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 31st day of January, 1st day of February and 5th day of April, 2000, before Wayne Cromwell Chivell, a Coroner for the said State, concerning the death of Sandra June Sanders.

I, the said Coroner, do find that Sandra June Sanders, aged 42 years, late of 44 Cinnamon Street, St. Agnes died at Glenelg on the 3rd day of September, 1997 as a result of salt water drowning. I find that the circumstances of death were as follows:-

1. **Reason for inquest**

1.1 On 1 September 1997 Dr. Martha Kent, consultant psychiatrist, detained Mrs. Sanders pursuant to Section 12(5) of the Mental Health Act. The detention order is part of the Modbury Hospital casenotes (Exhibit C.25a). Accordingly, on 3 September 1997, Mrs. Sanders was "detained in custody pursuant to an Act or law of the State" within the meaning of Section 12(1)(da) of the Coroners Act, and an inquest was therefore mandatory pursuant to Section 14(1a) of the said Act.

2. **Introduction**

2.1 At about 6.25p.m. on Wednesday 3 September 1997 a telephone call was received at the S.A. Ambulance Service from an anonymous caller advising of the presence of a female person having apparently collapsed on the beach near the rock wall at Glenelg.

2.2 Constables Westcott and Hodge and Cadet Roberts were tasked to attend the area. On arrival they spoke with ambulance officers Holmes and Adamson, who advised them that the person was deceased. The body was lying at the water line on the southern side of the breakwater. According to Constable Westcott:-

> "The body and clothing were wet and it appeared as if she had been in the water for some time and had been washed up on to the sand". (Exhibit C.22a, p1)

Constable Westcott also noted a number of abrasions on her stomach, midriff and back, which he thought were consistent with her having been washed against rocks and sand. Constable Westcott said:-

> "There were no visible signs of violence on the body and in my opinion the death did not appear suspicious". (Exhibit C.22a, p2)

2.3 A post mortem examination on the body of the deceased was performed by Dr. J.D. Gilbert, forensic pathologist, on 4 September 1997. Dr. Gilbert concluded that the cause of death was "salt water drowning" (Exhibit C.3a, p1). Dr. Gilbert commented that there were a number of injuries on the body, including abrasions which he thought were "clearly due to the abrasive effects of the body rubbing against sand or rocks after death", and a number of bruises which were "clearly at least a few days old", and other bruises which were more recent but which may have occurred "up to 48 hours before death". He said:-

> "2. ... Some may have occurred at around the time of death. The cluster of raised bruises over the lower back, some showing areas of overlying abrasion, appeared quite fresh though post mortem bruising due to impacts with rocks could not be excluded.
>
> 3. The distribution of the older bruises raised the possibility that the deceased had required forcible restraint in the days leading up to her death or had been involved in some form of scuffle". (Exhibit C.3a, p4)

3. **Background**

3.1 A comprehensive and very helpful chronology of Mrs. Sanders' illness was provided by her husband, Mr. Andrew Sanders, and is Exhibit C.1b. A summary of events which are relevant for the purposes of this inquest is as follows:-

- 1976 - marriage;
- 14 February 1980 - birth of daughter Rachel;
- 18 February 1980 - first signs of post-partum depression;
- 21 February 1980 - increasing signs of agitation and aggression (most uncharacteristic);
- 26 February 1980 - admitted to Hillcrest Hospital;
- 3 March 1980 - first electro-convulsive therapy ("ECT") - improvement noted;
- 1981 - relapse - admitted to Woodleigh House at Modbury Hospital;
- 1983 - birth of daughter Laura;
- 1989 - commenced work at South Australian Housing Trust - gradually increasing signs of distress during employment;
- 4 July 1997 - admitted to Woodleigh House with a diagnosis of major depression;

- 7 July 1997 - discharged from Woodleigh House - treating psychiatrist, Dr. Hay, not noted for follow-up;
- 19 July 1997 - referred by Dr. Hay to Northern ACIS Team for assessment. Dr. Symon attends home - finds depressive illness - re-admitted to Woodleigh House;
- 22 July 1997 - reviewed by Dr. Kent;
- 28 July 1997 - trial leave commenced;
- 5 August 1997 - discharged from Woodleigh House;
- 7 August 1997 - seen by Dr. Symon re employment - nothing untoward noted;
- 22 August 1997 - seen by Dr. Symon re employment - nothing untoward noted.

4. Admission to hospital on 28 August 1997

4.1 In the late afternoon of 28 August 1997 Mrs. Sanders was located unconscious in a park near her home in St. Agnes. She had taken an overdose of medication. A suicide note was found in the house when Mr. Sanders came home from work.

4.2 Mrs. Sanders was taken to Modbury Hospital where she required emergency treatment. She was admitted to the Intensive Care Unit, where she required artificial ventilation to maintain her breathing.

4.3 On 29 August 1997 Mrs. Sanders was detained pursuant to the Mental Health Act by Dr. Devonish, as he thought that she was psychotic (Exhibit C.17a, p2).

4.4 In the afternoon of 29 August 1997, Mrs. Sanders was seen by Dr Paul Dignam, the senior consultant psychiatrist at Woodleigh House, the psychiatric facility associated with Modbury Hospital. Dr Dignam confirmed Dr Devonish's order. His findings were:

> "I assessed her at 1-West and it was immediately apparent to me that there had been a dramatic change in the essential nature of her illness from what had been originally understood as a depression and seen framed in terms of marital distress issues, to an illness that was very much now a psychotic one. She was expressing delusional beliefs about possession by the devil and about being evil, and described various incidences of, for instance, obsessive hand washing and a belief that somehow the devil could come out of the tap into her body, things of this nature. On the basis of those delusions, we gave a diagnosis of a psychotic illness, and recommended to be transferred to Woodleigh, and the initiation of anti-psychotic drugs". (Exhibit C.28, p3-4)

Dr. Dignam initiated anti-psychotic medication (Stelazine) and an anti-depressant medication (Sertraline).

4.5 Dr. Dignam explained that he detained Mrs. Sanders because there had been an explicit change in her illness, to the extent that she had become psychotic, and her

condition carried inherent uncertainty having regard to the recent suicide attempt (Exhibit C.28, p5).

4.6 Dr. Dignam prescribed Sertraline at a dose of 50mg per day. This is unusually low for a person as deeply depressed as Mrs. Sanders was at that time. Dr. Dignam was unable to recall why he prescribed such a low dose, although he suggested that it could have been due to her recent overdose and the possibility that there was still some toxicity in her system. In any event, having regard to the fact that the medication takes a week or more to assert its effect, Dr. Dignam said that it could have made no difference to the outcome in this case (T.179). I accept his evidence about that.

4.7 Dr. Martha Kent, consultant psychiatrist at Woodleigh House, saw Mrs. Sanders on Monday 1 September 1997. Dr. Kent found that she was still psychotic. She was talking about spirit possession and displayed other delusional beliefs. She had no insight into her condition. She wanted to go home. Dr. Kent considered it dangerous to allow that, so she detained Mrs. Sanders for 21 days pursuant to the Mental Health Act (Exhibit C.18a, p9).

5. **Events of 2 September 1997**

5.1 Mrs Sanders was seen by Dr JN Symon, psychiatric registrar, in the morning of 2 September 1997. She described delusions with religious themes. Dr Symon said:-

> 'She gave an account that she could not switch her mind back on. She told me that she'd contacted a spiritualist who'd told her to .... pray, and that she'd seen a cross appear on the bathroom wall, and while holding an envelope she had seen a burn mark appear while she was holding it. She believed that this was true. She also described increasingly that she had no feelings for others or herself and described loss of interest in everything, worsening guilt, disturbed sleep, poor appetite, no motivation or energy. She felt that she was punishing her family excessively prior to admission, and on the basis of this had taken an overdose, feeling suicide was the only option' (Exhibit C27, p8-9)

Dr. Symon considered that Mrs. Sanders still had a major depressive illness with psychotic features. He decided to increase her dosage of Stelazine. She was already receiving 5mg in the morning and 5mg at night. He increased the nightly dose to 10mg (Exhibit C.27, p9). Dr. Symon did not consider that Mrs. Sanders was suicidal on that day. He said that if he had thought so, he would have arranged for her to be "specialled", which is one-on-one nursing care. Alternatively, she could have been transferred to a closed ward such as Brentwood at Glenside Hospital (T.92).

5.2 Mrs. Sanders was seen later that morning by Dr. Martha Kent. She approached Dr. Kent in an agitated state with a bizarre delusion that she was possessed by evil spirits and that this was causing her to pass ash in her stool. Dr. Kent became concerned at her apparent agitation. She requested the nurse manager, Ms. Bonnie Walter, to provide "close supervision" (T.133).

5.3 Ms. Walter acknowledged that she received the instruction (T.72). Unfortunately, it was not recorded in the casenotes, as it should have been. Indeed, there was no entry in the casenotes concerning Mrs. Sanders' mental state from approximately that time until 2.00p.m. on 3 September 1997, after Mrs. Sanders had disappeared (T.74).

5.4 Dr. Kent explained that she considered that Mrs. Sanders' mental state and behaviour needed to be monitored. After admitting that she could not remember the conversation in detail, Dr. Kent said:-

> "What I wanted to do was to flag to the nursing staff that Mrs. Sanders - that attention needed to be directed more to her, than maybe to other patients, that her needs had intensified. That her illness was, if you like, fragile or had apparently deteriorated and that therefore she needed to, in a sense, be prioritised amongst the patients as worthy of nursing staff attention and care". (T.134).

Dr Kent explained that she regarded Mrs Sanders' condition as unpredictable because:-

> "... we are not often aware of the moment by moment internal pre-occupations that people with psychosis have. But because those pre-occupations are so convincing and intense, people can do something which to our point of view seems bizarre or unexpected or dangerous or odd, and yet to them is compelling because of the psychotic thought processes and feelings that are occurring, which by their very nature are almost unknowable and which change from moment to moment. So she could have done anything really, depending on what the psychotic stimuli were directing her to do". (T135)

5.5 Dr Kent did not consider it appropriate to give Ms Walter a direction in relation to the nursing care to be provided. When asked who had the 'final word', she said:

> "We don't have protocols that are worded like that. We work collaboratively". (T150)

5.6 Dr. Kent expressed regret that her conversation with Ms. Walter was not recorded in the casenotes (T.136).

5.7 Dr. Kent did not consider that "specialling" Mrs. Sanders was necessary (T.137). She explained:-

> "We need particular evidence of departures from conformity to the treatment plan before we would institute particular manoeuvres, such as one-to-one specialling or Brentwood, because each of these, not only are expensive, not only do they disrupt the person's treatment, but they are intrusive". (T.154).

Certainly, if Dr. Kent had been aware that Mrs. Sanders absconded from Woodleigh House that afternoon, it is likely that she would have instituted either specialling or transfer to Brentwood (T.154).

5.8 As I have said, Ms. Walter acknowledged that she had such a conversation with Dr. Kent. Unfortunately, she did not comply with it. She was asked:-

> "Q. So did you ask the nursing staff to supervise her more closely?
>
> A. No I didn't. I bought to attention her mental state.
>
> Q. ... That wasn't done, is that correct?
>
> A. It depends whether you consider supervision a physical presence or not.
>
> Q. Observing, to supervise her more closely?
>
> A. Nursing observation is the gist of what psychiatric nurses do, we are observing our patients, we are making assessments of what their thinking is, where they're at, of what they are expressing to us, what their agitation level is, what their express wishes or wants are all the time, so nursing observation is the gist of psychiatric nursing.
>
> ...
>
> Q. If Dr. Kent as she says, asked nursing staff to supervise her more closely, what was done to carry out what Dr. Kent asked and specifically in relation to Mrs. Sanders?
>
> A. It was clearly communicated to all the staff that there was concern about the content of what Sandra was expressing in her delusional state". (T.35-36)

5.9 Ms. Walter was unable to recall which members of staff she had communicated this concern to. No entry was made in the casenotes about any such concern. I will discuss this issue in greater detail later.

5.10 Dr. Kent asked Dr. Symon to review Mrs. Sanders again. He did so, and found that she displayed the same symptoms as he had noted when he saw her earlier that morning. She denied that she was having suicidal thoughts and he thought that she was in no greater distress (Exhibit C.27, p10). Dr. Symon asked Dr. Rutson to review her physical health, to see if there was any basis for her complaints in relation to her stool. He took no other action. Again, unfortunately, no entry was made in the casenotes of Dr. Symon's further consultation. Dr. Symon acknowledged that a note should have been made (T.94).

5.11 Despite Dr. Kent's expression of concern having been communicated by Ms. Walter to the nursing staff, at some time during the afternoon of 2 September 1997 Mrs. Sanders absconded from Woodleigh House. Her absence was not noticed. She visited Father Vin Regan (now deceased) of John XXIII Catholic Church at Modbury that afternoon. Father Regan told Detective Campbell:-

> "Sandra spoke to me briefly but I could not make a lot of sense of what she was talking about. Sandra was agitated and not rational. I thought that Sandra felt some fear and was distressed. There was no talk of suicide by Sandra but she did speak of satanist experiences but I could not understand what she was saying. It was not rational. I did not talk with Sandra for long. Sandra then spoke with Sister Carmel and then left the office. When Sandra came to the office she basically dictated the terms. Sandra came and said what she wanted to say and then left when she wanted to". (Exhibit C21b, p1)

Sister Carmel Thomas also saw Mrs. Sanders at the church and was "a bit concerned" about her mental state (Exhibit C.20a), although not so much that she felt obliged to take any action.

5.12 Ms. Gabriella Kelly, a friend of Mrs. Sanders', said that she went to Woodleigh House, arriving at about 3.05p.m. Mrs. Sanders could not be found. She said that a staff member told her:-

> 'Sandra may have gone for a walk, or she could have gone to the shops' (Exhibit C9a, p1)

5.13 Mrs. Sanders came back at about 3.20p.m. She was hot and her face was flushed. She explained that she had been running. She told Ms. Kelly that she had seen "Father Vin" that afternoon, and explained that she went on the bus (Exhibit C.9a, p2).

5.14 When Ms. Kelly left Woodleigh House, at 4.45p.m., Mrs. Sanders accompanied her to the car park.

5.15 Ms. Kelly's evidence illustrates the lack of security at Woodleigh House for detained patients. From the evidence I have outlined above, it is clear that the staff were not alarmed at Mrs. Sanders' absence. The "name book" (Exhibit C.25b) records that Mrs. Sanders was present at 0800, 1230, 1700 and 2100 that day. This seems to have been the only formal procedure for checking the whereabouts of detained patients, or indeed any patients. In her interview with Detective Byrne, Ms. Walter asserted:-

> "... but we have an awareness of where our patients are all the time. That's part of our responsibility". (Exhibit C.25, p5).

Later, she said:-

> "Yes if, we're obliged to be aware of her whereabouts as a detained patient. If we were not aware of her whereabouts as a detained patient, that would be documented as of concern to us".

In my opinion, the evidence clearly demonstrates that staff at Woodleigh House did not have an awareness of Mrs. Sanders' whereabouts on the afternoon of 2 September 1997 at all. This lack of awareness had profound effects on what happened next day. If Mrs. Sanders' absence on 2 September 1997 had been noticed, procedures would have been put into effect which should have prevented her from leaving on 3 September 1997. I will deal with this issue in more detail later.

6. **Wednesday 3 September 1997**

6.1 There is considerable uncertainty about Mrs. Sanders' movements on 3 September 1997. She is recorded in the "Names Book" as having been present at 0800 and 1230. Ms. Dora Sanders (her mother-in-law) telephoned Woodleigh House at about 9.30a.m., and a patient answered and went to look for Mrs. Sanders but could not find her (Exhibit C.8a). I accept that this does not prove that Mrs. Sanders had absconded.

6.2 At 12.30p.m., Registered Nurse Gail Wood saw Mrs. Sanders when she came to lunch and recorded her presence in the book. She said:-

> "I did not see Sandra again and I am not aware of anyone else seeing her again". (Exhibit C.15a).

6.3 At about 1.20p.m., Ms. Paulette Freeling was travelling on the O'Bahn Bus towards Tea Tree Plaza, when the driver applied the brakes heavily to avoid colliding with a woman standing on the track. Ms. Freeling saw the woman standing motionless in front of the bus. She said that when the bus stopped and the driver yelled at the woman, she scampered up the embankment and ran away. She said:-

> 'I thought the woman looked like she was spaced out, she looked as though she had no concern for anything, like she didn't realise what was happening. I thought to myself, this woman was trying to do herself in. I thought that because of the feeling I got from the look on her face and why else would she have been standing on the track?' (Exhibit C24a, p2)

6.4 Ms. Freeling gave a statement to the police about the incident, although there is no record of any follow-up, or even of Ms. Freeling's statement having been recorded by the police (see the statement of Detective Byrne, Exhibit C.17c, p2). From Ms. Freeling's conversation with Ms. Vicki Carey, Mrs. Sanders' sister-in-law, and the

fact that the description of the woman seems to fit Mrs. Sanders, it seems likely that it was Mrs. Sanders standing on the O'Bahn track. I find that it was.

6.5 At some time in the early afternoon of 3 September, Mr. John Carey, Mrs. Sanders' father, came to Woodleigh House to see her. A staff member was unable to locate her, and another staff member told him:-

> "maybe Sandra has gone for a walk". (Exhibit C.6a, p1).

He searched the nearby shops and along a nearby creek without success.

6.6 At about 3.30p.m. Mrs. Sanders' niece, Holly Andrew, arrived to see her. When she couldn't find her in the visitors' room, she inquired and she, too, was told:-

> "perhaps Sandra has gone for a walk". (Exhibit C.10a, p1).

She was told that Mr. Carey had gone out to look for his daughter. Ms. Andrew said that no concern was expressed by the staff about Mrs. Sanders' absence.

6.7 When Mr. Carey returned, Ms. Andrew said that he looked "white and panicked" (Exhibit C.10a, p2). He said that he could not find his daughter. Ms. Andrew waited awhile longer and then inquired again, and was told by a staff member that they had telephoned the Sanders' house and there was no answer. Ms. Andrew said that she told them that "if you don't call the police I will" (Exhibit C.10a, p2). She was then told that the police were being called (at about 3.50p.m.).

6.8 Registered Nurse John Crook started his shift at 2.30p.m., and was told that Mrs. Sanders was missing. An extensive search of the building and grounds was then undertaken (Exhibit C.14a, p2).

6.9 It was not until 3.50p.m. that the police were notified (see the Missing Person Report, Exhibit C.17d). In that report, R.N. Wood reported Mrs. Sanders as having been missing since 2.00p.m. In fact, there is no evidence that she had been seen since 12.30p.m. (see the evidence of Ms. Walter at T.81).

6.10 Nothing further was learned about Mrs Sanders' movements until the staff at Woodleigh House were notified that her body had been found at Glenelg Beach. It is not known how she got there, although it is likely that she took public transport. It is not known how she drowned since there are no witnesses as to how or when she entered the water. The only real suggestion as to why she may have gone to Glenelg

Beach is offered by Mr Sanders in his interview with Detective Byrne on 2 February 1998:

> "I mean one of the things that I have put in this statement is that one of the spiritualists told her to run the bath water and state 'drive this evil spirit out of my body and send it to hell'. I guess that may be she thought that water was the cleanser. She used to fish off the breakwater in Queensland at near Sandgate with her father in her younger days, and may be she liked the ocean. But we didn't use to visit the sea very much". (Exhibit C.1c, p5)

7. **Issues arising at inquest**

7.1 The meaning of detention

As I have already mentioned, Dr. Kent detained Mrs. Sanders to Woodleigh House pursuant to Section 12(5) of the Mental Health Act 1993. There is no definition of "detained" in that Act. The ordinary meaning of the word, from the Shorter Oxford Dictionary, is "to keep in confinement or custody". Section 12(1)(da) of the Coroners Act refers to a person being "detained in custody".

7.2 The policy of the Mental Health Act in relation to detention is clear. It is to protect the person "in the interests of his or her own health and safety or for the protection of other persons" (Section 12(1)(c)).

7.3 Mrs. Sanders was detained to Woodleigh House, which is not a closed facility. Dr. Kent explained:-

> 'Woodleigh House is an open unit on the grounds of Modbury Hospital ... Like all hospital wards, or like most hospital wards, the doors are open and that I believe is appropriate ... In this regard, Woodleigh House is fulfilling the requirements of National Mental Health Policy, which is that it be accessible to the community ... What we need to balance at Woodleigh House is notions of independence, autonomy and responsibility each of the patients has and that the staff have, with notions of safety ... There are a lot of competing demands in this therapeutic environment and the very nature of this sort of ward demands a compromise solution which we seek to achieve at Woodleigh House. Above all, this environment needs to offer some sense of asylum, used in that old-fashioned sense of protection while people recover from mental illness. It is different from a gaol or a prison where people are incarcerated, that was the old style of psychiatric hospital wards. We do not seek to incarcerate people unless that is absolutely, clinically necessary and justified from the point of safety of patients and safety of staff ... In my opinion it would have been counter-therapeutic to have instituted incarcerative policies with a patient such as Mrs. Sanders ... There was every chance that it would cause a deterioration of her mental illness ... With every patient that I see I need to balance a sense of safety with therapeutic effectiveness and enhancing personal autonomy and independence ... We could institute a rule that said, for example, every

> person with psychosis or every person who had taken an overdose should be detained and transferred to Brentwood (a closed ward). But that is simply not practicable ... We have to make day-by-day, moment-by-moment decisions as to where is the most appropriate location for the management of a patient with mental illness'. (T127-9)

7.4 I accept what Dr. Kent says about that. However, I think it should be emphasised that where a patient has been detained pursuant to the Mental Health Act, a statutory duty has been imposed upon the institution to which that patient has been detained to ensure his or her own health and safety and the protection of other persons. Where a consultant psychiatrist has determined that the safety of such a patient is so clearly at risk that the very serious step of detention, with all the concomitant loss of human rights which that entails, is justified, then that duty is a very clear and a very high one.

7.5 However, that very simple proposition seems to have been clouded by issues of clinical exigency. Dr. Paul Dignam, the senior consultant psychiatrist at Woodleigh House, said in his interview with Detective Byrne:-

> "The use of the Mental Health Act in this context is difficult, because it, we use it primarily as a means of endorsing actions that we see to be clinically appropriate, where there is some opposition from the patient. But it gets used in other ways. For instance, a patient like Sandra that was in hospital, if for instance, she had not been detained when I got to her, I would not necessarily have detained. I would have said to the nursing staff treat her as a detained patient, in the sense that should she express her wish to leave she should be stopped. But because patients often are very compliant with treatment and they experience the use of the Mental Health Act as extremely intrusive and demeaning, we try and avoid that particular process where it doesn't actually serve to enhance what we're doing. And that's problematic. In a sense we're intruding on a patient's liberties, but on the other hand we're in fact giving them greater freedom by preventing that particular stigmatisation, and the assumption clinically is that we will do those things if it becomes necessary. When we have certain patients where different members of staff feel uncomfortable with that sort of greyness, we, I'm afraid we refer to that as a 'Clayton's' detention arrangement, and because it's obviously awkward for staff in certain instances we make that move explicit to get around that sort of problem. In the same way there are other sorts of patients that agree to be in hospital but want to be detained because some can't validate their position. And in this way we're not using the Mental Health Act in the way it's meant to be used, we were using it to enhance a particular aspect of the therapeutic relationship. I emphasise those points just to make the distinction between the way the Mental Health Act is written and the more complex way in which it gets used". (Exhibit C.28, p9-10).

7.6 I appreciate the subtleties involved in the distinctions Dr. Dignam has drawn, but I fear that, in this case at least, those subtleties may not have been clearly understood by the nursing staff. It is clear to me from the evidence that Dr. Kent fully understood

the degree of risk associated with Mrs. Sanders' illness. She acted appropriately in asking Dr. Symon to review her and asking the nursing staff to "closely supervise her". Unfortunately, this was not translated into action.

7.7 Nursing care

As I have already outlined, Ms. Walter acknowledged that she received the request from Dr. Kent but that she did not comply with it (T.35). The evidence of Ms. Walter, which I have quoted earlier in these findings, suggests to me that she held the view that all patients under her care were "closely supervised", and that no further action was required in relation to Mrs. Sanders. In particular, Ms. Walter sought to draw a distinction between close supervision of a patient and "close observation", which is defined in nursing parlance as keeping the patient in "visual line of sight". This must be the subject of a specific instruction in the same way that specialling the patient or transfer to a closed unit would require such a direction. Ms. Walter did not understand Dr. Kent's instruction in that way (T.36-7). She said:-

> "No, I didn't interpret it as a physical sighting instruction. I understood it to be a shared concern about her mental state and her delusional beliefs and the distress that that was causing to her.
>
> Q. Pardon me for being a little inelegant about this, but it's all very well to have a heightened concern about somebody. How does that help the person unless that concern is translated into action?
>
> A. The action doesn't have to be, to be with somebody 24 hours a day. The action can be in providing reassurances to that person, it can be providing sedating or anti-psychotic medication to that person. So there's a range of nursing actions that might be provided that will not necessarily entail a one-to-one supervision of that person". (T.38)

7.8 In my opinion, these high-sounding statements were not translated into any particular action at all. I have already outlined the fact that after Dr. Kent's request was made, there are no further entries in the hospital casenotes about Mrs. Sanders' mental state at all. There is no objective evidence that the nurses had any "heightened concern" for Mrs. Sanders, compared with their level of concern prior to Dr. Kent's request, or indeed compared with that displayed during Mrs. Sanders' earlier admissions when she was not detained. In my opinion, the subtleties suggested by Dr. Dignam and Ms. Walter were not communicated effectively to the nurses in terms of appropriate action.

7.9 The plain fact of the matter is that Mrs. Sanders was able to abscond from Woodleigh House on 2 and 3 September 1997 without being detected. Had those absences been

detected, Dr. Kent would have taken drastic action, either requesting specialling or transfer to Brentwood. In my opinion, the failure to detect Mrs. Sanders' absence constitutes a significant lapse in the quality of nursing care which should have been provided to Mrs. Sanders.

7.10 In my opinion, this conclusion is supported by the opinion of Dr. Tony Davis, consultant psychiatrist, who provided a report giving an overview of Mrs. Sanders' treatment. Dr. Davis concluded:-

> "Questions have been raised about the degree of supervision provided for Mrs. Sanders. The fact that she was able to leave the hospital to visit a priest on the 2nd September, and the fact that this was not mentioned in the case-notes, is a cause of concern. It suggests that at that point in time the staff may not have been paying sufficient attention to her to ensure that she remained on the unit, or very near the unit. The further problems experienced in locating Mrs. Sanders on the morning of the 3rd September also raise concerns about the degree of supervision provided. The case-notes do not indicate the frequency of observation of Mrs. Sanders, or the degree of concern about her mental state and suicidal ideation over the last 24 hours of her life". (Exhibit C.29)

7.11 Dr. Dignam acknowledged that the degree of supervision is a serious issue, although he did not accept that there are clear-cut solutions to the problem. He said:-

> "The question about the degree of observation and what level of restriction might be specified or should have been specified where Dr. Davis again refers to the lack of specificity on the subject - yes I would agree that there was a lack of specificity about such things. I don't think that's out of keeping with the way in which we run the ward because these things are in general dealt with moment by moment according to verbal conversation. My experience is that the processes of categorising those are not particularly effective; they are clumsy and artificial and the distinction between close observation and one-to-one observation and background observation is not at all clear-cut ... You can invite people to do it more conscientiously but you can't actually measure it ... Other units that I have worked at there has certainly been a tradition of categorising people according to various alphabetical codes and so on ... We have discussed with our staff the pro's and con's of that model and are not convinced that it actually improves clinical care". (T.180-1)

7.12 I acknowledge the difficulties Dr. Dignam alludes to. However, I think the short answer is that, if Mrs. Sanders' case is any guide, the "non-structured" model does not improve clinical care either. The clearer and more organised patient care regimes are, the less likely it is that mistakes will be made. Using vague platitudes like "heightened concern" do not appear to me to be helpful to nursing staff when they are receiving directions as to how to care for a patient who is at risk.

7.13 Documentation

In my opinion, the casenotes kept in relation to Mrs. Sanders' treatment were grossly inadequate. In particular, there is no relevant entry from about lunch time on 2 September 1997 until 2.00p.m. on 3 September 1997, after Mrs. Sanders had disappeared. In view of the fact that Dr. Kent had passed on her concerns to the nurse manager, Ms. Walter, and had requested "close supervision", I consider that this omission is especially serious in relation to Mrs. Sanders, who was a detained patient.

7.14 Dr. Davis' evidence supported this conclusion. He said:-

> "While medical records do not necessarily provide a full summary of all discussions and decision making processes, I do have concerns about the adequacy of the case-notes and the steps taken to monitor Mrs. Sanders' progress, particularly in her movements from the ward soon after her Detention Order was confirmed". (Exhibit C.29, p3)

7.15 Dr. Dignam accepted the force of these criticisms. Having referred to Dr. Davis' comments, he said:-

> "I can't argue with that". (T.180)

7.16 General care

Dr. Davis told me that, in his opinion, the general management of Mrs. Sanders throughout her admission was appropriate. He said:-

> 'The clinical features identified were consistent with a diagnosis of major depression with psychotic features, and the medications prescribed were appropriate for the illness. She was detained under the Mental Health Act in an appropriate manner' (Exhibit C29, p2)

7.17 Professor R.D. Goldney, of the Department of Psychiatry at the University of Adelaide, provided a report to Messrs. Finlaysons, solicitors for the South Australian Housing Trust (Mrs. Sanders' former employer), dated 12 January 2000. In that report Professor Goldney had reservations about Dr. Davis' conclusions, particularly about the adequacy of the dose of 50mg of Sertraline, when Mrs. Sanders had failed to respond to a higher dose previously. However, as I have observed previously, this had no effect on the eventual outcome.

7.18 Professor Goldney asserted that the staff at Woodleigh House did not have sufficient recognition of Mrs. Sanders' suicidal tendencies (Exhibit C.26, p7). Dr. Dignam took exception to this conclusion, pointing out that Mrs. Sanders "pulled the wool over our eyes - perhaps" (T.195). I accept that. However, I agree with Professor Goldney that

the evidence in this case demonstrates that, although Dr. Kent was appropriately concerned about the risk to Mrs. Sanders' safety, this was not adequately communicated to the nursing staff. If it had been, it would have been properly documented in the notes, and proper observation would have taken place which should have prevented her absconding without notice on two occasions.

7.19 Response to Mrs. Sanders' disappearance

The evidence suggests that Mrs. Sanders was last seen at 12.30p.m. Ms. Walter has acknowledged that there is no evidence that any staff member saw Mrs. Sanders after that time. It seems to me that, on the evidence of Mr. Carey and Ms. Andrew, it was not until after 3 o'clock that serious efforts were made to locate her, and she was not reported as a missing person to the police until 3.50p.m. As Professor Goldney observed:-

> "Even if she was last seen at 12.30 on 3/9/97, in my view it is not adequate for somebody who is detained not to be sighted by staff for at least three hours. I can think of no justification or explanation that would explain why it took so long for the police to be notified, other than for the fact that staff were simply not aware that Mrs. Sanders was missing". (Exhibit C.26, p9).

I agree with Professor Goldney. It seems to me the evidence is clear that the staff did not appreciate that Mrs. Sanders was missing and indeed both Mr. Carey and Ms. Andrew were told by staff members that Mrs. Sanders had probably gone for a walk. As I have already mentioned, this demonstrates a clear lack of appreciation of the severity of Mrs. Sanders' psychosis.

8. **Finding**

I find that Sandra June Sanders, aged 42 years, late of 44 Cinnamon Street, St. Agnes died at Glenelg on 3 September 1997 as a result of salt water drowning.

9. **Recommendations**

Pursuant to Section 25(2) of the Coroners Act, I make the following recommendations which I consider may prevent the recurrence of an incident similar to the circumstances of Mrs. Sanders' death:-

(1) That the administration of Woodleigh House institute a review of procedures with a view to addressing the issues which have been considered in this inquest, including:-

- a lack of appreciation on the part of nursing staff of the significance of detention pursuant to the Mental Health Act;
- a failure by the nursing staff to translate Dr. Kent's request for close supervision into action;
- failure to exercise an appropriate degree of supervision over a detained, psychotic patient;
- failures on several occasions to make any, or any adequate, entries in the casenotes of events relevant to Mrs. Sanders' treatment;
- a failure to act with a sufficient degree of urgency to Mrs. Sanders' absence on 3 September 1997.

Key Words: death in custody; psychiatric illness; suicide

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

Seal the 7th day of April, 2000.

……..……

Coroner