CORONERS ACT, 1975 AS AMENDED

SOUTH *AUSTRALIA*

FINDING OF INQUEST

An Inquest taken on behalf of our Sovereign Lady the Queen at Adelaide in the State of South Australia, on the 6th day of June, and 7th day of July, 2000, before Wayne Cromwell Chivell, a Coroner for the said State, concerning the death of Debby Edgell.

I, the said Coroner, do find that Debby Edgell, aged 39 years, late of 10 Halba Crescent, Paralowie, died at 10 Halba Crescent, Paralowie on the 11th day of February, 1998 as a result of neck compression due to hanging. I find that the circumstances of death were as follows:-

1. **Introduction**

1.1 Debby Edgell was born on 15 February 1958. She was married with no children.

1.2 On Wednesday 11 February 1998 Ms. Edgell and her friend Judy Muldoon went to visit a friend at the Lyell McEwin Health Service ("LMHS"). They returned home about 4.00p.m. with a carton of beer. Debby and another friend, Denise Agius, began drinking the beer. Debby also had "a few cones of cannabis" (Exhibit C.1b, p2).

1.3 James Edgell, Debby's husband, went out to a darts competition about 7.00p.m., and returned home at about 11.00p.m. to find his wife hanging from a beam of the rear pergola by a sheet. He said that she was still warm but he could not feel a pulse. He ran inside and called an ambulance, and then ran outside again and cut her down. He and his friend Jim McMahon gave her cardio-pulmonary resuscitation ("CPR") until the ambulance arrived (Exhibit C.1b, p3).

1.4 The ambulance crew took over CPR as soon as they arrived, and attempted defibrillation but to no avail. They ceased their attempts to resuscitate Ms. Edgell at

about 11.30p.m., as it was evident that the situation was hopeless. Her life was formally declared extinct by Dr. W.J. Monkhouse at 1.00a.m. on 12 February 1998 (Exhibit C.2a).

2. Cause of death

2.1 A post mortem examination was carried out on the body of the deceased by Dr. J.D. Gilbert, forensic pathologist, at the Forensic Science Centre on 12 February 1998. Dr. Gilbert confirmed that the cause of death was "neck compression due to hanging" (Exhibit C.3a, p1).

2.2 A toxicological analysis of Ms. Edgell's blood revealed the presence of:-

• venlafaxine	0.08mg/L	(therapeutic level)
• O-desmethyl-venlafaxine	0.30mg/L	(therapeutic level)
• alcohol	0.191%	
• tetrahydrocannabinol (THC)		
• 11-nor-9-carboxythc.		

Other prescription drugs she had used in the past, including promethazine, lorazepam and valproic acid were not detected in the blood (Exhibit C.4a).

2.3 Dr. Gilbert commented that the presence of THC and its metabolite indicated recent use of cannabis. The therapeutic levels of other drugs were not considered significant.

3. Background

3.1 Professor R.D. Goldney, Professor of Psychiatry at the University of Adelaide, has provided me with a report assessing the psychiatric care given to Ms. Edgell prior to her death (Exhibit C.12). He records that:-

> "There is no doubt that Ms. Edgell has had a long history of emotional disturbance, but there is little formal documentation of that prior to December 1997 when she came under the care of Lyell McEwin Health Services". (p5).

3.2 It is recorded in the casenotes that Ms. Edgell had been treated in the past by Dr. O'Brien, psychiatrist, and had received psychiatric medication in the form of prozac (an anti-depressant) and lithium (a mood stabiliser).

3.3 Mr James Edgell said that his wife had 'a lot of problems' in the past 4 years. He said:

"She has been in and out of depression during that time. She is always been seeing doctors but she only started seeing a psychiatrist since December last year.

Since then she has also been in and out of the Psychiatric Ward, 1G at the Lyell McEwin Hospital. She has been seeing Dr. Bruce Groves at White Road, Salisbury North clinic. She went into hospital just before Christmas and stayed for about three weeks. Whilst in the hospital that time she tried to slash her wrists. She spoke about killing herself and I'm not really sure about the reasons behind it and don't understand why she did it. I know she has a civil case with the Police Department but there was more to her worries than that. (About four years ago she was an Aboriginal Police Aide at Elizabeth).

I know she was drinking a lot of alcohol then and getting into cannabis. After she returned home from the hospital from the three week stay, she was only at home for a couple of days before she went back because she didn't feel comfortable at home. Then a couple of weeks ago she was home again and she tried to overdose on her medication (the anti-depressants that she takes). Debby is also a diabetic. I was home when she did this and again I couldn't understand it because we'd had a good day and everything was relaxed. These things seem to happen when everything appears well though. She went into the Modbury Hospital after this where she stayed for a short time before returning home last Wednesday 4th of February.

Debby continued to threaten to kill herself. She was very strong willed, especially when she had been drinking. She would say that she was going to cut her wrists or hang herself and so on. She'd say lots of things but not be too specific. I'd always take her seriously, but could usually get her calmed down and try to work through it with her and everything would usually be alright. She continued to regularly see Dr. Groves, at least once a week, she's seen him in the last couple of days.

I usually stay with her twenty-four hours a day, we do most things together. The only time I left her was on Wednesday nights when I go and play competition darts. Then I make sure there is someone to stay with her". (Exhibit C.1b, p1-2).

3.4 Ms Edgell's friend of twenty years, Susan Farquhar, confirmed this evidence. She said:-

"Debby generally does silly things and talks about killing herself nearly every Wednesday night, when Jim goes to play darts". (Exhibit C.5a, p1).

3.5 The casenotes of the South Australian Mental Health Service dated 23 December 1997 contain notes that Ms. Edgell was adopted at age four months, and was the victim of incest between the ages of 4 and 15 years. There was an ongoing battle with S.A. Police Department ("SAPOL") in relation to her former employment as a Police Aide, and "unresolved grief/loss related to her not being able to have children". Professor Goldney records that it is "unexpected" that these issues were not well-documented in the casenotes, having regard to their significance (Exhibit C.12, p6).

3.6 Ms. Edgell's first admission to a psychiatric ward was on 23 December 1997 at LMHS. Dr. Koopowitz, the psychiatrist who treated her there, diagnosed that she was suffering from a bipolar disorder, and prescribed sodium valproate, a mood stabiliser. Professor Goldney said:-

> "It is further pertinent to note that in the progress notes of her admission to the Lyell McEwin on the 29th of December 1997, Dr. Koopowitz had recorded that Ms. Edgell was not detainable. Dr. Koopowitz appears to have gone to considerable lengths to attempt to engage Ms. Edgell in therapy, with specific instructions to staff to accommodate her wishes, within the bounds of reason. However, it is evident from the comment on the day of discharge that Ms. Edgell had continued to abuse the freedom of an open ward by continuing her use of alcohol and cannabis and it is not unexpected that there was a quick relapse of her condition". (Exhibit C.12, p5).

3.7 On 2 February 1998 Ms. Edgell was admitted to Woodleigh House at Modbury Hospital, and discharged on 4 February 1998. Professor Goldney said:-

> "Her admission was marked by her arguing about medication and she apparently telephoned the ACIS team to complain about nursing staff in Woodleigh House. There was also the suggestion that she had used marijuana in the ward.
>
> In the progress notes it was recorded that she had been thinking about seeing a friend who had recently died in Heaven and a number of significant symptoms of emotional distress were recorded. These included 'voices from sub-conscious telling her to kill herself'". (Exhibit C.12, p4).

3.8 At that time the staff doubted the diagnosis of bipolar disorder, suggesting one of major depressive disorder instead. Professor Goldney said that he could "well understand" this diagnosis, although since Dr. Koopowitz had a longer opportunity to observe Ms. Edgell, Professor Goldney was more inclined to accept his diagnosis (Exhibit C.12, p6). He said that the distinction, in this case, was "somewhat academic" (T.63).

3.9 As to the quality of inpatient care Ms. Edgell received, Professor Goldney thought that the hospitals did the best they could in difficult circumstances. He said:-

> "It is pertinent to note at this point that it is particularly challenging to gain control of a person's condition when there is associated alcohol and cannabis abuse. To manage such persons in an open ward without any external control is at times virtually impossible and that proved to be the case with Ms. Edgell. Quite clearly Dr. Koopowitz contemplated the possibility of detaining Ms. Edgell, but one can understand his assessment that that was not possible. Furthermore, given Ms. Edgell's history, it would have been most unlikely that a detention, under the present legislation, could have been enforced for more than a few days. Thus it is evident that there really is no facility in which a person with Ms. Edgell's condition can be confined for an extended period of time, by which I mean a period of at least four to six weeks, during which freedom from drugs of abuse can be reached and the possibility of gaining therapeutic leverage with other medication can be attempted.
>
> Bearing the above points in mind, it is quite clear that the therapeutic options open to the team at the Lyell McEwin Hospital were quite limited, and I consider that they did pursue them to the fullest extent possible". (Exhibit C.12, p6).

4. **Events of 12 February 1998**

4.1 I have already mentioned that James Edgell left home at about 7.00p.m. to play darts. Ms. Edgell was still at home with her friends Judy Muldoon and Denise Agius. Mr. Edgell said:-

> "I know that something sometimes happens on Wednesday when I'm not with her but there was no reason for me to think that she wouldn't be alright. They had only had about three beers each by the time I left, but Debby had had a few cones of cannabis which she smoked through a pipe. She was starting to get pretty stoned. The other two don't smoke". (Exhibit C.1b, p2).

4.2 At about 10.30p.m. Ms. Edgell went across the road to Susan Farquhar's house. Ms. Farquhar said that she was "very drunk". She said:-

> "Debby then started saying about how she's got everything set up, and how she's got a noose set up over at her house. Debby then said how she just needed to find a proper beam to hang herself on, without breaking the carport. I knew that Jim must be at darts as it was Wednesday night and she was the drunkest that I've seen her for a long time. I knew that Debby's cousin, Denise, had been with her and had just left the house.
>
> After Debby had been speaking about suicide for a while, she asked me to phone a mental health service for her. Debbie then phoned 131465 and I heard her speaking to them on the phone. I heard Debby say on the phone, 'How do you know it's Debby, how do you know I'm drunk?' I then walked out for a while and I heard her say that she was suicidal. She asked for them to phone her house as she was going back home". (Exhibit C.5a, p1-2).

4.3 Ms. Farquhar said that by the time Ms. Edgell left her house, she "seemed fine", and said that she would see her in the morning (Exhibit C.5a, p2).

4.4 The telephone call referred to by Ms. Farquhar was taken by Mr. John Provis, a social worker employed by the North West Adelaide Mental Health Service, and who is a member of the Northern Assessment and Crisis Intervention Service ("ACIS"). The ACIS team consists of nurses, social workers, psychologists, trainee psychiatrists and consultant psychiatrists rostered on duty between 8.00a.m. and 10.30p.m., seven days a week (T.7). Mr. Provis related the conversation he had with Ms. Edgell as follows:-

> "Ms. Edgell was calling from a neighbour's home and it was quite obvious that she was affected by alcohol at that point. Ms. Edgell asked me if I would ring her at her home, in about ten minutes, as she was leaving this neighbour's house. I then rang her at her home address at about 10.10p.m. I engaged her in conversation and ascertained her reasons for calling our service. Ms. Edgell had been drinking with her neighbours and her husband was out of the home playing darts and he was expected home within the hour, she stated initially. Ms. Edgell stated that she was considering harming herself and had fashioned a noose. I engaged her in further conversation about what had brought her to this point and perused her casenotes as we spoke. Ms. Edgell's speech was slurred and her dialogue was alcohol affected, she told me that she had been involved in a car accident and her car had been written off but she had subsequently bought another one. She also voiced some anger about the fact that she had recently been admitted to Woodleigh House, at the Modbury Hospital and was angry about her perceived treatment there. She also stated that she had visited the psychiatric unit of the Lyell McEwin Hospital that afternoon wanting to speak to her treating psychiatrist, Dr. Mahatma about obtaining another outpatient time to see this doctor. She had missed her last appointment on 4/2/98 because she was actually in Woodleigh House. Ms. Edgell said that she did not want to be admitted to any hospital. I advised her that there was some difficulty about me arranging another appointment time for her with her doctor because I would need to confirm a time with that doctor and then let Ms. Edgell know. During this time I was trying to ascertain exactly when her husband would be home and I eventually learned that he was due home at about 10.30p.m. I also talked with Ms. Edgell about her returning to the neighbour's home until her husband arrived home but she declined on the basis that she did not want to drink any more alcohol. I expressed some concern about her intention to harm herself and as she would not return to the neighbour's home or give me a verbal guarantee of safety I informed her that one option that we had was to notify the police and ask them to visit her at our request to check on her safety. At that point she became fairly angry at the thought that police might visit her. I then spoke with her for some further minutes until she had vented her anger and shortly after the call was terminated with the understanding that my Team would telephone her the next morning and arrange an early appointment with her doctor if possible. My conversation with her lasted approximately 20 to 25 minutes". (Exhibit C.8, p2-3).

4.5 Mr. Provis telephoned Police Communications and requested that a patrol visit Ms. Edgell to check on her safety. However, he was told that no patrols were available, and that such a visit was considered an "ACIS" role (Exhibit C.8, p2). Mr. Provis said that his request was something they do "routinely", particularly in the evening and on weekends (T.20). This was the first time, to his knowledge, that the police had ever declined to attend (T.21).

4.6 After further consideration and discussion with a colleague, Mr. Provis decided that, since Ms. Edgell had visited LMHS earlier that day, and she had sought help from ACIS, and that she had agreed to make an appointment with Dr. Mahatma the following day, and that her husband was due to be home shortly, it was safe to take no further action (T.20).

4.7 Mr. Provis telephoned the Combined Regional Triage service ("CRT") who deal with all calls after the ACIS teams finish work at 10.30p.m., and alerted them in case Ms. Edgell telephoned later. He explained that if she had telephoned, the CRT would have directed her to the Accident and Emergency Department ("A&E") of the nearest public hospital (in this case LMHS), and, if necessary, recalled the on-duty ACIS team member to attend there (T.24).

4.8 Professor Goldney was not critical of Mr. Provis' actions. He said:-

> "When one further considers this history and Ms. Edgell's limited degree of compliance to treatment programs, I consider that the actions of Mr. Provis on the evening of Ms. Edgell's death cannot be criticised. I consider that he did take appropriate action and, having received the response from the police, there was nothing else that he could have done". (Exhibit C.12, p6-7, and see also T.72).

5. **<u>The availability of ACIS teams after 10.30p.m.</u>**

5.1 Any comments on this issue must be predicated on the fact that, as Professor Goldney pointed out,

> '.. it is evident that Ms Edgell hanged herself in a relatively brief period of time between when she was speaking with Mr Provis and when her husband returned home. Therefore one could not guarantee that any intervention which may have been put in place with the Police Department would have prevented this episode' (Exhibit C12, p7)

5.2 It is necessary that a clear system for the provision of crisis intervention in mental health after 10.30p.m. exists. In my opinion, the attendance of police without the

assistance of ACIS team members should be regarded as a last resort. It is unfair on police officers, who are not trained in mental health issues, and is unfair on the patient.

5.3 Commander Dean Angus is the Officer in Charge of the Strategic Development Branch at SAPOL, which is the section responsible for developing policies and procedures to assist operational police officers. Commander Angus told me that there had been an understanding that police would attend this type of case if called upon by ACIS, and that such an attendance was "not unusual" (T.36). Since the tape-recording of the conversation between Mr. Provis and the communications officer had not been retained, he was unable to explain why police attendance was refused in this instance. He said that the communications officer would have made the decision based upon his assessment of the urgency of the case and availability of patrols (T.37). But he agreed that, even if they were busy, and the call was non-urgent, he would have expected that the communications officer would have given the case a lower priority, rather than refusing to attend at all (T.36).

5.4 Commander Angus said that, as a result of this case, the Commissioner of Police had initiated discussions with the Department of Human Services ("DHS") in relation to the development of a Memorandum of Understanding ("MOU") to deal with the interface between SAPOL and ACIS teams in the community. The MOU had not been finalised at the time of the inquest, but Commander Angus hoped to have it before the Commissioner of Police in the next two weeks, who would then forward it to the Chief Executive Officer of DHS (T.40).

5.5 Commander Angus said that the MOU would deal with a very broad range of issues where the operations of police and ACIS teams come into contact, but in relation to Ms. Edgell's case said that, in general terms, in the event of a question arising where police involvement has been requested by ACIS, the matter would be referred to a higher authority, either the State Duty Officer or another commissioned officer (T.39).

5.6 In addition to this, there has been a series of meetings and seminars between the two agencies since Ms. Edgell's death, which should assist both agencies to deal with such an issue in a more satisfactory way in future.

5.7 Professor Goldney said that ideally, regardless of the time of day, Ms. Edgell's case should have resulted in a home visit by an ACIS team (T.84). He acknowledged that

there are safety issues involved in personnel attending residences where they do not know the patient or is or her associates, where the patient may be inebriated and/or angry, and where they do not have immediate back-up (T.85). He pointed out, however, that there is no magic about the time of 10.30p.m. He said that patients do not become more inherently dangerous after that time (T.74). If the concern is about safety, then the ACIS team can seek the attendance of police at the same time.

5.8 Professor Ross Kalucy is the Chief Advisor in Psychiatry, an appointment made pursuant to Section 6 of the Mental Health Act 1993. His role is to:-

> "advise the Minister and the Health Commission on matters relating to psychiatry;" (Section 7(a)).

Professor Kalucy explained that the ACIS teams had adopted a policy whereby they would be rostered on duty from 8.00a.m. to 10.30p.m. Outside those hours, the Combined Regional Triages service is available to take all calls, and can recall staff and call in police if necessary. There is a policy whereby ACIS teams will not attend private premises after 10.30p.m., but if recalled will attend at A&E departments if necessary. He denied that this was an issue of money. He said that the very few calls received after 10.30p.m. would not justify having an ACIS team on duty 24 hours a day (T.47).

5.9 Professor Kalucy argued that it was pointless for an ACIS team to attend at private premises without police as the police have powers to enter and search, and the ability to detain and convey a patient if detention proves to be necessary (T.53).

5.10 The difficulty with the current ACIS arrangements is that Mr. Provis was only presented with one option after 10.30p.m., and that was the attendance of police. Ms. Edgell had already refused to attend at LMHS. If the police had attended in time, they would have been forced to form an assessment about whether she was safe or not without the benefit of the training and experience that ACIS team members have. If they decided that she was not safe, their only option would have been to detain her under the Mental Health Act. In those circumstances, the possibility of an inappropriate decision being made is quite high.

5.11 Professor Kalucy confirmed Commander Angus' evidence about the MOU, saying that it was in the late stages of development. He said that it was based on a policy of

"mutual assistance" between SAPOL and DHS, and he was confident that it would work well (T.51).

5.12 The MOU has not yet been presented to the Chief Executive Officers, and I have not seen it. I do not propose to hold up the inquest in order to see it, and comment upon its provisions. I agree with the general comment of Professor Goldney that the MOU should not place too much responsibility on SAPOL officers where the mental health expertise of ACIS team members would more appropriately deal with the crisis (T.73). The unavailability of ACIS staff to perform these duties after 10.30p.m., in company with the police if necessary, is the one area which I think needs to be addressed.

5.13 It is a pity that the MOU has taken more than two years to develop. However, its development will be a positive step, and hopefully should avoid similar situations occurring in future. If so, consideration of Professor Goldney's suggestion of "psychiatric retrieval teams" can be postponed. If not, then that suggestion will warrant further consideration.

6. **Other issues**

6.1 Professor Goldney and Professor Kalucy debated a number of other issues arising from Professor Goldney's report. These included the argument that the present powers to detain patients pursuant to the Mental Health Act are focused on dealing with acute conditions, and do not allow psychiatrists to effectively treat people like Ms. Edgell, who are substance abusers lacking insight into their condition (T.65-7). Professor Goldney pointed out that the use of the words "in need of immediate treatment" in Section 12(1)(a) of the Mental Health Act gives rise to the problem. It has led, in his view, to the familiar "revolving door" culture of mental health treatment, with which all involved in the field are familiar.

6.2 Professor Goldney argued that, had LMHS or Woodleigh House been able to detain Ms. Edgell for a longer period, a month or more, there would have been a better chance of getting control of her problem (T.70). Professor Kalucy, on the other hand, argued that the law should only give power to detain people who are mentally ill, and once this condition has passed, the justification for detention also passes. He said that any argument in favour of extending the power to detain would be a significant "civil liberties" issue (T.57).

6.3 This is a policy issue about which people will have strong views on both sides. As the issue does not directly arise here, I have no power to make a recommendation pursuant to Section 25(2) of the Coroners Act. However, I commend the issue to the attention of the Minister for Human Services for consideration.

7. **Finding**

I find that Debby Edgell, aged 39 years, late of 10 Halba Crescent, Paralowie, died at 10 Halba Crescent, Paralowie on 11 February 1998 as a result of neck compression due to hanging.

8. **Recommendation**

I recommend, pursuant to Section 25(2) of the Coroners Act, that the Commissioner of Police and the Chief Executive Officer of the Department of Human Services consider, when developing their Memorandum of Understanding, how ACIS staff can be made available to perform home visits, in company with police if necessary, on a 24 hour per day basis.

Key Words: suicide; hanging; psychiatric services

In witness whereof the said Coroner has hereunto set and subscribed his hand and

Seal the 7th day of July, 2000.

……..……

Coroner