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TITLE OF COURT:	Coroner's Court
JURISDICTION:	Darwin
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DELIVERED ON:	29 July 2011
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HEARING DATE(s):	9 June 2011
FINDING OF:	Mr Greg Cavanagh SM
CATCHWORDS:	**Mental illness, treatment and care, suicide, after care, counselling for bereaved family.**

REPRESENTATION:

Counsel:

Assisting:	Jodi Truman
Department of Health	Sally Sievers

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IN THE CORONERS COURT
AT DARWIN IN THE NORTHERN
TERRITORY OF AUSTRALIA

No. D0086/2010

In the matter of an Inquest into the death of
NICHOLAS EDWARD SPRING
ON 30 MAY 2010
AT RAYMOND STREET, GUNN,
IN THE NORTHERN TERRITORY OF AUSTRALIA

FINDINGS

Mr Greg Cavanagh SM

Introduction

1. Nicholas Edward Spring ("Mr Spring") was a Caucasian male born on 9 September 1984 in Darwin, in the Northern Territory of Australia. Mr Spring was found by his mother shortly after 2.00pm on Sunday 30 May 2010, lying on his back, face up, on the ground in the area beneath the family home. There was a rope tied tightly around his neck and a ladder lying on its side near his body.

2. Mr Spring had apparently hung himself using rope that he had cut from a hammock that was used downstairs in the underneath area of the house. He had then apparently climbed onto the ladder and tied himself to one of the beams. This death was reportable to me pursuant to s12 of the *Coroners Act* because it was unexpected and unnatural and appeared to have resulted from an accident or injury.

3. In addition there is evidence, later referred to in these reasons, which satisfies me to the required standard that Mr Spring took his own life.

4. Pursuant to s34 of the Act, I am required to make the following findings if possible:

"(1) A Coroner investigating:

a. A death shall, if possible, find:

(i) The identity of the deceased person.

(ii) The time and place of death.

(iii) The cause of death.

(iv) Particulars required to register the death under the *Births Deaths and Marriages Registration Act*".

5. Section 34(2) of the Act operates to extend my function such that I may comment on a matter including public health or safety connected with the death being investigated. Additionally, I may make recommendations pursuant to section 35 as follows:

"(1) A Coroner may report to the Attorney General on a death or disaster investigated by the Coroner.

(2) A Coroner may make recommendations to the Attorney General on a matter, including public health or safety or the administration of justice connected with a death or disaster investigated by the Coroner.

(3) A Coroner shall report to the Commissioner of police and Director of Public Prosecutions appointed under the Director of Public Prosecutions Act if the Coroner believes that a crime may have been committed in connection with a death or disaster investigated by the Coroner"

6. Counsel assisting me at this inquest was Ms Jodi Truman. Ms Sally Sievers was granted leave to appear on behalf of the Department of Health. I thank each Counsel for their assistance in this matter. It is noted that Ms Lesley Dias, the mother of the deceased, Mr Antony Spring, his father, and Ms Salima Spring, his sister, were in attendance at the inquest, together with

other extended family members and friends. I am aware from the evidence that the circumstances of this death have caused significant distress to the family who have a number of concerns related to the assistance that was offered to the deceased by Top End Mental Health Services and the Cowdy Ward, before he died. These were matters that I considered carefully throughout this inquest.

7. Five (5) witnesses were called to give evidence at the inquest. Those persons were:

   a. Detective Sergeant Annette Cooper, the officer in charge of the coronial investigation;

   b. Lesley Dias, the mother of the deceased;

   c. Registered Nurse ("RN") Julie Middleton, nurse at the Cowdy Ward during the course of the deceased's final admission;

   d. Dr Donna Schakelaar, the treating psychiatrist for the deceased at the relevant time; and

   e. Associate Professor Robert Parker, Director of Psychiatry at Top End Mental Health Service.

8. A brief of evidence containing statements from family members, medical staff, St John Ambulance personnel, and police, together with numerous other reports, photographs, and police documentation was tendered at the inquest (exhibit 2). The deceased's medical files was also tendered in evidence (exhibit 3). Public confidence in coronial investigations demands that when police (who act on behalf of the Coroner) investigate deaths, that they do so to the highest standard. I would like to thank Detective Sergeant Annette Cooper for her investigation.

Formal Findings

9. On the basis of the tendered material and oral evidence received at this Inquest I am able to make the following formal findings in relation to the death of Mr Nicholas Edward Spring, as required by the Act:

   i. The identity of the deceased person was Nicholas Edward Spring who was born on 9 September 1984 in Darwin, in the Northern Territory of Australia.

   ii. The time and place of his death was 3.25pm at the Royal Darwin Hospital on Sunday 30 May 2010.

   iii. The cause of death was hanging.

   iv. Particulars required to register the death:

      a. The deceased was a male.

      b. The deceased's name was Nicholas Edward Spring.

      c. The deceased was of Caucasian descent.

      d. The death was reported to the Coroner.

      e. The cause of death was confirmed by post mortem examination carried out by Dr Terence Sinton.

      f. The deceased's mother was Lesley Anne Dias and his father was Antony Langdon Spring.

      g. The deceased lived at 14 Raymond Street, Gunn in the Northern Territory of Australia.

      h. The deceased was a university student at the time of his death.

Circumstances Surrounding the Death

Background

10. Nicholas Edward Spring was the youngest child to Lesley Anne Dias and Antony Langdon Spring. He was born in Darwin in the Northern Territory and lived most of his life in Darwin. In the last few years he lived with his mother. I heard and received evidence that whist the deceased was a very well loved and supported member of the family, he did get into some trouble with authorities in his teenage years and then in July 2003 at the age of 18 he suffered his first major episode of mental illness.

Mental Health Intervention

11. On the materials tendered before me it appears that as a result of that first major episode, the deceased was detained for the very first time as an involuntary patient for approximately four weeks at the Cowdy Ward at the Royal Darwin Hospital ("RDH"). His considered diagnosis at that time was drug induced psychosis with hypo-manic features.

12. Following his release, his father took him to Perth. The family was concerned that he had several bad influences in Darwin that were affecting his behaviour and contributing to his drug and alcohol abuse. Unfortunately the deceased also got into trouble with the law in Perth and he returned to Darwin in about April 2004. He was not under any treatment at that time, having not seen any mental health authorities at any time following his departure from Darwin.

13. The next major episode of mental illness then occurred in about August 2004, only four months after his return to Darwin. His mother describes him in her statement as having been depressed and paranoid around this time. On this particular evening, the deceased barricaded himself in the spare bedroom and stabbed himself in the neck with a pair of dressmaking scissors. This was clearly a serious and distressing act of self harm.

14. Again he was admitted to hospital and was a voluntary patient at Cowdy Ward for approximately four weeks. I heard that the deceased recognised that he was seriously unwell and told his mother that during his period of paranoia he had believed that his family had all been murdered because of him. At that time he was diagnosed with schizoaffective disorder. I heard evidence that this is a disorder that has features of both schizophrenia, such as hallucinations, delusions and distorted thinking, and also a mood component such as depression or mania.

15. Following his discharge, the deceased was placed on several different medications including anti-psychotics, anti-depressants, and mood stabilisers. A differential diagnosis was also being considered of bipolar disorder, or what is better known as manic depression. He was obtaining assistance as an outpatient at the Tamarind Centre. Unfortunately for his family, and also for the deceased, his behaviour deteriorated. His family recalled finding him unpleasant, aggressive, irritable, and uncaring during this time. He had been living with his family but they were unable to cope with his behaviour and he was found public accommodation.

16. Only three weeks after moving, and in about June 2005, he committed criminal offences and found himself in gaol. It is noted that he had stopped taking his medication and instead turned to illicit substances. As a result he was remanded in custody in July 2005 and sentenced to a significant period of imprisonment in September 2005, with a nine month non-parole period. During his incarceration he also became a client of Forensic Mental Health Services. It appears that his behaviour improved with this more stringent regime and regular medication. The diagnosis at that stage was schizoaffective disorder with a query as to hypomania.

17. In April 2006 he was released from prison and moved through various accommodations. Within a week of his release he was hospitalised at Cowdy Ward for a weekend. The diagnosis at that stage was drug induced

psychotic disorder. Approximately three weeks later in May 2006, he was again admitted to Cowdy Ward. This time as an involuntary patient for five weeks. His mother described the deceased at that time as being completely manic with enormous grandiose delusions. The diagnosis at this stage was bipolar mood disorder with a current manic episode with psychotic features. It appears from the material that alcohol and other substance abuse was a feature of most of his admissions. I received evidence that this made diagnosis of his condition even more difficult.

18. On or about 27 February 2007, the deceased's mother wrote to the Director of Mental Health Services and requested a review of her son's case. She raised a number of concerns regarding his care and supervision. A copy of her letter was tendered in evidence before me as part of exhibit 2. As a result, a review was undertaken by Dr Steve Robertson on 31 May 2007 and a copy of the report he prepared thereafter was also tendered into evidence (exhibit 11). During the course of this inquest I carefully considered the report and the matters set out therein. As stated during the hearing, I considered this an important document in relation to detailing the deceased's mental health and his particular needs.

19. In that report, the deceased was described as posing:

> "a serious diagnostic dilemma as evidenced by the multitude of differing diagnoses."

It went on to note that there were:

> "recurrent themes which include psychosis, disorganised behaviour, substance abuse, social dislocation, fecklessness, antisocial psychopathic traits and offending behaviour."

20. It was the opinion of the reviewing psychiatrist that:

> "Mr Spring will require ongoing mental health care and treatment with antipsychotic medication"

And because of his ambivalence to treatment it was:

> "Important that his medication be given in a form that ensures the highest degree of compliance. That currently being in the form of long acting depot formulation."

21. In terms of his prognosis, and importantly in the context of this inquest and my findings to follow, Dr Robertson stated that:

> "Mr Spring's prognosis would obviously be markedly improved if he were to curtail or even reduce his psychoactive substance misuse. It can be seen from his psychiatric file that Mr Spring is experiencing annual psychotic events which will have a cumulative negative effect upon his long term prognosis. We should aim at reducing or preventing these relapses thus the need for long term antipsychotic medication. His treating team should also be aware that his condition also leaves him vulnerable to other psychiatric sequelae particularly depression which should be treated if suspected."

22. It appears on the evidence that following that review, the deceased's condition was stable for a significant period. In fact he appears on the evidence to have had relatively stable accommodation in that time, formed good relations and continued with the fortnightly depot medication as recommended in Dr Robertson's report. I received evidence that the deceased was on a dose of 150 mg of zuclopenthixol decanoate each fortnight and that whilst this was not the usual dose (such dosage normally being 200 mg), it is clear that this relatively low dose had kept the deceased well.

23. Unfortunately in about January 2010, the deceased developed a condition known as tardive dyskinesia. I heard evidence that this is a difficult to treat form of dyskinesia, which is a disorder that results in involuntary, repetitive body movements. The particular form of the condition that was developed by the deceased was blepharospasm, which resulted in repetitive, forceful, sustained contraction of the eyebrows. I heard evidence that this caused the deceased a great deal of embarrassment and he found it distressing and painful. As a result, he decided to return to his doctor at Forensic Mental Health Services, namely Dr Solomon Agbahowe.

24. By the time the blepharospasm had commenced however, Dr Agbahowe had left Forensic Mental Health and Dr Donna Schakelaar had taken over as the Forensic Registrar of that service. Dr Schakelaar gave evidence before me that whilst she had only commenced in the position of Forensic Registrar in January 2010, she had in fact been employed with the service since August 2000.

25. I heard evidence that Dr Schakelaar saw the deceased for the very first time on 18 February 2010. She recalled that prior to seeing the deceased she had considered his file and understood he had been suffering from a:

> "bipolar type illness,"

but that he had been well for a considerable period of time and was on regular fortnightly depot injections.

26. Dr Schakelaar gave evidence that one of the significant difficulties with the development of blepharospasm for the deceased was that whilst it was not a "common condition", it was also not "uncommon" and occurred in about 20-30% of persons who take long term antipsychotic medication, which is what the deceased had been taking. Dr Schakelaar also noted it was something that was expected in people usually in their 40's and 50's.

27. Dr Schakelaar stated that deciding what to do with the deceased was therefore very difficult as he had been well for a significant period of time and she was concerned that if the medication was ceased, he would again become unwell. On the other hand he was also significantly distressed by the blepharospasm and the deceased had expressed the hope that because most of his episodes involved drug use, that perhaps his condition was more related to a drug induced psychosis rather than a mental illness per se, and that he would be able to cope drug free.

28. Dr Schakelaar gave evidence that as a result she thought carefully about what should be done. She stated that she undertook research as to

appropriate strategies and noted that whilst all antipsychotics have the potential to cause tardive dyskinesia, a change of antipsychotic may be helpful, as well as the use of benztropine for treating side effects. Dr Schakelaar stated that she discussed these options carefully with the deceased who did not want to change his antipsychotic medication, because it had worked so well. He was also keen to see if he could stay well without the medication and was aware that there was a risk that the blepharospasm could become permanent if he continued with his current medication.

29. As a result, Dr Schakelaar gave evidence that she discussed the option of ceasing the deceased's medication with the Forensic team at their weekly Thursday morning meeting. Dr Schakelaar accepted there was no formal note of such discussion to support her recollection. It is also clear that there was no recollection by her consultants of such a discussion taking place. In terms of the "weighing up" of her decision, Dr Schakelaar gave the following evidence (tp.28.4):

> "Once you consulted with Dr Robinson did you form that, as you'd thought, this was the only solution was to cease the medication?--- Well to cease the medication. Because there had been the issue of the substance misuse during other presentations, we were all hoping that, you know, he might get away with it and that he wouldn't relapse. The trouble is, you know, if you start him on something else there was no guarantee that something else would actually work for his mental state. And there was no guarantee that it wouldn't cause – wouldn't add to the dyskinesia in its own right. So it was not a nice position to be in."
>
> "And did you discuss those things with Nicholas as to the risks?--- Yes. We had to make him aware that there was always going – there was a risk of relapse. We were hoping that it wouldn't happen but we didn't know. It's an unknown. So that's why this thing about we need some follow up in the next six months. Because it would take probably about three, four months for the depot to completely wear off. And if you could get past six months then he's probably reasonably safe. Then we could, you know, it might have been just the drug induced component that it caused the problems in the past."

30. Thereafter Dr Schakelaar made a decision to cease the depot injections and agreement was reached with the deceased and his mother to be on the lookout for any signs of mania. Dr Schakelaar stated that the medication was ceased on 25 February 2010 and she anticipated that it would take approximately two to three months for the depot medication to start wearing off and for signs of relapse to occur.

31. I received evidence that in April 2010 his mother once again started to notice changes in his behaviour. He began sleeping with the lights on, going out at night to check on noises, refusing to catch the bus and regularly changing his mobile number. According to his mother, at the beginning of May 2010 at about midnight, a drunk cut through the bush next door to the family home. The deceased confronted the man and afterwards his mother could not convince him to return to bed. Her statement reveals that they sat up together for many hours, with the deceased telling his mother that he was fearful that someone was going to hurt them. It is clear that he showed real signs of paranoia returning. His mother described him as being very disturbed at this time and he told her that there were things she did not know about, that meant there were people out there to get him.

32. As a result of this incident, his mother contacted Dr Schakelaar and took the deceased to see her at Forensic Mental Health on 10 May 2010. According to the medical records (exhibit 3), Dr Schakelaar recorded the mood of the deceased as "not depressed", but feeling "isolated". A note was made to watch his paranoia and to be reviewed again in one month "or sooner if needed".

33. As circumstances would have it, things did not improve and on 12 May 2010, contact was again made with Dr Schakelaar after a further incident at home. According to the medical records, this time the deceased was recorded as being "clearly paranoid", with:

> "some insight but increasingly limited"

and:

> "tending to draw everything into a conspiracy"

which is:

> "almost but not quite at delusional intensity."

Dr Schakelaar gave the following further evidence (tp.32.2):

> "And when you saw him on that occasion what did you think was occurring then?---Well as I state, he's clearly paranoid and also he had been earlier in the week. I was getting quite worried about it. I was actually very close to sectioning him, I was that concerned. If he hadn't taken – basically I restarted medication and put him onto risperidone as a tablet because I could see that this was not just any old paranoia, this was actually getting unwell, mental illness."

34. As set out above, a decision was made for the deceased to be placed back on anti-psychotic medication. According to his mother, he was extremely concerned about this because of the side effect of the tardive dyskinesia. It is clear from the records however that the deceased wanted to be admitted to hospital even less and as a result he is recorded as "very reluctantly" agreeing to take the medication. His mother described him as being:

> "very, very angry and upset"

about having to take the medication again.

35. This time the deceased was commenced on Risperidone, being a "newer" form of antipsychotic. This was administered in the hope that it would be less likely to have side effects. I received evidence from Dr Schakelaar that it would take six weeks for depot medication to take full effect and therefore, despite the deceased being historically a "poor administrator" of oral medication, he was given oral medication as it would take effect sooner (than depot medication) once an effective dose was established.

36. From that time the deceased was in daily contact with the on call team of Top End Mental Health Services. It was noted that on 17 May 2010 both the team and the deceased's mother believed that there were signs of improvement in his condition, although he was still unhappy about taking his medication.

Events leading to the final admission to Cowdy ward

37. On 27 May 2010 however, the deceased advised his mother that he thought he should go to hospital. Ms Dias immediately rang the on call team and was told to bring the deceased into the Emergency Department at the RDH. They arrived there at about 9.00 pm and were met there by the deceased's sister. Thereafter Ms Dias recalls a four hour process taking place in order to have the deceased admitted. She records him as having to tell his story five times to different persons. He was seen by the triage nurse, then an emergency nurse, then an emergency doctor, then a mental health nurse, then the mental health registrar. According to his mother, this was distressing to the deceased and also to her.

38. The notes record the deceased being asked if has had any suicidal ideation, to which he says "yes" and described intense thoughts of self-harm over the last few days which were distressing to him and were increasing his anxiety. He is recorded as stating that he had a plan, but would not elaborate. When finally seen by Dr Usman Khalid (the on call psychiatric registrar), inquiries were made as to the possibility of the deceased undertaking treatment in the community. Again I received evidence that this suggestion also caused the family of the deceased significant distress, and I will return to this aspect later.

39. It is clear however that because of the risk of suicidal ideation and the inability of the deceased to guarantee his own safety, a decision was made that the deceased was a moderate to high risk of suicide and he was admitted as a voluntary patient to Cowdy Ward. I note that the Risk Assessment

Tracking Tool ("RATT") completed at that time recorded the deceased as a level 4 risk of suicide, which is high. In terms of the decision to admit the deceased as a voluntary patient when his risk of suicide was so high, I received the following evidence from Dr Schakelaar (tp.35.8):

> "Is it normal when someone has a risk assessment of 4 that they would still be voluntary, in your experience?---The vast majority I'd have to say would be sectioned. But Nick did actually have a lot of insight into this because he knew things weren't right in his head. He was wanting help, he was agreeing to take medication and he actually brought himself to hospital and that was a huge step for him because he didn't want anything to do with the hospital if he could avoid it. So the fact that he actually felt comfortable enough to actually go to hospital when he was starting to not feel as though he could cope, was a huge step. But – so the thing about keeping him as a voluntary patient. It's to sort of keep up a good therapeutic relationship because I think if we had sectioned him at that time we would have just lost that relationship altogether and he would have had no real say in what medication he'd have to take. This way he could have some input and we want to be able to keep that and he was agreeing to, you know, to stick around and he wasn't threatening to jump the fence or anything like that. So those concerns weren't there at that point in time."

40. On 28 May 2010 the deceased was seen by Dr Schakelaar. Her notes indicate that at that time the deceased continued to have what was described as:

> "feelings of death in his head,"

but no current intent to self-harm or harm others. He continued to be paranoid and the notes record that he was unhappy about being at Cowdy but recognised that it was a refuge for him.

41. In relation to the question of his risk assessment at that time, his status as a voluntary patient, and the question of leave from the ward, Dr Schakelaar gave the following further evidence (tp.36.2):

> "And your risk assessment was reduced, you gave him a lower- - -?---I felt because I'd been seeing him over the previous couple of

weeks, that he – I actually felt more comfortable about his mental state then than I did on that day when I first started the Risperidone. And you know, I specifically asked him if he felt like he could potentially harm himself and he was denying that at that point in time. So I think on that day he was actually having a reasonable day. But there were things of concern. Yeah, the paranoia was still there. There was some blinking stuff starting to happen and that concerned me because the paranoia was still there, that's why I decided to increase the medication yet again. I didn't feel that the two milligrams that he was on was keeping, was holding it enough. So I bumped it up to three. And then I made the notes when I was there on the Sunday when I was actually scheduled to be on call.

And you then also said that he could have leave but it was to be family only?---Yeah.

Can you tell the court why that was?---Well his family knew him best. And so – I didn't want him to be able to roam around. There was a suicide risk, I couldn't exclude that and that very serious attempt he'd had previously. I suppose I could tell you he wasn't that unwell but patients can deteriorate for various reasons at different times. You can't predict the future in that respect. So I didn't want him to be by himself when he – if the wrong thing came into his head he could potentially do something and potentially succeed. That's why I thought that if it was family it would be much safer because the other thing was he also was not enjoying the ward experience. The place was really busy, the ward was really full at the time. There was some difficult patients on that ward at that time as well and they're quite aggressive. He needed some time out just to be able to sort of distress from that situation as well. So that's why I was happy for him to have some periods of leave.

Can I ask you this, doctor? You said to his Honour a moment ago that he was at risk of suicide and that couldn't be excluded. Sometimes I've heard and I'm sure his Honour's heard during the course of inquests, there's known as a chronic risk where it's there all the time and then there's an acute risk where it's very very serious, right in that moment. Given that Nicholas had this condition, had had the previous quite serious suicide attempt, was he a person which would fall into that description of being a chronic risk of suicide?---It was the chronic risk. There was always the concern, ever since the relapse basically started and that was Lesley's biggest fear but we shared that fear.

> So when you say the relapse, you mean about 12 May?---Yes, when he first came in. Yes, so – but on the Friday the acute risk seemed to be much lower because he didn't have any concerns at that point and there was no intent there at that point. But like I said, you can't say what he's going to be like the next day or the day after. But based on what he was like on the Friday I was really happy for him to stay voluntary and to be able to have some leave with his family. Not to have leave by himself because of that chronic risk but I felt that, you know, with his family he would be safe."

42. I received evidence from RN Julie Middleton that the deceased had a very difficult evening on 29 May, into the morning of 30 May, 2010 in terms of his sleep and that contact was made with Dr Schakelaar requesting that there be a review of his medication. RN Middleton gave evidence that Dr Schakelaar stated she would undertake the review when she arrived at the ward. RN Middleton stated that she advised that the deceased was scheduled to go on leave with his sister and that Dr Schakelaar stated she would see the deceased when he returned to the ward. I note that during the course of her evidence, Dr Schakelaar stated that whilst she recalled a conversation with RN Middleton, she did not recall any discussion about his leave from the ward. Dr Schakelaar did however state that it was certainly her intention to review the deceased during her duties that day.

43. RN Middleton stated that when she spoke with the deceased, prior to his departure for leave, he appeared "quite pleased" about Dr Schakelaar reviewing his medication and "without hesitation" he told her what time he would be back from leave with his family. RN Middleton was very experienced in mental health and I accept her evidence that had she seen anything that caused her concern for the deceased, she would have delayed his leave for a review by the doctor and would have reassessed his level of risk. I accept that there was nothing said or done by the deceased which would have warranted a change in his assessment prior to his departure from the ward for the last time on 30 May 2010.

44. It is also clear from the statements provided by both the deceased's mother and sister that there was nothing said or done by the deceased in their presence that gave them cause for increased concern. It is clear, as is more often than not my experience in cases of suicide, that the deceased did nothing to reveal his plan to take his own life. I also understand that this makes it all the more difficult to understand and accept his actions.

45. As set out earlier in these reasons, the deceased was found by his mother downstairs at the family home in Gunn, shortly after 2.00pm on Sunday 30 May 2010. Her attention had been drawn after hearing a crash downstairs. She ran downstairs to see what had happened and found her son on the ground, on his back, with his arms spread out and one leg tucked under him. There was a rope around his neck. The last time that he had been seen by either his mother or his sister was sometime between 11.30am and 12 noon when they all went to have an afternoon nap.

46. Both Ms Dias and her daughter began doing everything they could to resuscitate the deceased, including calling 000 and seeking assistance. I also note that police, paramedics and an ambulance arrived at the scene very quickly. It is equally clear however that whilst there was a slight improvement in his physical appearance, the deceased remained asystole throughout and despite the fact that all that could be done, was done, it was to no avail.

Issues raised for consideration at this inquest

47. At the commencement of this inquest, Counsel Assisting outlined a number of issues that she suggested I may wish to consider as to whether I should make comment upon, pursuant to my powers under s34(2) of the Act. Those issues can be summarised as follows:

    1. The manner and sufficiency of the admission process to Cowdy Ward on 27 May 2010;

2. The sufficiency of the exchange of information from Cowdy staff to family members particularly when patients are undertaking leave from the ward with family;

3. The appropriateness of the decision making by Cowdy staff when dealing with the deceased on Sunday 30 May 2010, particularly in terms of his status as a patient and also his entitlement to ward leave.

4. The sufficiency of the decision making in relation to the handling of his condition particularly when his condition had been stable for so long and then deteriorated dramatically upon cessation of his medication following the development of tardive dyskinesia;

5. Family/carers receiving education and assistance following a suicide attempt to identify and manage their family member's illness.

48. I will now deal with each of the above matters in turn in light of the evidence I have received during the course of this inquest.

The manner and sufficiency of the admission process to Cowdy Ward on 27 May 2010

49. As stated previously, it is clear on the evidence that the family had to undertake a four hour admission process before the deceased was finally able to be admitted as a patient to the Cowdy ward. I note that the family considered this very upsetting and could not understand why their loved one, who was seriously distressed and stating that he needed help, was required to go through such a process given his history of admissions with Cowdy Ward in the past.

50. In terms of this process I received evidence from Associate Professor Parker that the requirement to go through the Emergency Department at the RDH is for patients who have not been seen "within two years". The deceased fell into this category. Professor Parker stated (tp.46.4):

> "Well it's the patients who haven't been seen, I think for about – within over two years. So the issue is that sometimes other issues can masquerade as mental illness. A thing particularly like with hypoglycaemia which – or sometimes cephalitis occasionally. I mean obviously that wasn't very apparent in Nicholas's case, it was fairly obvious it was a recurrence of mental illness. However, we have these protocols that are in place. So that's generally what we work through. Mainly again, it's to work for the best interests of the patient, so to make sure they actually get a comprehensive physical assessment, to make sure we're not missing anything before they go onto the mental health ward. And – so really – a lot of it can be a worry because the time involved. Really it's to get the best treatment for the patients and make sure they're properly cared for".

51. I note that unfortunately this process is the same in almost every major hospital in every major city across the country. Professor Parker was asked whether it was possible for there to be some sort of separate admission process that does not involve mentally ill patients sitting in the Oleander room located in the emergency area. I note that Professor Parker stated that this was something that could be reviewed (tp.47.2):

> "But it's in the end it's a resourcing issue. And that's the ED, that's really their property. The Oleander Room is the ED property. And we have – both the Director of Mental Health and I have regular discussions with ED on ways to make things better. So there are ongoing discussions. But obviously as your Honour's pointed out, it does relate to effectively resourcing. And we have to – so the Oleander Room has a certain purpose. It's also an area which is safe. I mean we have to have an area where people can be assessed that's within safe – for both clinicians and patients and their families. So unfortunately it's a compromising range of issues, it's often unsatisfactory."

52. In this regard I accept Professor Parker's evidence as to the relevant of resourcing and the need to have a location that is safe both to the patients and the clinicians involved. I also accept that this is something often reviewed and in such circumstances I do not consider it necessary to say anything further on this issue.

53. In terms of the requirement of the deceased to go through his history on a number of occasions with a number of different individuals, I note that Professor Parker stated the reason for this was as follows (tp.47.5):

> "Well I suppose every clinician involved has to do their own assessment. I mean the triage nurse would have been doing an assessment of triage. So that on the ED categories as to how important Nicholas's case was and a range of things. The ED physician would be doing a normal clinical assessment. The – I mean we've actually had ongoing work dialogue with ED because we've been actually dissatisfied with the level of referral. So I'm very happy that the ED doctor would have done a proper assessment of Nicholas. Our own doctor then would have had to do – I mean would have – and I've got very high regard for Dr Kelly to do the assessment of Nicholas. He would have had to do a sophisticated assessment - - - "

And further (tp.47.10):

> "That he has to do a more sophisticated assessment obviously to satisfy the criteria of the patient risk and also the issues of the Mental Health Act. And unfortunately those three layers often have to be done. And I'm not sure about the other assessments, but unfortunately there are three necessary assessments that have to occur when someone goes through ED".

54. As a result of this evidence, whilst I understand and accept that the process at the hospital is one that would have been distressing to the family on this particular evening, I also accept that the process is required to be undertaken to ensure that the person's behaviour is not related to their physical health and that their rights are not being unnecessarily impacted upon, as is required under the provisions of the *Mental Health and Related Services Act*. I therefore do not criticise the process undertaken although I note that where possible such admission processes should be streamlined to reduce the amount of time a person is waiting for assistance when they have mental health issues.

The sufficiency of the exchange of information from Cowdy staff to family members particularly when patients are undertaking leave from the Ward with family

55. I note that this was of particular concern to the family during this inquest. Both Ms Dias and her daughter had provided material to me which was tendered as part of the coronial brief expressing their significant concerns about what they considered they were not told of the seriousness of the deceased's condition. Ms Dias in particular referred to the use of "euphemisms", i.e. the use of an inoffensive word or phrase in substitution for one considered offensive or upsetting. In this case, using the phrase "self harm", rather than "kill himself."

56. Ms Dias gave evidence that she considered ordinary family members needed to be told things more bluntly about the condition of their loved one so that they could understand and assess the risk when taking them out on leave. Ms Dias stated that if she had been told that there was a risk that her son might kill himself during leave, rather than being described as "at risk of self harm":

> "I think we would have been a lot more – we wouldn't have left him on his own if we'd been told that". (tp.13.9)

57. In this regard, as I stated during the course of these proceedings, it is a fine line to be walked between being blunt and being too blunt. I agree that it is important that staff at institutions like the Cowdy Ward ensure that family and friends who take a person on leave understand very clearly the risk that their loved one is in at that time because of their mental state. However, in this particular case, the deceased was not exhibiting any signs to indicate that he was at greater risk of taking his own life, than he was when he was last with his family prior to his last admission. I accept that the staff at Cowdy ward considered carefully each time the deceased was to go on leave whether that was an appropriate decision and on this occasion there was nothing to indicate that he was considering suicide. The way in which the

deceased presented himself to his own family supports the assessment made by Cowdy staff. This presentation brings me to consider the next issue raised by Counsel Assisting.

The appropriateness of the decision making by Cowdy staff when dealing with the deceased on Sunday 30 May 2010, particularly in terms of his status as a patient and also his entitlement to ward leave.

58. As previously stated above, there was nothing in the deceased's presentation either to medical staff at Cowdy Ward, or to his family, to indicate that he was considering taking his own life. I note that his "risk" to self was something considered by RN Middleton before the deceased took his leave with his sister and left the ward. She stated that she considered he was a low risk and her reasoning for this was as follows (tp.19.10):

> "He wasn't voicing any suicidal ideas, any self harm ideas and he wasn't voicing that the night before neither. And during the night there wasn't any – and he denied Dr Shakelaar had seen him the night – the day before and he denied any(?)."

59. It was in fact noted by Dr Schakelaar following her attendance upon the deceased on 28 May 2010 that he could have leave, but "with family only". In this regard, Dr Schakelaar gave evidence that her reasoning for "family only" was because (tp.36.5):

> "Well his family knew him best. And so – I didn't want him to be able to roam around. There was a suicide risk, I couldn't exclude that and that very serious attempt he'd had previously. I suppose I could tell you he wasn't that unwell but patients can deteriorate for various reasons at different times. You can't predict the future in that respect. So I didn't want him to be by himself when he – if the wrong thing came into his head he could potentially do something and potentially succeed. That's why I thought that if it was family it would be much safer because the other thing was he also was not enjoying the ward experience. The place was really busy, the ward was really full at the time. There was some difficult patients on that ward at that time as well and they're quite aggressive. He needed some time out just to be able to sort of distress from that situation as well. So that's why I was happy for him to have some periods of leave."

60. As noted by Dr Schakelaar in her evidence, the deceased was a "chronic risk" of suicide, i.e. the risk was always present that he may take his own life. I accept that in those circumstances that if the risk of the deceased taking his own life was to be completely reduced, then this would have resulted in him never being able to undertake leave and that this would not have been in his best interests nor conducive to him taking responsibility for his own mental health and attempting to recover from his relapse.

61. In terms of this issue of leave, I received a report from Bronwyn Hendry, Director of Northern Territory Mental Health Services (exhibit 15). Within that report Ms Hendry relevantly notes as follows:

> "In response to Nicholas' death, leave was further tightened and all voluntary and involuntary patients are now required to remain on the ward for 48 hours to enable more comprehensive assessment and commencement and monitoring of treatment prior to consideration of leave. Agreement from voluntary patients regarding the 48 hour period is sought when they request admission. Consideration of an individual's subsequent leave is based on a daily risk assessment. If a person does not agree to their recommended leave arrangements and/or there is a change in their mental status the treating doctor will be asked to conduct an assessment."

62. I consider these are sensible changes and I am encouraged that these were determined and introduced without the need for a recommendation from myself.

63. I note that also raised for my consideration within this issue was the appropriateness of the assessment of the deceased as a voluntary patient. In this regard, I note that the deceased was admitted as a voluntary patient post his attendance at the RDH on 27 May 2010. Although "voluntary", the deceased was also categorised as a risk assessment of 4. I heard this is very high in terms of an individual's risk of harm to themselves or another.

64. Dr Schakelaar was asked during her evidence as to whether someone assessed as category 4 risk, should have been admitted on a voluntary basis. Dr Schakelaar gave the following evidence (tp.35.8):

> "The vast majority I'd have to say would be sectioned. But Nick did actually have a lot of insight into this because he knew things weren't right in his head. He was wanting help, he was agreeing to take medication and he actually brought himself to hospital and that was a huge step for him because he didn't want anything to do with the hospital if he could avoid it. So the fact that he actually felt comfortable enough to actually go to hospital when he was starting to not feel as though he could cope, was a huge step. But – so the thing about keeping him as a voluntary patient. It's to sort of keep up a good therapeutic relationship because I think if we had sectioned him at that time we would have just lost that relationship altogether and he would have had no real say in what medication he'd have to take. This way he could have some input and we want to be able to keep that and he was agreeing to, you know, to stick around and he wasn't threatening to jump the fence or anything like that. So those concerns weren't there at that point in time."

65. In relation to the question of voluntary or involuntary status I note that Ms Hendry's report also addressed this issue as follows:

> "The decision regarding whether care is provided on a voluntary or involuntary basis is a clinical decision based on many factors, including a person's right to be treated in the least restrictive setting possible. Issues of risk are also significant and are balanced against an assessment of the person's insight and ability to give informed consent for their treatment. Under the Mental Health and Related Services Act it is not possible, nor in many cases desirable, to mandate that all person's at risk of suicide are treated on an involuntary basis."

And further:

> "I need to acknowledge risk assessment is not a proven science and clinical judgment is required to assess the risk and determine the safest option for care, having regard for the person's preferences and their rights under the Act."

66. In this case it is clear that Dr Schakelaar saw the deceased very shortly after his admission and considered very carefully his status as a voluntary patient.

I accept her reasoning and make no criticism. As was noted by Ms Hendry, such a process is "not a proven science."

The sufficiency of the decision making in relation to the handling of his condition particularly when his condition had been stable for so long and then deteriorated dramatically upon cessation of his medication following the development of tardive dyskinesia

67. As was clear from the evidence before me, the deceased's condition had been relatively stable from May 2007 to November 2009. It was not until the development of tardive dyskinesia that the deceased once again began to access the assistance of any psychiatrist. At that time, Dr Schakelaar gave evidence that she considered the deceased's records before her first appointment with him. I accept her evidence in this regard, however I note that it is also clear on the evidence that Dr Schakelaar did not see all of the deceased's records prior to her making quite important decisions regarding his appropriate treatment.

68. In this regard Professor Parker gave evidence that at the time there were two separate record systems; one being a written record held on the "forensic filing system" and the other on the "Community Care Information System" ("CCIS"). Professor Parker noted that Dr Schakelaar did most of her work on the CCIS system. As stated by Professor Parker "ideally if she was doing a review she should have obtained the written record and reviewed it at length and made a decision". I agree.

69. Professor Parker noted that there were two systems still in existence, but there were moves to better integrate the two. I encourage the team to continue to do this so as to avoid the overlooking of such important information in future.

70. It also appears on the evidence that one of the significant difficulties that existed at the time is that Dr Schakelaar, and in fact the Top End Mental Health Service, was inundated with work and was short staffed. This resulted in Dr Schakelaar not specifying a more detailed follow up with the

deceased once his medication was changed, other than being seen by the nurses for his depot medication.

71. Professor Parker himself gave evidence that he considered the onerous working conditions at the time impacted on the decisions made by Dr Schakelaar (tp.43.3):

> "This is where the background factors impacted on Dr Schakelaar's decision. She was working very hard at the time. She was basically working 1.0 position and .75 and she often worked after hours beyond her time to actually do the work that she had. I think there was an issue that there obviously had been a previous consultant opinion in the written notes which wasn't in the CCIS system. So I think Dr Shakelaar when she ceased the medication, if she'd been aware of that written record, may have thought again about ceasing the medication. Again there was the potential of seeking consultant advice and probably preferable for Dr Shakelaar to have sought consultant advice either prior to or after taking the decision to stop the medication. But then again we looked at the consultant availability to the team at that time and given Dr Schakelaar's other workload and again it was a decision that probably should have been done but wasn't, I think for the reasons I've outlined."

72. In this regard I note that Professor Parker stated that had he been responsible for the deceased's care, and armed with the report of Dr Robertson of 2007 (which was not seen by Dr Schakelaar), he would have (tp.45.8):

> ".. looked at some psychotropic medication to try and control the symptoms of his schizophrenia, but at the same time try and reduce the horrible side effects he was getting from the medication."

73. I note that once Dr Schakelaar was aware that the deceased's symptoms were returning, this was what she was in fact attempting to do with the medication that she prescribed. It therefore appears that even if the deceased had remained on medication throughout, he may well still have suffered 'horrible' side effects.

74. Whilst I consider it inadequate that Dr Robertson's report (i.e. exhibit 11) was not a matter considered by Dr Schakelaar prior to her deciding to cease the deceased's medication, I do consider that she was endeavouring, as best she could, armed with the information that she did have, to try and reduce the very distressing side effect of the tardive dyskinesia for the deceased. I also consider that at the relevant time, Dr Schakelaar did have the best interests of the deceased in the forefront of her mind. I do not consider she was reckless or negligent in her decision making.

75. I note that since that time, whilst there are still two systems of recording a patient's information, the forensic team is better resourced. As highlighted by Professor Parker (tp.45.5):

> "I mean what has improved is we've got much better resource now as a forensic team. So there's a consultant psychiatrist much more readily available and given that time again, there would be probably much more time to review it from a consultant psychiatry…"

Family/carers receiving education and assistance following a suicide attempt to identify and manage their family member's illness

76. As stated previously, the family of the deceased have understandably been shocked and upset by the loss of their loved one. They expressed on many occasions the frustration of the lack of education and assistance received by family in such situations. I note that there is a difficulty in the sharing of confidential information with family, particularly where a patient is not psychotic and is willing to undertake treatment, as was the case with the deceased. I consider however that there can, and must be, an improvement in the assistance that is provided to family following a suicide attempt.

77. As I indicated during the course of proceedings, every other Coroners Office in Australia has grief counsellors. The Office of the Coroner of the Northern Territory does not provide this service. This must be addressed. Grief counsellors are trained social workers/psychologists, who are

experienced in meeting and talking with bereaved parents and relatives. This is a very important and necessary function.

Recommendation

78. As a result, I recommend that the Northern Territory Government give consideration to the merits of funding such a service here in the Northern Territory. If other jurisdictions in the country can recognise the vital need for such persons and such a service, I suggest the department and Justice consider it.

Conclusion

79. I have considered very carefully the report of Ms Hendry as to the changes made following their review of the circumstances surrounding Nicholas' death. I consider those changes appropriate and I encourage the Department to continue in its endeavours to improve services across the board with Top End Mental Health Services, particularly in light of the additional funding announced for suicide prevention.

80. The death of this young man is again a reminder of the significant needs of the mentally ill in our community and the continued responsibility of Government and the wider community to maintain efforts to improve services in the hope that this kind of death can be avoided in the future. Whilst such improvements cannot help the deceased's family in this case, I do hope that they can assist other families in future.

Mr Greg Cavanagh :

Dated this 29th day of July 2011

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GREG CAVANAGH
TERRITORY CORONER