CORONER'S COURT OF THE AUSTRALIAN CAPITAL TERRITORY

Case Title:	**Inquest into the death of BRANDON GEOFFREY SAGER**
Citation:	**[2021] ACTCD 8**
Findings Date:	21 December 2021
Before:	**Chief Coroner Walker**
Decision:	See [18]-[22]
Catchwords:	**CORONIAL LAW** – death in care – cause and manner of death – death by suicide – inpatient – ligature points – whether issue with quality of care, treatment or supervision – whether matter of public safety arising – matter of public safety arising but now addressed
Legislation cited:	*Coroners Act 1997* (ACT), s 13(1)(i); 52, 74 *Mental Health Act 2015* (ACT)
Appearances	Deputy Registrar S Baker-Goldsmith (Counsel Assisting)
File Number:	CD 276 of 2016

CHIEF CORONER WALKER:

1. The death of Brandon Geoffrey Sager, born 19 September 1973 and aged 43 when he died, was reported to the ACT Coroner because he died while subject to a psychiatric treatment order (PTO) under the *Mental Health Act 2015*. This brought his death within the Court's jurisdiction pursuant to s13(1)(i) of the *Coroners Act 1997* ('the Act').

Jurisdiction

2. When Mr Sager died, in November 2016, s3C(1)(c) of the Act described his death as being a 'death in custody'. I note my comments in the *Inquest into the death of Jacob Cameron* [2021] ACTCD 7 about the retrospective operation of the changes to the Act in January 2020 to rename such cases 'deaths in care'. Accordingly, I will also refer to Mr Sager's death as being a death in care in accordance with s13(1)(i) of the Act.

Background

3. Mr Sager was born in Canada. He later migrated to Australia with his family when he was a child. He was one of three siblings. His parents separated when he was 15 years old and he had a difficult relationship with his family from this time. Mr Sager left school

for a carpentry apprenticeship at age 16. He worked in the building industry prior to becoming unwell.

4. Mr Sager was a long-term consumer of ACT Mental Health services, starting from his early twenties. He was first formally diagnosed with schizophrenia in 1993 but had little insight into his condition. He made several suicide attempts which led to inpatient hospital admissions, the last being in 2013. Mr Sager's treating professionals considered on multiple occasions that it was appropriate that he be made subject to PTOs to provide treatment for his condition. Relevantly, a PTO was made by the ACAT on 14 July 2016 for a period of 6 months and was in place at the time of his death.

5. Mr Sager was admitted to the Brian Hennessy Rehabilitation Centre (BHRC) on 6 November 2012 due to concerns about his increasingly dysfunctional lifestyle. While Mr Sager's health improved while at BHRC, attempts at rehoming him in the community failed. He was reticent to the idea of living in a group house and wanted supported accommodation with 24/7 workers on site, which was being explored through the National Disability Insurance Scheme (NDIS) at the time of his death.

6. Mr Sager was described by BHRC residents and staff as a quiet, polite and reserved individual. He was able to function with close supervision but would still need to be prompted to eat and shower. Mr Sager had persecutory ideations that included that people at BHRC put rat poison in his tea, that the Public Trustee should hand him back his money, and that his father visited BHRC to spy on him. However, Mr Sager was considered a low risk resident at BHRC; he was accommodated in a villa rather than a ward and was allowed free access within the grounds and unaccompanied leave, subject to regular checks by staff.

Circumstances of Death

7. In 2016 the ACT Government announced that it would close BHRC and the services it provided would be delivered at a new facility at the University of Canberra. BHRC staff and Mr Sager's family report that this news caused him anxiety and he worried that he did not know where he would live. He did not, however, voice plans to self-harm.

8. On 31 October 2016, Mr Sager underwent routine assessment by a psychiatrist. The doctor reported that Mr Sager was in good spirits, showing no signs of paranoia, delusions or suicidal ideation.

9. On 6 November 2016, Mr Sager engaged in ordinary activities. He maintained polite and pleasant interactions with the staff and stated he was fine. He was last seen alive in the common area of BHRC at about 3:30pm.

10. At 5pm, a nurse conducting rounds of the facility observed that Mr Sager's room was locked. This was not unusual, as Mr Sager was a private person and would often lock his door. The nurse entered the room using a key and saw Mr Sager sitting on the floor with his back against the wardrobe. One end of a drawstring from a pair of tracksuit pants was tied to the wardrobe's door handle, and the other end was wrapped around Mr Sager's neck with Mr Sager leaning into the ligature.

11. The nurse immediately called for assistance and tried to remove the ligature from Mr Sager's neck. More staff attended and attempted to resuscitate Mr Sager. Sadly their efforts were unsuccessful.

12. Associate Professor Sanjiv Jain conducted a post-mortem examination of Mr Sager at the direction of the Coroner. He concluded that Mr Sager died from asphyxia due to hanging. No unexpected injuries were identified, nor any significant natural disease process. Prescribed medication at therapeutic levels were detected in Mr Sager's blood.

13. The police officers conducting investigations on behalf of the Coroner reported that no suspicious circumstances have been disclosed by their enquiries.

Formal Findings

14. This is a mandatory hearing pursuant to s34A(2) of the Act. That is why these proceedings have been held and determined in public despite there being no witnesses called. The course is adopted with the consent of Mr Sager's family.

15. I am required by s52(1) of the Act to make findings as to the identity of the deceased person, when and where they died, and the manner and cause of their death. I am also required by s52(4)(a) of the Act to state whether a matter of public safety is found to arise in connection with the inquest, and if I find such a matter, I may comment upon it. Further, as this is a death in care, I am required by s74 of the Act to include in the record of these proceedings findings about the quality of care, treatment and supervision of the deceased that, in my opinion, contributed to the cause of death.

16. I find that:

    i. Brandon Geoffrey Sager died on 6 November 2016 between approximately 3:30pm and 5pm at Room 5, Villa D, Brian Hennessy Rehabilitation Centre, 50 Mary Potter Crescent, Bruce in the Australian Capital Territory; and

    ii. The manner and cause of Mr Sager's death is asphyxia due to hanging - suicide.

17. In considering whether the quality of care, treatment and supervision of Mr Sager under his PTO and while at BHRC contributed to the cause of his death, I note that there appears to have been no indication of Mr Sager having suicidal ideation in the period after the attempt in 2013 to his death in 2016. Mr Sager was medically assessed in the week before his death and expressly denied any suicidal ideation. BHRC staff and Mr Sager's treating psychiatrist told police that there was nothing to alert them to any heightened suicidal risk immediately prior to his death. The treating psychiatrist has opined that Mr Sager's feelings of hopelessness could come on quite suddenly, without them being obvious to staff or showing in mental state examinations leading up to such a state. It is likely that Mr Sager experienced a rapid onset of such feelings prior to his death.

18. In considering whether a matter of public safety arises beyond the treatment and care of Mr Sager under his PTO and at BHRC, I note that issues of ligature-proof door handles in ACT mental health facilities was examined at some length in the *Inquest into the deaths of Anthony Bearham, Nicola Fisher, Christine Douch and Ken Lucas* [2021] ACTCD 1, albeit in the context of The Canberra Hospital. Mr Sager's inquest was adjourned pending the outcome of those matters. In her findings, Coroner Hunter discussed at length her concerns about the inappropriate design of the relevant door handles and found that they constituted a matter of public safety. Her Honour noted with approval, however, that by the time of delivery of her findings all such door hardware had been altered to recessed handles which removed a ligature point for those in inpatient care.

19. Additional evidence was received from Ms Katrina Rea, Executive Director of Mental Health, Justice Health and Alcohol & Drug Services, Canberra Health Services (CHS) in a statement dated 16 December 2021. Relevantly, Ms Rea states:

    a. the BHRC villas were closed in July 2018 when the Adult Mental Health Rehabilitation Unit (AMHRU) opened at the University of Canberra Hospital;

    b. part of BHRC stayed open as the Extended Care Unit. It was refurbished in 2021 and renamed the Gawanggal Mental Health Unit (Gawanggal). Gawanggal is a 10-bed open unit which admits consumers requiring both voluntary and involuntary mental health care;

    c. in both Gawanggal and the AMHRU, bedrooms are fitted with anti-ligature fittings, including but not limited to:

        i. non-weight bearing wardrobe curtains instead of wardrobe doors;

        ii. drawers with anti-ligature fittings; and

iii. anti-ligature bedroom fittings.

d. CHS has reviewed and updated its ligature risk operational procedures in February 2020 with regard to with the Australian Commission on Safety and Quality in Health Care's National Standards for Mental Health Services;

e. at both Gawanggal and the AMHRU, environmental safety checks are carried out both shift-to-shift and on an 'as needs' basis to review whether there is any ligature risk present in a bedroom; and

f. all staff working in Gawanggal and the AMHRU have completed anti-ligature training, including both theory and the practicalities of emergency safe removal of ligatures.

20. I commend CHS for its efforts in implementing Coroner Hunter's recommendations, both for ensuring that new facilities are built in a ligature-safe way and for reviewing and retrofitting existing facilities.

21. Accordingly, I further find that:

iii. pursuant to s52(4)(a)(i) of the *Coroners Act 1997*, a matter of public safety is found to arise in connection with this inquest, being non-ligature-proof door handles at Brian Hennessy Rehabilitation Centre, but that the matter has been addressed; and

iv. pursuant to s74, there is no evidence that the quality of care, treatment or supervision of Mr Sager under his Psychiatric Treatment Order or at Brian Hennessey Rehabilitation Centre contributed to his death.

22. I note the comments in the statement of Ms Jill Henderson, Mr Sager's mother, about his opinion of the good quality of care provided to him by the staff at BHRC.

23. I extend my condolences to Mr Sager's family and friends.

I certify that the preceding twenty-two [22] numbered paragraphs are a true copy of the findings of her Honour Chief Coroner Walker.

Associate: S Corish

Date: 21 December 2021