

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 4th and 5th days of October, and 14th day of November, 2000, before Wayne Cromwell Chivell, a Coroner for the said State, concerning the death of Sean Patrick Simmonette.

I, the said Coroner, do find that Sean Patrick Simmonette, aged 26 years, late of James Nash House, Oakden, in the State of South Australia, died at James Nash House on the 23rd day of January, 1999 as a result of respiratory arrest complicating hydrocarbon inhalation (sudden sniffing death). I find that the circumstances of death were as follows:-

1. **Reason for inquest**

- 1.1 Sean Patrick Simmonette was charged with serious offences of violence, including Threatening Life and Assault Occasioning Actual Bodily Harm. On 27 May 1997, he was found to have been mentally incompetent to commit these offences, and, although the facts were found proved, he was found not guilty. Pursuant to Section 269O of the Criminal Law Consolidation Act, 1935, he was detained, with a limiting period of three years.
- 1.2 On 20 February 1998 Mr. Simmonette was released on licence to Glenside Hospital. On 30 March 1998 it was reported that he was in breach of his licence, and, on 17 March 1998 his licence was cancelled and he was readmitted to James Nash House ("JNH"), Birdwood Ward, where he remained until his death.
- 1.3 Accordingly, on 23 January 1999 Mr. Simmonette was "detained in custody" pursuant to an Act or law of this 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 that Act.

2. **Background**

- 2.1 Sean Patrick Simmonette was a known abuser of a variety of substances (a “poly-substance abuser”) since he was about 16 years old. He had a series of admissions to Glenside Hospital when he became psychotic as a result of such abuse.
- 2.2 Mr. Simmonette’s psychiatric state deteriorated in 1996-7 when he began showing signs of paranoid schizophrenia. He had been described in the records as “dangerous when angered, needed strict supervision, acute and unpredictable” (Exhibit C.17a).
- 2.3 On 20 February 1997 Dr. Maria Tomasic, a psychiatric registrar, noted in the record that Mr. Simmonette was suffering from schizophrenia, anti-social personality disorder, amphetamine abuse and paranoid delusions. He reported auditory hallucinations. He was aggressive and agitated.
- 2.4 When Mr. Simmonette was readmitted to Birdwood Ward on 17 March 1998 he was prescribed anti-depressant medication (Chlorpromazine) due to irritability, restlessness and anxiety. He was also given Temazepam at night as a tranquilliser.
- 2.5 On 9 June 1998 Mr. Simmonette escaped from JNH by kicking in a mesh screen. He was found by police on 11 June 1998.
- 2.6 On 29 June 1998 Mr. Simmonette was found to have cut himself on the left inside elbow with a razor.
- 2.7 On 17 September 1998 Mr. Simmonette was found tampering with the lock to a door to an area where drugs are kept. He told staff he was “bored”.
- 2.8 Through the ensuing months, Mr. Simmonette continued to display drug-seeking and aggressive behaviour. On 14 January 1999 he admitted that he had taken another patient’s Clonazepam. He denied using “standover tactics”. This behaviour was repeated with another patient on 20 January 1999.
- 2.9 Dr. Craig Raeside, who provided a report to me concerning Mr. Simmonette’s treatment while at JNH, said that the combination of the three aspects of Mr. Simmonette’s illness, namely chronic paranoid schizophrenia, drug abuse and anti-social personality disorder, “together gave a particularly poor prognosis” (T.90). Unfortunately, with the widespread use of illicit drugs in the community, the incidence of people with such a combination of diagnoses is increasing.

3. **Previous incident**

3.1 On 20 January 1999, the following entry was made in the “Communication Book” for Birdwood Ward:-

“All Staff 20/1 P. Wingfield alleges that on Tues night 19/1 Simmonette and McDonald sprayed ‘Raid’ (fly spray) into plastic bag and inhaled and became dizzy - ‘to get a buzz’. Others tried it also, but he couldn’t remember who.
Cheers, Mary”. (Exhibit C.16c).

3.2 The Acting Clinical Unit Manager, Mr. Danny Stockdale, said that he became aware of that entry the following morning (21 January). He identified the author as Mary Woods, and said that she drew it to his attention at the handover.

3.3 Mr. Stockdale said that Mr. Simmonette was not spoken to about the incident. A search was conducted. He was unable to be sure that Simmonette and McDonald were closely observed. He said:-

“I’m unable to say whether I did or didn’t, the fact that we were discussing the area would indicate that I would’ve inferred that they should be observed, and I would say if you asked me yes, or no, I would err on the side of yes”. (T.44).

3.4 Nothing appeared in the Client Record about any closer observation or searches being done. Indeed, no mention of the incident appears in the record at all. Mr. Stockdale was unable to verify who searched what areas after the incident (T.54). He could confirm that the patient rooms were not searched (T.58).

3.5 Mr. Stockdale said that more attention was paid to Mr. Wingfield, who reported the incident, whom he described as “quite unwell” (T.60). Mr. Stockdale’s attitude could perhaps be illustrated by this piece of evidence:-

“two days before this man was doing striptease in the day room, the night before he said there were dwarfs on the roof, at the same time I don’t write down to check the roof for dwarfs”. (T.60).

3.6 In fact, Mr. Stockdale was an argumentative and unreliable witness who had not checked his facts thoroughly before giving evidence (see T.61-64). At one point, he suggested that it would not have been appropriate to note Mr. Wingfield’s allegations in the casenotes because of “freedom of information” (T.66). I have little faith in his opinions and will not rely upon his evidence when making findings herein.

3.7 Detective Senior Constable Fielding, who carried out a very thorough and thoughtful investigation into this matter, said that he was unable to verify what searches had been

carried out after this incident. He pointed out that no inventory had been done to determine what, if anything, may have been missing (T.78).

4. **Events of 23 January 1999**

4.1 The staff for the night shift at JNH commence work at about 7.30p.m. A handover from the day-shift staff takes place, and any problems are pointed out. Registered Psychiatric Nurse Robert Deans told me that the process takes about eight to ten minutes. He said that he saw Mr. Simmonette at about 7.45p.m. on 23 January 1999, when he came to the nurses station and asked for his haircutting equipment to lend to another patient (this was refused as Mr. Simmonette was Hepatitis C positive) (T.20).

4.2 Mr. Simmonette was in the smoking room after that time. Mr. Deans told me that patients are unsupervised in there, as most of the staff do not smoke (T.19). Although some parts of the smoking room are visible from the nurses station (about a quarter of it), others are not. He said:-

“We wouldn’t go in there particularly, unless we had to”. (T.19).

4.3 Mr. Deans saw Mr. Simmonette at the supper trolley at about 8.10p.m. and noticed nothing unusual about his demeanour (T.23).

4.4 At about 8.20p.m. Sean Simmonette collapsed in the smoking room. He had been sniffing fly spray. One of the patients, Lee Waters, described what happened to Detective Schneemilch:-

“Well we were sitting near the television watching TV, and he had a bag and some fly spray, and he was spraying the fly spray into the bag and breathing it in. And I got up to play cards with Ken, and then after a while I got sick of cards and I came back down and sat next to the television and Sean fell out of his seat onto the ground. I rolled him over onto his side and tried to wake him up. He was breathing, and I wasn’t sure what to do, whether to go to the nurses straight away or not, because it would mean several weeks being locked up for him, and he doesn’t like being locked. I should have gone to the nurses straight away.

...

And I kept an eye on him trying to wake him up for several minutes, then his breathing became erratic I think is the word, and he actually stopped for a second and his face started to change colour and so I went and got the nurses”. (Exhibit C.9a, p1-2).

Other patients gave statements to similar affect (see Kenneth Wipa, Exhibit C.10a, p2-4, and Hesham Galam, Exhibit C.10b, p2-3).

4.5 Another patient, Michael Carter, was seen to have taken the fly spray from the nurses station earlier that evening, when the nurses were busy. He was also seen to take it out of the room after Mr. Simmonette's collapse. It was found later in the toilet. Mr. Carter declined to discuss the matter with the investigating police (Exhibit C.10c).

4.6 At about 8.20p.m. Mr. Galam approached Mr. Deans and told him Sean Simmonette had collapsed. Three of the nurses ran into the smoking room and found Mr. Simmonette lying on the floor. He had no pulse. He was given CPR with oxygen. An ambulance was called and when they arrived (at 8.32p.m.), the ambulance officers took over. Paramedics arrived soon after that and more aggressive measures were taken, including the administration of adrenalin and attempts at defibrillation, but to no avail. Resuscitation efforts were ceased at 8.51p.m. (see Exhibit C.13a).

4.7 **Cause of death**

A post mortem examination on the body of the deceased was performed by Dr. R.A. James, Forensic Pathologist, on 24 January 1999. Dr. James found the cause of death was respiratory arrest complicating hydrocarbon inhalation (sudden sniffing death).

4.8 Dr. James commented:-

“He allegedly collapsed after sniffing Johnsons Raid. The propellant is hydrocarbon and the can contains an obvious warning ‘Intentional misuse by deliberately concentrating and inhaling contents can be harmful or fatal’. The post mortem has suggested that the deceased was a self mutilator (the scarred writing ‘HELP’ on the left abdomen) who has viral hepatitis presumably as a result of drug abuse. The casenotes suggest he was positive for Hepatitis C.

Abuse of propellants particularly hydrocarbons and particularly if they are concentrated by the use of a plastic bag are recognised to have the potential to cause unexpected rapid death. Toxicology has identified the presence of hydrocarbons although a formal report has not been received at the time of this report”. (Exhibit C.1b, p5).

4.9 A toxicology report from Mr. D.N. Sims, Senior Forensic Scientist, dated 26 July 1999, discloses:-

“Results:

1. The blood contained 0.10mg/L olanzapine (therapeutic concentration).
 2. No other common drugs were detected in the blood.
 3. Isobutane and butane were present in the lung and liver.
 4. Aliphatic hydrocarbons were present in the bag.
 5. Isobutane, butane and aliphatic hydrocarbons were present in the can of insecticide”.
- (Exhibit C.2a).

4.10 I accept Dr. James' evidence, and find that the cause of Mr. Simmonette's death was as he described.

5. **Issues arising at Inquest**

5.1 Response to incident on 20 January 1999

As I have described, when Mr. Simmonette suffered his final collapse on 23 January 1999, he was in the smoking room at JNH, out of the view of nursing staff, who were in the nurses station.

5.2 No special measures had been taken to supervise him, despite the previous incident on 20 January 1999. Dr. Raeside said that an appropriate response would have been:-

- to speak to Simmonette and McDonald about the allegations;
- search their rooms;
- observe them more closely;
- depending on the level of concern, perhaps remove them to a more secure environment;
- bring it to the attention of the medical staff;
- enter the incident in the casenotes. (T.95-96).

5.3 Clearly, none of these things occurred. I regard the response of the nursing staff to Ms. Woods' alert in the Communication Book as inadequate for that reason.

5.4 Security

Dr. Raeside agreed that the amount of fly spray and the potentially dangerous substances needed to be audited, particularly if information is received that something is missing (T.101).

5.5 Dr. Raeside was unable to suggest how a patient could have gained access to the nurses station, particularly during the busy period when nurses are more likely to be there (T.103). In any event, I note Mr. Stockdale's indication that fly spray is no longer kept on the ward at all (T.54).

5.6 Another security issue is the fact that patients could not be observed in the smoking room from the nurses station. Dr. Raeside said that he had been concerned about this problem for some time (T.104). He did not think that video monitors are the answer either (T.107). He said:-

“My view would be to have an open space with judicious use of furnishings, plants, etc., to break up the area to allow some degree of privacy but while still allowing staff to

easily see if something was to occur. I'm not an architect and it may be impossible to do that in that environment but I think that would be the ideal setting. Certainly new forensic units that I've seen, or newer than James Nash House, do that". (T.106).

5.7 Dr. Raeside thought that Detective Fielding's suggestion, that responsibility for security issues should be given to security officers who are not nurses, was impracticable and, for the reasons he discusses at T.110-111, I agree.

6. **Recommendations**

6.1 Had there been an adequate response to the incident on 20 January 1999, it is possible that Mr. Simmonette's death on 23 January 1999 could have been avoided. Of course, he was a person who habitually risked his life as a poly-substance abuser, but it was the duty of the staff at JNH to minimise the risk of that, by keeping potentially abusable substances away from him. I note that fly spray is no longer kept on the ward, but this is not the only substance which can be abused.

6.2 Further, had the ward been designed so that staff were able to see the patients whenever they needed to, Mr. Simmonette may not have been able to abuse the fly spray in the smoking room without being seen.

6.3 Accordingly, I make the following recommendations pursuant to Section 25(2) of the Coroners Act 1975:-

- nursing staff at James Nash House should be counselled about their failure to adequately respond to Ms. Woods' alert in the Communication Book on 20 January 1999;
- in particular, the need for significant incidents being noted in the Client Record, so that medical staff can be made aware of them, should be reinforced;
- security in Birdwood Ward should be reviewed, particularly so that if any information is received that an item may be missing, an immediate inventory can be conducted to verify that allegation, and further action can be taken;
- consideration should be given to redesign of Birdwood Ward (and Aldgate Ward as well) to address the concerns expressed by Dr. Raeside herein.

Key Words: death in custody; psychiatric institution; mental illness; substance abuse

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

Seal the 14th day of November, 2000.

Inq.No.40/2000

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Coroner