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 24th day of August and the 9th day of November 2001, before Wayne Cromwell Chivell, a Coroner for the said State, concerning the death of Norman Samual Dean Ball.

I, the said Coroner, find that, Norman Samual Dean Ball aged 35 years, late of 37 Hamley Crescent, Mansfield Park, South Australia, died at Mansfield Park on the 31st day of December 1999 as a result of neck compression from hanging. I find that the circumstances of the death were as follows:

1. Introduction

1.1. Norman Samual Dean Ball was an unemployed cabinetmaker. He lived alone at Mansfield Park.

1.2. At about 2:00am on Friday, 31 December 1999 a neighbour found Mr Ball hanging in the kitchen of his house. The neighbour, Mr McIntosh, called an ambulance, then smashed the kitchen window (exhibit C4a, p2).

1.3. The ambulance arrived at 2:12am and the paramedic, Phillip Knight, entered the house through the broken window. Mr Ball's body was cold to touch and it was clear that he was dead. Mr Knight certified this fact at 2:12am (exhibit C1a, p2).

1.4. Mr Knight found a note with 'fuck them all' written on it.

1.5. Police attended the house at about 2:15am and located another note which read:

> 'I was always there for people. Where is my help?'

The note went on to bequeath Mr Ball's meagre personal effects to his children.

1.6. The police found nothing suspicious about the circumstances of Mr Ball's death, and with the background evidence from his neighbour and wife, concluded that he had died by his own hand (exhibit C5a, p4).

1.7. Cause of death

A post-mortem examination of the body of the deceased was performed by Professor R W Byard, Forensic Pathologist, on 31 December 1999. Professor Byard concluded that the cause of death was neck compression from hanging. I accept his conclusions, and find that the cause of Mr Ball's death was as he has stated.

1.8. Dr Byard commented:

> 'Death is attributed to neck compression from hanging. There was no evidence of recent acute cerebral or other significant trauma. No underlying organic diseases which could have caused death were present.'
> (Exhibit C2a, p1)

1.9. Old brain injuries

Dr Byard also noted a healed curved craniotomy incision over the right temporo-parietal region of the head. He also noted a healed tracheostomy wound to the anterior neck. An examination of the brain revealed the presence of marked adhesions in the right middle and posterior cranial fossae, and haemosiderin staining (indicating that there had been haemorrhage in the area previously) but no focal lesions were identified (exhibit C2a, p4).

1.10. Toxicological analysis revealed that Mr Ball's blood contained:

(1) 7.2mg carbamazepine per litre. (non-toxic/therapeutic)
(2) 36mg paracetamol per litre. (high therapeutic)
(3) 1.1mg citalopram per litre. (toxic)
(4) 0.043% alcohol.
(Exhibit C3a)

2. Background

2.1. The neighbour, Mr John McIntosh, gave the following background information to the police:

> 'About a year or so ago 'Deano' was assaulted by someone and smacked over the head. Approximately 3 weeks ago the case against the guy who had beaten him up was lost in court. 'Deano' was hoping for compensation for his injuries from the court case and I

think he thought he wasn't going to get any. In the last 3 weeks 'Deano' has been very angry and depressed. 'Deano' wanted revenge against the guy who had assaulted him. 'Deano' came over at about 10:00 p.m. Wednesday, 29th December, 1999. He had a knife with a red handle, I think it was a pocket knife. The knife wasn't open, but he had it in his right hand and he was saying he wanted blood. He was also upset about someone taking his wallet. 'Deano' was always broke and never had any money as he didn't work. 'Deano' was in my loungeroom and he was very aggressive and I wanted him to leave. That was the last time I saw 'Deano' alive which was about 10:10 p.m. Wednesday, 29th December, 1999. I'm not really surprised he has hung himself. About a week and a half ago he tried to slash his arm and was admitted to the QEH Psychiatric wing. I visited 'Deano' a few times at the QEH and he said to me he didn't want to stay at the hospital. 'Deano' smoked dope, but I don't think he used any other drugs. I think he was on heaps of medication though.'

(Exhibit C4a, p3-4)

2.2. In a very thorough and informative Rehabilitation Summary prepared by Ms M Tuck and Dr M Jelbart at Julia Farr Services following Mr Ball's rehabilitation program from January to June 1999, a clear picture emerges:

'**Medical Rehabilitation Summary**

Dean is a 36 year old man who sustained severe multiple head and facial injuries after being assaulted with a wrench on the 4th February 1998. As a result he had significant cranio facial injuries including right subdural haematoma in the right fronto parietal region, depressed skull fracture extending through the zygoma and base of temporal bone, right temporal lobe contusion and extensive facial and base of skull fractures involving right external auditory canal and middle ear cavity. He required emergency right temporo parietal craniotomy to evacuate the haemorrhage and post operative progress was complicated by pseudo-diabetes insipidus. He also sustained an undisplaced C1 vertebral fracture and left sided pneumothorax. He was initially treated in Royal Adelaide Hospital and transferred for inpatient rehabilitation to Julia Farr Services from 25 February 1998 to 26 March 1998. He was referred for community rehabilitation at the Payneham centre from 05 January 1999 until 18 June 1999 for multidisciplinary treatment. Whilst he had made a reasonably good recovery in terms of physical control, balance and physical independence, he continues to experience difficulty in relation to memory, organisation of his time and managing strategies to assist his cognitive impairment. His progress in rehabilitation is summarised below.

Ongoing medical issues include:

- Persistent difficulty with sleeping related to perceived mental overactivity at night as a result of which he tends to sleep in thus perpetuating the disordered sleep/wake cycle. He has been advised to reduce his intake of caffeine, to increase his physical aerobic activities and to explore simple relaxation and music. He may require use of a short acting hypnotic agent such as Temazapam.

- Previous over use of alcohol and marijuana in association with a long term nicotine habit. Dean has seen Dr Jason White of DARU at Royal Adelaide Hospital and has

recently decided to quit alcohol consumption. He will require support and encouragement during this time and indeed it is possible that the withdrawal of alcohol may be aggravating his sleep difficulties.

- Dean describes persistent problems with the middle finger of his left hand wherein for no apparent reason the finger flexes towards the palm in the absence of pain or a trigger like phenomenon. He does have a previous injury to the extensor tendon of this finger but denied any previous problems. He also has some stiffness and tightness in the left index finger on full flexion which has not yet responded to use of topical anti-inflammatory medication. Oral anti-inflammatory medication may be helpful and an appointment for review at the Hand clinic of Royal Adelaide Hospital has been made for early August 1999.

- A repeat barium video fluoroscopy was arranged at Royal Adelaide Hospital in view of his complaints of episodic difficulty in swallowing, the results of this test were essentially normal.

- Dean has not regained a medical clearance for driving on account of recent seizure activity six weeks prior to discharge as a result of which a further EEG and CT scan with serum Tegretol levels have been arranged by his family practitioner. I do not yet have these results. Once he is considered fit to undertake the driving screening, off road perceptual testing and on-road practical testing can be arranged through the Community Rehabilitation Program, Payneham via contact with the Occupational Therapist.

- Dean was commenced on Cipramil 20mg daily at the recommendation of Professor Schioldann, Neuropsychiatrist on account of significant emotional lability and suicidal thinking during his program and it is recommended that he continue with this medication for some months. Further review by Professor Schioldann may be arranged if required by contacting Julia Farr Services.'

(Exhibit C9, p1-2)

2.3. Dr Simon Cameron had been Mr Ball's General Practitioner since 1995. He reported that Mr Ball suffered depression at that time, which he thought had been long standing (exhibit C8a, p1). By 1997 he was showing signs of nervousness, panic disorders, reclusiveness and abuse of alcohol and marijuana. These conditions remained reasonably manageable until Mr Ball was assaulted, following which he lost his job, his marriage failed and he became severely depressed (exhibit C8a, p3). He also developed epilepsy.

2.4. Dr Cameron last saw Mr Ball on 13 December 1999. He received no advice or contact from The Queen Elizabeth Hospital (TQEH) or from any other of Mr Ball's health workers after that time (exhibit C8a, p6).

3. Treatment at Crammond Clinic

3.1. Mr Ball presented at TQEH on 18 December 1999. He was agitated and had cut his inner forearm with a kitchen knife. He was assessed as being depressed, with a high risk of suicide.

3.2. Mr Ball absconded and the Acute Crisis Intervention Service (ACIS) and the police were called. He was found by the police and returned to TQEH where he was detained pursuant to the Mental Health Act 1993. He was admitted to Crammond Clinic, the inpatient psychiatric ward.

3.3. Mr Ball's detention was reviewed by Dr Rafalowicz, a consultant psychiatrist, on 19 December 1999. According to the casenotes, Exhibit C10, Mr Ball told Dr Rafalowicz that he had been angry at the fact that on 6 December 1999 the person who was responsible for his injuries had been acquitted. He had punched a hole in the door, and had then cut his arm.

3.4. Mr Ball told Dr Rafalowicz that his suicidal ideas had been consistent since the court case.

3.5. Dr Rafalowicz's assessment was that Mr Ball was suffering from depression, and was suicidal. He determined that Mr Ball's detention should be confirmed for three days, that his mental state and diagnosis should be reviewed (he suspected a major depression), that he needed more aggressive treatment for his depression, and assistance with strategies for anger management. He prescribed Olanzapine and Cipramil.

3.6. Mr Ball continued to be distressed and tearful throughout 19 December. He was seen by Dr Richard Allison, a consultant psychiatrist, on 20 December, 1999. Dr Allison thought that Mr Ball's condition did not require intensive treatment. He said:

> 'I formed the impression that that would be the best plan for him, to continue seeing his GP who knew him. I expected that he would manage and I certainly didn't think that he needed management - he didn't need a care manager or a key worker from the community team. Those workers are very hard pressed, they've got very large case loads and they manage chronic mental illness, like people with schizophrenia, on treatment orders. Mr Ball certainly didn't have a severe mental illness to warrant the use of the community team resources in that way.' (T42)

3.7. Dr Allison diagnosed an adjustment disorder with depressed mood in response to all of his 'losses' (T44). He wrote in the casenotes:

> 'plan for brief admission only'
> (Exhibit C10)

He said:

> 'I know that under stress he had a tendency to act out his bad feelings and harm himself even though he denied the extent of this, the evidence was there that he harmed himself but I did not think that a longer hospital admission would address the issue.' (T46)

3.8. In the morning of Tuesday, 1 December 1999, Mr Ball was seen by Dr M B Saraf, a Career Medical Officer at Crammond House. Dr Saraf had already discussed Mr Ball with Dr Allison, and was aware of his diagnosis (T9). She found no evidence of depression but 'anger ++' (T12). There were no suicidal thoughts. She endorsed the casenotes:

> 'for D/C (discharge) tomorrow
> liaise with GP'
> (Exhibit C10)

3.9. Dr Saraf's note was inconsistent with the three day detention order, which was not due to expire until midnight on 23 December 1999. In any event, she made no attempt to contact Dr Cameron or prepare a Discharge Summary on 24 December, expecting Mr Ball to still be at the hospital the next day (T27).

3.10. Dr Saraf finished the session at Crammond Clinic at 1:00pm, and Dr Allison started his session at about the same time. When they crossed paths, they discussed Mr Ball's case and agreed that he would stay until 22 December 1999 (T46).

3.11. Dr Allison saw Mr Ball again at 3:00pm on 21 December 1999. His note reads:

> 'He is not happy about having to stay one more day – no plans to self-harm … discharge on leave today.'
> (Exhibit C10)

3.12. Dr Allison explained his thought process as follows:

> 'Q. It was your expectation that Dr Saraf would talk to the GP at the time of discharge, is that the case.
>
> A. Yes, but that was the intent although later that day, having arrived on the ward in the afternoon I was aware of emergency admissions needing to come in and there would

> have been acute cases, much as Mr Ball would have been three days previously on the Saturday, or psychotic people, difficult to manage in the emergency department, we were constantly made aware of the queue of patients assessed by ACIS as needing admission to hospital and waiting sometimes for days in emergency departments or overflowing on to the medical wards. I was very conscious of the need to - to have as brief admissions as necessary and when I saw Mr Ball, saying that he wanted to go, I agreed to let him go because he didn't appear to need to be in hospital and there were others whose need was even greater.' (T47)

3.13. This is the phenomenon known as 'bed pressure', something I have considered in another inquest in the context of whether lack of resources were placing pressure on doctors making judgements about whether to discharge or not (see Roach, inquest 5/2001). That inquest also involved TQEH, although not Crammond Clinic.

3.14. In any event, Dr Allison gave Mr Ball leave for the rest of 21 December 1999, and authorised his discharge (T48). He wrote another leave form when he realised that Mr Ball was detained until 23 December 1999.

3.15. Dr Allison assumed that a Discharge Summary would be prepared that day. He attributed this error to his inexperience in TQEH procedures (T50). In fact, Dr Saraf did not learn of Mr Ball's discharge until much later, and she still did not know he had died when she wrote a Discharge Summary on 4 January 2000 (T22).

3.16. Dr Allison also wrongly assumed that Dr Saraf would liaise with Dr Cameron, the General Practitioner. He did not appreciate that the ward clerk was on annual leave, and did not have cover (T51), and so Mr Ball's discharge did not come to Dr Saraf's attention. I was told that, since that time, another full-time secretary has been appointed whose job is to type Discharge Summaries, and to ensure that all appropriate steps are taken when a patient is discharged.

3.17. Dr Allison said that he had not intended that Mr Ball should be referred to ACIS on discharge – he intended that Dr Cameron would follow up, and it was the failure to notify Dr Cameron on discharge which was the operative mistake (T56). In any event, all discharged patients get a card with the ACIS telephone number on it in case of a crisis.

3.18. Dr Allison said that there was no further contact with Mr Ball following his discharge on 21 December. As to what happened after that, a friend reported to Dr Allison:

'Norman had initially been buoyant and positive, and had bought a bicycle. He wasn't allowed to drive because of his epilepsy, he had to be seizure free for two years, but he was fit to ride a bicycle, and he had gone out with a girl prior to Christmas and she had stolen his wallet with $50 in it and he hadn't had a very happy Christmas, and he wasn't looking forward to a very happy new year, and it's clear that he got into another state at new year, he'd sustained further losses which had added to the succession of losses over the previous two years and the adversities in his childhood and the whole succession of difficulties had - the last straw was having his $50 stolen by a girl that he was taking out, and being alone at Christmas.' (T57)

3.19. Dr Allison also commented that the toxic levels of Citalopram found in Mr Ball's blood at autopsy may have increased his levels of agitation, and may have increased the risk of him acting more violently (T58).

4. Adequacy of treatment administered

4.1. I heard evidence from Dr A T Davis, a consultant psychiatrist in both private and public spheres since 1984. Dr Davis is a Senior Visiting Specialist at the Royal Adelaide Hospital, and a Senior Lecturer at Adelaide University. His report is Exhibit C12.

4.2. Dr Davis described Mr Ball's arm injury as a 'serious attempt at self-harm', and agreed with the provisional diagnosis on admission of depression and high suicide risk. He also agreed with the decision to detain him (T64).

4.3. Dr Davis was struck by the paucity of information available, particularly about Mr Ball's history, early in his admission. It was not until Dr Allison saw him at 3:00pm on 20 December 1999 that some of his history became clearer. However, he said that all staff were conscious of the suicide risk at that stage (T66). He thought that the problem was due to inadequate resident care for acute psychiatry. He said:

'Q. And is it your experience that perhaps some of those functions have fallen to nursing staff.

A. Yes, and casualty doctors. We're missing the critical middle person in the after-hours services. In times gone by when the acute work was say at Hillcrest and Glenside Hospitals, there was a resident trainee psychiatrist on night shift who was awake and fully functional, doing all this. I think now after 10 at night there's no such person, and each hospital is trying to decide how best to manage that, and a lot of it is falling to the casualty intern and a nurse, and it's a glaring understaffing issue.' (T75)

> 'In the day time and through until 9 or 10 at night there's a registrar in each hospital available, and they work very hard. I think after-hours we're going to have to move to a position where there's a registrar on deck, because the Adelaide I know well, I've seen dozens of people after-hours, and they're not necessarily being assessed by a registrar, which was a basic requirement for years, that was the standard of care in Adelaide. But I think it's being addressed now with Dr Tobin and others, and I think we'll see a move away from these sort of issues if that happens.' (T76)

4.4. Dr Davis thought Dr Allison's diagnosis was reasonable 'given the shift in mental state over the period of admission' (T66). He also agreed that Mr Ball required ongoing community care, from Dr Cameron, rather than extended inpatient treatment (T68).

4.5. For that reason, Dr Davis described it as 'imperative' that the General Practitioner was contacted and advised what happened during the admission. He also suggested that ACIS should have been involved as well (T68, T79).

4.6. In relation to Mr Ball's discharge on 21 December 1999, Dr Davis described the situation Dr Allison found himself in as 'tricky', but did not disagree with it. He said that if Mr Ball was to be discharged early, it was even more imperative that a community link be forged before discharge (T71), even with a telephone call to the General Practitioner or ACIS if workload prevents an immediate written communication (T72).

4.7. Dr Davis pointed out that, with his history of impulsivity and self-destructive behaviour, Mr Ball was 'pretty fragile and vulnerable' to further stress or trauma, such as that which apparently befell him around Christmas 1999. To that extent, better discharge planning at TQEH and, in particular, the establishment of a link to ACIS, would have been optimal, although it may not have prevented his suicide (T80).

5. Conclusion

5.1. In my opinion, the evidence in this case demonstrates that there had been inadequate discharge planning, and no arrangements had been made for Mr Ball's ongoing care before he was discharged from TQEH on 21 December 1999. Not even the basic step of a Discharge Summary, either psychiatric or nursing, had been attended to, and there was no attempt to contact the General Practitioner, Dr Cameron. Dr Allison acknowledged that this was a lapse in the procedures at the clinic (T56).

5.2. The apparent causes of these serious lapses were Dr Allison's inexperience with Crammond Clinic procedures, the lack of an appropriate system of communication between doctors, in this case Dr Allison and Dr Saraf, the lack of a system for discharge planning generally, and a shortage of administrative support staff during the Christmas holiday period.

5.3. These lapses were particularly serious because Mr Ball was a detained patient, he was considered a serious suicide risk only two days earlier, and his organic brain damage and his medication rendered him vulnerable to further stressors. In the context of his chaotic lifestyle, it is not surprising that an incident such as having his money stolen by a woman he had taken out would have been enough to precipitate the impulsive and self-destructive behaviour that led to his death.

6. Recommendations

6.1. Dr Allison gave evidence that extensive changes have been made at Crammond Clinic since Mr Ball's death (T52-54). Additional staff have been employed, and systems have been introduced such as discharge checklists and other administrative procedures which will hopefully ensure that a situation such as the one which arose in this case does not occur again. Time will tell whether these measures have been successful.

6.2. In those circumstances, I make no recommendations pursuant to Section 25(2) of the Coroner's Act.

Key Words: Suicide; Suicide Risk - Assessment Of; Psychiatric Illness; Hospital Treatment

In witness whereof the said Coroner has hereunto set and subscribed his hand and Seal the 9th day of November, 2001.

……..……
Coroner

Inq.No. 20/01 (3269/1999)