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 10th and 11th days of February, and 13th day of March, 2000, before Wayne Cromwell Chivell, a Coroner for the said State, concerning the death of Kenneth Charles Strangways.*

*I, the said Coroner, do find that Kenneth Charles Strangways, aged 34 years, late of Salvation Army William Booth Hostel, Adelaide, died at the Royal Adelaide Hospital on the 27th day of November, 1997 as a result of aspiration pneumonia following seizure with concomitant global severe anoxic encephalopathy following earlier respiratory and cardiac arrest. I find that the circumstances of death were as follows:-*

1. **Background**

1.1 Kenneth Strangways was born in Port Augusta on 10 September 1963. He was one of six children. Their father was an Arabana man whose people came from the Finke River area.

1.2 Kenneth's brother Bradley said that he was an average student at school in Port Augusta, and was not regarded as "retarded" (Exhibit C.12, p2). He worked on cattle stations after leaving school. His father died in 1982.

1.3 Bradley said that Kenneth was affected very badly by his mother's death in 1992. He said that he "lost the will to live". He drank even more heavily than before, and the family were unable to assist him. He said:-

> "He would drink with anyone anywhere and he came to live in Adelaide and hang around Victoria Square". (Exhibit C.12a, p3)

1.4 In 1992, it appears that Mr. Strangways was involved in a car accident, as a result of which he suffered head injuries. He underwent neurosurgery, and a plate was inserted in his head. His brother said:-

> "I was not aware of whether Kenneth had ever had a car accident. No-one told us about that. We know that he had a plate put in his head in the early 1990's and that he had bad head injuries. I know that there were many occasions when people would rob him and take his money because he was easy to take from and because he was always drunk. He was often assaulted and we could do nothing. We would ask him what happened and who did it and he wouldn't remember". (Exhibit C.12, p4)

1.5 In January 1993 Mr. Strangways had further surgery for a subdural haematoma at the Royal Adelaide Hospital ("RAH"). He was detained pursuant to the Mental Health Act following the operation, but was released to his brother's care at Elizabeth under the supervision of Northern Domiciliary Care. In a report dated 4 February 1994, a social worker described the background as follows:-

> "Mr. Strangways was referred to Northern Domiciliary Care in early 1993 after discharge from the Royal Adelaide Hospital, where he was treated for an acute subdural haematoma. The cause of the head injury is unknown. The client was found unconscious at a northern suburbs railway station - possibly bashed or simply paralytic. When an inpatient at the Royal Adelaide Hospital, he became restless and confused and absconded from the ward. He was later found in Rundle Mall - unconscious. The hospital applied for a custody order to keep him in for treatment. At the time, no relatives had come forward to claim him - it appears that they were unaware of his being in hospital. Subsequently, the Aboriginal Liaison Officer at the Royal Adelaide Hospital was able to track the family down and the client was discharged to his brother's home at the above address where he has since been living, under his care.
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> ...
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> *Medical*
> Kenneth suffers from several past head injuries, post traumatic epilepsy, alcoholism, poor seizure control, short-term memory impairment, occasional memory incompetence and can sometimes be aggressive and uncooperative when thwarted. He is often restless and agitated and has a short concentration span. His hospital medical notes indicate he also suffers from schizophrenia.
>
> ...
>
> *Way of Life*
> Kenny spends most of his time in the park, drinking with his mates. He gets up very early in the morning, well before the rest of the household wakes, and visits his drinking partners in their own homes. He then frequently proceeds to a local park where he meets other friends. His brother reports he usually comes home late in the evening, too inebriated to take his evening medication. His brother reports he spends all his money on alcohol and never pays rent or has money for food or other sundry items. It seems

> Kenny is vulnerable to predatory mates who take advantage of his good nature to borrow mercilessly from him when he is in his usual drunken state". (Exhibit C.14)

1.6 This chaotic and unhealthy lifestyle continued throughout the 1990's. Indeed, it is recorded that Mr. Strangways was conveyed to various detoxification centres by police and the Aboriginal Sobriety Group pursuant to the Public Intoxication Act on 110 occasions from 1985 until his death.

1.7 Mr. Strangways became known to Ms. Karen Mitchell, a Registered Nurse and Psychiatric Nurse, who, since 1995, has been working with homeless people in the inner city with the City Homeless Assessment and Support Team ("CHAST").

1.8 Ms. Mitchell said that she had a great deal of trouble getting services for Mr. Strangways because:-

> "I identified this man as one of the number of men and women who I deal with who fall through the gaps in service structures - didn't actually fit mental health services at all and the eligibility criteria for alcohol-related brain damage clients were non-existent within the services at the time and still are non-existent ... mental health feel that it's Drug and Alcohol's responsibility and Drug and Alcohol Services - I'm not sure whose responsibility they feel it is because they haven't got the facilities to actually deal with clients who have a query ... alcohol-related brain damage ...". (T.12)

1.9 At one stage Options Coordination - Brain Injury Service agreed to accept him as a client but were unable to provide secure accommodation for Mr. Strangways.

1.10 On 11 April 1996 Mr Strangways was detained pursuant to the Mental Health Act by Dr DJ Mead following an apparent suicide attempt. He improved considerably at Glenside Hospital, but was noted to be showing paranoid symptoms at that time (T28).

1.11 On 18 April 1996 the Guardianship Board made orders appointing the Public Advocate as "limited guardian" for accommodation purposes, Public Trustee was appointed Administrator of his estate, and Ms. Mitchell was appointed his "liaison person". On 23 April 1996, the Guardianship Board made further orders pursuant to Section 32 of the Guardianship and Administration Act authorising the guardian to enforce medical treatment and care, and detention at his place of residence.

## 2. The role of the Public Advocate

2.1 I heard evidence from Ms. Rennie Gay, who was the Assistant Public Advocate, and the delegate of the Public Advocate to act as guardian for Mr. Strangways after those orders were made by the Guardianship Board in April 1996.

2.2 Initially, Mr. Strangways was residing at Glenrowan Rest Home at Hyde Park, which had a locking system operated by a key-pad. At that and a similar institution, Mandeville Lodge, at Largs Bay, Mr. Strangways absconded a total of thirty or forty times. He was reported as a missing person to the police (T.97).

2.3 This had a number of problems:-

- because he knew he should not be at large, there was a danger that he would avoid essential services for him in Whitmore Square (T.97);
- the police were unhappy about continually arresting and returning him (T.97);
- there was a suggestion from Ms. Mitchell that he became even more depressed and suicidal when physically detained (T.21).

2.4 Similar problems were encountered when attempts were made to place him at the Aboriginal Elder Care Nursing Home, a place which Dr. Mead described as "more culturally appropriate". I was advised in a report from the Division of State Aboriginal Affairs ("DOSAA") that:-

> "The Elders Village was established as a unique residential care hostel facility for older Aboriginal people in metropolitan Adelaide. It is not designed to accommodate the needs of clients with dual disability nor is it resourced to provide the high level of intensive supervision such client require. However, in view of the absence of suitable accommodation for vulnerable Aboriginal clients entering the disability sector, the Elders Village has come to be a place relied upon to provide such care.
>
> Currently the profile of the Elders Village clients range from 24 years to 90 years. There is a constant call for more intake of younger, disabled Aboriginal clients who express a desire to reside in an Aboriginal facility. Some such clients may require 24 hour security arrangements for which the Village is not equipped. Mr. Strangways was accepted into this facility on more than one occasion but was reported to have absconded. Management of the Village and other Aboriginal service providers describe how the Village has become a 'dumping ground' for difficult Aboriginal clients.
>
> The Commonwealth who solely funds the Village apply standards of care akin to a Nursing Home and Hostel as prescribed under the Aged Care Act 1997 and resource the Elder Village accordingly. As a consequence they have expressed concerns at the standard of care available to clients at this facility. The Department of Human Services,

> responsible for provisions under the Mental Health Act, do not provide any funding supplements to the operations of the Elders Village. However younger Aboriginal clients with mental health problems and various intellectual disabilities are referred to the facility for residential care". (p.9-10)

2.5 Ms. Gay said that a facility was required where Mr. Strangways received secure care, augmented by care workers, especially Aboriginal care workers. She said that she did not favour a closed ward at Glenside, but even this would have required one-to-one augmentation of that type (T.100).

2.6 Finally, the best they could do was to negotiate a secure (in the sense that it was specifically allocated to him) bed at the William Booth Hostel in Whitmore Square which Mr. Strangways could use when he needed it. The services of the detoxification unit were also available as required (T.102).

2.7 Of course, there was no sense in which Mr. Strangways was detained to that Hostel. The management of these institutions could not and would not have undertaken such a responsibility (T.104).

2.8 Interestingly, the Public Advocate does not have a system for recording when the detention powers pursuant to Section 32 are being invoked in a given situation. I find this surprising. I think that it is essential that there be a permanent and easily accessible record of such invocation, so that police and other workers may refer to it quickly and ascertain the status of a particular client. In the event of a death, it would also enable authorities to determine whether a death in custody, within the meaning of Section 12(1)(da) of the Coroners Act has occurred, since there is a protocol which compels urgent police action in such an event.

2.9 Ms. Gay pointed out that Section 32 powers authorise, for example, forcing Mr. Strangways to take his medication against his will. In practice, this power was "a more difficult thing" (T.108), and she said that little could be done to enforce such powers if persuasion failed (T.113).

2.10 The Annual Report of the Public Advocate for 1998-9 discloses that the total number of people under the guardianship of the Public Advocate, as at 30 June 1999 was 191, and the figures fluctuated between 190 and 220, and yet the guardianship programme was "staffed by the Assistant Public Advocate and a temporary social worker on contract until the end of the month" (p.12).

2.11 This is clearly unsatisfactory. The report from DOSAA advises that the staff client ratio in Western Australia is 1 : 6, in New South Wales it is 1 : 19, and in Victoria it is 1 : 43. No agency can be expected to provide an effective case management service with a caseload of more than 1 : 150, as is the case in this State. In my opinion this is an extremely unsatisfactory situation, and one which calls for urgent review by the Department of Human Services.

## 3. **Further difficulties in finding accommodation**

3.1 Mr. Strangways was detained to Glenside again in July 1996, and was found to have been suffering from "alcohol psychosis" (T.30). On discharge from Glenside, Mr. Strangways was found to be unsuitable to receive Extended Care Services because of his "conviction to keep on drinking" (T.31).

3.2. Mr. Strangways was admitted to Glenside again in September 1996 with "Organic Brain Syndrome".

3.3 Another example of the difficulties encountered in getting treatment for Mr. Strangways is to be found in a letter from Dr. B.J. Kearney, then Chief Executive Officer at the RAH, dated 21 August 1997. As Mr. Strangways had been treated and discharged from the RAH on three occasions in the same day following epileptic seizures, Dr. Kearney wrote:-

> "The Director of our Emergency Department has reviewed Mr. Strangways' management in her Department since receiving your letter. Mr. Strangways is extremely well known to our Emergency Department as he presents 2-3 times per month following seizures. He has been admitted to this hospital so many times that his medical record contains five volumes. His seizures are related to both alcohol abuse and to a previous head injury. He does not take his anticonvulsant medications as prescribed by the medical staff. When he is admitted to this hospital he discharges himself. He has been offered referral to the Drug and Alcohol Rehabilitation Unit on multiple occasions and has always refused these services. Given that he does not take his anticonvulsant medications, it is to be expected that Mr. Strangways will continue to have frequent seizures.
>
> ...
>
> The Director of our Emergency Department can understand your concern in relation to not having staff who are comfortable with handling patients who have seizures. However, Mr. Strangways has consumed an incredible amount of hospital resources to no effect. The Director of our Emergency Department does not believe that it is appropriate to undertake an extensive evaluation of Mr. Strangways each time he presents following a seizure nor is it possible, or beneficial, to hospitalise him on each of

> these occasions. While I acknowledge that it is difficult for your staff it is also extremely difficult for our staff to manage Mr. Strangways in the Emergency Department. Given that he is not compliant with his medication and does not wish to accept help from the Drug and Alcohol Rehabilitation Unit and discharges himself when hospitalised he is proving to be a difficult management problem. It would seem that his seizures will continue given his above behaviour and there is nothing more the staff in our Emergency Department can offer". (Exhibit C.2a, p1-2)

3.4 One can only sympathise with the staff in Emergency Departments at Public Hospitals who are put in the situation of having to deal with seemingly intractable patients such as Mr. Strangways. They are clearly not equipped to provide the sort of longitudinal, case-managed care that he required.

3.5 However, I think it is fair to observe that Dr. Kearney's letter does highlight the fallacy in the argument that it was inappropriate to provide ongoing treatment because he continued to drink and was non-compliant with medication. The problem is that, due to his brain condition, Mr. Strangways lacked insight into these matters. As Dr. Mead said:-

> "That's right, but my argument would be that the reason for him not having an insight is a mental health issue and that needs to be addressed. I think what Dr. Kearney is saying is looking at it from a point of view of this man having some sort of insight or ability to make decisions about his treatment. My point would be that he doesn't have that ability and, therefore, the sort of services that should be offered to him are much different to someone who does have that capacity". (T.87)

4. **<u>Circumstances leading up to imprisonment and detention in 1997</u>**

4.1 On 16 July 1997 Mr. Strangways was arrested for stealing a wallet in Whitmore Square. He was remanded in custody. On 2 September, he was detained pursuant to the Mental Health Act to Glenside Hospital by Dr. C. Branson, psychiatrist. He found Mr. Strangways to be "psychotic, with paranoid delusions of a sexual nature. Wishes someone would shoot him". The detention was confirmed the following day, and he was transferred to James Nash House. On 5 September, Dr. C. Raeside, psychiatrist, issued a further 21 day detention order, and the order was repeated on 25 September 1997. This last order was due to lapse on 17 October 1997. The Guardianship Board offered to set a hearing for that day, but Dr. Maria Tomasic, the treating psychiatrist at James Nash House, was unavailable, so she decided to let the detention lapse pending a further hearing before the Board on 4 November 1997.

4.2 While in James Nash House, Mr. Strangways was examined by Mr. John Bell, Senior Clinical Psychologist, for the purpose of a neuropsychological assessment. As he had been abstinent for some time, a reasonable picture could be obtained of his level of functioning. Mr. Bell found:-

> *"Conclusion*
> Mr. Strangways has a history of several significant closed head injuries. Consistent with this is a test profile which indicates almost global deterioration in functioning, from an already limited intellectual capacity. All neuropsychological modalities tested were found to be profoundly impaired with the exception of his visual scanning capacities. Impaired capacities included frontal lobe functioning, visual and verbal memory function and a variety of left and right hemisphere cognitive capacities detailed above. These results have a significant bearing on his legal position with regard to fitness to plead and mental impairment at the time to committing the offence. It also has significant implications for his longer term placement as he would be unable to look after his day to day needs or manage his affairs such as budgeting etc." (Exhibit C.3a, p3)

4.3 Dr. Tomasic said that she had no doubt Mr. Strangways was suffering from a psychiatric illness when he came to James Nash House (Exhibit C.4a, p2). His condition steadily improved while there, but the psychological assessment confirmed that he required "long-term placement". Dr. Tomasic confirmed that Karingai Ward at Glenside Hospital was no longer available for such patients (p.5). This was confirmed in a telephone conversation with a staff member at Glenside on 30 September 1997, who advised that Mr. Strangways had been discussed at an intake meeting, but not accepted for rehabilitation because he had a diagnosis of alcohol-related dementia (p.8). That was the case even though Mr. Strangways had a psychiatric illness as well (p.9). They were told to refer Mr. Strangways to the Drug and Alcohol Services Council ("DASC"), who had no services for such people either, or back to CHAST, to Ms. Mitchell, to try and manage him in the community (p.10).

4.4 Ms. Mitchell attended the hearing of the Guardianship Board on 4 November 1997. Dr. Tomasic had originally applied for a "Continuing Detention Order", that is for actual detention, pursuant to Section 13 of the Mental Health Act. However, on 20 September 1997 she had sent a message by facsimile to the Board withdrawing that application, and seeking a "Community Treatment Order" instead. This message is in the Guardianship Board file, Exhibit C.14. The notes made at the hearing indicate that Mr. Strangways was a chronic suicidal risk, that his cognitive impairment was so great that he was unable to organise himself or make decisions, and that the best option was for him to be managed in a closed ward (T.37). It would seem likely that

Dr. Tomasic withdrew the application because of the attitude of the intake committee at Glenside Hospital. That was the impression gained by Ms. Gay at the hearing (T.107).

4.5 There seems to have been some confusion between Dr. Tomasic and Dr. Gorana Milosevic, who deputised for Dr. Tomasic at the hearing. Dr. Tomasic was under the impression that the Board granted a "community treatment order", Section 32 powers to the Public Advocate (i.e. to detain if necessary and to enforce treatment), and a continuing detention order and administration order for twelve months (see her interview with Senior Constable Gross, Exhibit C.4a, p11). She seems to have overlooked the message she sent to the Board. Dr. Milosevic seems to have been equally confused, as she wrote to the Guardianship Board on 11 November 1997, asking for confirmation of what took place on 4 November, as "I do not recall if a Continuing Detention Order was considered at this hearing" (see Guardianship Board file, Exhibit C.14). The Registrar of the Board replied on 14 November, saying "A Continuing Detention Order with Treatment Order was not sought".

4.6 In fact, the Guardianship Board made orders on 4 November 1997 in the form of a Community Treatment Order (Section 20 of the Mental Health Act), and orders for Guardianship, residence, authorising detention at his place of residence, treatment, administration and various procedural reviews (Section 32, Guardianship and Administration Act).

4.7 Paradoxically, the fact that a Continuing Detention Order was not made by the Guardianship Board on 4 November 1997, and that a Community Treatment Order was made instead, meant that Mr. Strangways was more likely to have received some case management from the Adelaide Continuing Care Team (ACCT), who had apparently accepted him on 14 November (T.114). Unfortunately, this could not be put into effect as Mr. Strangways' death supervened.

4.8 <u>Discharge planning</u>

This is an important issue because Mr. Strangways was due to appear in the Adelaide Magistrates Court on 11 November 1997 on the criminal charges. Negotiations were proceeding which may have resulted in his release, since it was generally agreed that he was unfit to plead, and he had been in custody since July. Dr. Tomasic thought that, if he was released from court, because he was still detained under the Mental

Health Act, he would be picked up from the court by the Eastern "ACIS" team and taken to Glenside (see Exhibit C.4a, p11). But this was not the case.

4.9 Ms. Mitchell related that this confusion was also present on 11 November at the court. She said that:-

> "As I recall I had some discussion around that and felt that he needed to go back to James Nash House, and it was decided that Ken would go back to James Nash House if charges were not revoked, and if charges were dropped, he would go to Glenside for assessment, and stay until the detention order was revoked. Therefore, it would give staff, myself and the Public Advocate, time to follow up on any case management options with the continuing care team". (T.41)

Ms. Mitchell was clearly under the misapprehension that there was an extant detention order on 11 November (see also T.44).

4.10 In fact, Mr. Strangways was discharged from court on 11 November 1997, the charges having been withdrawn. Since there was no extant detention order, he was released. I suppose Dr. Milosevic could have detained him there and then under the Mental Health Act, but she thought he had been detained on 4 November.

4.11 By some means or other, it is not clear how, Mr. Strangways was taken to Glenside Hospital where he was seen by Dr. Jenkins but not admitted. He then made his way back to the William Booth Hostel in Whitmore Square, obtained some money, then commenced drinking again. It is not clear how he got back to Whitmore Square - there is a suggestion that he walked, still wearing his Adelaide Remand Centre T-shirt and track pants (T.46).

4.12 When Dr. Tomasic found out that Mr. Strangways had not been admitted to Glenside Hospital, she telephoned Dr. Jenkins, who told her that he did not require admission because his problems were alcohol-related (Exhibit C.4a, p26). Dr. Tomasic made further representations, emphasising the multiple facets of Mr. Strangways' problem, and Dr. Jenkins agreed to re-assess him if he re-presented. Dr. Tomasic then telephoned Ms. Mitchell, but:-

> "She stated that she was uncertain now if this was the best idea, that he would be discharged in a few days anyway and that she could not find any alternative accommodation so perhaps he should simply remain at the Salvation Army" (Exhibit C.4a, p26)

Dr. Tomasic then left the matter in Ms. Mitchell's hands.

4.13 As things eventuated, I agree with the submission of Mr. Charles, counsel for the Strangways family, that there was a significant lack of discharge planning from James Nash House on 11 November 1997. It was unsatisfactory that the misunderstanding about Mr. Strangways' legal status after 4 November, which should have been obvious from the correspondence, led to a situation where he was simply cut adrift. Ms. Gay said:-

> "... if they are in James Nash for any period, they would normally be discharged to Glenside, where there would be some rehabilitation effort made before discharge to the community, and an expectation was that was going to occur in this case as well". (T.122)

I accept that this did not happen due to a misunderstanding about whether Mr. Strangways had been detained or not. This should not have occurred.

4.14 I agree with the observation in the DOSAA report:-

> "It is of vital importance that upon discharge from hospital extensive discharge plans are in operation to reduce the chronic and longstanding issue of homelessness and non-compliance with medication that had such a debilitating effect on Mr Strangways' life. However to achieve this, medical staff and social workers would have had to have some knowledge and understanding of the values, norms, and social backgrounds of Aboriginal people. Without this such personnel could not possibly understand either the underlying issues nor the barriers impeding progress in the life of Mr Strangways". (p.3)

4.15 Ms. Mitchell tried to contact Mr. Strangways on 12 November at the William Booth Hostel but he had gone "AWOL", and so she did not see him again until he was in the RAH on 17 November.

4.16 Mr. Strangways went to the Sobering Up Unit at Whitmore Square at about 9.55p.m. on 16 November. At that time his blood alcohol level was .165%. In the early hours of 17 November he collapsed during a major seizure, and was transferred to the RAH at 2.15a.m. At the RAH he suffered cardio-respiratory arrest. He was ventilated and maintained but remained deeply unconscious. Life support was eventually discontinued and he died on 27 November 1997. Dr. Kenneth Ooi, one of his medical attendants, gave the cause of death as:-

> "Aspiration pneumonia following seizure with concomitant global severe anoxic encephalopathy following earlier respiratory and cardiac arrest". (Exhibit C.1a)

4.17 No post mortem examination was directed or otherwise carried out. I accept Dr. Ooi's opinion and find that the cause of death was as he has stated.

## 5. **What treatment should Mr. Strangways have received?**

5.1 Dr. D.J. Mead from the Brian Burdekin Clinic in Adelaide told me in evidence that it was difficult to be precise, but he thought that Mr. Strangways' cognitive defects were primarily due to his head injuries and organic brain damage. However, alcohol could have contributed to this (T.59).

5.2 Dr. Mead also said that Mr. Strangways' epilepsy was poorly controlled, and he was having frequent seizures. His failure to take medication regularly was primarily responsible for this (T.59), although alcohol also made him more likely to fit (T.69).

5.3 Dr. Mead said that attempts were made to accommodate Mr. Strangways at the Aboriginal Elders Village at Davoren Park, but these were unsuccessful. He thought that this was a culturally appropriate place for him to go, but was concerned that it was not a secure facility.

5.4 Dr. Mead thought that Mr. Strangways' condition was so intractable, and his ability to look after himself was so limited, that it would have been appropriate to place him in a closed ward (T.62). However, he was aware that there were difficulties in convincing the Mental Health Service to accept responsibility for his care, since he was not considered to have a psychiatric illness. He was also aware that the Guardianship Board was unlikely to make a Continuing Detention Order if the relevant institutions were not prepared to provide that level of care (T.63). Dr. Mead was interested in making sure that the Continuing Detention Orders in place were ordered to continue at the Guardianship Board hearing on 4 November 1997. Unfortunately, the mix-up took place, and Mr. Strangways was discharged.

5.5 Like Dr. Tomasic, Dr. Mead was in no doubt that Mr. Strangways was suffering from a mental illness. He said that "alcoholic psychosis", and "organic brain syndrome", the two diagnoses that resulted in his detention to Glenside Hospital in 1996, were both mental illnesses (T.77).

5.6 Dr. Mead said that Mr. Strangways' cognitive defects interfered with his insight and judgment to the extent that he was unable to appreciate the significance and

importance of taking his medication regularly, and the bad effect that alcohol was having on his condition (T.67).

5.7 This was obviously the nub of the problem. It was not as if Mr. Strangways was deliberately avoiding medication, or indeed that he was making an informed choice to abuse alcohol. His brain damage was such that he was incapable of making rational choices about these issues, in the same way that he was incapable of forming an intent to commit a crime. Yet, treatment was being denied him, both at the RAH and at Glenside Hospital, for these reasons. This is a classic "Catch 22" situation.

5.8 Mr. Strangways had a mental health problem, and the fact that he had many other problems should not have prevented him receiving appropriate care from the Mental Health Service. They should have been providing him with long-term, secure, supportive accommodation (T.84).

5.9 Paradoxically, it would appear that services for patients such as Mr. Strangways have deteriorated, rather than improved, in the last few years. The statement of Mr. Brougham, Director, Glenside Services, indicates that since the closure of Hillcrest Hospital (Robertson House and Gallipoli Ward) all services were concentrated at Glenside Hospital (Karingai Ward). Mr. Brougham advised that:-

> "Funding from the Commonwealth for the treatment of alcohol-related brain damaged patients ceased in 1995 and so the State Government was unable to continue to provide such a specialised treatment program. ... Since 1995, the ward has mainly been involved in treating chronic psychotic patients with severe behavioural problems. There are still, however, clients with alcohol related illness in the unit, but their psychosis is the over-riding treatment issue".

5.10 On that definition, Mr. Strangways would not have qualified anyway, since, as Glenside decided in September 1997, his alcoholism, not his psychosis, was the "over-riding treatment issue". As Ms. Gay explained:-

> "There was no question that Mr. Strangways needed care. The problem was where that care would best be provided, and in South Australia our services obviously are divided diagnostically, so who and which service would take responsibility was always an issue. We had many discussions with the Aboriginal Elder Village by way of trying to encourage them to either increase their level of security. One of the problems, of course, with Mr. Strangways, was his Aboriginality needed to be respected, and we were very cognisant of the need to find a culturally appropriate facility, one in which he felt comfortable. There are very few Aboriginal - well, there are no Aboriginal services, that

> were sufficiently equipped to deal with somebody with the range of concerns that Mr. Strangways had, so we spoke to Aboriginal elders, we spoke to Mental Health, we spoke to some head injury facilities, we spoke to ACAT, and his circumstances changed over the period of the guardianship too, as his condition deteriorated. So what we had access to and what were viable options changed, but there was nothing tailored to meet Mr. Strangways' needs. We were also aware that Mr. Strangways was one of a group of people with similar needs in the city area. We attended meetings to talk about establishing a special facility for those people who were part of the development of a submission to the Supported Accommodation Assistance Program for such a facility. We also spoke to the South Australian Health Commission; the Aboriginal Health Unit, about the needs of that group. So we were talking to services, and we were talking to other people, also in other agencies, who might have an interest in promoting the development of a service that would accommodate Mr. Strangways and people with similar needs". (T.98-99)

5.11 In my opinion, the over-riding consideration in this situation should have been the degree to which Mr. Strangways was in need of care. Distinctions about whether or not he had a psychiatric illness, whether or not his cognitive deficit was due to trauma or alcohol, whether or not he was, at a given moment in time, psychotic, are academically interesting issues, but, in human terms, they were fundamentally irrelevant to Mr. Strangways. It was artificial, bureaucratic and inhumane to deprive him of care because of some arbitrary distinction in his diagnosis. The plain fact was, as Dr. Mead pointed out, that when he was in a safe, protected situation, receiving medication, his condition improved (T.88).

5.12 <u>Was Mr. Strangways mentally ill, nor not</u>?

In the Mental Health Act, 1993, "mental illness" is defined as "any illness or disorder of the mind" (Section 3).

5.13 If a person who is detained in an approved treatment centre has an illness which fits that description, and the illness requires treatment, and detention is necessary "in the interests of his or her own health and safety or for the protection of other persons", the Guardianship Board may order that the person be detained in an approved treatment centre for a period not exceeding twelve months (Section 13).

5.14 I do not think that it could be seriously disputed that Mr. Strangways' illness fitted those criteria. It is true that his organic brain damage was not remediable, but he nonetheless required treatment in the sense that, unless he was accommodated securely and medicated appropriately, he was unable to live independently.

5.15 On that basis, I am unable to fathom how he could have been refused treatment by the Mental Health Service.

5.16 Even the psychiatrists' definition of a mental disorder is wide enough to include organic brain syndrome, or alcohol-induced psychosis. In the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), "mental disorder" is defined to include:-

> "a clinically significant behavioural or psychological syndrome or pattern that occurs in a person ... with present distress ... or disability ... or with a significantly increased risk of suffering death, pain, disability or an important loss of freedom ... Whatever the original cause, it must currently be considered a manifestation of a behavioural, psychological or biological dysfunction in the individual ...". (p.xxi-xxii)

5.17 It would appear, on the evidence of Ms. Gay who was at the hearing, that Dr. Tomasic withdrew the application for a Continuing Detention Order because of the earlier intimation from the Glenside Intake team that her referral of Mr. Strangways to Glenside had been rejected (T.107). In my opinion, it should not have been up to them. If Mr. Strangways had adequate advocacy at the hearing, it may have been possible to persuade the Board to make an order in the face of opposition from Glenside. That, after all, is their role under the Act. In my view, as a practical matter, Glenside Hospital would have had no choice but to accept him if an order pursuant to Section 13 of the Mental Health Act had been made.

5.18 Treatment for Multiple Diagnosis Patients

I have already described the deprivation of care to patients who need it on the basis of diagnosis as artificial, bureaucratic and inhumane.

5.19 This topic was also raised by the Public Advocate in his Annual Report for 1998-9. In that report he highlighted, among other things:-

- the lack of facilities and programmes for brain injured people with violent behaviour;
- the lack of assistance and advocacy for mental health consumers at hearings before the Guardianship Board;
- the quality and nature of care and management programmes for people subject to detention orders;
- the number of people with a dual diagnosis who do not receive the range of treatment options they require;
- the failure of the mental health system to satisfactorily monitor compliance with Community Treatment Orders.

5.20 This situation was also the subject of an expression of grave concern by the Honourable Justice Bleby in the Criminal Jurisdiction of the Supreme Court last year, when His Honour noted the complete lack of resources to deal with brain-injured people. His Honour said:-

> "We are just allowing a significant and potentially valuable human resource in the community, through lack of interest, lack of concern, lack of resources, systematically to destroy itself, while at the same time casting on the scrap heap of society, with no resources whatever to care for them, people who become permanently debilitated by the process". (R v Tiger, No.161/1998)

## 6. Previous consideration of these issues

6.1 The International Covenant on Civil and Political Rights ("ICCPR") was adopted by the General Assembly of the United Nations in 1966 and ratified by Australia in 1980. In "Human Rights and Mental Illness", the Report of the National Inquiry into the Human Rights of People with Mental Illness, commonly known as the "Burdekin Report", the rights recognised by the ICCPR were listed. These included:-

- the right to life (Article 6);
- the right to liberty and security of the person (Article 9);
- the right to recognition as a person before the law (Article 16);
- the right ... to have access on equal terms to public service (Article 25);
- the right to equality before the law and the right to equal protection before the law (Article 26).

6.2 The Declaration on the Rights of Disabled Persons, adopted by the United Nations in 1975, recognises that people with disabilities (defined as a "deficiency, whether congenital or not, in his or her physical or mental capacities") are entitled to, among other things:-

- the same fundamental human rights, whatever the origin, nature, and seriousness of their handicaps and disabilities, as their fellow citizens, including the right to a decent life, as normal and full as possible
(Principle 2);

- the right to any necessary treatment, rehabilitation, education, training and other services to develop their skills and capabilities to the maximum (Principle 6).

6.3 The Burdekin Report conducted an extensive review of mental health services in Australia and produced a number of disturbing findings. Relevant to my inquiry are the following comments in the Report:-

- "Government programs frequently exclude mentally ill people because of rigid demarcation and poor coordination between departments and agencies" (p.337);
- accommodation is often geared towards "middle of the road patients - people who pose no difficulty and who are to some extent model patients" (p.363);
- there are special difficulties with finding accommodation for Aboriginal patients (p.364);
- "Clearly, Australians suffering dual or multiple disabilities are among the most vulnerable and disadvantaged in our community. It is a disgrace that for some of these groups there are pathetically few appropriate services available" (p.673);
- "Mainstream community health services are neither functionally accessible nor appropriate to the social and cultural needs of the Aboriginal community" (p.711);

  *Recommendation* -

  "Mental Health Services should not attempt to care for people with serious mental illness in the community until it can be demonstrated that appropriate accommodation and sufficient numbers of suitably trained community mental health staff are available to provide adequate care and support for them" (p.917).

- People with Dual or Multiple Disabilities

  *Findings*

  Specialist services for the many thousands of Australians affected by mental illness and some other form of disability are almost non-existent;

  People with dual or multiple disabilities are, consequently, shuffled from agency to agency - often without finding anyone who will assume responsibility for their care;

  Service providers lack the specialist training and have insufficient resources to deal with dual or multiple disability. Misdiagnosis is common and treatment often inappropriate. This can have devastating consequences.

  *Recommendations*

  Disability, mental health and drug and alcohol services should assume joint or collective responsibility, as appropriate, for the assessment, treatment and rehabilitation of people with dual or multiple disabilities;

Agency workers should receive special training to deal with the particular problems confronting individuals with dual or multiple disabilities;

...

Governments should fund the establishment or expansion of facilities for individuals with dual or multiple disabilities who need intensive inpatient care and treatment;

Research into the aetiology, prevention, assessment and treatment of all areas of co-morbidity should be accorded a high priority. (p.935-6)

- Aboriginal and Torres Strait Islander People

*Findings*:-

Not enough is known about the incidence or prevalence of mental illness among Aboriginal and Torres Strait Islander people;

The removal of children from their families, the dispossession of Aboriginal and Torres Strait Islander people and their continuing social and economic disadvantage have contributed to widespread mental health problems. However, mental health services rarely deal with the underlying grief and emotional distress experienced by Aboriginal people;

Mental health professionals have little understanding of Aboriginal culture and society. This frequently results in misdiagnosis and inappropriate treatment;

Existing mainstream mental health services are inadequate and culturally inappropriate for Aboriginal people;

Aboriginal communities do not have access to the knowledge or resources to care appropriately for many of their own people;

Many Aboriginal and Islander people are denied the right to adequate mental health services because they live in isolated areas;

The removal of Aboriginal people from remote communities for treatment in town can be extremely destructive to their mental wellbeing. This is particularly so for elderly people.

*Recommendations*

Governments must provide funding and resources to enable Aboriginal community-controlled health services to develop and deliver appropriate mental health services to Aboriginal people;

Joint research projects should be undertaken by Aboriginal communities and mental health professionals to determine the nature and extent of mental illness among Aboriginal people;

Governments should ensure that mental health policy, planning and program delivery is developed in consultation with Aboriginal people;

Tertiary courses for non-Aboriginal mental health professionals (particularly psychiatrists and nurses) should include material on Aboriginal history and contemporary Aboriginal society;

Mental health professionals should acknowledge the role and significance of traditional healers in certain communities;

Priority must be given to training Aboriginal health workers and other Aboriginal community-based resource people as mental health workers;

Health departments should identify positions for Aboriginal mental health workers in areas with significant Aboriginal populations;

Aboriginal liaison officers should be employed by relevant mainstream service providers to improve communication and consultation at all levels of the mental health system;

All government and non-government mental health services should provide cross-cultural training for staff;

Mental health services for Aboriginal people should be expanded to include community development, mental health promotion and primary prevention, and crisis intervention services for individuals and families;

Mental health workers must consult with family and community members before deciding that any individual affected by mental illness requires care or treatment away from the community. Community members should be kept informed about the treatment, progress and likely return of anyone removed from their community;

Health and community services departments should, in consultation with Aboriginal representatives, develop guidelines for the care of elderly Aboriginal people in remote communities. (p.937-9)

## 6.4 Royal Commission into Aboriginal Deaths in Custody

Recommendation 247 made by the Royal Commission also addressed the issue of cultural difference in health care delivery and the need for training. It was:-

"That more and/or better quality training be provided in a range of areas taking note of the following:

a) Many non-Aboriginal health professionals at all levels are poorly informed about Aboriginal people, their cultural differences, their specific socio-economic circumstances and their history within Australian society. The managers of health care services should be aware of this and institute specific training programs to remedy this deficiency, including by pre-service and in-service training of doctors, nurses and other health professionals, especially in areas where Aboriginal people are concentrated.

f) Aboriginal people often present to mainstream health care facilities with unusual health conditions and unusual presentations of common conditions, as well as urgent, life-threatening conditions. The training of health professionals must enable them to cope successfully with these conditions.

Recommendation 250

a) That effective mechanisms be established for communicating vital information about patients, between the mainstream and Aboriginal community-based health care services. This must be done in an ethical manner, preserving the confidentiality of personal information with the informed consent of the patients involved. Such communication should be a two-way process.

Recommendation 263
That where there is a high level of non-compliance by a range of Aboriginal patients with advice tended to them by health professionals, the health professionals should examine their styles of operation, with a view to checking whether those styles can be improved.

Recommendation 264
a) That there be a substantial expansion of Aboriginal mental health services within the framework of development, on the basis of community consultation, of a new national mental health policy.

Recommendation 287
That the Commonwealth States and Territories give higher priority to the provision of alcohol and other drug prevention, intervention and treatment programs for Aboriginal people which are functionally accessible to potential clients and are staffed by suitably trained workers, particularly Aboriginal workers. These programs should operate in a manner such that they result in greater empowerment of Aboriginal people, not higher levels of dependence on external funding bodies.

Recommendation 288
That all workers both Aboriginal and non-Aboriginal, involved in providing alcohol and other drug programs to Aboriginal people, receive adequate training. Priority training needs include:

a) Relevant cross cultural awareness and communication training for non-Aboriginal workers such as welfare staff who provide services to Aboriginal people
b) Skills training for Aboriginal alcohol and other drug treatment workers, particularly those who have recovered from alcohol problems themselves but have no formal training in the area.

## 6.5 Solutions

Clearly, there are no easy solutions in the area of delivering proper health care to people who have multiple illnesses and disabilities, particularly when they have the extra disadvantage that comes from having undergone the alienation and impoverishment which many Aboriginal people have suffered. I do not suggest that Mr. Strangways should have been locked up in Glenside for the rest of his life. I do suggest that thought, and resources, should have been applied towards helping him and other people in the same situation. Despite warnings from the Royal Commission, Burdekin, and the United Nations, that still does not seem to be happening. I agree with Dr. Mead, when he said:-

"Q. We heard from Ms. Mitchell this morning, who you have made some reference to as well. She had some concerns about Mr. Strangways being put, or locked up, she termed it as locked up, because there was evidence that she had experienced herself, from her observations and dealings with him, that he could become depressed and at times suicidal, so she had concerns about that. Do you have a comment to make about that against the background of your view that he should have long-term secure accommodation.

A. I certainly think there is a risk of that happening and I guess I think that there needs to be, perhaps, a creative approach to the management of people like this, that contains a mix of secure care and perhaps fairly intensive services, perhaps individual follow up, key worker type of thing, that allows some degree of freedom, but in a supervised

> fashion. I don't think that exists at the moment. But I believe that there is a real need for some creative thinking about that". (T.89)

6.6 Clearly, to achieve Dr. Mead's aims, a skilled practitioner was required to provide a case management service to Mr. Strangways, to help him find his way through the maze of agencies operating in this area. I agree with DOSAA that "such a practitioner (apart from Karen Mitchell) was disturbingly absent (from) the service environment".

## 7. **Recommendations**

7.1 From the evidence I have heard in this inquest, precious little has been achieved in relation to the provision of services for people with multiple diagnoses, particularly where alcohol is one diagnosis, since the Royal Commission and Burdekin reports were written and those recommendations were made.

7.2 Ms. Cliff, counsel for the S.A. Health Commission and the Royal Adelaide Hospital, told me that a Committee was about to deliver a report after a review of residential care for persons with mental illnesses, although she was unable to provide me with further details. It is of interest to note that I was told, in an inquest in 1997, that a working party had been set up to address the problem of people "falling between the gaps" between mental health and drug and alcohol treatment agencies (TenHoopen, No. 10/97, p5).

7.3 I see no reason to go further than repeat the recommendations made in the Burdekin Report and the Royal Commission into Aboriginal Deaths in Custody. These recommendations have been in the public domain since 1993 and 1991 respectively, and deserve better attention than they have received to date.

7.4 Accordingly, I recommend, pursuant to Section 25(2) of the Coroners Act, that the Government of South Australia review the provision of services to the mentally ill in this State, with a view to:-

- ceasing the denial of care to patients who need it on the basis of diagnosis;
- providing services to those with multiple diagnoses;
- providing mental health services to Aboriginal people.

7.5 I recommend, for reasons expressed earlier, that the Public Advocate should keep a written record of when the detention powers granted by Section 32 of the Guardianship and Administration Act have been exercised in relation to a particular person, and relevant details thereof.

7.6 I recommend that agencies involved in the secure care of mentally ill patients review their discharge planning procedures so that the misunderstandings that occurred in this case are avoided in future.

7.7 That the Minister for Human Services overview the staffing levels at the Office of the Public Advocate to ensure that the Office is able to provide a satisfactory level of case management and care to people whose guardianship has been entrusted to him.

*Key Words: mental illness; Aboriginal people; multiple diagnoses; Public Advocate; Guardianship Board.*

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

*Seal the 13th day of March, 2000.*

……………………………..………

*Coroner*

Inq.No.4/2000