RN Parker.[97] He stated Mr Sawan was made an involuntary patient, based on the information received from RN Parker; "*we took her recommendation very seriously.*"

44. Counsel on behalf of Monash Health accepted the risk assessment and referral was completed by RN Parker on 31 October 2011, and was forwarded to the CAT team. He conceded that it was not passed on to staff at P-block. The only transfer document staff received was a blank page with Mr Sawan's name on it and a line through it.[98] Counsel stated that the document was relevant, clearly contained significant risk factors, would have been an influencing factor and it should have been available to treating clinicians.[99]

45. There are two electronic tools that MMC clinicians can use to access medical records and patient alerts; the SMR, which is specific to Monash Health and the Client Management Interface (CMI), used by public mental health services.[100]

46. RN La Roche gave evidence that having access to 20 volumes of previous medical records is not helpful, rather what is important is a succinct intra-service referral and alerts that indicate current risks, past risks and the purpose of admission. If this information needs clarification, clinicians can then look to the medical records.[101] RN La Roche stated alerts systems were in place at MMC; there was an alert summary on the record folder[102] and the CMI also has an alerts system.[103] She gave evidence that the SMR now has an alerts folder that says what the

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94 Ibid (113); Page 102.
95 Transcript, Pages 132-133.
96 Transcript, page 151.
97 Transcript. Page 140.
98 Transcript, page 88.
99 Transcript, pages 233 – 235.
100 Transcript, page 95.
101 Transcript, page 194.
102 This was available to P-block clinicians but contained very little information.
103 Transcript, page 195.

incident is and where the reference to that incident can be found in the notes; she believed this system was probably in place at the time of the incident.[104]

47. At the time of Mr Sawan's death MMC was in the process of transferring over to the SMR system. RN La Roche stated it was available and accessible, but an analysis discovered that clinicians were not utilising the system and they were not necessarily aware of how to access it. There was an expectation that hard copy files would come to the ward. The analysis indentified that staff weren't routinely checking and incorporating information from the SMR into their assessments.[105]

48. RN La Roche conducted a preliminary investigation and was able to access Mr Sawan's SMR for the purpose of her investigation. At the time, she was concerned that the SMR had been available to clinicians but not accessed.[106] Counsel for Monash Health stated that Mr Sawan's medical records were scanned as a result of the Coroners request for medical records and were available within 72 hours of Mr Sawan's death; it was not the case that clinicians had not accessed the SMR.[107]

49. RN La Roche stated at the time of Inquest, MMC still had a mixture of paper based and scanned medical records. RN La Roche was hopeful that by the end of 2014, MMC would have a fully integrated electronic medical record system that would automatically populate risk assessments, static factors or historical events.[108]

Risk Assessments

50. A/Prof Wong reported in his statement to the Coroner, that if Mr Sawan's risk assessment remained low, his unaccompanied leave could continue. At Inquest, A/Prof Wong stated that this referred to Mr Sawan's risk of suicidality, self harm and absconding.[109] Dr Thomas' evidence was consistent with A/Prof Wong's.[110] RN Vuat stated "*when someone goes out on leave they're the things I'm thinking about.*"[111] RN Singh stated that if a patient is assessed as medium risk for suicidality, self harm or absconding, they will not be allowed leave.[112]

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[104] Transcript, page 196.
[105] Transcript, page 197.
[106] Transcript, page 198.
[107] Transcript, page 241-242.
[108] Transcript, page 197.
[109] Transcript, page 136.
[110] Transcript, page 73.
[111] Transcript, page 61.
[112] Transcript, page 101.

51. RN Singh believed he had become familiar with Mr Sawan's behaviour and the signs associated with risk. He relied on this familiarity when conducting risk assessments. The risk assessment conducted by RN Singh on 15 November 2011 at 3.15pm, documented that Mr Sawan's risk for suicidality, self harm and absconding was low. RN Singh stated he determined this based on Mr Sawan's answers to direct questions, such as "*do you have any ideas of killing yourself, self harming...or killing anyone else.*"[113] A/Prof Wong stated clinicians have to make a judgment on whether the responses received from the patient are reliable or not.[114] He believed the risk assessment conducted by RN Singh fell within the requirements for granting leave, adding that his risk of suicidality, self harm and absconding remained consistently low during his admission.[115] He stated if clinicians had known about Mr Sawan's arson history, he would have been asked specific questions about the risk of arson, regardless of how far in the past these instances were, as it remained a risk factor which needed to be assessed specifically.[116]

52. RN La Roche gave evidence that at the time of Mr Sawan's death, there was no protocol in place requiring a risk assessment be conducted prior to a patient's leave. On 15 November 2011, a risk assessment was conducted approximately 30 minutes before Mr Sawan went on leave. RN La Roche stated this was probably good practice rather than driven by protocol.[117] She further stated the timeliness of this assessment was quite reasonable in the circumstances.[118]

Mr Sawan's unescorted leave on the afternoon of 15 November 2011

53. A/Prof Wong gave evidence that leave is a part of a patient's treatment.[119] He stated the aim is to get the patient ready to return to the community and part of this process is to allow the patient to go on leave in a step-by-step manner.[120] No conditions were specified on Mr Sawan's 'Leave of Absence for an Involuntary Patient form' completed by A/Prof Wong. He stated that when there are no conditions, leave will be guided by a patient's risk assessment, mental state and their request for leave.[121] Dr Thomas similarly gave evidence that when a

[113] Transcript, pages 96 - 97.
[114] Transcript, page 139.
[115] Transcript. page 138.
[116] Transcript, pages 152 – 153.
[117] Transcript, page 205.
[118] Transcript, page 220.
[119] Transcript, page 131.
[120] Transcript, page 132.
[121] Transcript, page 158.

Consultant Psychiatrist specifies no leave conditions; this is at the discretion of nursing staff.[122]

54. Dr Thomas was of the understanding that leave for an involuntary patient is based on a patient's request. The Consultant Psychiatrist assesses the patient and if the patient is close or ready for discharge, they would be trialled on leave by starting accompanied leave and building towards unaccompanied leave and overnight leave. After leave has been approved, the allocated nurse conducts a risk assessment and then based on that risk assessment a patient is granted leave.[123] A/Prof Wong expects that if nursing staff had concerns about a patient's approved leave, they would contact the medical doctor on duty.[124] RN Singh stated that if a risk assessment did not accord with a patient's approved leave, he would talk to the nurse in charge, Consultant Psychiatrist and the treating team before allowing patient to go on leave.[125]

55. RN Vuat gave evidence that when a patient asks for leave the procedure followed by nursing staff is to check if the patient has been granted leave and then speak to the patient, determine why they want leave and then conduct a risk assessment.[126]

56. RN Vuat gave evidence she would have cancelled Mr Sawan's leave if she had been informed about Mr Sawan asking for petrol.[127] RN Zahau stated if she had the information, she would have cancelled Mr Sawan's leave and notified a doctor, as "it would have been of great concern."[128] A/Prof Wong would have terminated leave had he known about Mr Sawan asking for petrol and he would have determined him to be high risk.[129] Counsel for Monash Health conceded that it is highly doubtful Mr Sawan would have been granted unaccompanied leave if that information was available.[130] A/Prof Wong stated that if any patient asked for petrol, it would affect their approved leave, even without a history of arson. It is a potential risk and must be addressed seriously. [131] Counsel for Monash Health accepted A/Prof Wong's evidence and stated had Monash Health known about Mr Sawan asking for petrol, it would have caused

[122] Transcript, page 74.
[123] Transcript. page 70.
[124] Transcript, page 158
[125] Transcript, page 103.
[126] Transcript, page 41.
[127] Transcript, page 51.
[128] Transcript, page 161 and 169.
[129] Transcript. page 150.
[130] Transcript, page 92.
[131] Transcript, pages 155 – 156.

alarm bells to ring and as a matter of significance should have been brought to the attention of clinical staff.[132]

Response to Mr Sawan failing to return on time

57. It was determined at Inquest that Mr Sawan was documented to return from leave at 5.30pm.[133] When Mr Sawan failed to return RN Singh stated he spoke to the nurse who was on NCL observations who advised him he had not returned. He then called Mr Sawan's SRS in an attempt to locate him.[134] RN Singh stated "*we didn't determine he was missing...we just gave him one hour more otherwise we would have been...in the process of referring him to the police as a missing person.*"[135] RN Singh went on a meal break at 6.00pm and said he was going to implement the AWOL procedure after he finished his break.[136]

58. RN La Roche gave evidence that clinicians do not always call the police when a patient is missing if there is another way to get the patient back to hospital.[137] RN La Roche would expect the allocated contact nurse to check their patient returned from leave on time and this is overseen by shift leaders. When a patient does not return on time, the nurse in charge should be notified and there must be a discussion about how concerned clinicians are and what action should be taken.[138] RN La Roche stated that the procedure has "*been tightened up...I think people just exercise due caution and notify the police pretty much immediately.*"[139] However, she then qualified this saying there is still some flexibility based on risk assessments and Mental Health Act status.[140]

59. Counsel for Monash Health stated the events on the afternoon of 15 November 2011 should not have occurred and proffered an apology on behalf of the organisation.[141]

IMPROVEMENTS TO THE DELIVERY OF HEALTH SERVICES

60. I am satisfied that Monash Health undertook a root cause analysis after Mr Sawan's death, and in response made a number of recommendations to address identified care management problems.[142]

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[132] Transcript, page 197.
[133] Transcript, page 128.
[134] Transcript, page 122.
[135] Transcript, page 123.
[136] Transcript, page 123-124.
[137] Transcript, page 210.
[138] Transcript, page 210.
[139] Transcript, page 218
[140] Ibid.
[141] Transcript, page 249.

a. The review panel found that additional information, available in previous CAT team episodes of care did not appear to have been utilised by hospital staff when determining Mr Sawan's level of risk. In response, the review panel made a recommendation that the Mental Health Program develop a process for ensuring previously documented clinical information is readily accessible to all clinical staff.

    i. Action taken: The Mental Health Program determined that clinical staff should have and utilise access to the Scanned Medical Record to obtain relevant past history and provide up to date clinical information on all clients. In-service education sessions on the use of SMR were provided across all clinical teams by Health Information Services personnel. The Executive Director of Mental Health distributed a memo to all clinical staff instructing them to register that they had read and understood the SMR user guide. Team Managers were required to submit the register showing that 100% of their staff had signed off indicating that they understood the SMR user guide and had access to the SMR system. Orientation to the electronic medical record system is included in organisational and local induction procedures.

b. The review panel found that the concerns of the case manager did not appear to have been utilised in determining the patient's level of risk. In response, the review panel recommended the Mental Health Program ensure that information from all clinical and other relevant sources is incorporated and formally included in risk assessments and medical record.

    i. Action taken: review of the Clinical Risk Management (CRM) modules 1 & 2 training package was undertaken in April 2012 to include and highlight the need to incorporate all clinical and other relevant sources of information in risk management assessment. CRM training is compulsory for all Mental Health Program staff and now forms part of the Building of Expertise core competency training which is completed by all mental health clinicians. The Mental Health Nurse Education Team retains a data base to monitor and record staff attendances at CRM modules.

c. The review panel found that the Mental Health Act leave of absence of an involuntary patient form allows for leave to be approved in advance without the need for review of the patient's risk assessment immediately prior to leave. In response the panel made a

[142] Exhibit 10 – Statement of Kerrie La Roche, dated 10 December 2013.

recommendation that the Mental Health Program review Monash Health's 'leave of absence' Procedure to ensure that leave is reviewed in conjunction with changes in a client's most recent risk assessment and their level of nursing care.

i. Action taken: The Executive Director of Mental Health convened a working party in January 2012 to review the procedure. A revised procedure was developed which included the introduction of a leave form for voluntary patients. The new procedure was circulated to all staff. A follow up questionnaire was forwarded to staff to determine if they were aware of and understood the leave procedure. Results tabled in May 2012 showed that 99.1% had read the new procedure. Of these respondents 3.5% indicated that they did not understand the procedure and required further education.

ii. A comprehensive audit of leave procedure compliance in Mental Health was also conducted in July 2012. The report from this audit showed that all of the Leave of Absence forms audited were valid with regard to correct date range (the duration of authority was for no longer than seven consecutive days.)

d. The review panel found there was a failure to escalate critical information received by staff from a co-patient / visitor. Mr Sawan's approval for leave was not reviewed with the benefit of that critical information

i. Action taken: escalation procedures were understood to exist for mental health nursing staff. However, clear documented procedures were not available. A handover project was conducted in 2010-2011. The recommendations of the project included that 'standard work and instruction / protocols' be created. In response, acute inpatient unit's trialled new formats for handover which were observed, studied and critically reviewed. The mental health shift to shift handover implementation tool, using ISBAR principles, came out of that review.

ii. With regard to the failure to escalate critical information, the panel determined that there may have been non-system issues related to this case. The executive director of Mental Health reviewed the non-system issues.

COMMENTS:

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

1. I acknowledge the difficulty for health clinicians to manage and treat individuals with a mental illness. I also acknowledge clinicians have a difficult balancing act to synthesise information obtained from a number of sources including medical records, community case managers and their own contemporaneous assessment of a patient. Communication of information obtained about patients to other clinicians is the most effective tool in the development of the skill of analysing and assessing risks that may be attached to the information. Documentation of such communication is the means of securing it as a historical record.

FINDINGS

1. The standard of proof for coronial findings of fact is the civil standard of proof, on the balance of probabilities, with the *Briginshaw* gloss or explication.[143] The effect of the authorities is that Coroners should not make adverse findings against or comments about individuals, unless the evidence provides a comfortable level of satisfaction that they caused or contributed to the death.
2. I find the identity of the deceased is Moufid Sawan
3. I note Monash Health made a number of concessions at Inquest.
4. I find there were a number of shortfalls in the care provided to Mr Sawan, which I consider did not equate to the appropriate delivery of care required for involuntary psychiatric patients.
5. I find that Monash Health clinicians failed to fully inform themselves about Mr Sawan's extensive history, resulting in significant treatment decisions being made in a vacuum.
6. I accept the evidence of Associate Professor Wong, Dr Thomas, Registered Nurse Singh, Registered Nurse Vuat and Registered Nurse Zahau that had they known Mr Sawan was asking for petrol, his leave on 15 November 2011 would have been cancelled. I find there was a breakdown in effective communication between treating clinicians.

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[143] *Briginshaw v Briginshaw (1938) 60 CLR. 336 esp at 362-363.* "The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding, are considerations which must affect the answer to the question whether the issues had been proved to the reasonable satisfaction of the tribunal. In such matters "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences..."

7. In considering the totality of the evidence, I find that it has been proved to a *reasonable satisfaction*[144] the death of Mr Sawan could have been prevented on 15 November 2011.

8. I acknowledge and commend Monash Health on its internal review. While I was not privy to the primary document reflecting the internal review, I was advised of the relevant aspects.

9. I make no recommendation in this matter as I am satisfied on the evidence that Monash Health has responded to the identified shortcomings in its care of Mr Sawan and implemented restorative and preventative measures in response.

10. I accept and adopt the medical cause of death as identified by Dr Matthew Lynch and find that Moufid Sawan died from complications of cutaneous burns in circumstances where I am satisfied that he intended to take his own life.

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

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

Mr Frank Sawan

Mr John Snowdon, Monash Health

Ms Susan Van Dyke, Monash Health

Leading Senior Constable Amanda Maybury

Dr Mark Oakley Browne, Chief Psychiatrist

Signature:

AUDREY JAMIESON
CORONER
Date: **28 August 2015**

Coroners Court of Victoria

[144] Ibid.