Coroners Act 1996
[Section 26(1)]

Western *Australia*

RECORD OF INVESTIGATION INTO DEATH

Ref: 53/12

I, Barry Paul King, Coroner, having investigated the death of ***Gregory Laurence Hunt*** *with an inquest held at the* ***Perth Coroner's Court, Court 51, CLC Building, 501 Hay Street, Perth,*** *on* ***25 February 2014****, find that the identity of the deceased person was* ***Gregory Laurence Hunt*** *and that death occurred on* ***22 February 2011*** *at* ***Sir Charles Gairdner Hospital*** *from* ***ligature compression of the neck*** *in the following circumstances:*

Counsel Appearing:

Ms M Smith assisting the Coroner
Ms R Hartley (State Solicitors Office) appearing on behalf of the Health Department of WA, and Tracey Coleman, Gemma Vasoli and Dr Gabor Ungvari
Ms B Burke (Australian Nursing Federation) appearing on behalf of Timothy Chan

Table of Contents

Introduction 2
The Deceased 4
The Deceased at Graylands to 2010 5
The Deceased in prison 7
The Deceased's last admisssion to Graylands 8
Events leading up to the death 10
Cause and manner of death 12
Quality of supervision treatment and care 13

INTRODUCTION

1. Gregory Laurence Hunt (**the deceased**) died on 22 February 2011 after he had hanged himself while he was a patient at Graylands Hospital (**Graylands)**.

2. As the deceased was an involuntary patient under the *Mental Health Act 1996* at the time of his death, he was a 'person held in care' under section 3 of the *Coroners Act 1996*.

3. Section 22 (1)(a) of the *Coroners Act 1996* provides that a coroner who has jurisdiction to investigate a death must hold an inquest if the death appears to be a Western Australian death and the deceased was immediately before death a person held in care.

4. An inquest to inquire into the death of the deceased was therefore mandatory.

5. Under s.25 (3) of the *Coroners Act 1996*, where a death investigated by a coroner is of a person held in care, the coroner must comment on the quality of the supervision, treatment and care of the person while in that care.

6. The death of the deceased was investigated together with the death of nine other persons who immediately before death had been persons held in care as involuntary patients at Graylands under the *Mental Health Act 1996*.

7. A joint inquest commenced before Coroner D.H. Mulligan in the Perth Coroner's Court on 27 August 2012. Evidence specific to the deceased was adduced on 25 March 2013 when four witnesses gave oral testimony. The joint hearings were completed on 22 April 2013.

8. Coroner Mulligan became unable to make findings under s.25 of the *Coroners Act 1996,* so I was directed

by Acting State Coroner Evelyn Vicker to investigate the deaths.

9. To remove any doubt of my power to make findings under s.25, on 25 February 2014 I held another inquest into the death of the deceased. The evidence adduced in that inquest was that which had been obtained by Coroner Mulligan, including exhibits, materials and transcripts of audio recordings of the inquests. Interested parties who were present at the inquests before Coroner Mulligan were invited to make fresh or further submissions. All of the parties indicated their agreement with the appropriateness of the procedure I had adopted.

10. I should note that there was a great deal of evidence adduced at the inquest that was related to general or systemic issues pertinent to Graylands. That evidence was adduced to investigate whether those issues had a bearing on any or some of the deaths and to allow the coroner to comment on the quality of supervision, treatment and care of the deceased patients. For example, evidence of the condition of the buildings at Graylands containing wards was provided in order to allow the Court to investigate whether the physical environment of the wards would have been more therapeutic had the buildings been refurbished.

11. That general evidence was useful in providing an overview of the context in which the deceased persons were treated for their mental illnesses; however, in my view many of the issues the subject of that evidence were not sufficiently connected with all the respective deaths for me to comment on those issues under s.25 (2) or (3) of the *Coroners Act 1996* generally as if they did.

12. I have therefore not addressed those general issues separately from a consideration of each death. Rather, where I have come to the view that the issues were connected with the death or were potentially relevant to the quality of the supervision, treatment and care of the

deceased, I have addressed them in the respective findings.

THE DECEASED

13. The information available with respect to the deceased's personal history is scant, primarily because he was unwilling to disclose such information to hospital staff. To the extent that there is any information, some of it appears to be inaccurate.

14. It does seem clear that the deceased was born at King Edward Hospital on 8 January 1958 and that he had two older brothers. His mother has informed the Court that, when the deceased was four years old, his father was lost at sea during a fishing expedition and his death affected the three boys deeply.[1]

15. When the deceased's mother remarried, her new husband was a widower with a daughter. She and her children moved to her new husband's wheat and sheep property near Moora where the boys took readily to farming activities and sports. The deceased enjoyed cricket and football at which he excelled. He was a quiet likeable boy with a terrific sense of humour and an approachable soft manner. The deceased's mother and stepfather had two further children.[2]

16. According to the medical records, the deceased said that he finished year 12 at Kelmscott High School and then left Australia for London where he worked in the building industry, though this may be inaccurate.[3]

17. It does seem clear that in 1976 the deceased was diagnosed with schizophrenia.[4] At some stage after that he received a disability support pension as he was unable to find employment due to his condition.

[1] Ex 1, Vol 1, Tab 12; another source indicates that the deceased's father was lost at sea in November 1961
[2] Ex 1, Vol 1, Tab 12
[3] Ex 1, Vol 2, Tab 1, p31
[4] Ex 1, Vol 1, Tab 23

Records indicate that the deceased's father and one of his brothers also suffered from schizophrenia.[5]

18. Since he was first diagnosed with schizophrenia, the deceased had several admissions to mental health facilities, including Graylands, Heathcote Hospital and Bentley Mental Health Service. He was admitted to Graylands over 40 times before his death. He had no insight into his mental illness, and his condition did not significantly improve despite the use of various combinations of antipsychotic medications, but there was no proven history of suicide attempts or deliberate self-harm.[6]

19. The deceased lived an itinerant lifestyle characterised by homelessness and low level criminal activity such as assaults, public indecency and stealing,[7]. That lifestyle was punctuated by admissions to health facilities and prison.[8] He never married and had no children.[9]

THE DECEASED AT GRAYLANDS TO 2010

20. The following information relating to the deceased's early admissions to Graylands was provided by his last treating psychiatrist, Dr G S Ungvari, who reviewed the deceased's complete medical history of 11 volumes of records in order to provide the Court with a very useful report.[10]

21. The deceased was first admitted to Graylands in March 1981 as a voluntary patient following a recent history of heavy drinking and alcohol abuse. At that stage it seems that he was still able to function at a higher level and be relatively self-sufficient though he had been living in a hostel and had been receiving treatment for schizophrenia for some time. He was treated with

[5] Ex 1, Vol 1, Tab 20, p3; Tab 23
[6] Ex 1, Vol 1, Tab 20, p2
[7] Ex 1, Vol 1, Tab 30
[8] Ex 1, Vol 1, Tab 20
[9] Ex 1, Vol 1, Tab 12
[10] Ex 1, Vol 1, Tab 20

antipsychotic medication for about a month and was discharged to his mother's care.[11]

22. The deceased presented again at Graylands in February 1982 with paranoid hallucinations. After treatment and discharge, he was admitted again four months later with schizophrenia and secondary depression as a reaction to his schizophrenia. He responded well to treatment and was discharged after 20 days.

23. About a year later, in March 1983 the deceased was admitted to Graylands following a relapse of his symptoms after he stopped his medications. His response to treatment was not as straightforward as previously, but he was eventually discharged to live with a friend after a good remission was achieved.

24. In June 1983 the deceased was admitted to Graylands with the same presentation as previously, but at this time he told staff that he had made numerous suicide attempts and felt that he wanted to die because he could not go on with things. That statement was not substantiated. He was discharged after three weeks in an improved condition.

25. The deceased's sixth admission to Graylands took place over five days from the end of September 1983. During his seventh admission over 11 days at the beginning of February 1984, the deceased was found to be very depressed and extremely psychotic, but no antidepressant was administered. This admission was the last time that the deceased was noted to have suffered from depression.

26. For the next 26 years the deceased's condition deteriorated despite his regular and frequent admissions to Graylands and to other facilities, including Bentley Mental Health Service where he had several admissions.[12] He had an itinerant lifestyle and did not comply with medications, which may have

[11] Ex 1, Vol 1, Tab 20, p4
[12] Ex 1, Vol 1, Tab 20, p6; Tab 23

contributed to the ineffective results of his long-term psychiatric treatment.

THE DECEASED IN PRISON

27. The following is based primarily on a report provided to the Court by Joe Apai, Coordinator of Coronial Inquests at the Department of Corrective Services, following a request on behalf of Coroner Mulligan by Counsel Assisting. Mr Apai's report relates to the deceased's supervision, treatment and care in prison from 8 October 2009 to 8 April 2010.[13]

28. The deceased was received into custody at Hakea Prison on 8 October 2009 on assault and breach of bail charges. He was placed on the At Risk Management System and placed in a Crisis Care Unit cell overnight in accordance with departmental protocol until he was ascertained to be not at risk of self-harm. The next day he was placed on the Support and Management System whereby he was monitored and supported by an inter-disciplinary team given his vulnerability to the mainstream prison population.

29. In mid-December 2009 the deceased was transferred to the Frankland Centre at Graylands for treatment for four days due to his refusal to take medication, and upon return to Hakea he was again processed through the same admission procedure.

30. On 29 December 2009 the deceased was sentenced to six months imprisonment back-dated to 8 October 2009. The next day a parole checklist performed for his potential early release recommended that parole be denied because of a lack of a viable parole plan and because he still presented a risk to the community.

31. On 4 January 2010 parole was denied. On 18 February 2010 the deceased was transferred to Acacia Prison to serve the remainder of his sentence. He was eventually

[13] Ex 1, Vol 4, Tab 9

placed in the general population in a cell in which he was the sole occupant.

32. On 30 March 2010 the deceased was transferred to Frankland Centre for mental health review due to concerns raised by the manager of the unit in which the deceased was accommodated. The deceased was becoming intrusive and overly familiar with other prisoners, so the manager was concerned that he was at risk of assault.

33. On 8 April 2010 the deceased's sentence was completed, so he was no longer imprisoned under the *Prisons Act 1981*, but he remained at Graylands as an involuntary patient from then.

34. The Director of Health Services of the Department of Corrective Services commissioned consultant psychiatrist Dr Silva Bala to provide an independent review of the deceased's care and treatment in prison from 8 October 2009 to 30 March 2010. Dr Bala considered the department's three volumes of medical notes relevant to the deceased and provided a report dated 16 December 2012.[14]

35. Dr Bala concluded that the deceased had received appropriate psychiatric treatment while in custody.

THE DECEASED'S LAST ADMISSION TO GRAYLANDS

36. When the deceased was received into the Frankland Centre on 30 March 2010 his symptoms included delusions of grandeur, hostility and abusiveness. The admission notes relate that he had no feelings or thoughts of harm to self or others. He lacked spontaneity and displayed an angry sullen affect. He had no insight.[15]

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[14] Ex 1, Vol 4, Tab 2
[15] Ex 1, Vol 3, p41-43

37. The deceased stayed in the Frankland Centre until a bed became available in a civil ward on 11 June 2010. He was then placed in Montgomery Ward, a locked ward. He was moved to Plaistowe Ward, an open ward, on 15 June 2010, but was moved back to Montgomery Ward after he absconded and was brought back to Graylands by police the next evening.[16]

38. On 23 June 2010 he was again moved back to Plaistowe Ward and he was accepted into the rehabilitation stream of Graylands. He remained at Plaistowe Ward for five days, only to be returned to Montgomery Ward due to the deterioration of his mental state.[17] He was then moved back to Plaistowe Ward on 7 July 2010 where he remained until he died, though he did abscond overnight on 5 August 2010 before returning on his own the next day.

39. Over the next few months the deceased changed little. His symptoms of paranoid and grandiose delusions and his irritability with others fluctuated. He tended to remain dishevelled and he became increasingly prone to spend his days on a bench on the veranda of the ward.[18]

40. By November 2010 the deceased's treating team was considering preparing the deceased for discharge under a Community Treatment Order.[19] They faced a dilemma in that arranging accommodation for him in the community was difficult due to his risks and difficulty with engagement with others.[20]

41. On 1 February 2011 Dr Ungvari became the deceased's treating psychiatrist. On 3 February 2011 his new medical officer, Dr G Cuk, saw the deceased, who stated that he wanted to move on and that he had been told by the previous team that he could be discharged.[21] As a

[16] Ex 1, Vol 2, Tab 2, p71-74
[17] Ex 1, Vol 2, Tab 2, p79-83
[18] Ex 1, Vol 2, Tab 2; Vol 3 p118-137
[19] Ex 1, Vol 1, Tab 22
[20] Ex 1, Vol 3, p126
[21] Ex 1, Vol 4, Tab 3, Attachment 1

result, on 8 February 2011 the welfare officer at Graylands went to see the deceased, who expressed his desire for accommodation to be found for him. The deceased said that he was not happy with all the changes to staff. The welfare officer told him that options would be explored once the new treating team had got to know him.[22]

42. Dr Ungvari told the Court that for some time the deceased's condition was such that he would have been able to be discharged to a supervised and closely monitored community facility, at least for a while. That was the aim of the team, and the welfare officer was trying to find a hostel that could accommodate the deceased and would be willing to take him. It would take weeks if not months to find such a place.[23]

EVENTS LEADING UP TO THE DEATH

43. At 9.00am on 21 February 2011 the deceased acted as chairperson at a weekly patient meeting held at Plaistowe Ward. Such meetings were held to allow patients to air compliments, complaints or concerns. The deceased was in a happy mood and chaired the meeting with good humour.[24]

44. At 2.00pm that afternoon Tracey Coleman RN made an entry into Grayland's integrated progress notes for the deceased to the effect that, apart from attending the patient meeting, the deceased also wrote several letters that day. Nurse Coleman noted that the deceased was dishevelled and was not looking after his activities of daily living, but that he had adequate dietary intake and was not exhibiting overt psychotic features.[25]

[22] Ex 1, Vol 3, p134
[23] ts 67
[24] ts 34
[25] Ex 1, Vol 3, p137

45. Nurse Coleman later stated that there was nothing about the deceased's conduct during the early shift on 21 February 2011 that was cause for concern.[26]

46. The night shift on 21 February 2011 commenced around 11.00pm as usual. Between 11.30pm and 11.45pm the deceased was seen by a nurse, Gemma Vasoli RN, to be getting himself a coffee. Nurse Vasoli and another nurse saw the deceased again during a security check at 3.00am the next morning. At that stage, the deceased was walking from the men's bathroom back to the room he shared with another patient.

47. After 3.00am on 22 February 2011, Stephen West, a patient and a friend of the deceased, went to the men's bathroom to smoke a cigarette because he could not sleep. In the men's bathroom he could hear someone in a shower and had the feeling that it might be the deceased. He asked out loud if it was the deceased but there was no response. He went to the deceased's room in order to get tobacco.

48. When Mr West returned to the men's bathroom in about five or ten minutes he saw the deceased in a disabled persons' shower stall hanging by the neck with a shower hose connected to the wall. Mr West ran down the corridor toward the nurses' station to get help.

49. At about 3.40am on 22 February 2011 the nurses on the shift in Plaistowe Ward were in the nurses' station when Mr West banged on the nurse's station door and said that the deceased had hanged himself in the bathroom. The nurses immediately ran to the bathroom, taking with them cutters and calling for the medical emergency team. They saw the deceased still hanging with the shower hose around his neck.

50. Timothy Chan RN cut the deceased down so that CPR could be administered, and Nurse Vasoli went back to

[26] Ex 1, Vol 4, Tab 4; ts 37

the office for resuscitation equipment. Nurse Chan obtained a defibrillator from the ground floor and it was attached to the deceased, but no shock was given as instructed by the machine.

51. Ambulance paramedics arrived promptly and took over resuscitation. They conveyed the deceased to Sir Charles Gairdner Hospital where resuscitation attempts continued without success. The deceased was certified life extinct at 5.01am on 22 February 2011.

CAUSE AND MANNER OF DEATH

52. On 24 February 2011 Chief Forensic Pathologist Dr C.T. Cooke examined the deceased. Dr Cooke found marking to the skin of the neck and fractures of both sides of the thyroid cartilage. There was congestion to the skin of the face and small blood spots around the eyes consistent with neck compression. The lungs were congested, consistent with asphyxiation. Dr Cooke found no external evidence of recent injury to the limbs, neck, chest or abdominal walls and no fracture or bruising of the head.[27]

53. A toxicology analysis showed therapeutic levels of prescribed-type medications and no alcohol or other common drugs.[28]

54. Dr Cooke's conclusion, which I accept, was that the cause of death was ligature compression of the neck (hanging).

55. On the basis of the facts detailed above, I find that the manner of death was suicide.

[27] Ex 1, Vol 1, Tab 7
[28] Ex 1, Vol 1, Tab 8

QUALITY OF SUPERVISION TREATMENT AND CARE

56. The evidence establishes that the deceased suffered from the debilitating condition of schizophrenia from an early age and that, despite relatively short periods of respite, the condition gradually but inexorably deteriorated until he became chronically psychotic.[29]

57. For almost 30 years the deceased was a regular patient at Graylands where he was treated with a variety of medications with varying success. It seems that for many years the deceased's lack of insight into his illness and his unwillingness to comply with his medication regimes made treating him problematic to manage.

58. For at least the last few years of his time at Graylands, the deceased was a quiet and polite patient who kept a low profile.

59. In my view the evidence available to me consistently shows that the deceased received appropriate levels of supervision, treatment and care while at Graylands during his last admission.

60. As to the fact that the deceased committed suicide while at Graylands, it is clear that there was no basis for the staff at Graylands to have considered him to have been at risk of suicide. For years the deceased did not appear to have suicidal or self-harm ideation of any sort.

61. Dr Ungvari said that he could find no evidence that the deceased had ever had a full-blown depressive illness.[30] He said that it was relatively uncommon for a patient who had been suffering from a long-term psychotic illness to commit suicide out of the blue as the deceased did. He said that impulsivity was a risk factor and that the deceased used to be impulsive, but for the last year of the deceased's life he had not been impulsive at all.

[29] ts 67
[30] ts 66

62. Dr Ungvari noted that people who are suicidal usually give hints of some sort and that the deceased was in the company of well-trained nurses who knew him well, but he gave no hints at all.

63. Dr Ungvari concluded that the deceased's suicide was caused by an impulse which he could not resist and that the suicide was one which Graylands staff could not have prevented. There is no evidence to suggest otherwise.

64. As to the existence of the shower hose in the men's bathroom which the deceased used as a ligature with which to hang himself, in hindsight it would clearly have been preferable if a different shower arrangement had been in place at the time. That said, it would be speculative for me to find that the deceased would not have died had the shower hose not been available.

65. I accept that there is a reasonable argument that an open ward such as Plaistowe Ward where patients are at generally at low risk of self-harm does not warrant the removal of all ligature points. I also accept the submission that it is worth remembering that the patients in open wards have access to the whole of the facilities and grounds of Graylands, where ligature points abound.

66. A countering argument would be that places where patients can remain out of sight of staff and other patients should have ligature points reduced if reasonably practicable given that there is a potential for patients who suffer from impulsivity to harm themselves without notice and given that hanging as a means of attempting suicide is notoriously effective.

67. That logic seems to have been behind the fitting of other anti-ligature fittings in the bathroom on Plaistowe Ward prior to the deceased's death.[31] Evidence adduced on 18 April 2013 showed that, following the deceased's death,

[31] Graylands General Transcripts 18 April 2013 p. 67

the shower hose in the shower at Plaistowe Ward was removed and not replaced.

68. In these circumstances I am not in a position to offer a specific recommendation in relation to what further steps Graylands might take in order to address any remaining ligature points at the hospital.

69. However, in my view Graylands should continue to attempt to identify and, if reasonably practicable, remove potential ligature points as an ongoing improvement of the facility.

B P King
Coroner
11 April 2014