

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 5<sup>th</sup> and 28<sup>th</sup> days of April, 2000, before Wayne Cromwell Chivell, a Coroner for the said State, concerning the death of Laurie Joseph Scott.*

*I, the said Coroner, do find that Laurie Joseph Scott, aged 53 years, late of 7 Allenby Road, Ottoway, died at the Queen Elizabeth Hospital, Woodville on the 28<sup>th</sup> day of June, 1998 as a result of asphyxia due to upper airway occlusion by a foreign body (blanket). I find that the circumstances of death were as follows:-*

### 1. **Reason for inquest**

- 1.1 On 28 June 1998 Mr. Laurie Scott was the subject of an order for detention pursuant to the Mental Health Act. On 8 June 1998 Mr. Scott was detained pursuant to Section 12(1) of that Act by Dr. M.T. Jenkins at Glenside Hospital. Dr. Jenkins' order was confirmed on 9 June 1998 pursuant to Section 12(4) of the Act by Dr. Kumar, a psychiatrist. On 11 June 1998 a further order pursuant to Section 12(5) of the Mental Health Act was made by Dr. Kumar, which had the effect of detaining Mr. Scott for a period of twenty-one days. This order would have expired on 2 July 1998. On 18 June 1998 an order transferring Mr. Scott's detention to the Queen Elizabeth Hospital was made by Dr. Kumar pursuant to Section 16 of the Mental Health Act. This had the effect of continuing Mr. Scott's detention at the Queen Elizabeth Hospital until 2 July 1998. Accordingly, on the date of his death on 28 June 1998 Mr. Scott 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. **Background**

- 2.1 Mr. Scott was born on 25 March 1945. His history of psychiatric illness dates back to 1984, when he presented with a depressive illness. He was diagnosed with schizophrenia in 1991, when hospitalised in a psychotic state after setting fire to his house. He had many admissions to the Queen Elizabeth Hospital after that, usually involving an overdose of medication.
- 2.2 In the words of Dr. Tony Davis, the consultant psychiatrist who provided a report to me concerning Mr. Scott's treatment, Mr. Scott suffered from "a complex psychiatric disorder, with multiple diagnoses offered over many years. ... His medical diagnoses included Klienfelter's Syndrome (a chromosomal abnormality leading to intellectual retardation and aggression), epilepsy secondary to right occipital cavernous hemangioma, cataracts, borderline intellectual function, and a urinary tract infection. He had a past history of alcohol abuse" (Exhibit C.15, p1-2).
- 2.3 On 8 June 1998 Mr. Scott was admitted to Glenside Hospital following an overdose of Thioridazine. He was diagnosed with a severe depressive illness with psychotic features, and was detained pursuant to the Mental Health Act by Dr. Jenkins (Exhibit C.7a, p1).
- 2.4 On 10 June 1998, Mr. Scott was noted to have fallen down and hit his head, and he admitted next day that this was done with suicidal intent (Exhibit C.7a, p2). Skull X-rays did not detect any fracture. Mr. Scott remained isolative, depressive and delusional. On 16 June another head injury was noted, which Mr. Scott admitted was also self-inflicted, in an attempt to get out of Brentwood North, the closed ward at Glenside where he was accommodated.
- 2.5 On 18 June 1998, Mr. Scott was transferred to the newly opened Cramond Clinic at the Queen Elizabeth Hospital (the unit opened on 9 June 1998). He was placed in the High Dependency Unit ("HDU"). His medication regime was extensive, and included Dilantin, Olanzapine, Nitrazepam, Sertraline, Carbamazepine, Haloperidol, Clonazepam, Prazosin, Thiamine, Trimethoprim and Testosterone.
- 2.6 The operation of the HDU is described in the statement of Ms. Barbara Wieland, the Regional Manager for the North West Adelaide Mental Health Service (Exhibit C.6a,

p2). All five patients in the HDU were detained pursuant to the Mental Health Act. Ms. Wieland said:-

“The High Dependency Unit is a five-bedroom unit. It consists of two toilet areas and an open dining area which is 100 percent visible from a nursing observation station. A floor plan is available. There is a minimum of two staff any given time/shift. The nursing staff do regular rounds at intervals with constant observations. These observations include patient interactions. The High Dependency Unit is a secure area where persons that do not have authorisation cannot enter or exit. There is adequate lighting and these lights are turned down once all the patients have received their medication and are securely placed into bed. The perimeter of the unit is always locked. However, the patient rooms are closed but never locked”.

2.7 In HDU, Mr. Scott remained isolative and paranoid and agitated at times. On 23 June 1998 he was banging his head against the wall, although he calmed down after receiving medication. On 26 June 1998 he became agitated and angry that staff declined to return him to the open ward. He punched the wall causing damage. He was given further medication to calm him.

### 3. **Events of 28 June 1998**

3.1 On 28 June 1998 Mr. Scott was agitated again in the afternoon and settled with medication.

3.2 At 9.30p.m. Registered Mental Health Nurse Brian Clayton checked on Mr. Scott and offered him a cigarette, but he shook his head. Mr. Scott was lying on his back on his bed. He seemed “fine” (Exhibit C.9a, p2).

3.3 At 9.55p.m. Mr. Clayton went to Mr. Scott’s room again to deliver his medication and found him lying across his bed with one of his blankets stuffed “deep” inside his mouth. Upon checking, Mr. Clayton was unable to find a pulse.

3.4 Mr. Clayton called for the resuscitation team, who attended at 9.57p.m. They attempted resuscitation but were unsuccessful. Dr. Zimmermann certified life extinct at 10.25p.m. (Exhibit C.2a).

3.5 Mr. Clayton confirmed that he saw no person enter or leave Mr. Scott’s room from 9.30 to 9.55p.m. and, having regard to the lay-out of the HDU, where the doors to the patients’ rooms can be observed from the nursing station, it is unlikely that anyone could have entered Mr. Scott’s room unnoticed.

3.6 In those circumstances, I have no doubt that Mr. Scott's death was self-inflicted.

#### 4. **Cause of death**

4.1 A post mortem examination was carried out on the body of the deceased by Dr. J.D. Gilbert, forensic pathologist. Dr. Gilbert confirmed that the cause of death was "asphyxia due to upper airway occlusion by a foreign body (blanket)" (Exhibit C.3a, p1). Dr. Gilbert commented:-

"Death has been attributed to asphyxia due to upper airway obstruction resulting from a blanket being stuffed into the mouth. This is an unusual means of committing suicide presumably reflecting desperation and limited available options in the setting of a high dependency psychiatric ward. To achieve airway obstruction, the blanket must have been inserted to the extent that the pharynx as well as the oral cavity was occluded". (Exhibit C.3a, p4).

4.2 Dr. Davis agreed that the manner of Mr. Scott's death was "extraordinarily uncommon". He added:-

"I think it really does indicate a degree of agitation and desperation and determination to end his life. Physically it's barely conceivable how one can do it, but I suppose it's possible to suffocate oneself or asphyxiate oneself. So to me it does reflect an extreme determination". (T.64).

#### 5. **Treatment generally**

5.1 Dr. Davis was generally positive about the standard of treatment Mr. Scott received at the Cramond Clinic. He said:-

"Mr. Scott had a complex psychiatric disorder, which required treatment with multiple medications. I consider that the medications prescribed were appropriate, and in keeping with guide-lines for the management of a psychotic disorder and mood disorder. The use of Haloperidol and Clonazepam on an as required basis was appropriate, as these agents have generally been found to be the most effective medications to control agitation and acute exacerbations of psychoses.

Mr. Scott was treated in a closed ward at Glenside Hospital and in the High Dependency Unit at the Queen Elizabeth Hospital. This was most appropriate, given his degree of agitation and suicidal ideation. The attached documents indicate that staff were aware of the extent of his mental disturbance, and that appropriate observations were taken to monitor his mental state and progress. It is noteworthy that he requested transfer to the open ward on 26/6/98, but this was declined because of his disordered mental state and behaviour.

The documents indicate that appropriate staffing levels were maintained in the High Dependency Unit. I have not identified any facts that suggest that nursing practice did not follow the guide-lines for 'Nursing in a Secure Environment'.

With regard to the accommodation and furnishings at the Cramond Unit, I am not familiar with the High Dependency Unit, although I have observed the photographs and the floor plan of the Unit. These documents suggest that the accommodation and furnishings are appropriate for this type of institution. Of course, there are potential risks associated with the presence of portable furniture and bed-clothes and, unfortunately, in this instance, it appears that Mr. Scott was able to make use of bed-clothes to effect his own death. This was an extraordinary situation.

I did not identify any factors that indicated a need for special nursing in the High Dependency Unit, a practice that is sometimes justified when patients are highly suicidal or agitated.

I have not identified any alternative steps that could have been taken by staff, either at the Glenside Hospital or the Cramond Unit, to treat Mr. Scott's condition and avoid this unfortunate outcome". (Exhibit C.15, p2-3).

I accept Dr. Davis' evidence about these matters and find that there was nothing inappropriate in relation to Mr. Scott's treatment at the Cramond Clinic at the Queen Elizabeth Hospital.

5.2 Dr. Davis expressed some concern about an apparent lack of medical documentation in the Progress Notes. He said:-

"In particular, a plan of management is not made explicit, and a problem list, including suicidal ideation and behaviour, was not clearly identified. While I am not suggesting that the issue of suicide risk was minimised or ignored, I consider that the documentation of such issues is an important part of optimal clinical care". (Exhibit C.15, p3).

5.3 The Director of Nursing at the North West Adelaide Mental Health Service, Mr. Neville Phillips, explained that the nursing management plan was computerised on a program called Excelcare. This was updated after every shift. He said that although the program was useful for nurses, it was limited because input from other disciplines such as medical, social work, etc. was not included on the system. Computer management systems are clearly the way of the future. Indeed, I recommended in 1997 that such computerisation should be considered (Inquest Numbers 20/96, 31/96, 32/96, 8/97, 9/97 and 10/97). It is important that they not give rise to multiple records which will lead to misunderstandings. Mr. Phillips acknowledged this, and said that Excelcare is no longer used, and a new program with wider inputs is in the process of development. (T.55). I accept Mr. Phillips' evidence about this and will not make any further recommendations pursuant to Section 25(2) of the Coroners Act in that regard.

5.4 The only other issue was in relation to the location of oxygen equipment at the Cramond Clinic. At the time of Mr. Scott's death, the equipment was located in the main nursing station, which caused a slight delay, which did not affect the outcome. Another set of equipment has now been located in the HDU, and staff have been given further training in cardio-pulmonary resuscitation. Accordingly, no recommendation pursuant to Section 25(2) of the Coroners Act is called for in that regard either.

6. **Finding**

I find that Laurie Joseph Scott, aged 53 years, late of 7 Allenby Road, Ottoway, died at the Queen Elizabeth Hospital, Woodville on 28 June 1998 as a result of asphyxia due to upper airway occlusion by a foreign body (blanket).

7. **Recommendations**

There are no recommendations pursuant to Section 25(2) of the Coroners Act.

*Key Words: death in custody; suicide*

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

*Seal the 28th day of April, 2000.*