Coroners Act 1996
[Section 26(1)]

Western *Australia*

RECORD OF INVESTIGATION INTO DEATH

Ref: 47/17

I, Sarah Helen Linton, Coroner, having investigated the death of ***Vincent Tavita Tolai SCHWENKE*** *with an inquest held at the* ***Perth Coroner's Court, Court 51, CLC Building, 501 Hay Street, Perth*** *on* ***30 November 2017 and 1 December 2017*** *find that the identity of the deceased person was* ***Vincent Tavita Tolai SCHWENKE*** *and that death occurred on* ***11 December 2015*** *at* ***Sir Charles Gairdner Hospital*** *as a result of* ***complications of ligature compression of the neck (hanging)*** *in the following circumstances:*

Counsel Appearing:

Sgt L Houisaux assisting the Coroner.
Ms P Mangan (Minter Ellison) appearing on behalf of St John of God Hospital Midland.

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INTRODUCTION

1. Vincent Tavita Taolai Schwenke (the deceased) died on 11 December 2015 at Sir Charles Gairdner Hospital. At the time of his death, the deceased was an involuntary patient. He had been receiving care for a mental health condition at St John of God Public Hospital in Midland (SJOGPHM) but had been found hanging in the ensuite bathroom of his room on the morning of 10 December 2015. The deceased was resuscitated by hospital staff and taken by ambulance to Sir Charles Gairdner Hospital where he was placed on life support. Testing showed he had suffered a catastrophic brain injury and after discussing his poor prognosis with the deceased's family, doctors declared him brain dead and removed his life support on the morning of 11 December 2015.

2. As the deceased was an involuntary patient at the time of his death, he was a 'person held in care' for the purposes of the *Coroners Act 1996* (WA). In such circumstances, a coronial inquest is mandatory.[1]

3. I held an inquest at the Perth Coroner's Court, commencing on 30 November 2017 and concluding on 1 December 2017.

4. The documentary evidence comprised a comprehensive report of the death prepared by the Western Australia Police.[2] The author of the report, Senior Constable Nigel Brown, was also called as a witness at the inquest. In addition, evidence was heard from medical and nursing staff from SJOGPHM and staff from the State Mortuary in relation to some evidentiary issues.

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. In that context, the evidence at the inquest focussed primarily on the medical care and supervision provided to the deceased while a patient at Royal Perth Hospital (RPH) and SJOGPHM and leading up to the incident where he was found hanging. No concerns were raised about the deceased's care while he was at Sir Charles Gairdner Hospital (SCGH).

BACKGROUND

6. The deceased was born in New Zealand. He was of Maori descent with connections with two tribal groups. He completed his schooling in New Zealand before he moved to Perth with his family in 2008. He found work as a trade assistant and yard man. The deceased later obtained his scaffolding tickets and became a casual worker with skilled work forces. He had a solid employment history.[3]

7. The deceased enjoyed keeping fit and joined a gym where he took up boxing. He had no known physical or mental illnesses and was generally happy and

[1] Section 22(1)(a) *Coroners Act*.
[2] Exhibit 1.
[3] Exhibit 1, Tabs 1 and 2.

healthy. He was described as a sociable person who drank alcohol in moderation and was also a regular smoker of marijuana.[4]

8. In June 2014 the deceased attended the Heights Medical Centre in Alexander Heights He complained of vague neurological symptoms and fatigue. The deceased was diagnosed with possible fibromyalgia and had a series of blood tests, all of which yielded normal results.[5]

9. The deceased returned for review in July 2014 and was diagnosed with generalised anxiety disorder with somatic symptoms. He was started on the antidepressant medication escitalopram and referred to a psychologist. When he was reviewed again in August 2014 the deceased reported he was still taking the escitalopram and his anxiety symptoms were better and his neurological symptoms appeared to have resolved. There was an indication in the notes that the deceased would be referred to a psychologist for counselling, but this does not appear to have eventuated.[6]

10. Shortly prior to his death the deceased was given an opportunity to work on Barrow Island, which he was keen to take. However, the job opportunity was subject to the deceased successfully undergoing a drug screen. The deceased was enthusiastic about the prospect of getting the job and made a decision to cease smoking marijuana in preparation for the drug test. After ceasing marijuana use the deceased began to experience sleeping difficulties. He tried acupuncture without success and his mother then purchased some 'sleep aid' from a chemist, which also did not appear to resolve his insomnia.[7]

11. On 29 November 2015 the deceased consulted with general practitioner Dr Marhaf Kalaji at Rudloc Road in Morley. The deceased told the doctor of his difficulties sleeping after recently ceasing marijuana use. The deceased was prescribed Endep 25mg (amitriptyline), a tricyclic antidepressant medication that is also used in low doses to aid sleep.[8] The deceased's mother reported that the deceased took the amitriptyline tablets for two days but then decided the medication was not helping and threw the remainder of the tablets away.[9]

12. The deceased's mother indicated they then called out a locum doctor to their home as the deceased was still unable to sleep and was talking about self-harming to help him sleep. The locum doctor asked the deceased if he was hearing 'voices', which he denied. The deceased was prescribed temazepam and told if he felt like self-harming he should call an ambulance.[10]

[4] Exhibit 1, Tab 2.
[5] Exhibit 1, Tab 16.
[6] Exhibit 1, Tab 16.
[7] Exhibit 1, Tab 2 and Tab 7.
[8] Exhibit 1, Tab 17.
[9] Exhibit 1, Tab 7.
[10] Exhibit 1, Tab 7.

RPH ED ATTENDANCES 3 – 4 DECEMBER 2015

13. On Thursday, 3 December 2015 the deceased told his mother that he wanted to jump off Guildford Bridge in order to knock himself out so he could sleep. This caused her to call for an ambulance.[11]

14. The deceased was taken by ambulance to hospital and presented to the Emergency Department at RPH just before 9.00 am on 3 December 2015. He gave a history of insomnia, anxiety and low mood after ceasing smoking cannabis for the past two weeks. He denied any suicidal ideation at that time. The deceased's mother recalled he told the nurse that he had been banging his head at home to help him sleep and it was noted he reported bruising and a lump to his head from this conduct.[12]

15. The deceased had not been taking his amitriptyline. Following assessment he was advised to restart the amitriptyline and to see his GP for ongoing follow up.[13]

16. According to the deceased's mother, after leaving the hospital the deceased tried to get his prescription filled at a chemist in Bayswater but they declined to fill it as the prescription was missing some information.[14]

17. The deceased's mother recalled that the following day the deceased saw a doctor at Alexander Heights Family Practice and was prescribed more amitriptyline, although this is not reflected in the practice medical record.

18. Later that day, being 4 December 2015, the deceased re-attended the RPH ED at 10.06 pm. Again his major presenting symptom was ongoing problems with insomnia. It was noted that he had been seen in the ED the night before. The deceased presented as calm, pleasant and cooperative and his observations were all normal. He reported increasing thoughts of suicide and anxiety attacks, but with no intent or plan.[15]

19. The deceased's case was discussed with the psychiatry team, who suggested a trial of olanzapine 5 mg for 5 days and to refer him to a community mental health team through his GP. The deceased was administered one dose of olanzapine before being discharged.[16]

20. The deceased's mother reported that one of the tablets given to the deceased, which seems to be the olanzapine, appeared to help him sleep. On his return home the deceased went to bed and later told his mother he had slept for six hours on and off.[17]

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[11] Exhibit 1, Tab 7 [23] – [24].
[12] Exhibit 1, Tab 7 [26] and Tab 18.
[13] Exhibit 1, Tab 18.
[14] Exhibit 1, Tab 7 [30] – [31].
[15] Exhibit 1, Tab 18.
[16] Exhibit 1, Tab 18.
[17] Exhibit 1, Tab 7 [36].

RPH ED ATTENDANCE 7 DECEMBER 2015

21. The deceased returned to the RPH ED at around 6.00 pm on 7 December 2015. He was accompanied by his mother. She recalls the deceased told the triage nurse that he was feeling suicidal because he couldn't sleep although the hospital notes suggest that the concern about the deceased jumping off the Guildford Bridge was also mentioned.[18] The deceased appeared very confused during this presentation and he reported ongoing difficulties with concentration.[19]

22. The deceased had not been compliant with the medications previously prescribed and he was experiencing ongoing problems with insomnia, anxiety and confusion and felt afraid. The deceased's mother reported that his family had noted an acute change in the deceased's behaviour and personality over the preceding two to three weeks and he had regressed to almost childlike behaviour. He wanted her to be around all the time, slept in her bed and became upset if he was left alone. The deceased told a medical officer he was afraid he would hurt his mother, but was unable to explain why or how he might do so. A family history of schizophrenia was noted.[20]

23. Unlike at previous presentations, the deceased admitted suicidal ideation together with a plan, explaining he felt suicidal because of the thoughts of causing others harm.[21]

24. The deceased was assessed by various medical and nursing staff from the psychiatry department and the neurology department. Organic causes were looked for with the aid of examination, blood tests and a head CT scan. The blood tests showed a slightly raised white cell count. A head CT showed no acute pathology. A urine drug screen was negative for illicit drugs.[22]

25. At some stage the deceased's mother asked the deceased if he was feeling hungry and he told her that he was. She went to ask a nurse for some food and while she was talking to the nurse she turned and saw the deceased standing on the edge of the bed with his arms stretched out. The deceased then unexpectedly nosedived from his bed head first onto the floor. He then stood up and appeared to be climbing up onto the bed ready to jump again.[23]

26. Doctors and nurses attended. A psychiatric medical officer, Dr Murray, asked the deceased why he had done that but the deceased did not provide an explanation. His mother asked him if he was hearing voices, which he denied. However, Dr Murray queried whether the deceased was experiencing command hallucinations that were causing his bizarre behaviour. The deceased had sustained a laceration to his head in the fall, which was stitched and stapled. The overall impression was that the deceased had symptoms suggestive of a first psychotic episode and it was agreed he

[18] Exhibit 1, Tab 7 and 18.
[19] Exhibit 1, Tab 18.
[20] Exhibit 1, Tab 18 and Tab 19.1 and Tab 21.
[21] Exhibit 1, Tab 18 and Tab 19.1.
[22] Exhibit 1, Tab 18.
[23] Exhibit 1, Tab 7 and 18.

needed further assessment. He was made an involuntary patient under the *Mental Health Act.*[24]

27. The deceased was given a number of doses of midazolam and haloperidol overnight on 7 to 8 December 2015.[25]

RPH ASSESSMENT ON 8 DECEMBER 2015

28. The deceased's mother had gone home overnight to rest but returned to the hospital at about 8.00 am on 8 December 2015. The deceased had just finished his breakfast as his mother arrived and he was being observed by a nurse. The deceased started shaking and told his mother he was scared, so she sat with him on the bed and calmed him until he went to sleep. He woke up every so often and spoke a little, then went back to sleep.[26]

29. At 10.40 am on 8 December 2015 the deceased was noted to have developed a stiff jaw and rigid upper limbs, which were felt to be side effects of the antipsychotic medication he had been given. Further doses of the haloperidol were withheld and he was given benztropine instead.[27]

30. The deceased woke up late morning and appeared to be feeling a bit better. He had something to eat and drink but then started crying and drifted off to sleep again.

31. A full psychiatric assessment was requested, which was performed by Dr Wellborn on 8 December 2015. Dr Wellborn was of the opinion that the deceased had catatonia (intermittent muscle rigidity and mutism) and he was noted to be feeling anxious, fearful and suspicious. Diagnoses of anti NMDA receptor (anti-NMDAR) encephalitis and serotonergic syndrome were being explored.[28]

32. Anti-NMDAR encephalitis is a disease that occurs when antibodies produced by the body's own immune system attack NMDA receptors (proteins that control electrical impulses in the brain). Their functions are critical for judgment, perception of reality, human interaction, the formation and retrieval of memory and the control of unconscious activities such as breathing and swallowing (also known as autonomic functions). Many people complain of 'flu-like' symptoms around the time that their disease begins and the possibility that an infection triggers or contributes to the development of the disease is being actively considered in research. A diagnosis of anti-NMDAR encephalitis requires antibodies to be detected, which can be found in the blood or spinal fluid, although the tests on spinal fluid are more accurate.

33. The deceased was waitlisted for a bed in a secure psychiatric ward. While waiting for a bed to become available the deceased remained in a bed on the

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[24] Exhibit 1, Tab 7.
[25] Exhibit 1, Tab 18.
[26] Exhibit 1, Tab 7.
[27] Exhibit 1, Tab 18.
[28] Exhibit 1, Tab 18.

emergency ward. The plan was to repeat his blood tests, treat his catatonia with high dose lorazepam (a benzodiazepine) and obtain a neurological opinion regarding the possibility of anti-NMDAR encephalitis.[29]

34. At 5.15 pm the deceased was reviewed by a neurologist. By the time he was seen by the neurologist the deceased's parents reported that the deceased had slept for several hours in the ED and he was feeling better. The deceased denied any further suicidal thoughts or hallucinations. He was noted to have slightly increased tone but no focal neurological symptoms and no reported autonomic instability. The neurologist felt that the deceased had catatonia, which had improved after treatment with benzodiazepines. The neurologist concluded it was unlikely that the deceased had anti-NMDAR encephalitis. The neurologist formed the opinion that the deceased could be transferred and conveyed this view to Dr Wellborn.[30]

35. A bed became available at SJOGPHM in the secure ward of their Mental Health Unit. It was felt that the deceased's judgment was impaired and he did not have the capacity to make decisions about his treatment. He was considered to pose a risk to himself and his reputation, which are relevant factors in deciding to hold a person as an involuntary patient. The deceased's parents were told that the deceased would be transferred to the secure facility at SJOGPHM as an involuntary patient as he had harmed himself and did not have capacity to sign himself out as a patient.[31]

36. The deceased walked to the ambulance for his hospital transfer and appeared to his mother to be cheerful and happy. She told him she would meet him at SJOGPHM.[32]

TRANSFER TO SJOGPHM

37. The deceased was transferred in the early evening of 8 December 2015. He was admitted directly to the secure ward (4B) of the SJOGPHM Mental Health Unit. On arrival the deceased was seen by the Psychiatry Duty Medical Officer and the ward nurses. A Risk Assessment and Management Plan was completed and the deceased was directed to remain on 60 minute observations. He was seen to be quiet but settled.[33]

38. He was reviewed by the Psychiatric Duty Medical Officer, who completed a Mental Health Assessment. The deceased reported feeling depressed due to financial and family stress. He was noted to be guarded, with poor judgment and insight. A risk assessment form was completed. The deceased was assessed as a high risk of self-harm and medium risk of suicide. He was written up for temazepam, quetiapine and lorazepam and paracetamol to take as needed. He was to be reviewed by the team the following morning.

[29] Exhibit 1, Tab 21.
[30] Exhibit 1, Tab 21.
[31] Exhibit 1, Tab 7 and Tab 18 and Tab 19.1.
[32] Exhibit 1, Tab 7.
[33] Exhibit 1, Tab 19.1 and Tab 22.

39. The deceased's parents had gone home and collected some food and clothing for him, which they brought to SJOGPHM. They met the deceased in a waiting room and he seemed chirpy and was happy to return to his room after their visit.[34]

40. The deceased was reviewed by the team consultant psychiatrist, Dr Briggs, and a senior medical practitioner, Dr Tarani, at around lunchtime on 9 December 2015. The interview process in total took approximately one and a half to two hours. During the interview the deceased reported feeling better since transferring hospitals. He identified his main symptoms prior to hospitalisation as having trouble sleeping and feeling anxious and felt these symptoms had resolved. Dr Briggs considered the deceased showed marked improvement (both subjective and objective) in his mental state compared to his initial presentation at RPH. The deceased described his mood as happy although he was still troubled when discussing recent experiences and was somewhat vague and perplexed. There was no evidence of formal thought disorder and he denied any hallucinations (visual or auditory). He denied ongoing suicidal or homicidal thoughts or plans and was able to guarantee his safety on the ward. The treating doctors were not alarmed or concerned about his personal safety.[35]

41. He reported that he had been worrying about everything and couldn't sleep. He felt sad and depressed over the last few weeks and had felt like life was not worth living. He was worried about being unemployed. He claimed he felt comfortable on the ward but also indicated he no longer had thoughts of suicide or homicide and felt he didn't need to be in hospital. He expressed a preference to go home.[36]

42. The medical team's impression was that the deceased was suffering a psychotic illness that was atypical in nature. Several features of his history suggested an organic cause. The differential diagnoses were of possible resolving anti-NMDAR encephalitis, first episode psychosis or cannabis withdrawal related symptoms, although his marked improvement made the latter two appear less likely. The deceased did not appear psychotic or clinically depressed at the time of his interview.[37]

43. The deceased's parents visited him for lunch and brought more clothing, shoes and thongs. A nurse told them that the deceased wasn't allowed shoelaces so they took the shoes back home with them. During the visit the deceased appeared to be a little upset as he had heard that he was going to be locked up and didn't understand why. The deceased's parents were informed that he needed to be assessed for a further 48 hours and they could meet and speak with the deceased's doctor the following afternoon. The deceased's mother tried to reassure the deceased and explained that he had to stay in the hospital for his own safety.[38]

[34] Exhibit 1, Tab 7.
[35] T 6; Exhibit 1, Tab 19.1
[36] Exhibit 1, Tab 22.
[37] Exhibit 1, Tab 19.1 and Tab 22.
[38] Exhibit 1, Tab 7.

44. The deceased was placed on a Form 3C under the *Mental Health Act* authorising his continued detention in the secure ward for a period of ongoing assessment.[39] It was thought necessary given the potential fluctuation in his mental state and to allow for further observation and full organic workup to be performed. The deceased was spoken to by hospital staff and he expressed a preference to be discharged home as he was feeling better. However, it was eventually thought he was agreeable to ongoing admission after the reasons were explained to him. He was not given any regular antispsychotics in view of his improved mental state and was prescribed benzodiazepines on an 'as needs' basis.[40]

45. The deceased was reported to engage well in group activities that afternoon and no concerns were raised. The visual observation chart was recorded every hour and staff did not observe any concerning behaviour.[41]

46. The deceased rang his mother at about 5.30 pm that evening and asked if the rest of his family were coming to visit him. She assured him they were and told him to rest until they got there. The family went to the hospital and had a long visit. The deceased continued to tell his mother he was scared, which appears to have related to the behaviour of some of the other patients.[42]

47. A physical examination was performed by Dr Tarani at 7.25 pm that evening. No alarm bells were raised in relation to the deceased during that examination.[43]

48. The deceased spoke to the Nursing Shift Coordinator sometime after she started her shift at 9.00 pm. He appeared calm and settled and asked for a drink. He then returned to his room.[44]

49. The deceased was spoken to by Registered Mental Health Nurse Kim Peppiatt and Enrolled Mental Health Nurse Sandy Marks at about 9.30 pm. The deceased was in bed lying under the covers at the time. He was alert and made eye contact. The deceased was pleasant and communicating with the nursing staff although he did not initiate conversation. The deceased was offered his medication and accepted 20mg of temazepam and 1gm of paracetamol for his sore neck.[45]

50. The deceased was on 60 minute observations, so he was meant to be observed every hour by staff and a recording made of whether he was sleeping or awake and any other relevant observations. The deceased appeared to be asleep on most checks during the night. Nurse Peppiatt did not observe the deceased to get up at any stage. On one occasion Nurse Marks found the deceased not in bed. She went looking for him and found him in his bathroom. The deceased was facing her and Nurse Marks spoke to him and said, "I didn't see you in bed – I thought you had been

[39] Exhibit 1, Tab 22, 3.31.
[40] Exhibit 1, Tab 19.1.
[41] Exhibit 1, Tab 19.1.
[42] T 6, 8; Exhibit 1, Tab 7.
[43] T 6.
[44] Exhibit 1, Tab 11.
[45] Exhibit 1, Tab 8.

kidnapped."[46] The deceased stared at her and did not respond. Nurse Marks did not see the deceased return to bed at that time but he was noted to be in bed during the later security checks.[47]

51. The nursing staff recalled the night was busy and there were some complex issues dealing with other patients during the night, including a patient who continually undressed and another patient who was aggressive and trying to leave the ward. However, there were no issues with the deceased. The deceased was reportedly last checked at 6.05 am and observed to be sleeping.[48]

52. Nurse Marks gave evidence that there was nothing in the deceased's behaviour overnight that gave her any concern that he might harm himself. If she had felt any concern, there were steps she could take, but there was nothing about his behaviour that night that made her feel this was indicated.[49]

EVENTS SURROUNDING THE DEATH OF THE DECEASED

53. At about 7.00 am on 10 December 2015 Nurse Marks commenced the next security check with the morning shift nurse as part of the shift handover. They started at room 1 and checked each patient until they reached the deceased, who was in room 15. The deceased's room was the last room to be checked.

54. Nurse Marks looked through the windows of the deceased's room and noted the deceased was not in bed. She opened the door and heard running water in the ensuite bathroom. Nurse Marks knocked on the door and received no response. Nurse Marks knocked on the door again and called out that she was opening the door. She then used her keys and opened the bathroom door. Nurse Marks looked in to the bathroom and immediately saw the deceased hanging from the shower head.[50]

55. Nurse Marks recalled the water was running and she observed a wet white towel wrapped around the shower head. She saw a thin black cord, that she assumed was a shoelace, tied around the towel and around the deceased's neck. The deceased's feet were touching the floor and his knees were slightly bent. He was wearing black tracksuit pants but no shirt. Nurse Marks called to the other nurse to go and get help and the nurse activated the alarm button. In the meantime Nurse Marks removed the towel from the shower head so that she could lower the deceased to the floor.[51]

56. The other nurse then assisted Nurse Marks to lay the deceased flat on the bathroom floor. Nurse Marks checked for signs of life and could not find any.

[46] Exhibit 1, Tab 9 [10].
[47] Exhibit 1, Tab 8 and Tab 9.
[48] T 21; Exhibit 1, Tab 8 and Tab 11.
[49] T 21 -22.
[50] Exhibit 1, Tab 9 and Tab 10.
[51] Exhibit 1, Tab 9 and Tab 15.

Nursing staff began performing cardiopulmonary resuscitation and then the MET team arrived and took over the deceased's care.

57. The deceased was transferred to the Emergency Department, arriving there at 7.30 am. The ED staff had been alerted and were ready to assist with resuscitation. Return of spontaneous circulation was obtained but the deceased suffered four further cardiac arrests during the next hour. He was intubated and his cardiovascular instability gradually resolved and he became haemodynamically stable.

58. While the deceased was still in the ED a head CT scan was performed, which showed a likely significant hypoxic brain injury. His case was discussed with a doctor at Sir Charles Gairdner Hospital's (SCGH) Intensive Care Unit and a decision was made to transfer the deceased by ambulance to SCGH where he was admitted to the Intensive Care Unit.[52]

59. The deceased's family had been notified by a police officer as the hospital had experienced problems contacting them. The deceased's family followed the ambulance to SCGH. It was explained to the deceased's family that the deceased had a non-survivable brain injury and aggressive treatment was futile. The deceased's family stayed with the deceased throughout the night.[53]

60. On 11 December 2015 brain death testing was completed and his death was confirmed at 10.29 am.[54]

CAUSE OF DEATH

61. A post mortem examination was performed by Forensic Pathologist Dr Daniel Moss on 16 December 2015. The post mortem examination revealed a ligature mark to the neck and there was evidence of a "heart attack" (myocardial infarction). The lungs were noted to be firm and heavy and microscopic examination confirmed extensive bronchopneumonia.[55]

62. Toxicology analysis showed therapeutic levels of paracetamol and the benzodiazepine temazepam. Amitriptyline, nortriptyline and lignocaine were found in the liver.[56]

63. At the conclusion of all investigations Dr Moss found the cause of death was complications of ligature compression of the neck (hanging).[57] I accept and adopt the conclusion of Dr Moss as to the cause of death.

64. At a later stage, following the receipt of additional information obtained as part of the coronial investigation, Dr Moss requested further investigation to

[52] Exhibit 1, Tab 15.
[53] Exhibit 1, Tab 20.
[54] Exhibit 1, Tab 3.
[55] Exhibit 1, Tab 5.
[56] Exhibit 1, Tab 5.
[57] Exhibit 1, Tab 5 and Tab 6.

determine whether the deceased had NMDA receptor antibodies. The antibody testing was done and the result was negative.[58]

65. Microscopic examination of the brain was also performed, which showed changes of recent global cerebral ischaemia (consistent with what was previously known about the circumstances of the death) but was negative for encephalitis and letopmeningitis. Following those investigations the cause of death remained unchanged.[59]

MANNER OF DEATH

66. It is important to note that at the time the deceased put the ligature around his neck he was an involuntary psychiatric patient. This alone does not mean that he was unable to form an intent to take his life, but it is relevant to consideration of his mental state at the time of the relevant event.

67. Dr Amit Banerjee is a Consultant Psychiatrist and Head of Department at SJOGPHM's Mental Health Unit. He has held that position since the hospital opened on 23 November 2015 (only a few weeks prior to the deceased's death).[60] Dr Banerjee did not treat the deceased, but was involved in the hospital's review of the case after his death and had reviewed the deceased's medical records. Dr Banerjee was called as a witness at the inquest to answer questions about the deceased's care while in the hospital.

68. After reading the medical record and speaking to the relevant treating staff, Dr Banerjee had formed the opinion that the deceased had an acute polymorphic (meaning changing) psychotic disorder during his admission, the cause of which was difficult to determine although it is known to more commonly arise in non-Caucasian populations (noting the deceased was of Maori descent). While at SJOGPHM his symptoms had reduced and his mental state was reported to be improving but it was also noted that his mood fluctuated.

69. Dr Banerjee advised that the doctors who treated the deceased at SJOGPHM were very experienced mental health practitioners and they had not seen any behaviour that suggested he might have been actively suicidal.[61] One of them had reviewed the deceased at approximately 7.30 pm the night before he died, and had seen nothing to cause concern.

70. However, Dr Banerjee noted the difficulty with the deceased's suicidal ideation was that it appeared to be fluctuating, which made it a very difficult thing to pick when he might be suicidal. The evidence suggested the deceased's mental state had undergone a change on the morning that he hanged himself and has woken up actively suicidal.[62]

[58] Exhibit 1, Tab 5.
[59] Exhibit 1, Tab 5.
[60] T 49.
[61] T 8.
[62] T 10.

71. I explored with Dr Banerjee what he considered to be the level of the deceased's capacity to form an intention to take his life at that time, given his mental health issues. Dr Banerjee expressed the opinion that the deceased was likely suicidal but may not have had the full capacity to understand that he might die from his actions. Dr Banerjee believed the deceased's actions may also have been affected by his psychosis, given there was an element of lack of rationality in his behaviour overnight.[63]

72. The evidence before me does not allow me to reach a conclusion to the requisite standard that the deceased was in a position to know and understand the nature and consequences of his actions. Accordingly, I make an open finding as to the manner of death.

QUALITY OF SUPERVISION, TREATMENT AND CARE

73. 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.

Decision to hold the deceased as an involuntary patient

74. At the time the deceased was transferred to SJOGPHM as an involuntary patient, he had been expressing suicidal and homicidal thoughts and been behaving in a bizarre manner, which had led him to injure himself by jumping headfirst on to the floor. He was thought to be experiencing psychosis but a diagnosis as to the cause was difficult to identify. His capacity to make decisions about his medical care was also thought to be impaired by his psychosis. In those circumstances, I am satisfied it was appropriate to admit the deceased to a secure bed as an involuntary patient while further efforts were made to diagnose and treat his acute mental illness.

75. After a period of time at SJOGPHM the deceased's symptoms appeared to be improving and he indicated that he felt better and wanted to go home. Dr Banerjee acknowledged that the deceased had expressed a preference to go home, but noted his diagnosis was still not clear and his mental state was fluctuating, which weighed against a decision to discharge at that stage. Dr Banerjee believed it was necessary and appropriate to continue to detain the deceased while further efforts were made to diagnose his condition.[64] I accept the medical evidence that the highly unusual nature of the deceased's presentation made a clear diagnosis difficult, and in those circumstances it was appropriate to continue to keep the deceased as an inpatient while further investigations were conducted.

76. I also note that it appears that the deceased was agreeable to staying in hospital, once these reasons were explained to him.

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[63] T 11.
[64] T 3; 8 – 9.

77. The deceased's family expressed concern that the deceased had been frightened by the behaviour of other patients the night before he died. The evidence of the nurses on shift overnight confirmed that there were some disruptive patients engaging in behaviour that may have been confronting for other patients, such as the deceased.

78. Dr Banerjee acknowledged in his evidence that the secure mental health ward can be a traumatic environment, depending on what other patients are on the ward, and he was not surprised to hear the deceased had told his family he was frightened. However, it did not appear that the deceased communicated his concerns to the nursing staff. Dr Banerjee advised that mental health staff are aware of the need to be receptive to patient and family concerns, but in this case without those concerns being raised with staff, it was difficult for them to respond appropriately.[65]

79. The deceased's family have questioned why the deceased was not placed on closer observations given he had expressed thoughts of suicide and done an injury to himself while at Royal Perth Hospital. The deceased had been on hourly observations while at Royal Perth Hospital, and this was maintained once at SJOGPHM.

80. The evidence of Dr Banerjee was that the deceased's behaviour once at SJOGPHM had been reassuring and he had strongly denied any ongoing suicidal thoughts or plans. His condition was believed to be improving and after review by two experienced mental health practitioners on the day before his death, there were no concerns at that stage about his personal safety. The evidence of the nursing staff was that the deceased's behaviour did not flag any change in his level of risk while they observed him overnight. Nurse Marks, who had cause to speak to the deceased overnight, was clear that the deceased had not behaved in a way that gave her any indication that his mental state might be deteriorating.[66]

81. There are steps that can be taken to increase the level of observation of a patient who is believed to be at risk of harming themselves, which can escalate to the level of 'one on one' staff to patient observation. However, Dr Banerjee noted that having a staff member sitting 'one on one' with a patient can often be "seen as quite intrusive"[67] by a patient, and this may adversely affect their mental health. Therefore, it is a balancing exercise between monitoring at a level that is safe against minimising the impact of being in a closed environment and providing a patient with some privacy.[68]

82. In the case of the deceased, while it was known that he had been expressing thoughts of suicide prior to his admission at SJOGPHM, reassurance was taken from his generally settled behaviour once admitted and the apparent improvement in his symptoms, which he had himself expressed. This suggested to the experienced psychiatric team managing his case that the level of risk he presented to himself was low. Sadly, this ultimately proved to

[65] T 3; 8 – 9.
[66] T 6, 22; Exhibit 1, Tab 19.1.
[67] T 15.
[68] T 15.

be incorrect, but there is nothing in the medical notes to suggest that such a conclusion was unreasonable based upon what was known at the time.

83. The medical care the deceased received appears to have been of a reasonable standard and the evidence suggests his death was unpredictable and unexpected.

Ligature

84. An issue arose during the coronial investigation as to the ligature used by the deceased. After his death at Sir Charles Gairdner Hospital the Coronial Investigation Squad were notified of the circumstances of the death. Police officers attended at SCGH and then the following day police attended at SJOGPHM.[69]

85. Police officers were given an opportunity to examine the room at SJOGPHM where the deceased had been found hanging, which was then photographed, and they also met with hospital staff. At this time Senior Constable Nigel Brown was also handed the ligature, which had been taken from the deceased's room and carefully stored by hospital staff. It was appropriately secured in a hospital biohazard bag, which Senior Constable Brown did not open. Senior Constable Brown was told by hospital staff that it was a shoelace, and it appeared to him that it resembled "a black shoelace or possibly a long cord." The bag was photographed from the front and back, with its contents visible through the tinted plastic.[70] Attempts were also made to obtain the towel that had been described as being used with the seized ligature, but the towel could not be located. It was thought that it may have been inadvertently moved by cleaning staff at the hospital.[71]

86. After leaving the hospital Senior Constable Brown and another office conveyed the ligature in the bag straight to the State Mortuary, where the body of the deceased was being held. The purpose of delivering the ligature to the mortuary was to assist the forensic pathologist who would be conducting the post mortem examination.[72]

87. At the State Mortuary the bag containing the ligature was handed to the Manager of the State Mortuary, Mr Anthony Wight.[73] This action was later recorded by Senior Constable Brown as an entry in the police running sheet, which records the steps done by police as part of the investigation.[74] Senior Constable Brown confirmed at the inquest that he did not provide a property receipt to the hospital staff member who gave him the ligature, nor did he receive one from Mr Wight.[75]

88. Mr Wight provided a statement and also gave evidence at the inquest about the procedure that has until now been in place at the State Mortuary in

[69] T 7 – 10.
[70] T 11 – 12, 14; Exhibit 1, Tab 25, Photos 10 & 11.
[71] T 17 – 18.
[72] T 17 – 18.
[73] T 15.
[74] T 15.
[75] T 18.

regard to ligatures. In effect, if a ligature comes in with the body, it is videotaped as part of the initial admission examination of the body and then remains with the body. However, if a ligature comes in separately to the body, it is not recorded in any way and is not placed with the body. Instead, the ligature is simply placed by mortuary staff in the mortuary theatre in case the forensic pathologist wished to view it during the post-mortem.[76]

89. The problem with this system is demonstrated in this case, as there was evidence before me that the ligature could not be located when enquiries were made on behalf of this Court as to the precise nature of the ligature.

90. The forensic pathologist who performed the post mortem examination, Dr Daniel Moss, gave evidence at the inquest that he had viewed the admission video and confirmed that the ligature did not accompany the deceased's body. Dr Moss gave evidence that if the ligature was not with the body, he would usually make enquiry with mortuary staff to see if it could be located.[77] If Dr Moss has viewed a ligature as part of the post mortem examination process, he will always make a reference to doing so in the post mortem report, and will also photograph it as part of the documentation in a case such as this. The fact that there was no reference to the ligature in his report and no photograph of it, indicated that he did not have access to the ligature when performing the post mortem examination.[78]

91. Dr Moss and Mr Wight both gave evidence that it was not unusual for a ligature not to be present when conducting a post mortem examination involving a suspected hanging; indeed, in Dr Moss' experience there is a ligature available in less than half of the cases he sees.[79]

92. Neither Dr Moss nor Mr Wight disputed the evidence of Senior Constable Brown that he had delivered the ligature to the State Mortuary. A search was done of the State Mortuary at a later stage, but the ligature could not be located.[80] The evidence was to the effect that the ligature was most likely received from police and placed in the theatre prior to the post mortem, but that it was not brought to the attention of Dr Moss when he came to do the post mortem so he was unaware that it was available and did not view it. At some later stage it would have been disposed of as part of a periodical mortuary process of destruction of ligatures more than one month old.[81]

93. The fact that the ligature was lost had the result that the police investigation was unable to identify precisely what item the deceased had used to hang himself.[82] This also meant that the police were unable to identify how the ligature came into the possession of the deceased.[83]

94. The term 'shoelace' was used at an early stage in the investigation (including by the nurses who found the deceased) and it appears that other people

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[76] T 28 – 29, 35; Exhibit 1, Tab 27.
[77] T 36 – 37.
[78] T 36 – 38.
[79] T 31, 33.
[80] T 32.
[81] T 29, 31 - 32.
[82] T 24.
[83] T 24.

adopted the term and it was perpetuated throughout the investigation. However, Senior Constable Brown acknowledged in his evidence that the repeated reference to a shoelace was potentially misleading. The evidence was that the hospital staff had not permitted the deceased to have shoes with shoelaces, and his parents had taken them home. It was suggested that it may have been a drawstring cord taken from an item of the deceased's clothing, such as a pair of tracksuit pants or sweatshirt or some other item. However, this theory could not be tested given the ligature was not examined by hospital staff or police officers prior to handing it to the State Mortuary and the ligature was subsequently lost.[84]

95. After the failings in the ligature management system were highlighted during this coronial investigation, steps were taken by the WA Police to improve the system of recording and retaining such items. During the inquest Senior Constable Brown advised that since that time the Coronial Investigation Squad has firmed up practices and procedures in relation to ligature management and there is now a positive management system in place. There is now a clear procedure that documents the police management of the ligature, which is treated as an exhibit, and ensures that the ligature is safely stored until three months after the coroner's findings are completed.[85]

96. This procedure deals with how the ligature is handled by police and provided to the State Mortuary, and how it is collected and store by the police after the post mortem examination is complete. However, there is still a gap in the procedure while the ligature is in the possession of the State Mortuary.

97. Dr Jodi White has been a forensic pathologist at the State Mortuary for many years and has recently taken the position as Head of Department, which in effect replaces the former position of Chief Forensic Pathologist at the State Mortuary. Following enquiries by the Coroner's Court in relation to the location of the ligature in this case, Dr White conducted a review of the Coronial Mortuary and Forensic Pathology Procedures Manual. Dr White ascertained that the manual refers to an Exhibits Book in which exhibits such as ligatures are intended to be entered by the Mortuary Manager on receipt from police. However, further enquiries by Dr White with mortuary staff established that no such exhibits book has been kept, at least for several years, and Dr White was unable to locate one at the State Mortuary.[86]

98. Subsequent to this inquiry, Dr White reviewed mortuary procedures and documentation for receipt of exhibits (being all non-clothing/personal property items) relating to a death Dr White gave evidence at the inquest and confirmed that there was no current system for logging ligatures and no process for recording the receipt of ligatures that come in separate to the body. Dr White also advised that she has now written up a final procedure, which is about to become official and be put into practice by mortuary staff. The procedure will include the receipt of all exhibits, date of receipt and person receiving the item, as well as any later examination and disposal of the item (including where collected by CIS officers). Where an item comes in

[84] T 20.
[85] T 21 – 23; Exhibit 1, Tab 29.
[86] Exhibit 1, Tab 30.

separate to the body, it will be mandatory for the mortuary staff member who receives the item to speak to the case pathologist so that they are aware it has been received.[87]

99. Dr White indicated that audits will be undertaken to make sure that the process is working well and being followed after it is implemented.[88]

100. I am satisfied that the new procedure implemented by the WA Police and the proposed procedure for the State Mortuary is designed to ensure that coronial exhibits that accompany, or are associated with, a body held at the State Mortuary will be documented and retained in an appropriate manner to preserve them until the coronial investigation is concluded.

Hospital procedures re ligatures and ligature risk minimisation

101. Without being able to identify what the deceased used as the ligature, it is difficult to comment on how this death might reflect upon SJOGPHM's practices involving patient's access to items that might be used to harm themselves in such a manner.

102. However, to the extent that this issue could be explored, I note that Mr Neil Rigby, the Nurse Unit Manager at SJOGPHM gave oral evidence at the inquest and a detailed report was provided by Mr Jeffrey Williams, the Director of Nursing at SJOGPHM, both providing information about the admission procedures, as well as the design of the unit in terms of hanging point minimisation.[89]

103. Following the death of the deceased SJOGPHM also initiated its own internal investigation into the circumstances of the death, known as a 'root cause analysis'.[90] One of the recommendations of the root cause analysis was to suggest a review of the mental health policies to include searching of patients and removal of property that may cause harm. Specifically, it suggested the removal of shoelaces from all secure mental health unit patients, irrespective of the patient's risk assessment, as well as removal of any other property deemed to be a risk.[91]

104. Contrary to the recommendation for removal of all shoelaces that arose from the internal hospital review, the Chief Psychiatrist wrote a letter to the SJOGPHM encouraging the hospital to reintroduce shoelaces "as the overall dignity of appropriate street dress is important for both reintegration with the community and a person's sense of self worth."[92] Instead, the Chief Psychiatrist recommended that shoelaces should only be removed from a specific patient where it is considered necessary for the safety of a specific individual.[93]

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[87] T 43 – 45; Exhibit 1, Tab 30.
[88] T 46.
[89] Exhibit 1, Tab 19.
[90] T 25.
[91] T 26.
[92] Exhibit 1, Tab 19.1 and 19.11.
[93] Exhibit 1, Tab 19.1 and 19.11.

105. The current admission process for the Mental Health Unit involves a patient being assessed by a medic and nurse and then they are allocated a room. The patient is asked if they have any prohibited items (such as knives, firearms and anything else that can be used as a weapon, as well as alcohol, drugs and medication). They are then searched and their property is also looked through and checked off, with each item booked on a property list. All items that are considered to create the potential for self harm or harm to others are removed. What items are removed will depend upon their risk assessment. It may impact upon the type of clothing the patient is able to wear, as some clothing items may include potential ligature risks, such as shoelaces. All items removed from the patient's property are stored in a secure box in the nurses' station or returned to family members.[94] This is an improvement on the procedure at the time the deceased was admitted, as it appears from the internal review that no property list was completed for the deceased, which made it harder later on to identify what items of property he had available to him at the time of the attempted hanging.[95]

106. Mr Rigby advised that at the present time SJOGPHM continues to assess cases individually, as suggested by the Chief Psychiatrist, rather than having a blanket list of items to be removed (as recommended in the root cause analysis).[96] In assessing the level of risk associated with items, hospital staff are given guidance in the form of a guideline, which sets out 'prohibited items' that are inherently dangerous, such as knives, tools and sharp things, that could be used by patients as a weapon to harm themselves or others. The next level down are 'restricted items', which includes clothing items such as belts and shoelaces and dressing gown cords.[97]

107. Patients are assessed by a medical team on a daily basis as a minimum and all patients are allocated a nurse each shift, so they are assessed on a shift-by-shift basis to determine whether the level of risk has changed. If the risk has escalated, further personal items may be removed or, if the risk is thought to have reduced considerably, further items may be returned. There will also be a risk assessment prior to specific activities, such as ground access. It was described by Mr Rigby as a constant process.[98]

108. Mr Rigby also confirmed that if someone was thought to be actively suicidal or at very high risk of self harm, the removal of items would be accompanied by an increase in the level of clinical observations.[99]

109. Some of that risk can also be managed by the way the physical environment is constructed. In this case, SJOGPHM in Midland was a brand new hospital, which meant that its construction had been able to take advantage of the latest technology and up to date knowledge about ligature minimisation strategies. It was intended that the Mental Health Unit be as patient-centred as possible within the limitations of building a safe and therapeutic environment. The minimisation of ligature points was a key part

[94] T 37; Exhibit 1, Tab 19.1 and Tab 19.14.
[95] Exhibit 1, Tab 19.13.
[96] T 27.
[97] Exhibit 1, Tab 19.14.
[98] T 29; Exhibit 1, Tab 19.1.
[99] T 29.

of that strategy, but it is important to note this process involves *minimisation* of ligature (or hanging) points rather than *elimination*, as removal of all potential ligature points would not result in a therapeutic environment. The Office of the Chief Psychiatrist was involves in all aspects of the Mental Health Unit's design, construction and approval and there was extensive consultation with other key mental health experts in the design phase.

110. There was evidence before me that the Chief Psychiatrist had conducted an onsite inspection prior to the hospital opening and identified a number of key rectifications related to ligature minimisation and hanging points, such as the installation of 'anti-ligature' door handles, all of which were completed prior to the hospital opening.[100]

111. Nevertheless, as is now known, the deceased was able to access materials during his stay to hang himself in the en suite bathroom.

112. After the event, photographs were taken of the shower head, which shows it to be a very small, angled shower head with no arm extending it from the wall.[101] It is clear from the rest of the photos of the ensuite and bedroom that the room has been designed to reduce hanging points.

113. Some attempts were made by police officers to replicate the fashioning of the ligature on the showerhead, as described by the staff who found the deceased, but the testing proved inconclusive due to a poor recollection of how the towel was involved. However, it did seem clear that it was not easy to form a ligature with a bootlace on its own.[102]

114. As part of the internal hospital investigation the Chief Psychiatrist also attended the hospital and accompanied the senior management team to look at the bathroom and try to determine how the deceased was able to utilise the shower rose as a hanging point. It was noted that the design of the shower head is such that it does not have any identifiable part that could be used as a ligature point. Mr Rigby gave evidence that they were unable to determine how it was done, which is consistent with the evidence of the police investigators.[103]

115. Mr Rigby confirmed in his evidence that they have not had a repeat incident involving the shower rose being used as a hanging point.[104]

116. I am satisfied on the evidence before me that significant efforts have been made to minimise the opportunity for mental health patients at SJOGPHM to commit self harm, in particular by hanging. The death of the deceased, so soon after the Mental Health Unit had begun operating, prompted further review and consideration of ways in which the risk could be reduced further. However, I also accept that the measures that can be taken to prevent a patient hanging themselves must still be balanced against preserving the rights and dignity of each patient. In that regard, I accept that it is proper

[100] T 31; Exhibit 1, Tab 19.1.
[101] Exhibit 1, Tab 25, Photos 5 & 6.
[102] T 16 - 17.
[103] T 30; Exhibit 1, Tab 19.1.
[104] T 30.

where possible for medical staff to make an individual assessment of each parent's risk rather than implementing blanket bans on personal items other than clearly dangerous items such as knives.

CONCLUSION

117. The deceased was a 24 year old man who developed sudden onset symptoms of psychosis and mood disorder with suicidal thoughts. The symptoms developed after he stopped smoking marijuana for several weeks (having smoked it regularly for approximately a decade) in preparation for a new job. Up to that time the deceased had worked regularly and had no major psychiatric history.

118. With the support of his family the deceased took appropriate steps to obtain medical treatment, initially seeking help from a general practitioner and later presenting at a hospital ED as his symptoms escalated. He was eventually admitted to SJOGPHM Midland Psychiatric Unit on 8 December 2015 as an involuntary patient. Unfortunately, no clear diagnosis was made for his psychotic symptoms, although anti-NMDAR encephalitis was suspected and his cessation from marijuana use was also considered a possible contributor.

119. Before a final diagnosis could be made, and while still an involuntary patient at SJOGPHM, the deceased sustained irreversible brain damage after attempting to hang himself in his room.

120. The deceased's death occurred only a short time after the Mental Health Unit at SJOGPHM had opened and in spite of a rigorous design process aimed at reducing the risk of a patient self-harming. His death prompted an internal hospital review process as well as a coronial investigation. Unfortunately, the exact manner in which the deceased had been able to form a ligature could not be replicated, but the investigation process has identified other ways in which the care of patients at the Mental Health Unit could be improved.

121. The family of the deceased provided information to counsel assisting prior to the inquest about some of their concerns and the elder sister of the deceased gave evidence on behalf of the family at the inquest. It was apparent that his sudden and unexpected death has caused the deceased's family immense grief. They raised various questions and concerns about the hospital processes and procedures, both in relation to the care of the deceased and the liaison with the family after his death, and they acknowledged attempts were made to answer them during the inquest. In conclusion, the family also expressed their thanks to the nursing staff for reviving him enough that they were able to say goodbye to him before he died.

122. The decision of the deceased to take his life was unpredictable and sudden and I am unable to determine if he was truly suicidal, and not psychotic, when he did the act. Although in hindsight additional steps would have been able to be put in place to reduce his opportunity to self-harm, I am satisfied that the hospital care provided at SJOGPHM was appropriate and of a

reasonable standard and hospital staff responded appropriately to the level of risk he appeared to present to himself at that time. They also acted promptly and appropriately to provide him with emergency care when he was later discovered hanging.

S H Linton
Coroner
January 2018