

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 13th and 14th days of March, and 16th day of June, 2000, before Wayne Cromwell Chivell, a Coroner for the said State, concerning the death of Fallon Wanganeen.

I, the said Coroner, do find that Fallon Wanganeen, aged 26 years, late of 16 Burdon Street, Elizabeth Park, died at the Lyell McEwin Hospital on the 30th day of June, 1997 as a result of neck compression due to hanging. I find that the circumstances of death were as follows:-

1. **Reason for inquest**

1.1 On 30 June 1997 Mr. Wanganeen was the subject of a Detention Order made pursuant to Section 12(5) of the Mental Health Act made by Dr. P.A. Roughan on Saturday 28 June 1997. Accordingly, he 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 Fallon Wanganeen was born with the name Gordon Wilfred Rigney on 21 December 1970. Just prior to his last admission to the North West Adelaide Mental Health Service at the Lyell McEwin Hospital (“LMH”) in June 1997, he had been living with his cousin, Julie Ann Drover, in Elizabeth Park.

2.2 Mr Wanganeen had a troubled life. The first time he seems to have come into contact with the mental health system was in 1987 at the age of 18, when he was admitted to the Lyell McEwin Hospital following an overdose of Naprosyn (anti-inflammatory

drug). He does not appear to have received any formal psychiatric treatment at that stage.

- 2.3 On 29 June 1995 Mr. Wanganeen was admitted to Glenside Hospital, on transfer from the Royal Adelaide Hospital, where he had been admitted after attempting to suicide by gassing himself. He was initially detained to Brentwood House, and then became a voluntary patient, and remained at Cleland House until his discharge to a hostel (Exhibit C.5a, p2). There was no follow-up action following discharge.
- 2.4 On 11 January 1997 Mr. Wanganeen was admitted to the Port Augusta Hospital following an attempt to hang himself. He “voiced strong suicidal tendencies” (Exhibit C.5a, p2). He was transferred to Glenside Hospital on 12 January 1997 and was admitted to a closed ward on arrival.
- 2.5 During the first several days of the admission to Glenside Mr. Wanganeen exhibited highly disturbed behaviour. Clinical Nurse Fiona Bell said:-

“On the first two to three days Wanganeen stabbed himself with a biro, banged his head, feet and hands on walls, chewed up pieces of paper and tied a shirt around his neck wanting to hang himself. ... He was put into seclusion on 13 and 14 January. ... After seclusion Wanganeen was transferred to the Grove annex. Observations were not so intense at this unit. In the next few days Wanganeen constantly threatened suicide, climbed on to the roof of the unit a couple of times, and as a result was transferred back to Brentwood House on 20 January.

At Brentwood he burnt himself with a cigarette, again voiced suicidal tendencies, wouldn't take medication, stated he wanted to be a woman, and tried to hang himself with a pyjama top. When put into seclusion he would place mattresses in front of the window so that observations could not be made on him. ... He threatened not to eat. On 24 January he picked up a chair and threatened staff with it. When confronted he threatened to break a window. Other staff were called and he was placed in seclusion. Injections had a minimal effect on him. He removed his canvas gown and tied it around his neck tightening same. ... He then tried to tear his canvas blanket with his teeth and that was taken from him. ...”. (Exhibit C.5a, p2-3)

- 2.6 Mr. Wanganeen's behaviour gradually improved and he was discharged on 28 January 1997, planning to go to his mother's house.

- 2.7 Dr. Craig Raeside, consultant forensic psychiatrist, provided a report to me giving an overview of Mr. Wanganeen's psychiatric treatment. In his report dated 23 September 1999, he commented:-

“Interestingly staff during that admission thought that most of Mr. Wanganeen's suicide behaviour was not suicidal in intent, but rather was associated with his anger. A note at the time of his discharge indicated that much of his self-harm behaviour was thought to be triggered by his perceptions of rejection, particularly involving his family, homosexuality, and Aboriginal status”. (Exhibit C.22, p2).

- 2.8 As in previous admissions, there was no follow-up following discharge from hospital.

3. **Final admission to Lyell McEwin Hospital**

- 3.1 On 25 June 1997 Mr. Wanganeen was found collapsed in a park near Butterfield Road, Elizabeth Park by Ms. Margaret Coory, who worked nearby. Ms. Coory returned to work and called the police (see Exhibit C.6a).

- 3.2 Police called the SA Ambulance Service, who transferred Mr. Wanganeen to LMH. Mr. Wanganeen told the ambulance officers that he had taken ten Panadeine Forte tablets and that he wished to “go to sleep and not wake up” (Exhibit C.7a, p1). They administered Naloxone (Narcan), which reversed the effect of the codeine. They also administered 100 percent oxygen. As a result of this treatment, Mr. Wanganeen's conscious state improved considerably and he was able to converse quite satisfactorily. According to Ambulance Officer A.R. McRostie:-

“It was during transit that the patient expressed that he was depressed due to a situation crisis due to personal problems and indicated suicidal tendencies”.
(Exhibit C.7a, p2)

- 3.3 At the Lyell McEwin Hospital Mr. Wanganeen was seen by Dr. S.A. Goodyear, Emergency Registrar. Dr. Goodyear admitted him to hospital, initially to Ward 1F, until the medication had ceased its effect with the intention of him being transferred to Ward 1G. As he was agreeable to admission, he was not detained pursuant to the Mental Health Act (see Exhibit C.8a).

- 3.4 On 26 June 1997 Mr. Wanganeen was seen by Dr. R.P. Nagesh, consultant psychiatrist. He appeared quite depressed and uncommunicative. He told Dr. Nagesh that he was a drug user, using cannabis and amphetamines, and that he supported his habit with male prostitution. Dr. Nagesh said:-

“He was quite fed up with his situation and didn’t feel much hope for himself”.
(Exhibit C.9a, p2)

He told Dr. Nagesh that he had no immediate plans to harm himself at the hospital.

3.5 At about 2.00p.m. that day Mr. Wanganeen was transferred to Ward 1G, and he was seen by Ms. M.P. Aberle, a Registered Mental Health Nurse. Ms. Aberle’s assessment was similar to that of Dr. Nagesh (Exhibit C.10a, p2).

3.6 On Friday 27 June 1997 Mr. Wanganeen became agitated for some reason. He was given Diazepam by Ms. Aberle in the morning. In the afternoon he telephoned Ms. Drover, his cousin, and told her that he had taken drugs. She said:-

“I told him to stop being silly and to stop taking drugs. He seemed upset because I growled at him for taking drugs”. (see Exhibit C.1b, p2)

Ms. Aberle confirmed that he was upset. She noticed that he was crying (Exhibit C10a, p3).

3.7 Later in the afternoon Ms. Vicki Rigney, the Aboriginal Liaison Officer, collected some personal effects for Mr. Wanganeen. When she returned to the hospital, she said that he was “very upset”. She said:-

“He told me he would never jeopardise Julie’s kids. He said Julie wouldn’t believe him. He said he wasn’t going back to Julie’s. He was crying and very upset. He didn’t know where he was going to when he left the hospital. He told me he had told his Mum he didn’t want to live any more”.
(Exhibit C.15a, p2).

It would appear that Mr. Wanganeen interpreted his cousin’s displeasure over his drug-taking as an indication that she did not want him back in her house as he may put her children at risk.

3.8 At about 5.00p.m. that afternoon, Ms. Aberle noticed Mr. Wanganeen looking agitated again and gave him more Diazepam (Exhibit C.10a, p3).

3.9 At about 7.30p.m. Mr. Wanganeen went to leave the ward. One of the staff followed him and, after discussion, he came back without a fuss.

3.10 Dr. S.M. Malone, a resident medical officer, spoke to Mr. Wanganeen on 27 June 1997 as well. She said that he told her that he attempted suicide to hurt his family because they had not accepted him as a homosexual. He told her about being sexually

abused by a fat man as a child of six. He told her of his father being murdered some years ago. He said that he was using amphetamines and marijuana, and that he wanted to stop taking drugs. He told her that his suicidal tendencies had developed after he had told his family he was homosexual eight years previously (Exhibit C.11a).

- 3.11 During the evening of 27 June 1997, Registered Psychiatric Nurse J. Tuckfield said that he noticed a change in Mr. Wanganeen's mood. He had become tearful, sullen and isolative. He was reluctant to go to his room at 11.30p.m. when the lights were put out, and eventually sat on the floor refusing to go. He was carried to his room. He then barricaded himself inside by placing two beds end to end and putting two plastic chairs in the gap. The door was forced open and the duty doctor was called. He was highly agitated and struggled with the staff on the way to the seclusion room. He was speaking of the Wanjina and Kadija, which Mr. Tuckfield, correctly I think, described as "mystical Aboriginal spiritual figures".
- 3.12 Dr. Hashim was called, and she made an order detaining Mr. Wanganeen pursuant to the Mental Health Act at about 1.05a.m. on Saturday 28 June 1997.
- 3.13 At 3.15a.m., the door to the seclusion room was unlocked, but locked again at 6.00a.m. before Mr. Wanganeen woke.

4. **Altercation between Wanganeen and Baker**

- 4.1 When the day shift commenced duty at 7.00a.m. on Saturday 28 June 1997 there was a hand-over from the previous shift at which information about the events leading to Mr. Wanganeen being placed in seclusion were explained. Registered Mental Health Nurse Timothy Reynolds went to see him. Mr. Reynolds was alone, although he said that he was carrying a portable alarm. In his first statement to police (Exhibit C.19, p2), he said that the seclusion door was already open, although he acknowledged in evidence that this was not so (T.11). At Mr. Reynolds' invitation, he left the seclusion room and went into the "secure day area room" to eat his breakfast.
- 4.2 Mr. Reynolds said that as he was leaving, Clinical Nurse James Baker pushed past him into the closed area in an angry state. He said:-

"Mr. J. Baker said to Mr. Wanganeen 'You're a fucking asshole and you will behave in my ward otherwise you'll be back in the slot' (seclusion). He was pointing his finger

menacing at the client and persistently swearing at him loudly. This continued for perhaps a minute. Mr. Baker then stormed out of the closed area. I don't believe the client did anything to provoke this. I discussed with Mr. Baker in the back nursing office that the client did not require this form of firm limit setting as firm limits had already been set by the night staff. I informed Mr. Baker that I had already spoken to the client and he'd given his assurance he would be cooperative. Mr. Baker and myself then agreed, through consultation to keep Mr. Wanganeen in the closed/locked area for that morning". (Exhibit C.19c)

- 4.3 Mr. Baker's version of these events is considerably different. He said that he was "frustrated" about Mr. Reynolds' failure to comply with Occupational Health and Safety protocols in relation to entering the seclusion room alone, and releasing Mr. Wanganeen without telling him first, since he wished to be present in order to assess him. He said that he spoke to Mr. Reynolds and that they "disagreed about Fallon coming out of the secure area at that time". He said that as they were talking, Mr. Wanganeen tried to walk past them into the general area. He said that their conversation was as follows:-

"I said, Where do you think you are going?
 He said, To get a coffee.
 I said, No you're not, you're going to stay in the closed area, one we will be brought for you.
 He said, You can't fucking do this.
 I said, Well I can, you're a detained (patient) under the Mental Health Act.
 He said, It's cause I'm fucking black you are doing this.
 I said, No, it's a consequence of your fucking behaviour last night. When you prove you can fucking behave yourself and prove yourself you can come out here".
 (Exhibit C.20, p2-3).

- 4.4 There is a third version of this conversation, although it is hearsay. The Aboriginal Liaison Officer, Vicki Rigney, said that at about 6.10p.m. that evening she received a telephone call from Mr. Wanganeen complaining that they "locked him in the room because he started to run amok over coffee". She said that he expressed some anger about what "Jim the head nurse" had said to him. He told her that Jim had said:-

"If you want to act like a cunt we'll treat you like one". (Exhibit C.15a, p2).

- 4.5 Mr. Reynolds said that Mr. Wanganeen was "markedly distressed" after the incident with Mr. Baker (Exhibit C.19c, p1). At about 1.00p.m. Mr. Reynolds received a telephone call from the switchboard advising that Wanganeen was at the front desk

wanting to make a complaint, and asking for the Glenside telephone number. She said that he was “polite and courteous”.

4.6 This altercation received a considerable degree of attention at the inquest. The incident resulted in an internal inquiry which found Mr. Baker had acted in an unprofessional manner. He eventually resigned from the North West Adelaide Mental Health Service. He said that he did not have the resources to fight what he obviously regarded as a constructive dismissal (T.73).

4.7 I doubt that it is possible to resolve the factual dispute between the parties as to precisely what was said to Mr. Wanganeen that morning. Clearly, there is a history of antagonism between Mr. Reynolds and Mr. Baker. Mr. Reynolds seems to have been a person who takes, in Mr. Baker’s words, a more *laissez-faire* approach to patient management, whereas Mr. Baker seems to have been more of a disciplinarian. Clearly, Mr. Baker had become frustrated and angry at Mr. Reynolds’ disagreement with his methods, and this occurred in the context that they had both been competitors for Mr. Baker’s job in 1995.

4.8 Having regard to the demeanour of the witnesses when they gave evidence, and since it is only necessary to resolve this issue of fact on the balance of probabilities, I am satisfied that Mr Baker was abusive and aggressive towards Mr Wanganeen. In those circumstances, I think it is unnecessary to resolve precisely what words were used. Offensive language was used which, whether the patient had used similar language or not, is unprofessional. What is even more unprofessional, in my view, is that Mr Wanganeen became caught in the “cross-fire” (a term Mr Baker acknowledged in cross-examination at T79), to the extent that he became distressed and preoccupied by the incident throughout that day and the next day. I will deal with this issue again later.

5. **Further events of 28 June 1997**

5.1 At about 8.30a.m. on Saturday 28 June 1997 Mr. Reynolds found a rope which had been fashioned from a patient gown in the seclusion area where Mr. Wanganeen had been. He said that he asked Mr. Wanganeen about this, and was told that he would have hung himself if he could have found somewhere to do it. He mentioned this in his first statement to the police (Exhibit C.19, p3), although interestingly he did not mention it in his letter to Ms. Wieland, the Regional Director of North West Adelaide Mental Health Service, dated 3 July 1997, when he made allegations which eventually

led to Baker's resignation. He did not record the incident in the casenotes (T.43), a serious omission I will discuss again later.

- 5.2 Mr. Wanganeen was seen by Dr. Penelope Roughan, Senior Psychiatrist at LMH, at about 10.00a.m. that morning. Dr. Roughan said in her statement:-

“I found Fallon Wanganeen to be an extremely angry man. He was in the closed observation area of the ward. He frankly admitted to rage with people, mainly family members, who he described as having betrayed him. He said he would like to kill himself at times in order to punish them”. (see Exhibit C.18a, p2).

Dr. Roughan did not find symptoms of psychosis, nor evidence of major depressive illness. She diagnosed “depressed mood, relating to family pressures, social circumstances, substance abuse” (Exhibit C.18a, p2). She made an order for detention pursuant to the Mental Health Act for a further three days.

- 5.3 By agreement with Mr. Reynolds and Mr. Baker, Mr. Wanganeen was released from the closed ward at 11.00a.m. Both men agreed that his behaviour had been acceptable until that time. However, Mr. Wanganeen was clearly still agitated about the altercation with Mr. Baker, since he approached Mr. Reynolds several times “seeking reassurance”. As I have already mentioned, at 1.00p.m. he was found at the switchboard wanting to make a complaint to Glenside about Mr. Baker's behaviour. According to the casenotes, on his return he was threatening litigation and wanting to call the Aboriginal Liaison Officer about the incident.

- 5.4 At 7.00pm that evening, Mr Reynolds noted that Mr Wanganeen was still ‘anxious but he seemed settled’ when he went off duty at 7.42pm. (Exhibit C19, p4). Mr Tuckfield, who was on night duty, still considered him at risk. He described him as ‘reasonably settled but tearful’. He said they ‘kept a close look-out’ all night, and that:

“we normally do checks one to two hourly but with Wanganeen we checked every hour and if we heard any noises we would check him”. (Exhibit C.12a, p5).

6. **Events of 29 June 1997**

- 6.1 Mr. Wanganeen was noted to be cooperative and compliant throughout the day, although he received Diazepam at 8.00a.m. and 3.00p.m. for “agitation”. The nurses recorded in the casenotes (Exhibit C.19d) that he continued to have “fleeting suicidal ideas”. At 6.00p.m. he approached Mr. Reynolds, saying he wanted to be discharged but declined to discuss the matter further. Mr. Reynolds gave him Clonazepam (a major tranquilliser) as he appeared “agitated and angry” (Exhibit C.19, p4).
- 6.2 At about 7.30p.m. Mr. Wanganeen approached Mr. Reynolds and gave him his bag containing his jeans “so that I can’t hurt myself”. Mr. Reynolds gave the bag to Messrs Lloyd and Alcorn at the hand-over to the night duty staff. He did not record this incident in the casenotes. In my opinion, he should have done so, as it was a significant indication that Mr. Wanganeen still considered himself at risk. In his statement (Exhibit C.13a, p2) Mr. Lloyd said, in relation to the hand-over:-

“I was also made aware that Tim, a day nurse, had received a telephone call from a friend of Fallon’s. This friend stated to Tim that Fallon was going to tear up his jeans and commit suicide. Tim informed the caller that he already knew of Fallon’s intention”.

Mr. Reynolds denied that he had received such a telephone call. It may be that there was some communication misunderstanding during the hand-over. This would have been avoided if Mr. Reynolds had made an entry in the casenotes.

- 6.3 For the remainder of that evening, Mr. Wanganeen related in a reasonably normal way to the staff. Registered Mental Health Nurse Brian Alcorn observed him several times during the evening. He said:-

“At that time he seemed pretty settled. During the evening he mixed with other patients and was listening to music and playing the piano. I saw him get a coffee just prior to us putting the tea and coffee away at about 10.30p.m. At about 10.30-11.00p.m. Fallon was in the courtyard having a cigarette. I went to speak to him. I asked him how he was and (he) mentioned he was feeling restless. He said he had medication earlier in the day and didn’t want any more”. (Exhibit C.14a, p3).

Enrolled Mental Health Nurse Amanda Retallack (formerly Newey) also saw Mr. Wanganeen several times during the evening and she “found him to be quite approachable” (Exhibit C.21a, p2). She said:-

“Once I recall at the piano, when he smiled and spoke freely and again at 11.15p.m. when I suggested and offered him a warm milk and honey drink, just to help him settle and sleep, as he had had a bad night the night before. He didn’t want to bother but was quite happy with the attention. He did have the drink in the end”. (Exhibit C21a, p2-3)

- 6.4 Ms. Retallack said that Mr. Wanganeen was prepared to discuss the future, which is usually a good sign that a patient is not planning suicide. She said that they discussed his future plans, buying a house, furthering his education and coming off drugs. He discussed “making mistakes in the past”, and assured her that he would approach staff if he felt himself to be at risk.

7. Events of 30 June 1997

- 7.1 At about 12.05a.m. Mr. Alcorn noticed that Mr. Wanganeen’s door was open. He was sitting up in bed still awake. Mr. Alcorn gave him 20mg of Temazepam and .5mg of Clonazepam. Both drugs are sedatives.

- 7.2 About five minutes later Mr. Wanganeen came to the nurses station asking if it was alright to go outside for a cigarette. This request was denied, as it may have reduced the effectiveness of the medication. He seemed to accept this and returned to his room. At about 12.30a.m. Ms. Retallack went into his room. She said that he was in bed but still fully clothed. She convinced him to get undressed and get into bed. As she left the room, he followed her out and put a packet of cigarettes in the rubbish bin, saying:-

“If I’m giving up drugs I might as well give up the smokes”. (Exhibit C.21a, p4).

Ms. Retallack said in evidence that she looked at the clock when this occurred, and it was about 12.30a.m. Again, this behaviour indicated that he was looking to the future, and contra-indicated suicide.

- 7.3 At about 12.45a.m. Mr. Lloyd said that Mr. Wanganeen complained that the lights at the nurses station were keeping him awake. The lights were turned off and the three nurses moved to the reception area, about ten metres away, to help him sleep (see Exhibit C.13a, p3). This is the last occasion on which he was seen alive.

8. Discovery of death

- 8.1 Ms. Retallack commenced an observation round at about 1.50a.m. She went to Mr. Wanganeen’s room first because he had been restless earlier. Upon entering the room

she saw him in a sitting position in the wardrobe, with his legs jutting straight out and with a sheet attached to his neck and tied to the hanging rail in the wardrobe. She called for help, and Messrs Lloyd and Alcorn came immediately. They undid the ligature and placed him on the floor. They commenced cardio-pulmonary resuscitation and Ms. Retallack sounded the blue alert. Within five minutes or so Doctors Barron and Jones and other staff arrived on the scene and commenced extensive efforts at resuscitation. Unfortunately, these efforts were unsuccessful and Dr. Jones pronounced Mr. Wanganeen deceased at 2.10a.m.

9. **Diagnosis and treatment at LMH**

9.1 Diagnosis

When Dr. Roughan detained Mr. Wanganeen, she diagnosed “depressed mood”, although there were no signs of major depressive illness, nor evidence of psychosis (C.18a, p2). Glenside Hospital had diagnosed “adjustment disorder with depression and anxiety” (T.111).

9.2 Dr. Raeside said that, in his opinion, Mr. Wanganeen had a “borderline personality disorder” characterised by chronic depression alternating with rage, disturbance of self-image, identity and judgment, and difficulty establishing relationships with others (C.22, p6). He disagreed with Glenside on the basis that Mr. Wanganeen’s disorder was long-standing, whereas the other condition tends to come and go (T.112).

9.3 When asked how a borderline personality disorder is treated, Dr. Raeside said:-

“The treatment of any personality disorder is difficult and treatment as far as a cure, if you like, of getting rid of a condition, is usually not successful. There’s no evidence of any particular medication or treatment that will actually eradicate that condition. ... Treatment usually consists of helping the person to become more functional, adapt to their circumstances better, respond to stress in a more productive and adaptive way so that the treatment usually focuses on decreasing the stress, whether it be through medication or counselling or changing their social circumstances, or providing them with various coping strategies to deal better with their life, and that may lead to less depression and less anxiety as well”. (T.112).

At T.134 he added:-

“Borderline personality disorder has almost become a sort of pejorative term in mental health, that if someone is diagnosed as having that condition then they almost automatically are placed in a difficult patient basket which may be justified in some cases but not always. Usually I think the appropriate clinical judgment is look beyond the personality disorder and look what the issues are at the time and determine whether

hospitalisation is appropriate for those issues and not for the borderline personality disorder”.

9.4 Management plan

Dr. Raeside had some criticisms of the treatment Mr. Wanganeen received at LMH. Soon after he was first admitted from Ward 1F on 26 July 1997, R.N. Aberle made a detailed note in the Medical Record (C.19d). She took an extensive history (indeed, there are a number of commendably detailed notes in the record), a mental state assessment, drew up a “Problem List/Risk Assessment”, a “Management Plan” and “Medication” list.

9.5 There is something of an inconsistency in the Management Plan, in that R.N. Aberle directed that staff should “check whereabouts regularly (at least ½ hourly)”, and then wrote “Nurse as Category ‘R’ initially”. A Category “R” patient need only be observed every two hours.

9.6 Dr. Raeside said that this was an appropriate management plan, at least for the first few days of admission. However, he offered the “minor criticism” that a more comprehensive management plan was not then developed. He said:-

“So what I think the management plan should, in my opinion, contain would be at least an introductory type of statement of what the aim of management is. Sort of, if you like, philosophical statement of what we’re trying to do with this person. Then there should be some short time, depending on the type of person but in this particular case, there would (be) some short term type of goals relating to different issues. The usual nursing practice is to have a problem list and identify the problems and then have some sort of management bridge of those problems. That can work in certain circumstances but it has its shortcomings in that it doesn’t really distinguish between immediate short term and long term problems. For example, Mr. Wanganeen had a number of problems that weren’t going to be changed in any way by a three or four day admission and so it would be important to identify what were the issues that needed to be addressed. For example, one of the first ones might be his safety or the safety of others and then under each of those goals, would be some statement of how that was to be achieved or what would be done if particular things didn’t occur. For example, if he was better known to the staff it might have included something like such as at what point should he be discharged if he was non-compliant. For example, if he refused to take medication, would that warrant him be discharged from hospital or would it warrant him being placed in a closed ward. Those are areas that should be discussed amongst staff members”. (T.190-1).

9.7 Observations/Record Keeping

As I have said, Category “R” patients require observation at least every two hours. The evidence is that Mr. Wanganeen had been sighted by R.N. Lloyd 65 minutes before his body was discovered, and there had been a conversation with R.N. Aberle fifteen minutes before that. This is within the maximum period, so the regime was complied with. Dr. Raeside said that Category “R” was an appropriate rating (T.119). I do not see that there were grounds to require observations every fifteen minutes, as Mr. Podobnik, counsel for the family of the deceased, submitted there should have been (Written Submission, p21). I do not accept that Mr. Wanganeen was overtly suicidal that night.

9.8 However, if there was a regular observation regime in Ward 1G, the notes do not record this. Dr. Raeside observed that:-

“... there was no indication in the documents that he received any closer observation than other patients whilst in the open ward”. (C.22, p6).

9.9 A major omission from the casenotes was R.N. Reynolds’ failure to note finding the “rope” in the seclusion room on 28 June, and Wanganeen’s comments that he would have used it. This was a significant event which should, in Dr. Raeside’s opinion, have led to a psychiatric review before he was released from seclusion (T.125). He thought that such an event would have justified keeping him in seclusion for another couple of days, with daily reviews (T.126). Reynolds also failed to note the fact that Wanganeen gave him his jeans on 29 June, “so that I can’t hurt myself”. This was another important omission.

9.10 The altercation with Baker

I have already described Baker's behaviour during this incident as unprofessional. The incident clearly agitated Wanganeen to a considerable extent, although his behaviour later that afternoon and during the night gave the indication that he had settled down somewhat.

9.11 Dr. Raeside conceded that the incident was not a "major precipitating event" (T.131), but despite searching and able cross-examination by Mr. Humphries, counsel for Baker, he refused to dismiss it as being of no relevance. He said:-

"I think I also stick my neck out and say that from what I read that it was likely that he was going to successfully suicide at some point anyway, given that history. But I don't think you can discount it as of being no relevance. I think it has to be seen as part of what occurred during those few days". (T.140).

Mr. Humphries submitted that I should not make a finding which involved his client in Wanganeen's death. I do not think that Dr. Raeside's evidence enables me to go that far. It was a relevant event in the overall scheme of things.

9.12 Another factor is that the altercation may have affected the decision to prematurely release Wanganeen from seclusion at 11.00a.m. By the afternoon, he was allowed to go to the kiosk and front desk unescorted. Dr. Raeside thought that this seemed to be an over-compensation, that his treatment went from one extreme to the other (T.142). This is a significant issue. The behaviour of staff should not be allowed to intrude upon the patient's treatment in that way.

9.13 Communication with Wanganeen's family

In his Written Submission, Mr. Podobnik argued that:-

- “• notification of relatives did not occur;
- no family members or support services, other than the Aboriginal Hospital Liaison Officer, were asked to visit”.

Mr. Bonig, counsel for North West Adelaide Mental Health Service, replied that:-

“3.1 Wanganeen's past history suggests that it was as a direct result of either actual or perceived conflicts with his relatives that he attempted to take his own life or sought treatment. Therefore contact with family members needed to be considered within the ambit of Wanganeen's requests.

- 3.2 Wanganeen did have contact with his relatives namely:
- 3.2.1 Wanganeen spoke to his cousin (Ms Drover) on 26 June 1997 when she visited him, and on 27 June 1997 when she spoke to him by telephone,
 - 3.2.2 on 27 June 1997 he was visited by his mother.
- 3.3 On 27 June 1997 he stated at 1530 hours that he did not want anyone but ‘cousin he lives with to be aware of admission’.
- 3.4 Later on 27 June 1997 he advised Ms Rigney that he did not want to ‘talk to Julie if she rings up’.
- 3.5 Wanganeen was provided with a weekend contact number which he used to contact Ms Rigney if he required”.

Mr. Bonig’s replies effectively answer Mr. Podobnik’s criticisms, which do not require further discussion.

9.14 Staff training and sensitivity to Aboriginal issues

Mr. Podobnik also submitted that there was an “apparent lack of staff training and insensitivity to the specific needs of Aboriginal patients”. I do not consider that the evidence demonstrates this. Indeed, R.N. Tuckfield displayed a good degree of cultural sensitivity when speaking to Wanganeen about cultural issues. None of the staff was cross-examined on this topic, and I see no evidence before me (with the obvious exception of Mr. Baker, who has since resigned) of lack of training or insensitive behaviour.

9.15 Furniture

Finally, I was told that the wardrobe rails have now been replaced with plastic hooks which will not bear a heavy weight so they cannot be used as hanging points. This sensible suggestion was made by the investigating officer, Constable Curtis (C.16a, p2). I would commend this measure to all psychiatric institutions.

10. **Finding**

I find that Fallon Wanganeen, aged 26 years, late of 16 Burdon Street, Elizabeth Park, died at the Lyell McEwin Hospital on 30 June 1997 as a result of neck compression due to hanging.

11. **Recommendation**

Pursuant to Section 25(2) of the Coroners Act I recommend that management at the Lyell McEwin Hospital reinforce with both medical and nursing staff in Ward 1G the necessity for a clearly structured management plan for patients, and the need for proper note-keeping of relevant events.

Key Words: death in custody; psychiatric institution; hanging

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

Seal the 16th day of June, 2000.

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Coroner