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 14th and 15th days of November, and 12th day of December, 2000, before Wayne Cromwell Chivell, a Coroner for the said State, concerning the death of Christopher John Felstead.

I, the said Coroner, do find that Christopher John Felstead, aged 33 years, late of 10 Cale Court, Craigmore, in the State of South Australia, died at One Tree Hill on the 8th day of March, 1999 as a result of carbon monoxide poisoning consistent with inhalation of car exhaust fumes. I find that the circumstances of death were as follows:-

1. **Introduction**

1.1 On Monday 8 March 1999 a car was noticed in the vicinity of a dam near the Kersbrook-One Tree Hill Road. Mr. Trevor Eime investigated, and saw a black hose connected from the exhaust pipe to the rear passenger window. He then saw a male figure inside the car and he called the police.

1.2 Constables Stephen and Frick attended at about 6.40p.m. Ambulance Officers were already on the scene. They told the police that the person in the car was deceased. The body was conveyed to the Gumeracha Hospital and, at 9.05p.m., Dr. M.A. Lang formally pronounced life extinct (Exhibit C.2a).

1.3 The body was later identified as that of Christopher John Felstead, date of birth 7 October 1965. The identification was performed by Mrs. C.A. Russell, sister of the deceased.

1.4 Detectives Gillan and Whitaker from Elizabeth Criminal Investigation Branch attended at the scene, and their investigations revealed that there were no suspicious

circumstances surrounding the death of Mr. Felstead (Exhibit C.7a, p5). It is clear that he died as a result of his own act.

2. Cause of death

2.1 A post mortem examination was carried out on the body of the deceased by Dr. R.A. James, Forensic Pathologist, on 10 March 1999. Dr. James concluded that Mr. Felstead died as a result of carbon monoxide poisoning consistent with the inhalation of car exhaust fumes (Exhibit C.3a, p1).

2.2 A toxicological analysis performed by Ms. H.E. Felgate, Forensic Scientist, revealed that Mr. Felstead's blood contained:-

- 74% of the haemoglobin was in the form of carboxyhaemoglobin, which is a lethal level;
- 0.13mg/L oxazepam (subtherapeutic level);
- nil alcohol. (see Exhibit C.4a).

3. Background

3.1 Mr. Felstead had a long history of mental health problems. Although it is not clear from the record, it appears that he had an initial admission to the Lyell McEwin Health Service ("LMHS") in the late 1980's.

3.2 Mr. Felstead was admitted to the LMHS on 4 March 1996. A past history of major depression was noted. An entry in the casenotes reveals that he would have been detained if he had attempted to leave hospital in the early phases of his admission, but that did not become necessary. Mr. Felstead's condition improved, and the final diagnosis was of an "Adjustment Disorder with depressed mood".

3.3 Mr. Felstead was again admitted to LMHS on 29 November 1998 following suicidal behaviour. The record makes reference to marital discord and problems with WorkCover. Mr. Felstead was detained pursuant to the Mental Health Act by the Accident and Emergency staff. On 30 November 1998 this detention was revoked by Dr. Watson, a psychiatrist, and Mr. Felstead was discharged on 2 December. The Discharge Summary records that Mr. Felstead had been admitted following a mixed drug overdose, including Diazepam, Prozac, Aropax, Zoloft and Neurofen "in attempt at suicide". The Summary continues:-

> "The psychiatric unit felt Mr. Felstead would benefit from some time as an inpatient in 1G under their care but unfortunately there were no beds available ...". (Exhibit C.11).

3.4 Mr. Felstead was next admitted to LMHS on 7 December 1998. The Discharge Summary records:-

> "GMU (General Medical Unit) admission for respite and assessment of mental status following overdose with multiple drugs last week".

A diagnosis of "Adjustment Disorder with depressed mood and suicidal ideations" was made, and he was discharged on 9 December on the basis that:-

> "Presents with understandable depression due to unresolved WorkCover issues and recent break-up of relationship with his wife ... His mood has improved during this short stay in ward and he is able to guarantee his safety now and is keen to go home".

Despite this rather rosy assessment of his condition, Mr. Felstead was discharged with a prescription for the anti-depressant medication Aropax (Paroxetine) at a dose of 30mg, which is higher than the usual dose of 20mg. Additionally, he was prescribed the anti-psychotic drug Zuclopenthixol, 10mg at night. Professor R.D. Goldney, who provided an overview of Mr. Felstead's treatment, commented:-

> "That is not a standard preparation for a person with an Adjustment Disorder". (Exhibit C12, p3).

3.5 Following his discharge on 9 December 1998, Mr. Felstead was followed up by the Assessment and Crisis Intervention Service ("ACIS"), and was seen on 17 and 28 December 1998, and failed to keep an appointment on 4 January 1999. He was not followed up further, because he had intimated that he would see his general practitioner and a private psychiatrist (see the letter of Dr. Roughan, Exhibit C.10, p1). Mr. Felstead telephoned ACIS on 9, 12 and 13 January 1999 to say that he was depressed and had suicidal thoughts. Dr. Roughan states that these conditions were "settling rapidly after discussion with the Triage worker" (Exhibit C.10, p1). On 13 January 1999 Mr. Felstead was admitted to LMHS again, having taken an overdose of Zuclopenthixol and Ativan (a tranquilliser). Again, he was diagnosed with an Adjustment Disorder with depressed mood. Although Dr. Watson thought that Mr. Felstead would benefit from a course of anti-depressants and tranquillisers, no such medication was prescribed.

4. **Admission 16 February 1999**

4.1 On 8 February 1999 Mr. Felstead saw Dr. Nicholas Ford, a psychiatrist in private practice at Trinity Gardens. Dr. Ford was alarmed by his presentation and, having noted his condition, concluded that Mr. Felstead was severely depressed and that his depression carried the more "malignant" characteristic of melancholia. He also noted the four previous attempts at suicide, one of which involved deliberately driving his car into a tree.

4.2 Dr. Ford also noted the serial short admissions to LMHS, and was concerned that he had not received the more intensive treatment his condition required. He was reluctant to refer him back to the public health system. He was also reluctant to refer him to a private hospital in the absence of an indication from his Workers Compensation insurer that they would meet the cost thereof. Dr. Ford resolved that he would prescribe the anti-depressant medication Doxepin, and entered into a "contract" with Mr. Felstead, whereby he agreed not to attempt suicide without contacting Dr. Ford first.

4.3 Notwithstanding his contract, Mr. Felstead took a major overdose of a mixture of drugs on 12 February 1999, and was not found until 14 February, when his sister went to the house. Ms. Russell took her brother to LMHS. She said that he was still "very groggy". She said that the staff in the Accident and Emergency Department told her at about 11.00p.m. that he would be admitted overnight, but that at 2.00a.m. on 15 February 1999 she received a telephone call asking her to come and pick him up. She said:-

> "He to me appeared exactly the same as when I left him, say three hours earlier. He was groggy, he was confused, he was crying. He grabbed my hand, you know was very emotional and in such a physical state still that the doctor organised for a wheelchair to put Chris into to be wheeled out to my car, which I was advised to pull up in front of where the ambulances drop off patients and things, and an orderly wheeled him to my car and he got in and I brought him home". (Exhibit C.1d, p4).

4.4 When Dr. Ford found out what had happened, he telephoned the ACIS team and spoke to Dr. Tom Paterson, a senior psychiatric registrar. His letter to Dr. Paterson reads as follows:-

> "Thanks for admitting Chris Felstead, age 33, who first presented on Feb.9 with major depression and melancholic features, prominent passive, aggressive and dependent traits, OD last weekend, everything in the cupboard. Found Sunday, OD Friday. Attempted suicide by crashing car, circa three weeks ago, overdose 29.11.98, there are more overdoses - all related to loss of employment secondary to elbow injury, problems with

> mum and separation from wife and possibly death of father. Chris is quite clear he wishes to die and I think needs a longer admission than the previous three days. ... Current medication, Cipramil 20, started 3/52 ago, Doxepin 10mg night, Oxazepam 7.5-15, I suspect effects or may be useful given previous partial response to SSRIs". (T36-37).

4.5 Dr. Ford said that Mr. Felstead was quite happy to go to hospital, and so he did not see the need to detain him pursuant to the Mental Health Act, although he would have detained him had he been unwilling to be hospitalised (T.77).

4.6 When Mr. Felstead arrived at LMHS, he was seen by Dr. Paterson, who made extensive notes in the medical record. Dr. Paterson noted a twelve-month history of depression that began in the months after his WorkCover injury. He also noted Mr. Felstead's matrimonial breakdown in October 1998, which made his depression much worse. He noted his history of suicide attempts.

4.7 Dr. Paterson formed a diagnosis of "Major Depressive Disorder", with a possible alternative diagnosis of Adjustment Disorder with depressed mood. He admitted Mr. Felstead to Ward 1G, with a treatment plan including observations, a mood/sleep chart, medication and daily review, with a note "query WorkCover issues".

4.8 Unfortunately, Mr. Felstead's admission to Ward 1G did not last long. He was reviewed on 17 February 1999 by Dr. Dorji, a psychiatric registrar who was on an exchange programme from Bhutan. Dr. Dorji has since returned to Bhutan, and so I have received no evidence from him. However, Dr. Dorji's note reads:-

> "He feels more settled and relaxed today although he reports poor sleep. He is not very clear why his private psychiatrist (referred him) for admission as the feelings of helplessness, hopelessness and poor self-esteem has been a part of his emotions over last few months".

Dr. Dorji indicated that Mr. Felstead was to be discharged the next day. At a ward round that afternoon it was noted:-

> "Keen ++ to go home today. Discussed at ward round. Community men's group at Munno Para information given to Chris. He will arrange follow-up with private psychiatrist Dr. N. Ford. Chris was able to guarantee his safety on discharge and left the ward in company of his sister to return to his own home".

4.9 It is to be noted that Dr. Dorji does not appear to have consulted anyone else prior to Mr. Felstead's discharge. He appears to have ignored the opinions of both Dr. Ford, who is a senior psychiatrist, and Dr. Paterson, an experienced registrar, that Mr.

Felstead was at serious risk. Indeed, he did not even do Dr. Ford the courtesy of advising him of Mr. Felstead's discharge, let alone take into account his opinions. Dr. Ford did not become aware that Mr. Felstead had been discharged until 18 February when he telephoned LMHS.

4.10 Dr. Ford was clearly outraged by this decision. In a letter to the Workers Compensation insurer dated 18 February 1999 (Exhibit C.8a), he said that he was "puzzled to the point of bewilderment by these actions". He said:-

> "Further it is my belief that he will require hospitalisation. I think after three requests to the Lyell McEwin Hospital it is clear that they lack the wherewithal to treat him and I would prefer to treat him myself in a private psychiatric hospital. I believe this man is seriously at risk of suicide". (p.2).

Dr. Ford sent a copy of that letter to Dr. Penny Roughan, the Director of Psychiatry at North West Adelaide Mental Health Service ("NWAMHS").

4.11 Dr. Ford did not see Mr. Felstead again after 16 February 1999. He was told on 18 February when he telephoned LMHS that Mr. Felstead had an appointment to see him on 23 February 1999. Mr. Felstead cancelled that appointment, and Dr. Ford rang the ACIS team. He was later advised that they went to see Mr. Felstead, but he was asleep (Exhibit C.8b, p11).

4.12 Mr. Felstead visited Mr. Dennis LeCornu, his rehabilitation consultant, on 5 March 1999, and told him that he had missed his appointment with Dr. Ford because all he could do was "put him back in G1" (see Exhibit C.8c). Mr. LeCornu wrote to Mr. Albanese, MMI Workers Compensation, on 9 March 1999, urging him to expedite consideration of Dr. Ford's request for admission to a private psychiatric hospital. He described this as a "possible life-saving strategy". Unfortunately, that letter was written a day after Mr. Felstead committed suicide.

4.13 In fact, Mr. LeCornu arranged for Mr. Felstead to go back to see Dr. Ford, on 9 March 1999, but again this was a day too late.

5. <u>Quality of treatment at Lyell McEwin Health Service</u>

5.1 Dr. Ford was extremely critical of the quality of care offered to Mr. Felstead by LMHS. He said:-

"It's my view that very basic psychiatric procedures and tenets were breached. I am surprised still that this was allowed to happen, I believe the patient had a significant depressive illness and should have been hospitalised for longer". (Exhibit C.8b, p12).

5.2 Dr. Ford's diagnosis of a depressive illness was supported by the diagnosis of Dr. Paterson, who saw Mr. Felstead on 16 February 1999.

5.3 Professor Goldney agreed with Dr. Ford's assessment. His comments on the treatment administered to Mr. Felstead at LMHS were as follows:-

"1. I consider that it is probable that Mr. Felstead had a major depressive disorder. This was recognised by Dr. Ford, and there is also clear documentation of such a diagnosis in the Lyell McEwin Health Service records.

2. I appreciate the subtleties of diagnosis in regard to the different types of depression, but it is evident from the prescription of anti-depressant and anti-psychotic medication by personnel of the Lyell McEwin Health Service that Mr. Felstead's condition was considered to be relatively severe.

3. The follow-up in regard to Mr. Felstead's prescription of psychotropic medication is not clearly described. It may well have been appropriate, but I cannot see it documented.

4. I have concerns about the suggestion in mid-January that psychotropic medication could be prescribed by Mr. Felstead's general practitioner, as one could reasonably anticipate that more guidance than that should be provided by a specialist psychiatric service to a general practitioner. It is not clear whether there was specific medical contact with Mr. Felstead's general practitioner following that admission. One would have anticipated that that should have occurred if there were any particular concerns about the ongoing prescription of psychotropic medication.

5. Mr. Felstead had a significant number of suicide risk factors and these appear to have been appreciated, though perhaps more so by Dr. Ford than by members of the Lyell McEwin Health Service.

6. I have concerns about the comment of Dr. Roughan that 'The public system is, as you know, no longer funded to provide in-patient facilities for other than brief assessment for people with major social crises'. I hope that that does not represent the true state (of) affairs. In-patient assessment is used for persons with significant psychiatric illnesses, which are often associated with major social crises. If there does not appear to be adequate funding for appropriate management for persons with significant psychiatric illnesses, then it behoves us as clinicians to advocate on behalf of our patients for the provision of such services.

7. Dr. Roughan's further statement, which in a sense is a corollary of the above, is that 'Community support is what we are now to provide where major psychiatric illness is not the issue'. This statement also concerns me, as all depressive conditions, not just major depression, are significant psychiatric conditions with a considerable degree of morbidity and in fact mortality. Again we as clinicians are not serving our

> patients well unless we advocate for appropriate facilities to ensure the safe management of those who are afflicted with depressive conditions.
>
> Having noted the above, it is important to add the rider, as I have done previously, that even with the best of care one cannot always prevent suicide. However, in my view there are certain features about Mr. Felstead's care which have not been optimal". (Exhibit C.12, p8-9).

5.4 Dr. Roughan wrote a letter to Dr. Ford dated 9 March 1999, giving her response to his criticisms. Before giving her response, Dr. Roughan did not read the medical record from the LMHS, but relied solely on the ACIS casenotes. As such, Dr. Roughan was unaware of Dr. Ford's letter, Mr. Felstead's admission on 16 February 1999, and Dr. Paterson's diagnosis.

5.5 As a result of this, Dr. Roughan made the assertion:-

> "At no time has any doctor seeing him considered that he suffered from a major depressive illness and overall the diagnosis of Adjustment Disorder with depressed mood and suicidal ideation has been a consistent one. A discrepancy between the beliefs of the private and public systems seems to be arising here. The public system is, as you know, no longer funded to provide inpatient facilities for other than brief assessment for people with major social crises. In addition, where other funding is available (such as WorkCover or private insurance), every effort is made to avail the patient of these facilities because of the major difficulties in the provision of beds in the public system". (Exhibit C.10, p2).

5.6 Understandably, Dr. Ford was even more outraged after he received this letter.

5.7 The facts were that two senior practitioners, Dr. Paterson and Dr. Ford, had both diagnosed a major depressive illness and Dr. Dorji's discharge of Mr. Felstead on 17 February 1999 was ordered in the face of these diagnoses.

5.8 Dr. Roughan acknowledged this deficiency, and agreed that Mr. Felstead needed more intensive and comprehensive treatment than he received at LMHS. She agreed that he should not have been discharged on 17 February 1999, and, indeed, if he had evinced an intention to leave the hospital, he should have been detained pursuant to the Mental Health Act (T.48-49).

5.9 This case seemed to demonstrate quite severe tensions between the public and private mental health system in this State. Even though it was written on a false premise, Dr. Roughan's comments, that the public system is no longer funded to provide inpatient facilities for other than brief assessment of people with major social crises, is of great

concern. The evidence before me suggests that, even if Mr. Felstead did have an Adjustment Disorder with depressed mood and suicidal ideation, he should still have been given inpatient treatment (see the evidence of Dr. Ford at T.22). Dr. Roughan agreed (T.49). She explained that what she attempted to convey in her letter was that brief assessment is given when social crisis is the only problem. Where there is a depressive illness, then naturally this should be treated, especially if the patient is suicidal.

5.10 I have some reservations about Dr. Roughan's assurances, in view of the history of Mr. Felstead's serial admissions. As far back as 1996 he had been diagnosed with major depression, and detention was considered. Yet in late 1998 and early 1999 he received nothing more than "revolving door" treatment on the basis that he had an Adjustment Disorder. I suspect that this diagnosis was incorrect, and that he had a major depressive illness all along. Even if he did not, the depressive features of his Adjustment Disorder should be been treated more effectively. Professor Goldney pointed out:-

> "... depressive conditions, whatever their precise delineation, are particularly significant in causes of morbidity and indeed mortality in our community. I consider that it behoves psychiatrists to provide comprehensive assessment and management for persons with depressive conditions, be they major depressive disorders or Adjustment Disorders with depressed mood, or indeed any other type of depressive condition". (Exhibit C.12, p7-8).

5.11 I find that Mr. Felstead's discharge from LMHS on 17 February 1999 by Dr. Dorji was inappropriate, and set in train a series of events which led to his death. Although this could be categorised as human error, I find that it occurred in the context of a number of previous admissions where the same thing occurred. It is tragic that there was an opportunity to change this cycle of inappropriate treatment through Dr. Ford's intervention and Dr. Paterson's thorough assessment, but this opportunity was lost.

6. **Recommendations**

I recommend, pursuant to Section 25(2) of the Coroners Act, that Dr. Roughan and NWAMHS should review the treatment approach taken in Mr. Felstead's case, to determine whether pressures of a systemic nature, including the lack of availability of beds, played a part in Mr. Felstead's death which they have not acknowledged up to now. Such a review might also consider how a more thorough and rigorous approach

might be taken to the treatment of depressive disorders of whatever kind, taking into account Professor Goldney's comments.

Key Words: psychiatric illness; suicide risk

In witness whereof the said Coroner has hereunto set and subscribed his hand and Seal the 12th day of December, 2000.

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Coroner