LOCAL COURT of NEW SOUTH WALES

Coronial Jurisdiction

Inquest:	**Inquest into the death of William Alexander MacKENZIE**
Hearing dates:	21 - 23 February 2011
Date of findings:	04 March 2011
Place of findings:	Glebe
Coroner:	Deputy State Coroner Scott Mitchell
Findings:	**I find that William MacKenzie (born on 24 October, 1947) died on 9 June, 2008 at 55 Moorhead Street, Waterloo of multiple injuries sustained after he jumped from his 15th storey home unit at a time when he was a mentally ill person.**
Recommendations:	**I recommend that the South Eastern, Sydney and Illawarra, Shoalhaven Local Health Network review its training programmes and materials concerning the *Mental Health Act 2007* so as to ensure compliance with the provisions of the Act and, in particular, to ensure, where practical, that all staff exercising powers or functions under the said Act are conversant with its procedures and requirements.**
File number:	0921/08
Representation:	Dr P. Dwyer (Counsel Assisting) instructed by Ms L. Molloy (Crown Solicitor's Office) Ms Lonergan (Councel) representing St Vincent's Hospital and the other medical practitioners Mr Davis (Councel) representing Dr Reyes

REASONS FOR DECISION

WILLIAM ALEXANDER MacKENZIE **921/08**

The Inquest

This is an inquest into the death of William Alexander MacKenzie. Mr. MacKenzie was born on 24 October, 1947 and died at 55 Morehead Street, Waterloo on 9 June 2008. Mr. MacKenzie was unmarried and, as far as I know, childless but he had two former partners from previous relationships who maintained an interest in him. One is Louise Guthrie of Kahibah, NSW with whom he had a *de facto* relationship from 1988 to 2004 and the other is Cecelia Jarvis who shared a *de facto* relationship with him for about 5 years up until his death.

Dr. P. Dwyer of Counsel, instructed by Ms. L. Molloy of the Crown Solicitor's Officer appeared to assist the Coroner while Ms. Lonergan of Counsel appeared for *St. Vincent's Hospital,* Darlinghurst and for the medical practitioners interested in this matter other than Dr. Michael Reyes for whom Mr Davis of Counsel appeared.

The *formal documents* including the *P79A* Report, the *I.D.* Certificate, the Autopsy Report and the Certificate of Analysis from the Division of Analytical Laboratories are **EXHIBIT 1** in the proceedings. **EXHIBIT 2** is the coronial brief.

The following persons appeared to give evidence:-

- Detective Senior Constable Peter Kench, the police officer-in-charge of the investigation;
- Dr. Michael Reyes who was the Resident Medical Officer at St. Vincent's Hospital when Mr. MacKenzie was taken there;
- Clinical Nurse Consultant Beaver Hudson of *St Vincent's*;
- Dr. Edward Wims who was the Psychiatric Registrar who assessed Mr. MacKenzie;
- Dr. Olaf Neilssen a Psychiatrist and expert witness;
- Professor Kay Wilhelm, the Consultant Psychiatrist *on call* at the time of Mr. MacKenzie's visit; and
- Dr. Paul Preisz.

The inquest was heard at Parramatta on 21 to 23 February, 2011 inclusive.

The Cause of Death

The *Autopsy Report* prepared by Dr, Szentmariay on 4 December, 2008 identified the cause of death as *Multiple Injuries* which included:-

- Grossly flattened skull and face;
- Massive skull and base of skull fractures;
- Fracture of the maxilla and mandible, bilateral;
- Separation of pons from midbrain, multifocal extensive brain laceration, bilateral;
- Carotid artery laceration, bilateral, full thickness with accompanying sheet-like haemorrhage;
- Fracture of the hyoid bone x 2, intact thyroid cartilage;

- Laceration of both lungs;
- Extensive laceration of heart, ascending aorta;
- Mild laceration of liver (mostly posterior aspect);
- Pancreas fragmented in multiple pieces;
- Laceration of anterior stomach;
- Laceration of both kidneys;
- Bilateral rib fractures, all ribs affected;
- No gross vertebral fracture;
- Separation of anterior pelvis (pubic bones).

In addition, Dr. Szentmariay found atherosclerotic cardiovascular disease featuring major coronary arteries with up to 40-50% narrowing and benign nephrosclerosis.

Contact with Police

At about 8.30am on 9 June. 2008 three officers from Surry Hills Police Station, Senior Constable Froml and Constables Rispen and Wooden were called to *Foster House* at Surry Hills in response to reports of a man who turned out to be Mr. MacKenzie acting erratically and in an abusive manner. They were later joined by two other officers, Constables Mangabat and Sutton. Senior Constable Froml made contact with the man and he told her *"I just want the number for Alcoholics Anonymous"* and when she approached him to hand him a brochure, he told her to *"fuck off."* Not unreasonably, police directed him to move on and when he told them he was *"not fuckin going anywhere,"* they arrested him, charged him with refusing to comply with that direction and took him back to Surry Hills police station. He was released at about 10.50am.

Later that day, at about 12.15pm, the same three officers responded to a further report of a man behaving erratically and they found Mr. MacKenzie lying on the carriageway at the intersection of Bourke and Foveaux Streets, Surry Hills. There is a suggestion that, prior to the arrival of police, he had been running into traffic, apparently in an attempt to kill himself. He appeared disoriented and told police *"I want to die. I want to kill myself"* but he also expressed a wish to go to a *mental asylum* so they took him to the emergency department at *St. Vincent's Hospital* at Darlinghurst where Constable Rispen completed a section 22 form containing information that *" Mr. MacKenzie was found lying in the middle of a major road, attempted to assault any person who tried to assist him. Stated that he wanted to die. Stated that his life is over and was not going to eat or drink again, no insight or care for his own wellbeing."*

There is no criticism of police who seem to have performed their difficult function with skill, respect and compassion.

Dr. Reyes

At *St. Vincent's*, Mr. MacKenzie was first seen by Dr. Michael Reyes, a second year *RMO* engaged in the third month of his rotation as a psychiatric resident. As he approached the patient, Dr. Reyes had available to him notes from *Royal Prince Alfred Hospital*, Camperdown indicating that Mr. MacKenzie had been an involuntary patient at the *Missenden Unit* from 17 March until 2 April, 2008 where he had been diagnosed as suffering from *bipolar affective disorder* and that his treatment on discharge had been a combination of *olanzapine* 20 mg per day (an antipsychotic) and *valproate* 500 mg twice daily (a mood stabilizer.) Those same notes indicated multiple previous admissions to *RPA* and similar diagnoses although perhaps not in such close detail.

Dr. Reyes found Mr. MacKenzie *"hostile and guarded"* and unwilling to say anything much. Mr. MacKenzie *"looked threatening, would not sit down and had an aggressive demeanour."* He had cut his lip in or *en route* to the emergency department and had proceeded to smear the wall with his blood. Dr. Reyes found it wise to defer taking blood which, routinely, he would have done at an early stage in order to exclude infection and intoxication. Instead, he charted *PRN* medications *Olanzapine* by mouth, *Haloperidol* or *Midazolam* intramuscularly and *Diazepam* intravenously. In point of fact, none of these medications was administered until after Dr. Wims had seen Mr. MacKenzie with Dr. Reyes some two and a half hours later and, even then, it is doubtful that *Olanzapine* was ever administered. Deferring any further initial examination, Dr. Reyes wrote *"needs further assessment when sober"* and he contacted the Psychiatric Registrar, Dr. Edward Wims, who saw the patient in Dr. Reyes' company shortly after 2pm.

Dr. Olav Nielssen Psychiatrist of Macquarie Street, Sydney provided expert medical evidence regarding Mr. Mackenzie's treatment at *St. Vincent's Hospital* and his report forms part of the Coronial Brief. Dr. Neilssen has no criticism of Dr. Reyes' initial decision to defer a thorough examination of Mr. McKenzie and to hold him while he calmed down and he notes with approval that Mr. MacKenzie was detained in a glass-fronted room providing for ease of supervision and that he was continuously observed at 15-minute intervals. As Dr. Neilssen notes, Dr. Reyes failed to complete a physical examination as prescribed but in view of Mr. MacKenzie's truculence, that omission was perhaps understandable and, on the positive side, Dr. Reyes managed to establish important aspects of Mr. Mackenzie's past history, diagnoses and treatment. Dr. Neilssen was comfortable that Dr. Reyes had acted wisely in calling for Dr. Wims.

Dr. Wims' first intervention

Dr. Wims noticed Mr. MacKenzie briefly as he was first brought into the emergency department and placed in a room. Mr. MacKenzie was agitated, spitting, struggling with police and, later, smearing the walls with blood. He remained oppositional and aggressive and was threatening and shouted abuse when, at about 2pm, Dr. Wims, accompanied by Dr. Reyes, introduced himself and commenced to undertake his assessment. In that assessment, Dr. Wims was aware of the earlier admissions at *Royal Prince Alfred Hospital* and diagnoses and he read the *RPA* notes. In the Form 1 *Medical Report as to Mental State of a Detained Person,* Dr. Wims wrote of the patient - *"Attempted assault of individual. Agitated. Stating wants to die. Known history of bipolar disorder"* and he noted as his conclusion *"probably relapse of bipolar disorder."* Then Dr. Wims ticked the box provided in the Form 1 indicating his opinion that Mr. MacKenzie was *"a mentally ill person."*

Dr Wims told the inquest that, even at 2pm, he believed that Mr. MacKenzie was intoxicated but it is not clear how he had come to that view and, significantly, no traces of alcohol were shown in the toxicology analysis after Mr. MacKenzie's death. Dr. Wims said that it was not because Mr. MacKenzie smelt of liquor because he did not smell any. No blood tests were undertaken. The evidence suggests that Mr. Mackenzie had not taken alcohol for many years and the diagnosis of *alcohol related brain damage* mentioned in the *RPA* notes was and remains unconfirmed. It was not until about 7pm in the course of Dr. Wims' second assessment that Mr. MacKenzie announced that he had drunk rather a lot of rum and, at any event, Mr. MacKenzie was hardly a reliable historian. From the outset, Mr. MacKenzie was staggering and acting irrationally but his affect was at least as consistent with mental illness as with intoxication and Dr. Wims made no mention of alcohol intoxication when he came to fill out the first *Form 1* certifying that Mr. MacKenzie was a mentally ill person. I do not

accept that, at the time of his first assessment of Mr. MacKenzie at about 2pm, Dr. Wims had any idea that alcohol played any part in the patient's presentation.

When the first assessment was completed, Dr. Wims, unnecessarily in my view, directed Dr. Reyes to place the patient on a *Schedule 1* under the *Mental Health Act* which he did. Dr Reyes chartered *Olanzapine* 10ml orally, and *Haloperidol* and *Midazolam,* 10ml, each intramuscularly. There is doubt as to whether Olanzapine was actually administered but *Haloperidol* and *Midazolam* certainly were. Dr. Neilssen described the medication administered at about 2.30 as *"a combination of a potent antipsychotic medication and a short acting benzodiazepine, which was considered to be appropriate based on (Mr. MacKenzie's) reported agitation, disorganized thinking and the provisional diagnosis of a relapse of bipolar disorder"* which he, Dr. Neilssen, regarded as appropriate.

Mr. MacKenzie was then secured and was asleep from 3:10 to 5:25pm. Dr. Reyes then went off duty.

Dr. Wims' second intervention

When Dr. Wims returned to Mr. MacKenzie at about 7pm he found Mr. MacKenzie *"much more settled, alert, oriented and calm."* Dr. Wims described him as *"cooperative," "pleasant," "ingratiating"* and *"almost obsequious"* with none of the aggression or truculence he had earlier displayed. Mr. MacKenzie denied any thoughts of self-harm or of harming others and *"there were no obvious signs of major affective disturbance – neither elation nor depression."* Dr. Wims saw this changed affect as an indication that, when first seen, Mr. MacKenzie had been intoxicated and that, with the passage of time, he had regained his sobriety and Mr. MacKenzie was happy to admit that he had drunk a lot of rum earlier that day and described himself as an alcoholic. The notes indicate that Dr. Wims found Mr. MacKenzie still somewhat sleepy and it may be that what he was observing was the sedating effect of the medication of the patient rather than the passing of his intoxication.

Despite Mr. MacKenzie's history of very significant mental illness, diagnoses, including a recent diagnosis, of *bipolar affective disorder* and repeated admissions to hospital including a lengthy admission to a major metropolitan hospital only three months earlier, on reassessment Dr. Wims changed his mind. Despite his earlier finding, he determined that Mr. MacKenzie was neither mentally ill nor mentally disordered. He decided instead that Mr. MacKenzie's affect earlier in the presentation had been as a consequence of intoxication and of his resentment at having been detained by police. And, having decided that alcohol, uninfluenced by mental illness, had been at the root of Mr. MacKenzie's troubles on that day, Dr. Wims certified in a second *Form 1* document that Mr. MacKenzie was neither a mentally ill nor a mentally disordered person and, accordingly, ordered that he be discharged from *St. Vincent's.*

There was little evidence available to him that Mr. MacKenzie had taken any alcohol at all so that it seems to me that Dr. Wims' second finding was very insecurely based. Neither police not anybody else at *St. Vincent's* suggests that Mr. MacKenzie he smelt of alcohol and his partner Cecelia Jarvis' evidence is that Mr. MacKenzie had been abstinent for many years. It is significant that, despite Dr. Reyes initial attempts, bloods were not taken, even at the time of the second assessment when Mr. MacKenzie might have cooperated, so that no test results were available to point to intoxication and to support Dr. Wims' diagnosis. Perhaps Dr. Wims made a false assumption or perhaps, given his note that *"the patient... ...admits to having been intoxicated earlier today,"* he was misled by Mr. MacKenzie himself although he must have been aware that Mr. Mackenzie was an unreliable historian.

In his notes for 18.55 pm on 9 June, 2008, Dr. Wims recorded details of his second interview with Mr. MacKenzie, He saw the patient as *"v reticent to give any information"* and he regarded Mr. MacKenzie's presentation as *"somewhat factitious eg unable to say what his address was or where he spent last night of if he had been staying at Foster House."* Dr Wims noted that *"I don't believe Mr. MacKenzie when he says this. I suspect his being very selective in what information he gives away."*

Mr. MacKenzie went on to tell Dr. Wims that *"he slept here (at the hospital) last night"* which was plainly false. Evidently the imaginative explanation offered to the inquest by Professor Wilhelm, namely that Mr. MacKenzie, having awakened from his medication-induced sleep at 5.25pm, may have confused that period of sleep with his previous nights' sleep, did not occur to Dr. Wims who merely assumed that Mr. MacKenzie's statement was false.

According to Dr. Wims, the patient *"was unable to say how much he's had to drink but admits to having been intoxicated earlier to day. Drink of choice is rum."* Then, as noted by Dr. Wims, Mr. MacKenzie went on to say that his *"only concern is that he's an alcoholic"* although, had he thought about it, Dr. Wims might have wondered whether another *concern* might have been the *bipolar affective disorder* which had repeatedly landed Mr.MacKenzie in hospital. Dr.Wims might also have wondered whether Mr. MacKenzie's account of himself was not influenced by the circumstance, pointed out by Dr. Nielssen, that, under the *Mental Health Act*, behaviour due to intoxication, by itself, does not constitute a mental illness or disorder so that a decision by Dr. Wims that the earlier presentation had been solely attributable to alcohol abuse would have left the hospital with no basis for holding the patient against his will.

However that may be, Dr. Wims formed the view that intoxication and resentment at having been detained were the cause of Mr. Mackenzie's peculiar affect earlier in the day and, because neither provided a proper basis for holding him and because he no longer appeared to Dr. Wims to be mentally ill or mentally disordered, he was discharged.

Mr. MacKenzie's History

To this day, that remains Dr. Wims' position. One might have thought that the insights gathered at *Royal Prince Alfred Hospital*, whose notes were available to him, and at Wyong Hospital might have given him pause. One might have thought they would have dissuaded him from dismissing out of hand, as I think he did, the high probability that, despite the appearances of the moment, Mr. MacKenzie remained a mentally ill person at 7pm on 9 June, 2008.

Until about 2004, Mr. MacKenzie seems to have led a happy and relatively healthy life and to have made significant achievements. He had overcome an unhappy childhood and had found worthwhile employment as a drug and alcohol counsellor for the Salvation Army at *Foster House* in Surry Hills. And he had been in a long-term *de facto* relationship for some sixteen years. Then, in about 2003, his circumstances unhappily changed. He was dismissed from his employment, his relationship sadly came to an end and he became more and more depressed as his unlawful use of cannabis increased. There is a very real limit to the degree to which this inquest can explore with precision the various factors which gave rise to this deterioration in Mr. MacKenzie's health and the passage of years would render that almost impossible. Suffice to trace his mental health status by reference to his various hospitalisations and his various diagnoses from time to time.

In 2004, Mr. MacKenzie was placed on a schedule and hospitalised for a month at the *Missenden Unit* at the *Royal Prince Alfred Hospital,* Camperdown. Then, on 26 April, 2005 he was admitted to that unit once again and held as an involuntary patient until discharged on 20 June, 2005. On that occasion, he was diagnosed with *"bipolar affective disorder-*

manic phase (initial presentation) and bipolar affective disorder-bipolar depression (later phase of admission), anti-social traits also noted. Discharged on Clozapine 10mg mane, 20mg nocte and Sodium Valproate 500mg mane, 700mg nocte." On admission, Mr. Mackenzie had expressed suicidal ideation and, judging from the prescribed medication and the length of the admission, I think his condition as at 26 April, 2005 was very serious indeed.

The *RPA* notes reveal that, even on discharge, Mr. Mackenzie continued to experience symptoms of psychoses and volatile moods and, intermittently during 2005, he was in the care of the *Camperdown Community Mental Health Team.*

From 13 March to 7 April, 2006, Mr. MacKenzie was an involuntary patient at *Rozelle* where to a fresh diagnosis of *"bipolar affective disorder"* was added a diagnosis of *"substance use disorder."* The *Discharge Summary* notes that Mr. MacKenzie was *"reluctant to take regular medication due to side effects (olanzapine and sodium valoprate.)"*

From 9 to 19 January, 2007, Mr. MacKenzie was an involuntary patient at Wyong Hospital suffering symptoms of *bipolar disorder* and, from 17 March to 2 April, 2007, he was once again at *RPA* with a diagnosis of *bipolar affective disorder* and *hypomania.*

Sporadically during 2006, 2007 and the first half of 2008, Mr. MacKenzie had contact with the *Redfern Community Mental Health Team* but he was often non-compliant with medication and he and Ms. Jarvis his *de facto* partner struggled to deal with his ill health. In late April, 2008, Mr. MacKenzie reported to Case Worker Scott Lowe of the *Redfern* team that he was no longer prepared to take *Zyprexa* (an antipsychotic) which had been prescribed for him and that he would take his prescription *Epilim* (for epilepsy) not *as directed* but only when he thought he required it. Mr. Lowe stressed the futility of that position but, obviously without effect and by 4 June, 2008, when Mr. MacKenzie next consulted the *Redfern* team, he had been off his antipsychotic medication for two months and, not surprisingly, his health was declining.

What went wrong

Even at 7pm on 9 June, 2008 when Mr. MacKenzie in his apparently pleasant, sedate and cooperative mood was interviewed by Dr. Wims, there were signs that all was not well and that it was unwise of Dr. Wims to ignore the possibility or perhaps even the probability that the foundation of what had been seen during the day was mental illness rather than alcohol abuse. One of those signs was the *factitious* presentation which Dr. Wims had noted. Professor Wilhelm would have the inquest believe that such behaviour is quite commonly encountered at *St. Vincent's* but, in my opinion, whether it is or not, it should, when accompanied by a history such as Mr. MacKenzies', be a warning that the patient might not be as well as perhaps he appears, that caution is indicated and that the diagnosis of *no mental illness* needs to be confirmed.

As Ms. Guthrie expressed it in the letter she sent to the inquest *"the issue with Bill's diagnosis appears to me to be that it relied too heavily on Bill's statements about his current mental state at one point in time and not enough emphasis was given to his behaviour in the preceding twelve hours, his history of mental illness, previous admissions and previous suicide attempts."*

This view is reinforced, it seems to me, by the availability to Dr. Wims of information, had he sought it, that Mr. MacKenzie was not compliant with his medication and probably had not been for a matter of months. His failure to make any enquiry in that regard was a missed opportunity to gauge the likelihood of mental illness.. So were Dr. Wims' failure to order

blood tests and perhaps his failure to order that a physical examination be carried out as hospital procedures and good practice required.

The *Mental Health Act*

It is a requirement of section 27 of the *Mental Health Act 2007* that a person brought to a mental health facility by a police officer pursuant to a notice under section 22, as Mr. MacKenzie was, be examined by an authorised medical officer as soon as practicable (but not later than 12 hours) after the person arrives at the facility. The evidence at this inquest demonstrates that, until relatively recently, the emergency department of *St. Vincent's Hospital* was not a *mental health facility* within the meaning of this section. Instead, I was told that there had been an agreement entered into by *St. Vincent's Hospital* and the police to treat the emergency department as though it were a declared *mental health facility* and for the police sometimes to bring apparently mentally ill or mentally disordered persons to the emergency department rather than to *Caritas* (which was a declared *mental health facility*) and for the hospital to accept those persons into the emergency department and assess them there before determining whether they should be admitted to *Caritas* or to the hospital's emergency psychiatric centre, known as *PECC* or discharged.

In those circumstances, it is not clear that, strictly speaking, section 27 had anything to say about Mr. MacKenzie's treatment but the hospital acted is if did and, in particular, Dr. Wims was called to assess the patient at about 2pm and then completed a *Form 1* certifying that Mr. MacKenzie was a *mentally ill person.*

Thereafter, the processes set forth in the *Mental Health Act* were robustly ignored. In the first place, Dr. Wims directed Dr Reyes to place the patient on a *Schedule 1* having been under the mistaken impression that such was necessary in order to hold the patient and to authorise medication necessary to enable a mental health assessment whereas the section 22 notice would surely have been sufficient. Then, having assessed the patient and certified that he was a *mentally ill person,* Dr. Wims performed a second assessment some five hours later, decided that Mr. MacKenzie was not *mentally ill* and discharged him. What section 27 would have required is that Mr. MacKenzie, having been assessed as *mentally ill* be examined by a second medical officer, this time a Consultant Psychiatrist, who would either endorse the first opinion or not. If the Consultant Psychiatrist was unable to agree that the patient was *mentally ill* or *mentally disorder*, a third opinion would be required before the patient would be brought before the tribunal. This is quite a complicated procedure but Dr. Wims cut the *Gordian knot* simply by reassessing Mr. MacKenzie himself and writing out a second *Form I* at 7pm, declaring the patient to be neither mentally ill nor mentally disordered. In effect, he provided his own second opinion and then, when those two opinions differed, avoided the requirement of a third opinion by discharging the patient himself. Dr. Wims' evidence on that point, with which Professor Wilhelm, who was the *on call* Consultant agreed, is they *would have* discussed Mr. Mackenzie's case from time to time during the day but Professor Wilhelm could not recall having done so and neither had any notes on which they could rely. But Dr. Wims admitted that he had advised Professor Wilhelm of Mr. MacKenzie's discharge only *after* the event and I am not sure that she would have agreed with his view that she would have endorsed his decision at any event.

Dr. Wims discharged Mr. MacKenzie without providing for any *follow up* which Dr. Neilssen and even Professor Wilhelm told the inquest was a serious omission.

Was Mr. MacKenzie mentally ill?

With the wisdom of hindsight, it is clear to me that, when Dr. Wims made his final assessment, Mr. MacKenzie was unwell and unfit to go home. Even ignoring what we now know happened not three hours later, I believe it was clear at the time of the second assessment that Dr. Wims, alerted by the earlier diagnoses and the history, should have arranged a second assessment by a Consultant Psychiatrist and otherwise acted in accordance with the scheme provided in section 27 of the *Mental Health Act 2007* rather than, effectively, tearing up his first Form ! and giving a second opinion himself. At the very least, assuming that the provisions of the *Mental Health Act* did not apply, he should have arranged a very thorough complete and painstaking *follow up* were he to discharge the patient. Dr. Neilssen's opinion, with which I respectfully agree, is that *"the circumstances of Mr. MacKenzie's admission and the psychiatric history that was available justified continued involuntary admission for a period of observation necessary to confirm the diagnosis."* Instead, so certain was Dr. Wims that mental illness was not a factor that Mr. MacKenzie was allowed go on his way. It seems to me that, even ignoring what we now know happened to Mr. Mackenzie, its now clear that he was mentally ill. As Dr. Neilssen reports, *"in light of the history of a diagnosis of bipolar disorder after a two week admission in a major metropolitan hospital three months earlier... ...I do not consider the diagnosis made at the time of the second interview* (that is of alcohol intoxication and resentment at having been detained) *to be complete."*

On discharge, Dr Wims noted *"no follow up required."* Even
Professor Wilhelm, who does not agree with my understanding of the situation, believes that it had been far from clear that mental illness had played a part in Mr. MacKenzie's affect and behaviour and sees the question facing Dr. Wims as his *judgement call*, told the inquest that she was particularly uncomfortable that no *follow up* had been ordered.

Dr. Nielssen's opinion is that this was manifestly inadequate. In the first place, he points out that as many as 30% of people who are given parenteral sedation such as *haloperidol* as Mr. MacKenzie was experience a *dystonic* reaction or muscle spasm in the days after the injection. Secondly and I think much more significantly, *"the history of bipolar disorder and previous treatment with a moderate dose of mood stabilising and anti-psychotic medication suggests that some kind of psychiatric follow up was indicated."* Thirdly, there was the matter of substance abuse which, if it had truly been a major presenting problem, was particularly requiring to be addressed. It is unlikely that good wishes and encouraging noises on the steps of the hospital would have been sufficient to Mr. MacKenzie's needs. And fourthly, no thought seems to have been given as to where Mr. MacKenzie would spend the night, how he would get there in his sedated condition and who, if anybody, would be available to care for him there.

Professor Wilhelm was prepared to concede that the failure to arrange adequate *follow up* had been an error. Her opinion was that, in the situation which faced Dr. Wims, his appropriate options had been either to arrange adequate *follow up* by contacting *RPA* or perhaps the *Redfern Community Mental Health Team* who were familiar with Mr. MacKenzie and arranging prompt intervention, perhaps even that night or next morning if those who knew Mr. MacKenzie's history and condition thought that appropriate. Otherwise, she thought the appropriate option had been to admit Mr. Mackenzie to *St. Vincent's* and hold him over night or pending a further consultation. But all that said, Professor Wilhelm was unwilling to criticise the decision to discharge Mr. MacKenzie.
In the event, Dr. Wims discharged the patient with *"no follow up required."*

Mr. MacKenzie is Discharged

Acting on Dr. Wims' instructions, an intern, Dr Shiva Rayar, prepared the *Discharge Summary* relying largely on the terms of the police section 22 *Notice* and Dr. Wims' assessment notes. In farewelling Mr. MacKenzie on the steps of the hospital, Dr. Wims "... *encouraged him to consider giving up alcohol and advised him to speak to his GP regarding this."*

The Fall

Having been discharged from *St. Vincent's,* Mr. MacKenzie returned home. At that stage he was living in unit # 1505 situated on the 15th. floor of 55 Morehead St.,Waterloo. That building is part of a complex of residential buildings owned and operated by the *NSW Department of Housing* and bounded by Redfern, Young, Phillip, Morehead and Kettle Streets, Redfern and Mr. MacKenzie secured accommodation there in 2005. Initially, he occupied a ground floor unit but, in mid 2008, he swapped his ground floor unit for the 15th. floor unit of a friend who wanted to keep a kitten and needed a ground floor flat in which to do so. The 15th. floor unit contained a balcony overlooking Young Street about 45 metres below but was unsuitable for keeping a pet. An additional reason for the swap was that Mr. MacKenzie felt *vulnerable* on the ground floor and was happy to have premises which he regarded as more secure. The swap was a private arrangement but was ultimately sanctioned by departmental management when it came to their attention.

At about 9.40pm on 9 June, 2008 police were called to the car park of the premises in connection with a person lying in the car park having fallen from a home unit in the tower building. The same officers attended and that person turned out to be Mr. MacKenzie who was dead and was positioned on the floor of the car park area and the Young Street side of the tower building, about 5 metres south of the tower. Scattered about him were various items including two knives, a hammer, a wristwatch, a motorbike helmet, a black jacket, a smashed picture frame and a broken cricket stump.

A crime scene was set up in Mr. Mackenzie's home unit. The front door was unlocked by police who entered and searched the unit. It appeared to Detective Senior Constable Adam Solar on whose statement I rely *"neat and tidy and in good order. There was no sign of any struggle and no suspicious circumstances."*

The findings

I find that William MacKenzie (born on 24 October, 1947) died on 9 June, 2008 at 55 Moorhead Street, Waterloo of multiple injuries sustained after he jumped from his 15th storey home unit at a time when he was a mentally ill person.

Recommendations

The evidence in this inquest demonstrates that some medical, nursing and perhaps other staff at *St. Vincent's Hospital* may have a less than satisfactory understanding of the provisions of the *Mental Health Act 2007*. We heard evidence that the section 27 scheme was less than adequately understood. We heard that some staff members thought that a schedule was necessary before a patient could be held or given medication to facilitate an assessment. There seemed to be some confusion as to the effect of a section 22. We were told that some medical practitioners thought that a Consultant Psychiatrist could delegate his or her section 27 responsibilities to give a second opinion to an unqualified practitioner and, obviously, in some quarters, there was confusion as to whether the medical officer supplying

the first opinion under section 27 could short cut matters by providing his or her own second opinion.

Clearly, the compliance of the hospital with the provisions of the *Mental Health Act* is important and I was told by Ms. Lonergan of Counsel that *St. Vincent's Hospital* would embrace a recommendation to that end.

Accordingly, **I recommend that the South Eastern, Sydney and Illawarra, Shoalhaven Local Health Network review its training programmes and materials concerning the *Mental Health Act 2007* so as to ensure compliance with the provisions of the Act and, in particular, to ensure, where practical, that all staff exercising powers or functions under the said Act are conversant with its procedures and requirements.**

Magistrate Scott Mitchell,
NSW Deputy State Coroner,
Glebe.
4 February, 2011