CORONER'S COURT

File Number:	2657/2009
Name of Deceased:	Samuel DIBLEY
Hearing Dates:	28-30 November 2011and 1 December 2011 at Coffs Harbor and 13 December 2011 at the Coroners Court Glebe
Location of Inquest:	Coffs Harbor and Coroners Court Glebe NSW
Date of Finding:	13 December 2011
Coroner:	Magistrate P.A. MacMahon Deputy State Coroner

Representation:

- Mr B Thompson, Solicitor Advocate assisting the Coroner instructed by Ms R Fraser, State Crown solicitors Office,
- Mr R O'Keefe instructed by Ms T Le, Slater & Gordon for the Dibley family,
- Mr B Hull instructed by Ms Z Officer, Holman Webb for Dr P O'Brien,
- Mr M Fordham instructed by Ms P Monchoff, Guild Litigation for Mid North Coast Local Health District,
- Ms P Robertson NSW Nurses Association for Registered Nurses Greg Norton Baker, Jane Hand, David Dunn, Russell Webb and Edwina Pearce.

Note: Certain evidence given during this inquest is subject to a non-publication order pursuant to section 74 (1)(b) of the Coroner's Act 2009

Non-Publication Orders made pursuant to Section 74(1)(b) Coroners Act 2009

1. The photographs that form part of Exhibit 2 in the proceedings,
2. The names, initials and any other evidence that might identify patients, other than Mr Dibley, admitted to the Mental Health Unit, Coffs Harbour Health Campus and referred to in evidence during the course of the inquest.
3. The evidence as to the mechanics of Mr Dibley's death other than the fact that he died as a consequence of hanging by the use of his own belt and a hole in the door to his wardrobe.

Order made pursuant to Section 75 (5) Coroners Act 2009

A report of the proceedings, subject to the non publication orders made in accordance with section 74(1) (b), is permitted.

Findings made in accordance with Section 81(1) Coroners Act 2009

Samuel Dibley (born 1 July 1985) died on 23 May 2009 at the Coffs Harbour Health Campus, Coffs Harbour in the State of New South Wales. The cause of his death was cerebral hypoxia following strangulation that occurred as a consequence of him hanging himself by a belt with the intention of ending his life on 20 May 2009 whilst an involuntary patient in the Mental Health Unit of that Health Campus.

Recommendations made pursuant to Section 82 Coroners Act 2009

To the Minister for Health and the Minister for Police:

That NSW Health and NSW Police develop a protocol governing procedures to be adopted in the investigation of critical incidents that occur in NSW Hospitals. Such a protocol will be expected to cover the procedure for advising police of such incidents in a timely manner, the preservation of the "crime scene" (that is the physical location of the incident), the securing of exhibits and other relevant documents, the identification of relevant witnesses and the taking of statements from such witnesses.

Introduction

1. Samuel Dibley was a 23-year-old young man who resided in Coffs Harbour in the mid-coast area of New South Wales in 2009. On 19 May 2009 Samuel was admitted as an involuntary patient to the Mental Health Unit (MHU) at the Coffs Harbour Health Campus (CHHC). At 7.34am on 20 May 2009 Samuel was found in his room strangled by a belt around his neck. Efforts were made to revive him however those efforts were unsuccessful. Samuel was declared deceased at 9.34pm on 23 May 2009.

Law governing the inquest

2. The applicable legislation at the time of Samuel's death was the Coroners Act 1980 (the Old Act). The Coroners Act 2009 (the Act) repealed the Old Act. The Act commenced on 1 January 2010 and is therefore applicable to this inquest. The relevant legislation is therefore the Coroners Act 2009. All legislative references in this finding will, unless otherwise specified, be to that legislation.

3. Section 6 defines a *reportable death* as including one where a person died a *violent or unnatural death* or under *suspicious or unusual circumstances.*

4. Section 35 requires that all *reportable deaths* be reported to a coroner.

5. Section 18 gives a coroner jurisdiction to hold an inquest where the death or suspected death of an individual occurred within New South Wales or the person who has died or is suspected to have died was ordinarily a resident of New South Wales.

6. Section 27(1)(b) provides that if it appears to a coroner a person died, or might have died, in circumstances to which Section 23 applies then an inquest is mandatory.

7. Section 23 (b) deals, in part, to circumstances in which the death occurred whilst the deceased is *in lawful custody.* It also gives the State Coroner, or one of the Deputy State Coroners, exclusive jurisdiction to hold such an inquest.

8. Section 81(1) sets out the primary function of the coroner when an inquest is held. That section requires, in summary, that at the conclusion of the inquest the coroner is to establish, should sufficient evidence be available, the fact that a person has died, the identity of that person, the date and place of their death and the cause and manner thereof.

9. Section 82 of the Act provides that a coroner conducting an inquest may also make such recommendations, as he or she considers necessary or desirable, in relation to any matter connected with the death with which the inquest is concerned. The making of recommendations are discretionary and relate usually, but not necessarily only, to matters of public health, public safety or the conduct of services provided by public instrumentalities. In this way coronial proceedings can be forward looking, aiming to prevent future deaths. It is not the role of the coroner to attribute blame.

10. Section 74(1)(b) provides that a coroner in coronial proceedings may, if in the opinion that it would be in the public interest to do so, order that any evidence given in the proceedings not be published.

11. Section 75 deals with the circumstances in which the death the subject of the inquest was self-inflicted. Section 75 (5) provides that where a coroner makes a finding that the death of a person was self-inflicted a report of the proceedings (or any part thereof) must not be published unless (and to the extent that) the coroner holding the inquest makes an order permitting the publication of the report.

Findings of fact

12. Samuel's identity, the date and place of his death and the cause of his death were not matters in issue during the course of the inquest. His mother, Robyn Hyland, identified Samuel's body on 24 May 2009 at the CHHC. Dr J Beaini, a medical practitioner employed by the CHHC, certified that Samuel was deceased at 9.34pm on 23 May 2009 and Dr M Govan, another medical practitioner employed by CHHC, gave the cause of Samuel's death as being *severe hypoxic brain injury as a result of strangulation.* Dr B Beer, who undertook a post mortem examination, recommended the cause of death be given as *cerebral hypoxia secondary to gravity dependent strangulation /hanging.* I accept this evidence as to identity, date and place of death and the cause thereof.

13 The manner of Samuel's death was also not an issue at the inquest. The police investigation found no evidence of the involvement of any third party in Samuel's death. I accept that evidence. Although making a finding that a death of a person was self-inflicted is one that is made cautiously in Samuel's case there was little doubt that his death was the result of action taken by him with the intention of ending his life. I am comfortably satisfied that it was.

Issues for inquest

14. As mentioned above on 19 May 2009 Samuel was involuntarily admitted as a patient to the MHU of the CHHC. That admission occurred in accordance with the provisions of Section 19 Mental Health Act 2007. The reasons given justifying the involuntary admission was that it was concluded that Samuel was considered *to be a mentally ill person* and that *it was necessary for his protection from serious harm.* As such Samuel's circumstances amounted to *lawful custody* and an inquest by either the State Coroner or a Deputy State Coroner was mandatory. (Sections 23(b) and 27(1)(b)).

15. A mandatory inquest examining the death of a person who has died whilst been involuntarily admitted to a mental health facility has important public interest ramifications. The deceased, as an involuntary patient, had no choice but to be admitted. That admission therefore gave rise to an obligation on the part of those who had made the decision to provide medical, psychiatric and other appropriate care for the person who has had their freedom taken away from them. The primary issue for inquest therefore related, in general terms, to an examination of the care provided with a view to determining whether or not there were any systemic deficiencies that contributed to Samuels death and if so was it appropriate to make any Section 82 recommendations. To do this is necessary to undertake an analysis of Samuel's involvement with the CHHC and the MHU.

16. The evidence available at inquest showed that, in the period leading up to 18 May 2009, Samuel was experiencing a depreciation of his mental health state. This, at least in part, appeared to be the result of Samuel's abuse of substances primarily alcohol and cannabis. His father, John Dibley, was most concerned for his welfare and tried to support him. On 18 May 2009, believing

that Samuel required medical assistance and was unlikely to seek it himself, Mr Dibley feigned chest pains and called an ambulance. As a result Samuel was taken to the CHHC Emergency Department (ED) arriving at about 6pm.

17. At about 8.30pm Dr Hulekar examined Samuel. He obtained a history of suicidal ideation over the previous two days on a background history of smoking marijuana. Dr Hulekar proposed that the mental health nurse (the ACS) assess Samuel.

18. Unfortunately the ACS working that evening, David Dunn, was unable to assess Samuel due to his workload. Ms Hyland, Samuel's mother, was given the number of the Mental Health Access Line (MHAL) and they were contacted.

19. Candice Selakovic, the mental health worker on the MHAL, spoke to Samuel for a period and then to Ms Hyland. The conversation with Samuel was terminated early because Samuel was not engaging. Samuel was assessed as *presenting with anxiety and emerging psychosis.* It was considered that his thought form was *derailing* and content *suicidal.* It was noted that Ms Hyland was insistent that Samuel go home that evening under her supervision. A MHAL handover form was sent to the MHU but received after Samuel was discharged.

20. In the meantime Dr Dulekar had a conversation with Dr Peter O'Brien, the on-call psychiatrist, and it was agreed that as Samuel could not be assessed that evening he should be allowed to return home under the supervision of his parents and return the next morning. Samuel was discharged at about 9.40pm.

21. At 8.59am Samuel represented in ED and was seen by Dr Klingensmith at 9.50am. Samuel agreed that he had told ED staff the previous day that he felt like harming himself but that it was *for effect* in order to get the upper hand in an argument with his father. He denied any thoughts of suicide and when asked if he would harm himself he responded *no way*. Dr Klingensmith formed the impression that Samuel possibly suffered from a personality or affect disorder and that he was an unlikely immediate risk to self. He referred Samuel to the ACS for assessment and ordered routine blood screening.

22. David Dunn, the ACS who had been recalled to work that morning to undertake the role of acting Clinical Nurse Consultant, assessed Samuel between 10.30am and about 11.30am. Mr Dunn's assessment was undertaken with the assistance of a NSW Health questionnaire *Mental Health A1 – Assessment of Current presentation Adult* and a self assessment prepared by Samuel on a NSW Health questionnaire *Mental Health SR1 – Self Report Measures for Adults and Older People K10 + LM.* Having undertaken the assessment Mr Dunn formed the view that Samuel ought be admitted as an involuntary patient as he was concerned for his safety and considered that such an admission was the least restrictive action that could be taken to ensure his safety.

23. Mr Dunn discussed his assessment of Samuel with Dr Peter O'Brien who was, once again, the on-call psychiatrist. Mr Dunn recommended that Samuel be admitted to the low dependence unit (LDU) of the MHU as an involuntary patient. Dr O'Brien agreed and prescribed Risperdone, an antipsychotic medication, and Diazepam and Temazepam, drugs used for mild sedation and short-term relief of symptoms relating to anxiety disorders.

24. Dr Thomas, a Psychiatric Registrar, assessed Samuel following Mr Dunn's assessment. Dr Thomas formed the view that Samuel was suffering from *cannabis-induced psychosis on a background of harmful cannabis use.* He recommended that a drug and alcohol worker should review Samuel when he was *more coherent.*

25. Because it was considered that Samuel would not cooperate it was decided he should be admitted as an involuntary patient in accordance with the provisions of the Mental Health Act 2007. Mr Dunn subsequently prepared a Schedule in accordance with section 19 of that Act and Dr Klingensmith confirmed his admission in accordance with section 27(a) of that Act. Samuel was subsequently admitted to the MHU as an involuntary patient.

26. Following Samuel's admission he was allocated to a double room and he shared that with another patient.

27. As a patient in the LDU of the MHU Samuel was the subject of regular observation by MHU staff. The record of the events of the night and early morning are minimal as, at the time, it was the practice to record observations on an exception basis. Samuel received Risperdone and Diazepam at 6.30pm and when Nurse Doak observed him awake at about 2am on 20 May 2009 he was given Temazepam to assist him to settle. Subsequently, at about 3am, he was seen by Nurse Pearce to be asleep.

28. Other than the above there are no records of observations taken by MHU staff. It was suggested at one stage during the inquest that there were extended periods between observations during the night. Staff rejected this suggested. I accept that observations were conducted regularly during the night in accordance with the then applicable policy. Nothing however turns on this, as

shortly before 6am Samuel was awake and seen by Nurse O'Brien waiting to enter the MHU courtyard.

29. Nurse Pearce opened the courtyard and dining area at about 6am. She gave evidence that she saw Samuel in the courtyard speaking with other patients. She did not observe anything that caused her concern.

30. At about 6.45am Nurse Pearce was waiting near the door to the courtyard for the patients to return inside. It was the procedure that the courtyard was closed from about 7am during the handover between shifts. Whilst she was there Samuel came and sat with her for about 10 minutes.

31. In her statement dated 20 April 2010 Nurse Pearce described her interaction with Samuel at that time in the following terms:

> *Initially I noted him to be smiling and polite. I attempted to engage him in conversation. However I observed him to be preoccupied and thought disordered. He had an intense, slightly startled appearance, but did not voice any concerns or requests. I did not note any blood or lacerations on Sam Dibley. I informed Sam Dibley that breakfast would be at 0800 hrs and he then left the lounge room at approximately 06.55 hrs.*

32. When Nurse Pearce gave evidence she was asked about her observations at that time and in particular her observation that he appeared to be preoccupied. She indicated that he was preoccupied with his own thoughts however when she asked his if he was all right it appeared to have *brought him to the moment.* She then engaged him in conversation at the end of which she suggested that he have a shower. Nurse Pearce then locked the courtyard door and Samuel left the area.

33. Nurse Pearce was examined as to her conclusions about Samuel's mental state following her conversation. She said that she did not consider him to be at risk. She also said that there was no cause for alarm. He was not displaying any distress. She asserted that had she observed any matters of concern she would have advised the nurse in charge. Had that been the case there was nothing preventing her from doing so even if she were in the courtyard.

34. Samuel was last seen proceeding in the direction of his room. He was not observed from then until 7.34am when found by Nurse Hand. It would seem from the evidence now available that he may have subsequently sought to harm himself in his bathroom using a razor and or towelling. It appears that it was after this he used his belt to end his life. There was no direct evidence available as to what Samuel did from the time he entered his room until Nurse Hand found him in his room at 7.34am.

35. We know that that was the period during which the handover was given from the night shift to the day shift was the time that Samuel acted to end his life. Nurse O'Brien gave the handover on behalf of the night shift staff and whilst that occurred two nurses were in the HDU and one nurse and a security officer were in the LDU. There is no evidence available to suggest that anything happened during that time that was out of the ordinary. Indeed Samuel's actions were such that the patient in the bed next to his who was resting there at the time was not disturbed by his actions. The two beds were separated only by a piece of furniture.

Discussion

36. There was no suggestion raised during the course of the inquest that the efforts made to revive Samuel once he was located were not appropriate. The

issue for inquest was whether or not the care provided to Samuel prior to those events was appropriate and whether or not anything occurred that ought have alerted the staff as to the possibility of Samuel becoming actively suicidal.

37. Most of the staff of the CHHC and the MHU who had dealings with Samuel gave evidence at the inquest. Those that did appeared to be seeking to assist the investigation. They also appeared to be truthful in their responses to sometimes-difficult questions. All staff appeared concerned for Samuel and affected by what had happened to him. Samuel was of course an involuntary patient in the MHU because he was a risk of self-harm however no staff member identified anything in their dealings with him, or their observations of him, that suggested that Samuel had active plans to harm himself. I accept that this was the case.

38. In determining whether or not Samuel's death might have been prevented it is useful to examine what might have prevented it. Certainly the evidence available indicates that Samuel was suffering an acute psychotic episode that included paranoia and delusions. He was clearly at risk of self-harm. That was the reason why it was appropriate for him to be admitted as an involuntary patient. The risk of self-harm might have been ameliorated by him being admitted to the HDU where the level of observation is much greater and the personal items allowed to the patient are restricted.

40. Had Samuel been in the HDU he would have been more closely observed, he would have had his belt removed and it was possible that his death would have been prevented. There was, however, no suggestion that the placement of Samuel in the LDU was inappropriate. The various assessments of his risk of self-harm had not identified anything to suggest that he was actively suicidal. In addition this was his first admission to a MHU and the possibility of him

being further harmed by his admission to an area that was inappropriately restrictive was high. I am satisfied that Samuel's admission to the HDU would have been inappropriate.

41. Within the LDU of course Samuel could have been more closely observed and his belt and other such items could have been removed. To make the decision to remove such items it would have been necessary for Samuel to display active suicidal intention. This is where the observation of Nurse Pearce was so important. As I have already mentioned her observation was that Samuel was preoccupied with his own thoughts. Nurse Pearce had a period of about ten minutes talking with Samuel and found nothing in that conversation to cause her alarm. I accept that all conversations staff have with patients in the MHU are in fact a part of a process of continuous mental state assessment and that Nurse Pearce's conversation with Samuel that morning was part of that assessment. That assessment did not indicate to Nurse Pearce that Samuel was at the time actively suicidal. Perhaps he was not and his subsequent action was more spontaneous. On the state of the evidence available we can never know one way or the other.

42. Having regard to the evidence available to me I am satisfied that the actions of the medical and nursing staff at the CHHC were appropriate and that whilst Samuel's death was a tragedy for both his family in particular and the community in general the treatment he was provided whilst a patient, both before and after he was scheduled as an involuntary patient at the CHHC was not a contributing factor to his death.

Other Issues

43. Three subsidiary issues arose during the course of the investigation of Samuel's death they being the availability of the hole in the wardrobe door that Samuel used as a hanging point, the preservation of the room in which he was found and matters relating to the decision to make his organs available for donation.

44. The evidence was that Samuel used a hole in the door to his wardrobe as a hanging point. The hole was apparently there as a result of the removal of a doorknob that might have been used has a hanging point. The evidence at the inquest was that the doors to the wardrobes have now been removed. The hanging point has therefore been removed. The availability of a hanging point was clearly a contributing factor to Samuel's death. I accept the evidence that that hanging point has now been removed and as such it is not necessary for me to make a recommendation to that effect pursuant to Section 82 of the Act.

45. As mentioned above Samuel was found at about 7.34am on 20 May 2009 at which time CPR and other efforts were made to revive him. He was subsequently taken to the Intensive Care Unit and those efforts continued. The police were not advised of the circumstances until 23 May 2009 during which time the room was cleaned and subsequently made available for other patients. As a consequence the possibility of obtaining relevant evidence from the room was lost.

46. It is accepted that the immediate focus of the staff's efforts was on the attempts to care for Samuel and the legal obligation to report the matter in accordance with the Coroners Act did not arise until Samuel's death occurred. The response of the CHHC to the circumstances was not, however, an

adequate one. Finding Samuel as he was on at 7.34am 20 May 2009 could have come about in one of three ways they being either by accident, intentional self-harm or the action of a third party.

47. In Samuel's case it appears to be assumed by CHHC staff, correctly as it has turned out, that it was his own action. It was not, however, the prerogative of the CHHC staff to make that assumption. That is a matter in the first instance for the police and if a death occurs the coroner. The possibility of a homicide would need to be excluded. It was therefore necessary for police to have been advised immediately and the scene preserved for examination by crime scene officers. Even in a case such as this where intentional self-harm is reasonably suspected it was immediately apparent that due to his poor prognosis the matter was likely to be the subject of a coronial investigation and the police ought to have been notified.

48. During the course of the inquest I was advised that His Honour Deputy State Coroner Magistrate H Dillon in the Inquest touching the death of Aaron Kennedy was faced with a similar issue and in giving his findings on 22 December 2010 recommended to the Minister for Health and the Minister for Police in accordance with Section 82 as follows:

> *I recommend that the Commissioner of Police and NSW Health consider developing a protocol or Memorandum of Understanding governing procedures to be adopted when police are investigating critical incidents in NSW hospitals. Such a protocol might be expected to cover the taking of statements from relevant witnesses, the securing of "crime scenes" (that is the physical location of the incident) and the securing of exhibits and relevant documents.*

I was also informed that discussions were about to take place between NSW Health and NSW Police to prepare a response to His Honours recommendation. I appreciate that matters move slowly in the bureaucracy and there has been a change of Government in New South Wales since His Honour

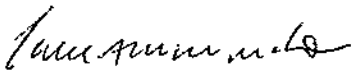
made his recommendation however it has been almost a year since it was made and although I am satisfied that the failure to advise the police in a timely fashion did not adversely interfere with the investigation of Samuel's death such a failure could do so in other circumstances. As such I consider it is appropriate that I make a recommendation in terms similar to that of Magistrate Dillon but responding specifically to the facts in this matter.

49. Once it became apparent that the possibility of Samuel surviving was remote his family considered the making of and organ donation. A donation of some of Samuel's organs was subsequently made. The provisions of the Human Tissue Act 1983 govern organ donation after death. In the circumstances of a reportable death Section 25 of that Act requires a coroner to give approval to such a donation.

50. At the inquest the documentation available raised the question of whether or not the required approval of a coroner had been obtained. The records provided did not refer to the obtaining of approval and there was no documentation on the file evidencing approval under Section 25(2) having been given. In these circumstances I requested that further investigation of the donation to be undertaken. I was subsequently provided a copy of the approval given in accordance with Section 25(2) of the Human Tissue Act by Deputy State Coroner Magistrate M MacPherson. I accept that evidence and am satisfied that prior to the subject organ donation occurring the approval of a coroner was sought and obtained.

51. As I have already mentioned Section 75 deals with the circumstances in which the death the subject of the inquest was self-inflicted. Section 75 (5) provides that where a coroner makes a finding that the death of a person was self-inflicted a report of the proceedings (or any part thereof) must not be

published unless (and to the extent that) the coroner holding the inquest makes an order permitting the publication of the report. In this case Samuel's family do not object to the publication of a report of the inquest. They consider that it would be in the public interest that a report occurs. I agree with them and propose make an order in accordance with Section 75(5) allowing a report to be published subject, of course, to the terms of the non-publication orders made during the course of the inquest.



Magistrate P A MacMahon
Deputy State Coroner
13 December 2011