

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 26th and 27th day of November and the 3rd day of January 2002, before Wayne Cromwell Chivell, a Coroner for the said State, concerning the death of Randall John Pettitt.

I, the said Coroner, find that, Randall John Pettitt aged 34 years, late of 'Sunset Cottage', Hoskin Street, Terowie, South Australia, died at Terowie on the 6th day of September 1999 as a result of neck compression due to hanging. I find that the circumstances of the death were as follows:

1. Introduction

- 1.1. Randall Pettitt was born on 1 September 1965. He was an unemployed electrician, and he lived at 'Sunset Cottage', Hoskin Street, Terowie, South Australia.
- 1.2. Between 4:30pm and 5:00pm on Wednesday, 8 September 1999, Mr Pettitt's former partner, Leanne Harvey, found him hanging from a cross-member in a shed at the rear of his property.
- 1.3. Senior Constable (now Sergeant) Andrew Stott of the Peterborough Police was called and he attended the property at about 6:20pm. When he attended, Mr Pettitt was still suspended from the rafter.
- 1.4. On closer inspection, Senior Constable Stott noted that Mr Pettitt's body was rigid from rigor mortis. He noted that the body was suspended by a dog lead consisting of a chain with a 'choker' ring around the neck, the other end being attached to the rafter by means of an 'S' shaped hook.
- 1.5. The body was taken down and conveyed to Peterborough, where Dr C Dearlove pronounced life extinct at about 9:30pm that evening. (Exhibit C2a).

- 1.6. Senior Constable Stott searched the premises which were generally untidy. He said that he found an open flagon of Hock wine in a paper bag, empty plastic containers of Clonazepam and Fluoxetine, a small quantity of cannabis, and a large number of weapons including knives, daggers, machetes, swords, baseball bats, clubs and other weapons. (Exhibit C11a, p2).
- 1.7. There were no signs of forced entry and no grounds for suspicion concerning Mr Pettitt's death.
- 1.8. I accept Senior Constable Stott's conclusions, and find that Mr Pettitt died by his own hand.
- 1.9. A post-mortem examination of the body of the deceased was performed by Dr J D Gilbert on 10 September 1999. Dr Gilbert confirmed that the cause of death was neck compression due to hanging. (Exhibit C3a, p1).
- 1.10. A toxicological investigation revealed that his blood contained a therapeutic concentration of Fluoxetine (0.12mg/ltr), and also Cineole which is the chief constituent in oil of eucalyptus. (Exhibit C4a).

2. Background

- 2.1. Mr Pettitt had a lengthy history of psychiatric illness. The Glenside Hospital casenotes (Exhibit C14), contain correspondence which describes admissions to the Bendigo Psychiatric Centre in 1994 following a self-inflicted gunshot wound to the right foot. He admitted at the time that he intended to shoot himself in the head but passed out after shooting his foot. The provisional diagnosis at that time was reactive depression, but he began talking of hearing voices. His mood improved with anti-depressant medication and he was discharged with a final diagnosis of drug induced psychosis with depressive features, and was given anti-depressant and anti-psychotic medication.
- 2.2. In 1997 Mr Pettitt was admitted to the Broken Hill Hospital for short periods on four separate occasions with varying diagnoses including depression, personality disorder, and drug overdoses. Following one discharge on 22 June 1997, the psychiatrist said:

‘He will require close followup. Since discharge we have been having discussions with him about having a longer inpatient stay in Orange and the possibility of looking at other treatments for his depression. He remains at the risk of suicide.’

(Exhibit C14a)

3. Admissions to Glenside Hospital

- 3.1. On 5 August 1999, Mr Pettitt presented to the Peterborough Hospital. He was described as suicidal and verbally aggressive and displaying disordered thought processes. He was detained by Dr John Birss, a general medical practitioner, pursuant to Section 12(1) of the Mental Health Act 1993. He was conveyed to Adelaide and admitted to Glenside Hospital as a patient of the Rural and Remote Mental Health Service.
- 3.2. On 6 August 1999, the order made by Dr Birss was confirmed by Dr R Kumar, a Psychiatrist at Glenside Hospital, as is required by Section 12(4) of the Mental Health Act 1993.
- 3.3. On 8 August 1999, Mr Pettitt was examined by Dr Nicholas Adams, Psychiatrist, who made an order pursuant to Section 12(5) of the Mental Health Act 1993 for a further detention for a period of 21 days.
- 3.4. During this admission, Mr Pettitt's differential diagnoses included a manic episode with psychotic features, schizo-affective disorder, drug induced psychosis with a psychotic episode (query manic), and schizophrenia.
- 3.5. It is noteworthy that during this admission, Mr Pettitt expressed the wish to leave hospital and return to Terowie (on 9 August 1999 with Dr Miller and 18 August 1999 with Dr Green) but on each occasion the doctors decided to keep him in the hospital for a further period.
- 3.6. By 24 August 1999, Mr Pettitt's condition was considered stable enough to discharge him, so an order was made pursuant to Section 12(8) of the Mental Health Act 1993 revoking the 21 day order.
- 3.7. On that day, a lengthy hand written discharge summary prepared by Dr Juliette Green was sent by facsimile to Ms Helena Hucks of the Community Mental Health Team at Peterborough, and to Dr Birss.
- 3.8. On 28 August 1999, Mr Pettitt was again detained pursuant to Section 12(1) of the Mental Health Act 1993 by Dr Birss. He was conveyed to Adelaide and seen by Dr Green at Glenside Hospital. Dr Green's note is as follows:

'Randall is a 33 year old man living in Terowie. Recently discharged from R&R (Rural and Remote) 24/8/99. Spoke to police today, told them he was suicidal hence taken to

Peterborough Hospital and detained. Randall says he has felt depressed ever since he got home – depressed about Hep C status, break up with girlfriend and fights with friends. Drank a flagon of port yesterday and said he wanted to hang himself by the dog collar in the shed. Says he wants to burn the house, can't care for himself and would be better off dead ...'

(Exhibit C14a)

3.9. On 29 August 1999, Mr Pettitt was reviewed by Dr Susan Cosoff, Consultant Psychiatrist. She found that Mr Pettitt was no longer intoxicated and there was no evidence of psychosis. Pursuant to Section 12(4) of the Mental Health Act 1993, Dr Cosoff revoked Dr Birss initial detention order. Mr Pettitt entered into a 'safety contract' and agreed to remain at Glenside Hospital as a voluntary patient.

3.10. On 30 August 1999, Mr Pettitt was seen by Dr Green who noted 'fleeting suicidal symptoms', but no psychotic symptoms. Dr Green commenced him on Fluoxetine, an anti-depressant medication.

3.11. On 31 August 1999, Mr Pettitt was seen by Dr Green again. Her note reads:

'He has plans to hang himself soon. However, he agrees to a verbal safety contract.'

(Exhibit C14a)

Her diagnosis was of major depression with major social stressors. He entered into another 'safety contract' with staff.

3.12. Dr Green was so concerned about Mr Pettitt that she discussed his case with Dr Andrew Czechowicz, the Director of Inpatient Services at Glenside Hospital. Dr Czechowicz agreed to see Mr Pettitt the following day and to consider whether he needed a Continuing Detention Order with rehabilitation. This is a more long-term approach to psychiatric treatment.

3.13. Dr Green's internship ceased on 31 August 1999, and she was replaced by Dr Hockley.

3.14. On 1 September 1999, Dr Czechowicz reviewed Mr Pettitt's progress with Dr Hockley. He was noted to be still depressed and suicidal. Part of Dr Hockley's note reads:

'Suicidality – he is happy to stay as an inpatient and has no plans of self-harm if he remains at Glenside – if allowed to go home at this point he will hang himself.'

(Exhibit C14a)

Dr Hockley noted that there was a:

‘Low threshold for detention and transfer to Brentwood if he displays any features consistent with self-harm/suicidal/homicidal behaviour. Needs 1/52 (one week) for Fluoxetine to become effective then reassess.’

(Exhibit C14a)

- 3.15. On 2 September 1999, Mr Pettitt was seen by Dr Hockley again, and although he expressed ‘no suicidal/homicidal ideation’, Dr Hockley described him as a ‘moderate to high risk’ of suicide.
- 3.16. Later that evening, Mr Pettitt told a nurse that he remained ‘homicidal towards former associate (male) saying if he had a gun he “would have finished him off”. Was undeterred about outcome of jail as consequence.’.
- 3.17. On 3 September 1999, Mr Pettitt was reviewed by Dr Czechowicz on a ward round with Dr Hockley. Dr Czechowicz found that Mr Pettitt had ‘settled’ and that ‘acute psychotic homicidal and suicidal thoughts no longer evident’. He diagnosed a schizo-affective disorder and advised the continuation of treatment ‘locally’ with visits by the nurse and Dr Birss. Dr Czechowicz did not specify when Mr Pettitt should be discharged, although Dr Hockley made a note that the discharge date was ‘6/9/99’.
- 3.18. 6 September 1999 was a Monday. For some reason, perhaps connected with bus timetables, Mr Pettitt was discharged from Glenside Hospital at 07:15am on Saturday, 4 September 1999. The casenotes record:

‘Followup has been arranged by medical staff’

(Exhibit C14a)

3.19. Discharge planning

Ms Helena Hucks, the Community Mental Health Nurse based at the Mid-North Regional Community Health Service at Peterborough, stated that she received a copy of Dr Green’s handwritten discharge summary by facsimile on 24 August 1999, as I have already mentioned. She was unable to contact Mr Pettitt so she telephoned Glenside Hospital on 31 August 1999, and learned that he had been readmitted on 28 August 1999.

- 3.20. Ms Hucks said that she was telephoned on 2 September 1999 and was told that Mr Pettitt would be discharged on 3 September 1999. She informed them that she would

not be able to contact Mr Pettitt until after 7 September 1999 for a follow-up consultation, since the service was not available over the weekend, and she was going to be away on 6 September 1999.

- 3.21. Ms Hucks did not receive the discharge summary from the second admission until after Mr Pettitt's death (see her statement, Exhibit C12a).
- 3.22. With the concurrence of Mr Bonig, counsel for Dr Czechowicz, counsel assisting me contacted Dr Birss at Peterborough. He advised by letter that he also received a copy of the Discharge Summary by facsimile on 24 August 1999, but not the Discharge Summary for the second admission. He did not recall having received a telephone call concerning the second discharge, and I accept his statement that he would have noted it if he had. He can still recall being surprised to learn of Mr Pettitt's discharge when he heard that he had been found dead.
- 3.23. On the basis of this, I find that Dr Birss was not advised by Glenside Hospital of Mr Pettitt's discharge on 3 September 1999, and that it was left to Mr Pettitt to contact Dr Birss upon return to Peterborough. Since they knew that Ms Hucks was unavailable until 7 September, the staff at Glenside left Mr Pettitt without support until then.

4. Standard of treatment received by Mr Pettitt

- 4.1. I obtained a report from Dr A T Davis, a Consultant Psychiatrist with wide experience in both the public and private mental health systems in South Australia. Dr Davis' report is Exhibit C15.
- 4.2. As to the treatment received by Mr Pettitt as an inpatient, Dr Davis advised me that this was of a generally high standard. He said:

‘With regard to the diagnosis and treatment, I consider that every attempt was made to assess his mental state and a working diagnosis of schizo-affective disorder seems most appropriate. This occurs in a man with features of a personality disorder, and background history of poly-substance use and dysthymia.

During his inpatient stay, he was managed with a combination of anti-psychotic and anxiolytic medication, as well as an anti-depressant. The drugs chosen were appropriate for the condition, and prescribed at generally accepted therapeutic levels. There were concerns about compliance and hence there were limits on the range of medications prescribed. His major treatment plan included use of a depot anti-psychotic on a regular basis. There was some consideration of application for a Community Treatment Order. This was not pursued as Mr Pettitt indicated that he would be voluntarily compliant. It

was considered that if it was not the case, it would be appropriate to apply for a Community Treatment Order.

Mr Pettitt was initially managed in a closed ward, and then transferred to an open ward at Glenside Hospital. The notes indicate that the staff were aware of his suicidal ideation and propensity and this issue was taken very seriously throughout his admission. There are frequent references to the issue of suicidality.

Mr Pettitt was able to contain any self destructive or hostile impulses whilst in the open ward, and the notes suggest that his general management was appropriate and satisfactory '.

(Exhibit C15, p3)

4.3. However, Dr Davis was critical of the standard of discharge planning which was undertaken prior to Mr Pettitt's discharge from Glenside Hospital on 4 September 1999. He pointed out that Mr Pettitt was still suicidal on 1 September 1999 and he was assessed at being of moderate to high risk of suicide on 2 September 1999. I have also mentioned that Mr Pettitt referred to homicidal thoughts on the evening of 2 September 1999 to a nurse.

4.4. That being the case, Dr Czechowicz's decision to discharge Mr Pettitt was made on the basis that his condition had been 'settled' for a period of only a day or so. Dr Davis commented:

'I consider that optimal management of Mr Pettitt would have included a longer stay as an Inpatient, to ensure that his recent improvement in mental state was sustained and that his suicidal ideation was fully resolved.'

(Exhibit C15, p4)

4.5. Another issue is that Mr Pettitt had only commenced taking Fluoxetine on 30 August 1999. It usually takes between two and three weeks for that medication to have some effect, and four to six weeks to have full effect. It therefore seems that Mr Pettitt was discharged before that medication had the opportunity of helping to stabilise his condition.

4.6. When Mr Pettitt returned to Terowie, the same stressors which were operating on him prior to his admission would have been present. Alcohol and illicit drugs would have again become available, the two former friends, in relation to whom he was alternately fearful and homicidal, were still in the town, and his relationship with his former partner remained problematic in view of his Hepatitis C infection. The

presence of all of these factors, combined with his history of suicide attempts, placed him at high risk of a further attempt.

- 4.7. Finally, there were insufficient support mechanisms available in Terowie or the surrounding area to assist Mr Pettitt even if an early discharge was justified. If, for example, the Mental Health Nurse was available to provide intensive support with at least daily, if not twice daily contact for the first week or so following discharge, an earlier discharge might have been possible, but Dr Czechowicz made it clear that such supports are not available in country areas (T50).
- 4.8. Dr Davis told me that it was generally held in the mental health system that it was a bad idea to discharge a patient on the weekend, where there are no professional services available, and where the patient may be returning to a lonely house with depressing memories (T90).
- 4.9. As it transpired, Mr Pettitt was discharged on Saturday, 4 September 1999 in circumstances where the staff at Glenside Hospital knew that Ms Hucks was not available to see him until at least Tuesday, 7 September 1999. Unfortunately, by that time Mr Pettitt had already died.
- 4.10. Of course, Mr Bonig, Counsel for Dr Czechowicz, was correct to point out that suicide is an unpredictable phenomenon, and that it cannot be said that Mr Pettitt's death was directly attributable to poor discharge planning. Even if Ms Hucks had been available to see Mr Pettitt on the day of his discharge, there is nothing to suggest that Mr Pettitt may not have committed suicide a week or a month later.
- 4.11. However, I do not consider that that submission is to the point. In my opinion the conclusion is inescapable that the poor discharge planning undertaken by Glenside Hospital prior to Mr Pettitt's discharge on Saturday, 4 September 1999 increased the risk of Mr Pettitt's suicide. In view of the instability of his condition, and the lack of support available, Mr Pettitt should not have been discharged until better planning was undertaken.
- 4.12. Another issue in relation to the poor discharge planning is that Dr Birss was not consulted prior to either of the discharges from Glenside Hospital. Dr Birss, a General Practitioner in a regional centre, conscientiously undertook his responsibilities by detaining Mr Pettitt twice under the Mental Health Act 1993

because he was so concerned about his condition. I am sure that detention of a patient is a difficult thing for a medical practitioner to do, particularly when he must continue to live and practice in the community where the detention has taken place. And yet, on both occasions, Mr Pettitt was discharged from Glenside Hospital without prior consultation with Dr Birss.

- 4.13. If patients are to receive effective treatment in the community after their discharge from hospital, then the Mental Health System must communicate better with General Practitioners. It must be intensely frustrating, indeed annoying, for General Practitioners to see a patient, whom they have recently detained, return to their community without further explanation.
- 4.14. It is particularly disappointing to find that such difficulties were still being experienced in 1999. I was advised in 1996 that the amount of communication with, and support of, country General Practitioners was being increased, with use of such advances as telemedicine (see the report concerning the death of Heather Dale, inquest number 40/95). The then Regional Director for Northern Country Health at the South Australian Health Commission said:

‘In addition there will be much more involvement by the General Practitioner in the case of a mental health patient ... and assistance will be provided to them when the patient is sent home and the General Practitioner resumes the general follow-up care together with the follow-up team.’ (p11)

- 4.15. Nothing of the sort happened in this case, and I hope I was not being misled at the time.

5. **Recommendations**

- 5.1. I was told by Dr Czechowicz that in the time since Mr Pettitt’s death, a number of steps have been taken in the hope that the number of deaths of this type can be reduced:
- A more systematic and frequent monitoring and recording of a patient’s mental state and in particular suicidal ideation, during their stay as an inpatient is now undertaken;
 - Increased use of ‘telemedicine’ is made whereby, in a case such as Mr Pettitt’s, a teleconference between Ms Hucks, Dr Birss, Mr Pettitt and Glenside staff would have been held prior to his discharge.

I agree that both of these steps should prove useful in such cases. But, in view of past experience, I will believe this evidence when I see it in action.

- 5.2. Another issue, which arose in this case and still does not seem to have been addressed, is bed pressure. Dr Czechowicz told me that there is still pressure on staff to discharge patients, whose condition appears to have improved, to make room for other patients whose condition requires hospitalisation. He explained:

‘In general we have pressure on the resources that we have and to some degree that influences decisions about how long people might stay ...’ (T47)

He added:

‘... we have a tremendous pressure - even today I think there are six people that are waiting for admission and I don't know how that issue was resolved that time. So the system is working under significant pressure which is not much different now than it was two years ago.’ (T53)

- 5.3. Dr Davis also referred to this issue. He said:

‘... because one of the common pressures, is pressure on beds. Just looking for the person who's seen to be the least in need of a bed.’ (T76)

- 5.4. This issue is also not new. In October 1997 I delivered findings in inquests arising from the deaths of six people, either psychiatric patients, or their therapists or carers (Chandraratnam in 1992, Hogarth in 1993, Ciampi, Proctor, Lewin and TenHoopen all in 1994). In these findings, I referred to the phenomenon known as ‘malignant alienation’, namely the feeling of staff in situations where they feel powerless to change a bad system. In TenHoopen for example, I said:

‘Clearly, such a syndrome is exacerbated by difficulties such as understaffing, underfunding, lack of training, and lack of cohesion in the organisation in which people work.’ (p33)

I recommended at that time that the existence of such a phenomenon should be recognised and addressed.

- 5.5. The clouding of clinical judgment by bed pressure is part of the same syndrome, in my opinion. The constant existence of such pressure has an insidious effect on clinical judgment to the extent that the culture of an organisation can change, and quick turnover of patients becomes the norm because there is no realistic alternative.

- 5.6. In those circumstances, the very serious issue of whether bed pressure clouded the judgment of the clinicians in this case arises. If there had not been so much pressure for Mr Pettitt's bed, Dr Czechowicz and the staff may have been more inclined to persuade him to stay at Glenside Hospital, until such time as his condition had stabilised for a more substantial amount of time, and a more adequate time had elapsed for the Fluoxetine to take effect. On the basis of the evidence before me, I can only conclude that their actions would probably have been different. After all, Dr Green had asked Dr Czechowicz to consider a Community Treatment Order.
- 5.7. I know that Dr Margaret Tobin, the Director of Mental Health Services, and her staff are presently conducting studies and reviews into such areas, but it is a matter of great concern that these issues have been known, and solutions have been proposed, since at least 1996. Dr Tobin's ability to influence events is obviously limited by the availability of resources.
- 5.8. I therefore recommend, pursuant to Section 25(2) of the Coroner's Act, 1975, that the Minister for Human Services reviews the extent of the resources made available to the Mental Health System in this State, with a view to determining the extent to which:
- bed pressure is still influencing clinical judgments in relation to discharge of patients;
 - problems in relation to communication with country practitioners, apparent in 1996 or earlier, still had not been addressed in 1999 at the time of Mr Pettitt's death; and
 - whether inadequacy of resources, or other factors, may be playing a part in these ongoing problems.

Key Words: Suicide; Psychiatric/Mental Illness; Country Areas – Medical Services

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

Seal the 3rd day of January, 2002.

.....
Coroner