

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 5th and 28th days of April, 2000, before Wayne Cromwell Chivell, a Coroner for the said State, concerning the death of Caleb Sody.

I, the said Coroner, do find that Caleb Sody, aged 20 years, late of U21/61 Victoria Street, Forestville, died at the Queen Elizabeth Hospital, Woodville on the 25th day of July, 1998 as a result of ruptured heart and aorta due to fall from a height. I find that the circumstances of death were as follows:-

1. **Reason for inquest**

1.1 On 25 July 1998 Mr. Caleb Sody was the subject of an order for detention pursuant to the Mental Health Act. On 9 July 1998, Mr. Sody was detained pursuant to Section 12(1) of that Act by Dr. Keane at the Queen Elizabeth Hospital. That order was confirmed pursuant to Section 12(4) of the Act by Dr. McKenny, a psychiatrist. On 12 July 1998, a further order for detention for a period of 21 days was made pursuant to Section 12(5) of the Mental Health Act by Dr. Lawson. This order was still current at the time of his death. Accordingly, on the date of his death on 25 July 1998 Mr. Sody 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 Caleb Sody was born on 12 December 1977. He was described by his mother as an “intelligent child who did very well at school” (Exhibit C.1b, p1).

2.2 During his late adolescence, however, problems in his social interactions began to emerge, and he became paranoid and withdrawn. Dr. Tony Davis, a consultant psychiatrist who provided a report to me in this matter, described this phase as a

“prolonged prodrome of illness, extending back to 1995 or thereabouts” (Exhibit C.32, p2). Mr. Sody became increasingly isolated and withdrawn from his family, he left accommodation they arranged for him, and generally showed signs of illness. His father said:-

“The next time I heard from him when he was in the hostel in Gilles Street in Adelaide. He asked me for money. I met him and he was very bad mentally, he thought the whole world was insane. I gave him a few hundred dollars and implored him to seek help with me. He refused and said ‘you are all insane’”. (Exhibit C.5a, p2).

- 2.3 In 1997 Mr. Sody commenced a Bachelor of Arts degree at the University of Adelaide and continued with his studies until the time of his death. His illness prevented him from achieving real academic success, however.
- 2.4 In June 1998 Mr. Sody had travelled to Victoria and Tasmania. On 11 June 1998 he was found at Mount Buller, having taken an overdose of sleeping tablets, and almost dying of exposure. He was detained to the Wangaratta Hospital. He was diagnosed as suffering from a disorganised schizophrenic illness, and Olanzapine was prescribed at a dosage of 15mg per day. This appears to have been the first time Mr. Sody received any form of psychiatric treatment.
- 2.5 On 9 July 1998 Mr. Sody was transferred from Wangaratta to the Queen Elizabeth Hospital. As I have already mentioned, on that day a detention order pursuant to Section 12(1) of the Mental Health Act 1995 was made by Dr. Keane, and this was confirmed the next day by Dr. McKenny. On 12 July 1998, a further order for detention for a period of 21 days was made.
- 2.6 The Cramond Clinic at the Queen Elizabeth Hospital had been opened on 9 June 1998. Mr. Sody was admitted there on 9 July 1998. He was classified “R”. This classification was made on the basis that he required observation at 30-minute intervals (see the statement of Dr. Williams, Exhibit C.25a, p2). His Olanzapine medication (described by Dr. Williams as an atypical anti-psychotic) was continued. On 14 July 1998 he was given an intra-muscular injection of 200mg of Zuclopenthixol, another anti-psychotic medication, and on 20 July 1998 the dose of Olanzapine was increased to 20mg at night.
- 2.7 Between 10 July 1998 and 19 July 1998 Mr. Sody was given day leave in the company of his parents. His mother said that he was ‘very quiet’ during the times she

was with him. She said that he 'hated it' at the Queen Elizabeth Hospital (Exhibit C1b, p4).

2.8 Mr. Brett Sody agreed. He said:-

"When Caleb was transferred to the QEH I saw him about every other day. I spent a lot of time with him. I was very pleased that at last he was getting treatment and had been officially diagnosed.

I found that he was in a terrible state at the hospital. He was extremely quiet, he did not speak unless he was spoken to. He was extremely agitated and never smiled. He was sullen and morose, he seemed to have a deep anger and sadness. I thought that after some time here he was improving". (Exhibit C.5a, p3).

2.9 Dr. Williams saw Mr. Sody on 13 July 1998 and later on 20 July. Her findings were important, and I set out the relevant parts of her statement in full:-

"I saw Sody in a direct interview situation on 13 July 1998 and this was during our ward round and I spoke to him. I noted that he was psychotic, and his affect was blunted and he was very withdrawn and perplexed. He was guarded and suspicious during the interview and denied any illness and said that he wanted to go home to his parents. There was evidence of thought disorder and poorly defined persecutory delusions. I specifically asked him about his suicide attempt and he had difficulty explaining this and stated that it was because he wanted to see what the experience of death was like. He appeared very perplexed when he said this to me. My assessment from that interview was that he remained very unwell and psychotic although there had been some improvement since admission. In my opinion he required further inpatient treatment and detention and that the detention order was clearly appropriate.

I was informed by a Dr. Keane and Dr. McKenny (the other consultant) that there had been some granting of special leave of detention for him to spend some time with his separated parents, and that it was considered helpful in his management. He had been anxious to spend some time with his parents. I was not aware that from the 13th to the 19th that he was being allowed daily leave for a few hours with his parents.

I next interviewed him on 20 July 1998. This was at the end of a family meeting with both his parents and a social worker, Ruth Walter was present, as was Dr. Maram Afshar. ... After the family meeting on 20 July 1998 I spoke with the client. In my assessment his mental state had not significantly improved since my previous interview on 13 July 1998. He was clearly opposed to being in hospital and having any treatment.

I discussed the leave he was having with his parents and they indicated that they were uncomfortable with Caleb because he appeared sullen and uncommunicative. As I was concerned that he was at risk of harming himself on leave and because of the need for close observations of his mental state I cancelled all leave for him.

I last spoke to Sody on 23 July 1998 at 1.00p.m. The intern doctor Dr. Afshar had asked me to speak to him because he was asking for a definite discharge date to be given to him and he was once again complaining about the restrictions of the detention order. When I interviewed him I thought that there was some evidence of improvement in his

mental state, as he appeared more active and was walking around the ward and was a little less disorganised in his thoughts and more communicative. I thought that the explanation for this may have been that the injection of Zuclopenthixol was probably beginning to have a therapeutic affect on him. I explained to him that when his current 21 day order expired we may have to consider extending it. I made a remark that I could not accurately forecast discharge dates and that it depended on his progress". (Exhibit C.25a, p3-5).

- 2.10 On 21 July 1998 Mr. Sody's appeal to the Guardianship Board against his detention order was heard and dismissed. Dr. Afshar, who accompanied him to the hearing, said that he was "very unhappy" about the result (Exhibit C.10a, p2).
- 2.11 Both Mr. and Mrs. Sody saw Caleb on 24 July 1998, and both noticed a significant improvement in his demeanour and presentation (Exhibit C.1b, p4 and Exhibit C.5a, p3). His mother said that this was "the best I've seen him".

3. **Events of 25 July 1998**

- 3.1 On Saturday 25 July 1998 Mr Sody was allocated to the care of Registered Mental Health Nurse Catherine Bishop. She commenced duty at 7.00am and worked until 3.30pm. She said that she thought that she had established good rapport with him, and they spoke on 'numerous occasions' during her shift. She said that he told her he had no 'suicidal ideations', a term she thought was 'well-rehearsed' (Exhibit C23a, p2).
- 3.2 Ms. Bishop noted that Mr. Sody was prepared to discuss the future. She said:-

"Sody spoke several times about his plans for the future with his parents coming to see him and his study. This is not typical of a person who is contemplating suicide in the immediate future". (Exhibit C.23a, p2).

- 3.3 At 3.00p.m. Registered Mental Health Nurse J.L. Roberts took over the care of Mr. Sody from Ms. Bishop. He was unable to locate his patient in the clinic, so he informed the Clinical Nurse Consultant, Mr. P.G. Roberts, who suggested that he continue to search for him, and that he notify Mr. Sody's relatives. CNC Roberts commented:-

"I considered that it was premature in the circumstances to submit a Missing Persons Report. Clients going missing from the clinic for short periods of time is not uncommon. However, each client's absence is assessed individually depending on their current mental state. I was not unduly concerned by Caleb's absence at that time knowing that he was more stable by recent reports and had been known to wander the corridors before". (Exhibit C.7a, p3).

3.4 Mr. Roberts proceeded to search the general area around the grounds of the Queen Elizabeth Hospital, including a café on Woodville Road, until about 5.00p.m. He said that he also attempted to contact Mrs. Sody on two occasions but was unsuccessful. As to what happened next, he said:-

“I was then called to the High Dependency Unit to assist with a disturbed patient. I then went to tea at about 1830 hours. I took my meal break in the clinic staff meal room. I saw Phil Roberts there and advised him that I had still not located Sody. I told him that I was going to put in a Missing Persons Report. Phil agreed that I should do this”. (Exhibit C.6a, p2).

Both men left the meal room at about 6.55p.m. and, on their way back to the clinic, Mr. Roberts saw a crowd of people out the front. He went into the ward and commenced to fill out the Missing Person Report, but it transpired that Mr. Sody had jumped from the maternity building only a matter of minutes earlier.

3.5 At about 5.15p.m. Registered Midwife Denise Olds had gone to Birthing Unit 2 on the 5th floor of the maternity building, which is close by the Cramond Clinic. She was restocking and checking the equipment. She went to the nurses’ station to collect an item of equipment, and while doing so she left the door to unit 2 unlocked for about five minutes. When she returned, she placed the item in the trolley outside the unit and did not look inside (Exhibit C.26a, p2).

3.6 At around 6.50p.m., a person was seen standing in a window frame on the 5th floor of the maternity building. Registered Mental Health Nurse Margaret Wallace said that she was called outside by one of the patients. She said:-

“I saw a person standing in a window frame holding each edge and looking west. I am not sure if the window is intact or not. The person then pushed away from the window and leapt out. The person came out feet first and fell in vertical position as though standing up. The person was inert, he was not moving his arms or legs and was not calling out. I did not see the impact because the Cramond Clinic building was in the way. I observed the fall for about two or three floors. I called to a nurse at the desk to put through an emergency code”. (Exhibit C.24a, p2).

3.7 Ms. Wallace and others ran to where he had fallen, and recognised Caleb Sody. She was unable to find a pulse, and there was no respiration. Cardio-pulmonary resuscitation was commenced, and Mr. Sody was conveyed to the Emergency Department, but despite efforts to resuscitate him, his death was pronounced at 7.30p.m. (see the certificate of Dr. Durairaj, Exhibit C.2a).

- 3.8 When the incident became known, Ms. Olds and a colleague went to Birthing Unit 2 to “see what was happening”. She said:-

“On entering the room by unlocking it with a key I saw a pair of black boots and socks on the floor near the three-seater lounge as though someone had sat on the lounge to take them off. I saw the vomit bowl and tubing had been removed from the side unit and placed on the bed. The metal drawer had been completely removed from the side unit and placed on the lounge. The lounge is under the western window which was broken. The light was on, and the television was on which I had turned off. The bed appeared to have been used”. (Exhibit C.26a, p3).

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, on 27 July 1998. Dr. Gilbert confirmed that the cause of death was ruptured heart and aorta, due to fall from a height (see Exhibit C.3a, p1).

- 4.2 Dr. Gilbert commented:-

“Death was due to rupture of the heart and aorta resulting in massive bleeding into both pleural cavities. These injuries would have proved rapidly fatal and medical intervention would have been futile. Other injuries noted included bilateral femoral fractures. No significant head, spinal, pelvic or upper limb injuries were identified, though radiological investigation at the QEH suggested the presence of a crush fracture of the first cervical vertebra with displacement”. (Exhibit C.3a, p4).

- 4.3 Ms. Janice Gardiner, forensic scientist, performed a toxicological analysis of a blood specimen taken from Mr. Sody. The analysis revealed that his blood contained 0.05mg/L of Olanzapine, which she described as a “probable therapeutic concentration” (Exhibit C.4a).

5. **Issues arising at inquest**

5.1 **Level of supervision**

As I have already pointed out, Mr. Sody had been detained to the Queen Elizabeth Hospital pursuant to the Mental Health Act. A detention is authorised by the Mental Health Act “in the interests of his or her own health and safety or for the protection of other persons” (Section 12(1)(c)).

- 5.2 For this same reason, Dr. Williams cancelled Mr. Sody’s leave on 20 July 1998 (see her statement, Exhibit C.25a). She did not, however, make it particularly clear that she considered that a higher level of supervision than before was required for Mr.

Sody. Her note in the casenotes merely records that she regarded further day leave as “inappropriate + + +”. It may have been inappropriate for a number of reasons other than suicide risk.

5.3 Dr. Tony Davis said that he did not consider that it was necessary, in light of Dr. Williams’ note, to increase the frequency of checks of Mr. Sody to a higher rate than half-hourly, and did not consider it necessary to transfer him to the High Dependency Unit, which is a “closed” environment (T.71).

5.4 Dr. Davis said in his report:-

“The question of the appropriateness of the Cramond Unit in the accommodation of detained psychiatric patients is raised. This is a vexed issue, which confronts acute psychiatric services throughout South Australia. Many detained patients are managed in open wards, which is considered to be appropriate. Provision is made for closed ward management when clinicians have concerns about a high risk of suicidal behaviour or aggressive or threatening behaviour towards others.

It is widely accepted that it is not possible, or desirable, to accommodate all detained patients in a closed ward. Even though closed ward management may reduce the risk of suicide, this risk is not eliminated altogether. Furthermore, such a measure would be generally seen as excessively controlling and restrictive.

In general terms, I consider that the Cramond Unit is an appropriate place for the management of detained patients, even though the facility is not closed in a formal sense. The documents indicate that the nursing staff and medical staff were fully cognisant of the suicide risk and took steps to try and minimise the chance of this throughout the admission. Unfortunately, Mr. Sody left the ward without communicating with his nurse, and proceeded to act on his suicidal impulses. He had not communicated these thoughts or impulses to his nurse earlier that day”. (Exhibit C32, p3).

5.5 Treatment generally

Dr. Davis was positive about the standard of treatment received by Mr. Sody at Cramond Clinic. He said:-

“I consider that Mr. Sody received appropriate treatment for his schizophrenic illness throughout his stay in the Cramond Unit. He received appropriate medication and intensive support from the medical and nursing staff. He was classified as a significant risk of suicide, and was accordingly registered for half-hourly observations by nursing staff.

He was allowed to leave the ward for short periods under supervision between 10 and 19 July but was restricted to the ward after review by Dr. Williams on 20 July.

The documents indicate that he was assessed at frequent intervals and managed in an appropriate manner. The nursing and medical notes are clear and comprehensive and

provide a good summary of changes in his mental state and plans of management”. (Exhibit C.32, p2).

I accept the evidence of Dr. Davis about those matters.

5.6 Response to disappearance

When he realised that Mr. Sody was missing, Mr. Roberts searched the hospital for two hours or so, then responded to a call to the High Dependency Unit. He then took his meal-break, and it was not until after then, at about 6.55p.m., that he decided to take positive steps towards notifying the police of Mr. Sody’s disappearance.

5.7 In this respect, he followed the directions of his superior, CNC Roberts. These actions were confirmed as appropriate by Mr. Neville Phillips, the Director of Nursing at the North West Adelaide Mental Health Service (T.35-37).

5.8 The procedure referred to is contained in Exhibit C.30. The procedure gives no instruction as to when a Missing Person Report should be made, and simply states:-

“When notification to police of a missing client is required ... the Senior will ensure that:

- the full Missing Persons Report Form is faxed to the appropriate Police Station.
- the appropriate Police Station is contacted by phone to confirm fax received and add details as required.” (p.5).

5.9 The procedure makes no mention of notifying hospital security staff, or taking steps to notify any other agency. In my view, this is important. Mr. Roberts had little chance of finding Mr. Sody in such a large complex as the Queen Elizabeth Hospital by himself. Obviously, Cramond Unit did not have staff reserves sufficient to allocate more people to assist him. In those circumstances, the best chance of help was from security staff, since substantial parts of the complex are monitored by video surveillance, and the guards are equipped with radios.

5.10 In my view, the situation should have been regarded as more urgent than it was. If it was decided that it was necessary to observe Mr. Sody every 30 minutes within the unit, an absence of more than 30 minutes from the ward should have been treated with alarm. In my view, an alarm should have gone out to hospital security no later than 3.30p.m.

5.11 Dr. Davis agreed. He said that waiting until 6.55p.m. or so was “quite an extraordinary delay” (T.77). He added:-

“I would have thought about half an hour would be a time at which you would start mobilizing other contacts”. (T.78).

5.12 As to police notification, it should be borne in mind that even if the police had been notified, they would not have searched for Mr. Sody within the hospital perimeter. They were more likely to simply alert patrols in the area to look out for Mr. Sody in the streets. As such, they would not have found him even if they had been notified.

5.13 Design of Cramond Clinic

I was provided with a plan of the new clinic (Exhibit C.12b) in the Scott inquest (Inquest No. 15/2000). That demonstrates that in certain circumstances, there is no direct line of sight between the nurses' station and the entrance/exit to the unit. This is an important factor which has been highlighted to me in other cases where detained patients are accommodated in open wards - the ability of staff to monitor the movement in and out of the unit is an important management tool.

5.14 Although it is now too late to redesign the unit, perhaps it is necessary to consider other means of ensuring that staff are aware of who is coming in and out of the building. I would certainly suggest that, if similar clinics are to be designed in future, this principle should be borne in mind.

6. **Finding**

I find that Caleb Sody, aged 20 years, late of U21/61 Victoria Street, Forestville, died at the Queen Elizabeth Hospital, Woodville on 25 July 1998 as a result of ruptured heart and aorta due to fall from a height.

7. **Recommendations**

Pursuant to Section 25(2) of the Coroners Act, I recommend that:-

- (1) the Policy and Procedure Manual for the North West Adelaide Mental Health Service in relation to “missing clients” be amended to provide specific instruction as to when steps should be taken in relation to a missing client, and that the unaccounted for;
- (2) consideration hospital security system should be notified at an early juncture when a client is be given to how staff at Cramond Unit can monitor ingress and egress to the building since they are unable to keep a visual line of sight over the entrance.

Key Words: death in custody; psychiatric illness; suicide

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

Seal the 28th day of April, 2000.

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Coroner