

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 8th, 9th and 10th of October and the 29th of November 2002, before Anthony Ernest Schapel, a Coroner for the said State, concerning the death of Corey Shane Richardson.

I, the said Coroner, find that, Corey Shane Richardson aged 21 years, late of Martins Bend, Berri, South Australia died at the Glenside Campus of the Royal Adelaide Hospital, Eastwood, South Australia on the 21st day of April 2000 as a result of cardio respiratory arrest associated with butane abuse (inhaled).

1. Introduction

- 1.1. Corey Shane Richardson was born on 22 December 1978. He was 21 years of age when he died on 21 April 2000.
- 1.2. Corey Richardson, the deceased, died in room 6 at the Rural and Remote Ward at the Glenside Campus of the Royal Adelaide Hospital ('Glenside') at 226 Fullarton Road, Eastwood. The deceased was an inpatient at Glenside and was at the time of his death detained pursuant to Section 12(6) of the Mental Health Act 1993 ('the Act'). He had originally been apprehended on Wednesday, 22 March 2000 after an incident that had taken place at premises at Wright Road in Monash.
- 1.3. Because the deceased was at the time of his death a detained patient, he was a person detained in custody within the State pursuant to an Act or law of the State. Therefore by virtue of Sections 12(1)(da) and 14(1a) of the Coroner's Act 1975 the State Coroner was obliged to hold an inquest into the cause and circumstances of this death. I have been directed by the State Coroner to hold the inquest and I did so on 8, 9 and 10 October 2002.

- 1.4. The deceased's cause of death was cardio respiratory arrest associated with butane abuse by inhalation. The deceased's body was located at about 12:40am on 21 April 2000 by a nurse who was at that time conducting her routine bed checks. The deceased was found in a wardrobe in the room that he occupied alone at Glenside. He was in a sitting position with his head slumped forward. Appropriate resuscitation efforts were fruitless. A partially empty butane gas cannister was located in the wardrobe. Another empty can of butane was located elsewhere in the room.
- 1.5. It is evident that the deceased had inhaled some of the contents of either or both cans of butane located in his room. He died as a result. The subsequent post-mortem examination confirmed this. For reasons that I will explain it is my finding that the deceased had deliberately inhaled the butane, but unintentionally caused his own death. Suicide in my assessment can be discounted.
- 1.6. This inquest examined the cause and circumstances of the deceased's death. In particular, it examined the circumstances in which the deceased may have acquired the butane and the circumstances in which the deceased was able to possess and ingest this substance without detection in his private room.
- 1.7. The main focus of this inquiry related to the circumstances described in the preceding paragraph. However, evidence was publicly given in the inquest as to the effect of butane inhalation on the human body and in particular the mechanism by which such inhalation can lead to the death of a person. Accordingly, these findings will serve as a public warning as to the dangers of butane inhalation.

2. The effects of butane inhalation and the cause of death in this matter

- 2.1. Before dealing with the particular circumstances of the deceased's death, it is as well to set out in detail the evidence that was adduced before me in relation to the deleterious effects of butane inhalation, and how that inhalation led to this unfortunate outcome.
- 2.2. Dr Ross James who is the Chief Forensic Pathologist and the Forensic Science Centre in Adelaide and a Senior Clinical Lecturer in Forensic Medicine at the University of Adelaide performed the post-mortem examination in respect of the deceased. He prepared a detailed report in relation to the post-mortem examination and he also gave evidence in open court before me on 9 October 2002.

- 2.3. The deceased as I have mentioned was 21 years of age at the time of his death. The fact that he died as a result of butane inhalation was confirmed both during the course of the post-mortem examination itself and by toxicology analysis which showed that butane was present in samples of lung and liver tissue. The deceased had been an otherwise physically healthy young man.
- 2.4. Butane is one of the low molecular weight hydrocarbons that are commonly used as propellants in spray cans that are freely available to anyone in the community. In addition, butane as with other gases such as methane, ethane and propane are often used in lighter fluid. Butane is sadly ingested as a substance of abuse. It is ingested generally in a confined space, for example by inhaling the substance from a plastic bag or by inhaling the substance whilst in a bath. In this particular instance, the deceased had deliberately placed himself in a cupboard and inhaled the butane in that confined environment. Butane, as with the other substances I have mentioned, is heavier than air. If sprayed in a confined space it will displace the oxygen therein. Inhalation of the substance in that circumstance will result in the person being deprived of necessary oxygen. This will in turn possibly lead to lack of consciousness, asphyxia, cardiac arrest and death. Deaths from butane inhalation have been described occasionally and appear either to be the result of such anoxia (deprivation of oxygen) or the result of cardio sensitivity with decreased oxygen, increased carbon dioxide and increased adrenalin level.
- 2.5. Apart from possibly causing the death of a person, butane abuse can cause mental disturbance as a result of the asphyxia. Behavioural side effects can include dizziness, numbness, slurred speech, delusions and occasional hallucinations. In a normal domestic setting, for example spraying in an open kitchen or bathroom, butane is quite safe. This is because the gas disperses. It is when the substances are ingested in such a concentration that they displace oxygen from the atmosphere that the deleterious effects occur.
- 2.6. Since 1998 there have been a number of deaths associated with butane and propane abuse. On 23 January 1999 Sean Patrick Simmonette (inquest 40/2000) died in James Nash House, Oakden after inhaling Johnson's Raid, an aerosol product the propellant of which is a hydrocarbon. Butane was detected in his bodily tissues. His death was the subject of a coronial inquest, the findings in which were delivered by the State

Coroner on 14 November 2000. Dr James provided a report to that inquest. He had stated the following:

'Abuse of propellants particularly hydrocarbons and particularly by use of a plastic bag are recognised to have the potential to cause unexpected rapid death.'

Dr James' observations were published in full in the body of the State Coroner's findings in that inquest. The product with which the Simmonette inquest was concerned was contained in a receptacle that bore the following warning:

'Intentional misuse by deliberately inhaling contents can be harmful or fatal.'

The canisters, the subject of the present inquest, bore no such warning. The product in question is Golden Bell butane which, according to the information on each canister, was imported by Golden Bell Australia Pty Ltd.

The cans however bore this direction:

'Use in well ventilated area.'

This to my mind did not adequately address the actual intrinsic dangers associated with deliberate inhalation of the concentrated gas.

I have recently examined the containers of several aerosol products on sale in a city supermarket. Many of these products purport to have butane as their propellant. Most of them bear the warning in the same terms as that stated on Johnson Raid, the subject of the Simmonette inquest. Some do not. I examined a can of butane lighter refill. It bore no warning relating to the effects of inhalation. Golden Bell butane canisters still bear the same information as set out on the two such canisters located in the deceased's room.

Most often, warnings relating to the effects of inhalation of the concentrated product are contained within other less relevant information. The warnings are by no means prominently displayed, unlike the usual warning as to flammability that is displayed within a red diamond. In fact some products, whilst bearing the written warning to which I have referred, also bear a prominent green diamond containing the information that the product is 'non-toxic'. Toxicity is a separate issue, but it seems to me that such a prominently displayed claim might well lead those who read no further to believe that ingestion of the product is not harmful. This is an unsatisfactory situation in my view.

- 2.7. I return to the question of warnings in my recommendations. It is true that the potentially harmful or fatal consequences of the inhalation of hydrocarbon propellants is information that has for some time existed in the public domain. However, I am led to the conclusion that a public warning as to the deleterious effects of hydrocarbon inhalation should now be issued. Put bluntly, the deliberate inhalation of butane and other similar gases in a confined space, for whatever dubious so-called recreational benefit it might have, is a very dangerous practice and it caused the death of Corey Shane Richardson in this instance.

3. Circumstances

- 3.1. The deceased is the son of Mr Ronald Wilfred Richardson of Berri. Prior to his detention in March 2000 the deceased was living in a caravan in the Riverland. The deceased's father had entertained the suspicion that his son was using marijuana and, after his son was detained, he had located a container of butane gas in the course of cleaning out the deceased's caravan. The deceased's father had suspected that the deceased was suffering from schizophrenia because some of his behaviour was in keeping with schizophrenic symptomatology as described in texts that Mr Richardson had read. Although his son's behaviour and mood swings had caused him concern, the deceased had at no stage displayed any signs of suicidal behaviour and had never given any indication to his father that he wanted to kill himself.
- 3.2. The deceased came to be detained under the Act as a result of the following incident. The occupants of a house in Wright Road, Monash had found the deceased inside their house without their permission. Evidently the deceased had entered the house in order to have a shower in the bathroom of the premises. He had entered the house by reaching through a window and unlocking the rear door. There appears to have been no other motive on the part of the deceased such as an intended theft. It is obvious from this incident and from observations made of him in the next few weeks whilst under psychiatric care that he was a very disturbed man. Police were called to the Wright Road premises and found that the deceased was very confused and disoriented. He did not seem to know where he was, his speech was very slow and disjointed and he was incoherent. Constable John Gardner of the local police apprehended the deceased for his own safety, utilising powers under Section 23(1) of the Act.

- 3.3. The deceased was conveyed by the police to the Riverland Regional Hospital at Berri. There the deceased was examined by Dr John Penna and he was found to be delusional and making very little sense. He was assessed at that stage as having schizophrenia and certain medication was prescribed. The deceased was admitted to the hospital overnight during which he remained agitated. In the morning he was observed to be psychotic and arrangements were made for him to be transported to Glenside which is a gazetted approved treatment centre under the Act. Dr Penna issued an order for admission and detention in an approved treatment centre pursuant to Section 12(1) of the Act. He signed this order on 22 March 2000 at 8:30am. That order was confirmed by a psychiatrist on 23 March 2000 at 11:40am by way of a confirmation of initial detention order pursuant to Section 12(4) of the Act. This confirmation took place at Glenside.
- 3.4. The deceased was admitted to the Brentwood North facility at Glenside on the afternoon of 22 March 2000. The Brentwood North facility is utilised for the treatment of detained patients. It is a closed ward environment which means that patients are confined to the ward. The deceased was seen at 12:30pm by Dr Fiona Nicholas who found that he was extremely psychotic. She was, however, able to obtain a history from him that included significant recent substance abuse. He said that he had been using LSD and had been sniffing butane. On 23 March 2000 the deceased was seen by Dr Brian McKenny who was the psychiatrist in charge of Brentwood North. On 24 March 2000 Dr McKenny again examined the deceased, this time with a Dr Lynette Yong. Drs McKenny and Yong formed the view on this day that the deceased had become more compliant and he agreed to certain medical investigations. They decided that he could be transferred to an open ward on that day, albeit while still under detention. The deceased was transferred to an open ward at 7:00pm on 24 March 2000. That ward was the Rural and Remote Ward at Glenside. The deceased had mentioned to Dr Yong at Brentwood North that he had been 'sniffing'. He did not specifically mention that he had been using butane when examined by Dr Yong, but as earlier observed he had admitted to Dr Nicholas when first seen at Glenside that he had been abusing that particular substance. Dr Nicholas had made an entry in the Glenside patient records to that effect on 22 March 2000. These records went to the Rural and Remote Ward when the deceased was transferred there.

- 3.5. After the deceased was transferred to the Rural and Remote Ward at Glenside on 24 March 2000 he was still under detention. The ward is more correctly known as the Rural and Remote Mental Health Service. It was established in 1996 after the closure of the Hillcrest Hospital and it basically services the tertiary mental health needs of all people outside metropolitan Adelaide. It has an inpatient service with beds on the Glenside Campus. It was at the material time under the administration of the Flinders Medical Centre, but it is now administered by the Royal Adelaide Hospital. The inpatient service of the Rural and Remote Ward comprises 23 beds. It is an open unit. The ward caters for both voluntary and detained patients, the majority of whom come from country South Australia. Each patient is accommodated in his or her own room. I was told by Dr Kenneth Fielke, who practices as a consultant psychiatrist at the Rural and Remote Ward, that the vast majority of patients within the ward are detained patients, although some do come to the ward voluntarily. The ward caters for an acute group of patients such as those who cannot be looked after in their local hospitals or in the community. The length of stay in the ward is on average 7 to 10 days. It provides treatment for psychiatric patients and also is concerned with the implementation of management plans and the formulation of community management plans to prepare the patients for reintroduction into the community.
- 3.6. One of the more significant features of the Rural and Remote Ward is that it is an open ward, in direct contrast to Brentwood North which is closed. The openness of the Rural and Remote Ward means that patients are during the day able to leave the confines of the ward. Patients from the ward are generally free to move within the Glenside Campus grounds. They are also able to receive visitors except when they are confined within the ward at night time. Visitations are not monitored. The ward is locked at 9pm and so patient movement is restricted after that hour. It is opened again at 6am. The detained patients are able to mingle and associate with voluntary patients. However, whereas voluntary patients do not have any restriction imposed upon them in terms of leaving the Glenside Campus grounds, detained patients are not permitted to leave the Glenside grounds except when accompanied by one of the Glenside staff or pursuant to a formal leave arrangement. However, the fact of the matter is that a detained patient is physically able to leave the campus because there are no fences or other impediments stopping them from leaving. Detained patients are advised of their obligations to remain on the Glenside Campus. However, all of this

means that patients who are prohibited from leaving the grounds except with permission, co-mingle with patients who can come and go as they please.

- 3.7. The deceased was seen and treated by a number of psychiatric medical practitioners whilst at the Rural and Remote Ward but he was principally under the care of Dr Christina Lawry who was at that time a first year psychiatric registrar under the supervision of a consultant psychiatrist within a multi-disciplinary team. In early April 2000, the deceased came to be under the care of Dr Fielke to whom I have already referred. By that time the principal psychiatric carers of the deceased were Drs Fielke and Lawry. In addition, a number of nursing staff members were responsible for his care on a daily basis within the Rural and Remote Ward.
- 3.8. Dr Fielke told me in evidence that in effect there were two possible differing diagnoses in respect of the deceased's illness. Firstly, it was suspected that he was suffering from schizophrenia. Secondly, it was thought that his psychosis was possibly due to the effects of drug abuse. Dr Fielke explained the differential diagnoses in these terms:

'I think that initially the diagnosis was unclear in the sense that certainly the features on his history and mental state were consistent with a psychotic illness. The cause of that psychotic illness, though, was somewhat less clear in that Corey did describe the use of a number of street substances including marijuana, amphetamines and solvent use, so that one of the ongoing challenges throughout the admission was to try to differentiate how much his symptoms – the symptoms that are representing may be related to substance use as opposed to the possibility that there was an underlying – a functional psychotic illness like schizophrenia that the substances had actually brought forward or unmasked. So that, although it was clear that this was a first presentation of a psychotic illness, the exact nature of that psychotic illness needed to be eluded through the course of admission and in an ongoing way.' (T23-24)

Dr Fielke said that in order to diagnose properly a drug induced psychosis, there is a need to have the patient off illicit substances for at least one month. He said that there were difficulties in making such a diagnosis where patients 'are continuing to use drugs in an open ward where drugs at times are available' (T29). He acknowledged that there is 'a constant struggle' (T69) against detained patients in open wards having access to contraband items in general. I agree that it would obviously be very difficult to make a diagnosis of drug induced psychosis in a setting where patients were secretly gaining access to and consuming illicit substances such that a diagnostic environment could not be maintained. In the event, Dr Fielke told me that in his view

the nature of the deceased's symptoms seemed more consistent with an underlying schizophrenic illness and that was to an extent corroborated by a family history and by behaviour as described by the deceased's father. It appears, however, that no firm diagnosis was ever made because, again, a diagnosis of schizophrenia has to be based upon observation of symptoms over a period of time, in this case for 6 months (T70). In my view, little turns on the precise diagnosis. It has to be observed however, that it was highly undesirable for this patient, against a background of drug abuse in the past, to have access to and be able to consume drugs within the confines of his ward, especially given that he was a detained patient.

- 3.9. As it transpired, later in March 2000, staff within the Rural and Remote Ward had difficulty obtaining the deceased's compliance with the taking of oral medication. There was a documented incident where the deceased had kicked medication contained in a cup out of the hand of the person endeavouring to administer it. As a result, the deceased was transferred back to the Brentwood North unit on the evening of 29 March 2000. This meant that the deceased was once again confined within a closed environment.
- 3.10. The plan was to transfer the deceased to Brentwood North for secure ward management until his psychotic symptoms had resolved significantly.
- 3.11. After his transfer a nurse, Louise Barford, searched the deceased's room in the Rural and Remote Ward. She did so in order to collect his belongings and in the course of the search she located a number of items that she considered inappropriate for him to have. She evidently compiled an incident report in relation to this matter on the night in question, that is 29 March 2000, and she also made a note in the patient's record on 2 April 2000 after his eventual return from Brentwood North back to the Rural and Remote Ward. She found the following items on 29 March:
 - 2 Ventolin inhalers
 - 1 bottle of RAID which is an ant killer
 - 2 bottles of vitamins
 - 1 pair of nail scissors
 - 1 spray container of deodorant
 - 1 bottle of peroxide

It has been established that these items were not in his possession when he was originally admitted to Glenside in March. Any items of such a nature would have been removed from his possession. It can safely be concluded that the deceased had acquired these items after he had been admitted to the Rural and Remote Ward on 24 March 2000. Many of these items were clearly inappropriate for the deceased to have. Dr Fielke told me that his possession of ant killer and peroxide were in keeping with the nature of his psychosis and that it did not necessarily carry the implication that he was consuming those substances. I pause here to observe that the RAID container was described as a bottle. I do not know whether this is literally true or whether, as in the Simmonette inquest, it was contained in an aerosol canister. However, the possession of the spray container of deodorant prompted Nurse Barford to note in the patient's record on 2 April 2000, in conjunction with her note about the possession of that substance, that the deceased had abused butane gas in the past.

- 3.12. There is no evidence that the deceased had consumed or otherwise ingested any of the substances found in his room, but his possession of them was a matter for concern. They had obviously been secretly acquired at a time after his admission. Of some note was the fact that 2 Ventolin inhalers were amongst the items. The deceased's father in evidence told me that his son was periodically asthmatic. Ventolin was kept for the deceased by the nursing staff at Rural and Remote and administered to him from time to time. I was told in evidence that a patient's medication in the Rural and Remote Ward was kept by the nurses and was not permitted to be kept in the patient's individual room. This would include Ventolin. The fact that the deceased had Ventolin in his room on this occasion is consistent with his being an asthmatic, but Dr Fielke told me that in his experience Ventolin could be used to dilate the airway thereby enhancing the desired effect of butane inhalation.
- 3.13. It is unclear as to whether or not the fact of the finding of these items in his room had been conveyed to the medical and nursing staff at Brentwood North on the day of his transfer to that facility. However, it is evident that at some point in time Dr Yong of Brentwood North became aware of this because she has noted in the patient's record on 31 March 2000 that 'R+R found some chemicals under his bed (Ant Rid)'. On 31 March 2000, the deceased was assessed by medical staff at Brentwood North to be suitable for re-transfer to the Rural and Remote Ward. Dr Yong has noted on 31 March 2000 that the deceased had settled well in Brentwood North with no

management problems and had become compliant with nursing directions and medication. It was also noted that he was suitable for transfer back to the Rural and Remote Ward. She has also noted, having discussed the matter with Dr McKenny, that the deceased, while still having psychotic symptoms and being thought-disordered, remained settled and had stated that he would comply with medication and try to keep off 'the substances'. Accordingly he was transferred to the Rural and Remote Ward on that day.

- 3.14. After his transfer on 31 March 2000, the deceased remained in the Rural and Remote Ward until the day of his death, namely 21 April 2000. It is evident that he was allowed to return to the Rural and Remote Ward on the basis of his recorded assurances that he would comply with medication and try to keep off 'the substances'. However, it seems to me that his assurance that he would try to keep off substances was, to say the least, equivocal and a matter that required appropriate consideration in his management in an open ward. He stated he would try to keep off the substances but at no time gave any positive assurance that he would do so. Dr Yong's note conveys an impression that there was an almost tacit acceptance that 'substances' that he might consume might somehow be available to him. The fact that he gave no unequivocal assurance, and his already demonstrated propensity and ability to acquire and hoard contraband items was a matter which in my opinion dictated an enhanced degree of scrutiny of the deceased's movements and his associations within Glenside. Another matter that would have required a regime of close observation was the fact that the deceased was said to have a propensity for aggressive behaviour and the possibility of him bringing weapons into an open ward would in those circumstances obviously have to be considered. Noteworthy is the fact that weapons including knives and a cross-bow were said to have been found in his caravan after his original apprehension.
- 3.15. I mention the issue of potential aggression, not because it has anything to do with the unfortunate outcome here, but because it was another factor to be considered in deciding upon a proper regime of management and observation.

4. **The issues**

- 4.1. The principal issue ventilated at the inquest was whether, in the circumstances that prevailed after his transfer to the Rural and Remote Ward, any closer observation was made of the deceased and, if so, with what effect.
- 4.2. It is evident that between 31 March 2000, when he was returned to the Rural and Remote Ward, and 21 April 2000 the deceased acquired two cans of butane. On the morning of his death the police located the two cans of butane. Also in his room there appears to have been yet another Ventolin inhaler which one can see in photographs that were admitted (Exhibit C34b). The Ventolin inhaler was a contraband item. He had earlier in the night used a Ventolin inhaler that had been kept by the nursing staff. That had been retained by the staff. I don't know how he came to have another inhaler. There is also no direct evidence as to how he came to be in possession of the two canisters of butane. There are a number of possibilities. One possibility is that he was given the two canisters by a visitor. However, as far as the deceased's father was aware, the only visitors that the deceased had in the entire time he was at Glenside were himself and the deceased's sister. The deceased's sister had visited on one occasion with the father and the father assured me in evidence that he had not provided the butane canisters to the deceased. I accept the father's evidence regarding this. Another possibility is that the deceased persuaded a voluntary patient, or a detained patient who was not being carefully scrutinised, to obtain the butane from a source outside the campus. A third possibility is that the deceased himself left the grounds of Glenside and acquired the butane off campus. The two butane canisters bear the label of a chain of stores called 'Cheap As Chips'. The price label bears a price in respect of each can of \$2.00. A Constable Carolyn Schild of the Adelaide CIB investigated this matter and she gave evidence before me. She testified as to enquiries she had made of the Cheap As Chips management. At the time with which this inquest is concerned there was a Cheap As Chips store located on Glen Osmond Road near the Glenside Hospital Campus. The store was about 300 metres from the Rural and Remote Ward building and it would seem that a journey on foot to and from that store would only take a matter of minutes. A witness by the name of Sandra Deluca, who was the clinical nurse consultant manager of the Rural and Remote Ward at the time, but who was then on leave, told me that it would take about three minutes to walk from the Rural and Remote Ward to the Cheap As Chips store. Senior

Constable Schild told me that her enquiries of the Cheap As Chips chain management revealed that there had been seven cans of this particular brand of butane purchased from the Glen Osmond Road store in the four days prior to the deceased's death. Three such cans had been purchased on 20 April, two on 19 April and another two earlier that week. There had been no cans of butane reported stolen in that week.

- 4.3. The deceased had access to money whilst he was in the Rural and Remote Ward. I was told in evidence that detained patients were not permitted to possess money as a matter of course, but could access funds, kept on their behalf, for the purpose of buying everyday items from the hospital canteen. Butane was not an item on sale at the canteen. The deceased had been admitted to Glenside with \$20 cash in his possession. From time to time other sums of money had been placed into his account and he had occasionally withdrawn some of that money. On 12 April 2000 the deceased had \$50 in his account and on that day he withdrew the whole of that sum. In the normal course of the events he would have been asked to state a reason for withdrawing that sum and would have had either to produce evidence of a purchase by way of a receipt or produce the goods themselves, and in addition repay the change into his account. The ledger relating to his account reveals that the staff member who had been involved in the withdrawal of the \$50 on 12 April 2000 was a Ms Catherine Andrews who was the acting clinical nurse consultant manager at the Rural and Remote Ward at the time. Nurse Andrews was asked to provide an affidavit in relation to the circumstances in which she came to be involved in this withdrawal of those funds. The affidavit and statement are Exhibits C27b and C27c. The statement of Andrews states that she now has no recollection of giving the deceased \$50 on 12 April 2000. She said:

'Our procedures at the time would have been to ask Corey why he wanted the money, and I may have asked him, to, for example, bring back a receipt to show me that he had spent the money for the reasons he told me. Also, as Corey was a detained patient, he would always have been accompanied by a member of the nursing staff to the shops unless he had a Form 9 leave signed by the psychiatrist. I cannot recall accompanying Corey Richardson to the shops on any occasion.

Although I cannot now recall giving \$50 to Corey, I would not have given it to him for no reason. He would have had to explain to me why he wanted the money.'

Andrews' recollections in this regard are not particularly helpful. She was asked to provide this statement only recently. I accept that Ms Andrews would have asked for

and been provided with a reason as to why he wanted the money, but the reason should be documented. The ledger is unhelpful in this regard. It simply reveals the size and nature of each transaction but does not record the reason why any withdrawal was made, including the one on 12 April 2000. On that day the deceased mentioned to a social worker that he had difficulties with some bills. I think it unlikely, however, that his withdrawal of \$50 was associated with that issue. His ability to pay bills in cash in a situation of detention would have been limited.

- 4.4. The deceased's clothing was searched after his death and \$30 in notes was located in the pocket of his jeans. Some loose change amounting to about \$6 was also located in the room. There is no evidence as to how the deceased was able to retain these funds, but it is plain from the evidence that his retention of this money was contrary to the Rural and Remote Ward requirements, given that he was a detained patient. Mr Richardson senior told me that he had not given the deceased any money whilst he was detained at Glenside. I believe him. The withdrawal of \$50 occurred nine days prior to the deceased's death. After that withdrawal, he had not redeposited the change, if any, into the account as was required. An inference is available that the money he retained, namely about \$36 in total, was part of the \$50 that he had withdrawn from his kitty on 12 April 2000.
- 4.5. I think the possibility that the deceased was given the butane containers by a casual visitor is the least likely scenario. I think it is more likely that he either purchased the containers himself with the money he had withdrawn or had another patient purchase them for him. I am unable to determine which of these two possibilities is the more likely. Certainly, as we will see, the deceased would have been able to leave Glenside and purchase the canisters himself. If that did occur, and it could have, then it reveals a most unsatisfactory state of affairs in respect of the ability of detained patients to move on and off the campus. Equally, if detained patients are in a position to be able successfully to inveigle voluntary patients to do their bidding, then this is also an unsatisfactory state of affairs, and raises an issue as to whether detained patients and voluntary patients should be able to co-mingle.
- 4.6. There were, I find, positive indications that the deceased would be liable to acquire substances of abuse whilst in the Rural and Remote Ward. Firstly, he had a documented history of drug abuse generally and butane abuse in particular. Secondly, he had demonstrated the ability to acquire and retain contraband items in his room in

the Rural and Remote Ward as evidenced by Barford's findings on 29 March 2000. One of those items, namely the deodorant spray, had prompted concern on the part of Nurse Barford and she had documented her concerns. Thirdly, his assurance that he would try to keep off substances was equivocal and the fact that he had been released to an open ward environment in the knowledge that he had expressed such a vague guarantee might only have served to have encouraged him to acquire what he wanted. In those circumstances, there was in my opinion the need for extra vigilance on the part of the Rural and Remote Ward staff, particularly in relation to the deceased's movements and associations. The deceased was a detained patient and the staff of the Rural and Remote Ward would have been legally entitled to place reasonable restrictions on the movements of the deceased so as to prevent or at least minimise the opportunity for him to acquire contraband items. The evidence is plain to me that it would have been the responsibility of the staff at Rural and Remote to address those issues. It is true that the use of many illicit substances could have been deterred by compulsory urine analysis. However, such analysis is unsuitable to detect the ingestion of substances such as butane, and in any case, the urine analyses that were conducted did not reveal the ingestion of any illicit substance that could be detected upon such an analysis.

- 4.7. Random searching of a patient's room was a concept that was resisted. Ms Deluca told me:

'We never ever searched on a routine basis. It was an open ward and it was sort of trying to - it was an environment where we tried to make people as comfortable as possible. The only time that we might search a patient's room is that if we had genuine reason to believe that they might be in the possession of either a dangerous weapon or an illegal substance and then that would generally occur with the patient there with us.' (T171)

She also said:

'There's a hospital policy regarding searching a patient's rooms and we were permitted to search a room on that proviso, that we actually believed that they might have been in possession of something. It wasn't custom or practice because patients have rights to privacy and so - yes, unless we believe there was good cause to do that we didn't.' (T172)

- 4.8. However, Ms Deluca in relation to the same subject matter said:

'A. I was asked previously about searching rooms regularly when we knew that somebody might have a substance abuse problem. I can't exactly recall my answer to that, but I think what I'd like to make clear is that it isn't normal process to search a patient's room. When we had somebody who had a substance abuse problem, we

would ask those patients if they minded from time to time, that if we searched their room with them being present and it was certainly an agreement that we would have with the patient. So it wasn't a prescribed management necessarily of the patient, but it wasn't also that it didn't occur.

- Q. In what circumstances would you say to a patient, look we'd like to search your room with you present.
- A. If we felt that there was some indicator, some indicator in their manner or behaviour or whatever, that they may have used something, or if as part of the counselling process and that commitment by them, that contracting by them, that they weren't taking anything, we may well say to them well then how about we confirm that by just checking your room now and making sure that there's nothing there, and so it would be done with the patient.
- Q. Would you from time to time there after as it were, randomly ask them.
- A. Oh yes, we would how about we check your room now and make sure everything's going fine, yes.
- Q. Without giving them any warning.
- A. Yes.' (T202-203)

- 4.9. At the time of his death, the deceased was a Category 3 patient. A Category 3 patient is defined as follows:

'Is detained with evidence of increased personal risk, possibly angry about being detained and ambiguous or ambivalent about admission to the hospital'

Dr Fielke said that the categorisation did not carry any implication in terms of the intrinsic openness of the patient's environment (T103). Rather, the categorisation was more relevant to the degree of vigilance required. He agreed that if the deceased was ambiguous or ambivalent about admission to hospital, that would indicate a possibility of him absconding, albeit possibly only for a short period of time (T103). Ms Deluca's interpretation of such a categorisation was that it could refer to somebody who was not certain about whether they wanted to stay or go, 'so that there might be a possibility that they might leave the campus' (T157).

- 4.10. Short of random searching, which would presumably have had at least a deterrent effect in relation to the acquisition of contraband items, closer scrutiny of the movements of the deceased in my view was warranted. So much was acknowledged by Ms Deluca and his categorisation as a 3 patient implies that. Ms Deluca also said that in the circumstances that prevailed he ought to have been counselled about the problem and that nursing staff should have spoken to him regularly about whether he had been using any substance of abuse and he should have been reminded not to have

any such things in his possession. It seems to me that in this particular case random searching might have been indicated. However, Ms Deluca resisted the suggestion that spot searches of the deceased's room would have been warranted in the circumstances because as she put it:

'The Rural inpatient unit is in the process of assisting people to move back into the community. Long term management of any sort of substance use or abuse would be part of the management that we would be handing over to the community teams, and people within that team. So we would not unless we have good reason to believe that he was actually in possession of it to search his room. We wouldn't start routine checks, no.'
(T174)

Ms Deluca agreed that the equivocality of the deceased's assurance that he would try and keep off substances gave rise to a need for greater supervision and monitoring of the deceased's situation when returned to the open ward. She said:

'I would expect initially too, that there would be increased monitoring of his presence within the unit, who he might be associating with and generally how he is presenting.'
(T186)

Ms Deluca also said that if nursing staff were concerned about a patient possibly leaving the campus then they could increase the frequency of their observation to the extent that they could require the patient to report to them every 15 minutes.

- 4.11. The evidence is by no means clear as to what steps were taken if any to improve the necessary vigilance as far as the deceased's movements and associations were concerned. When the deceased was transferred back to the Rural and Remote Ward on the afternoon of 31 March 2000 a nursing management plan was prepared. This nursing management plan seems to be identical to the nursing management plan that had originally been drawn up on 24 March 2000 when he had first been admitted to the Rural and Remote Ward. In fact, what appears to have occurred is that the nursing management plan of 24 March 2000 has been cut and pasted, as it were, and placed on the deceased's file on 31 March 2000 to serve as the nursing management plan for the ensuing period. That plan inter-alia states:

'? observe for evidence of illicit drug use.'

There does not appear to be any other entry in relation to observation of movement and association. However, the nursing entry of 31 March 2000 compiled by a Nurse Bienewitz records:

'I have told him that he cannot leave the ward plus must let staff know in future if he wants to go to canteen or walk.'

- 4.12. The evidence is not satisfactory as to what measures, if any, were implemented to ensure that his movements were scrutinised. In particular there is no documented evidence of the deceased being required to report to staff at regular intervals nor any documented evidence of the deceased reporting to staff when he desired to leave the ward. In short, there is no material to support the notion that the restrictions contemplated by Nurse Bienewitz were enforced. The statement of Catherine Andrews, who was the acting clinical nurse consultant manager for the Rural and Remote Ward from the time of the deceased's transfer to his death, states in her recently provided statement:

'I have also been asked whether I can recall if any particular arrangements were put in place in relation to the monitoring or supervision of Corey's movements, or checking his possessions after these items were apparently found in his room. Again, I have no recollection of that. If Corey Richardson had been transferred to Brentwood Ward from Rural and Remote Ward then I am sure I would have been informed of the transfer and the reasons for that. If particular arrangements were put in place for supervision or monitoring of Corey upon his return to the Rural and Remote Ward then they should be documented in the Nursing Care Plan, and there should be records in the relevant progress notes if those requirements were actually put into effect. The matters set out in the Nursing Care Plan should have been discussed by the relevant team responsible for Corey's care, and I would expect that the whole Nursing Care Plan would be expected to be reviewed every three to five days. If there were issues of suicidality then the Nursing Care Plan should have been referred to daily by members of the treating team. The Nursing Care Plan should have a review date on it, and there should be a signature to show whether or not the matters set out in the Nursing Care Plan were reviewed and addressed.'

(Exhibit C27c, p1-2)

There is nothing in the deceased's progress notes from 31 March 2000 onwards to suggest that any particular arrangements had been put in place for supervision and monitoring of the deceased or whether any such arrangements were actually enforced. In particular, I can find nothing which would lead me to conclude that the deceased's movements in and out of the ward were curtailed or restricted or whether any regime

of reporting, be it every 15 minutes or otherwise, was effected. Ms Deluca told me in relation to such a regime:

'It may be documented in the progress notes. Sometimes the nurses might set up a small chart for the patient to sign in and let us know that they were there. But it was more of the token effort of report – you know – it was the token of acknowledging that the person had been reported, rather than an official chart or a piece of documentation.' (T160)

There is no documented evidence that a practice was either established or maintained that required the deceased to inform staff when he wanted to go for a walk or go to the canteen. I do not see any documented review of his Nursing Care Plan after 31 March 2000 nor any of the type of documentation referred to in the above passage taken from Ms Andrews' statement. A conclusion is therefore open that no effective restriction was placed on the deceased that might have prevented the foreseeable acquisition and use of contraband substance.

- 4.13. What is plainly established is that after 31 March 2000 the deceased was able to acquire funds without any documented reason, was able either to retain the change from that acquisition or to acquire further funds from an unknown source, and was able to acquire the canisters of butane and retain them in his room for an unknown period of time. This is all in the context of the fact that this man was a detained patient whose access to and use of substances was a factor relevant to one of his differential diagnoses. Even if he was required to report every 15 minutes his freedom of movement in the intervening periods could have enabled him to go to and return from the Glen Osmond Road Cheap As Chips store. One has to recognise that the difficulties associated with attempting to prevent patients, be they detained or voluntary, from acquiring contraband items are significant. On the other hand, it seems to me that whilst the possibility of detained patients acquiring contraband items in the context I have described cannot be totally avoided, there are measures which can be taken to reduce its incidence. In this particular case I am left in a state of disquiet as to whether the necessary enhanced regime of observation was ever implemented or maintained in relation to the deceased after 31 March 2000. There does not appear to have been any closer observation than the customary two hourly checks. I am mindful of the fact that the deceased's death occurred three weeks after the events of the end of March to which I have referred and that his condition had improved.

Nurse Joanne McConaghy told me this:

- 'A. So it was three weeks from the event, so you'd always have that in the back of your head you would be aware. Absolutely no indications that there was an issue with those sort of things now. I don't - he was by all accounts improving in his mental state. I don't know what do you do, do you search the room every single day because -
- Q. I suppose I'm asking you that. Did you consider firstly of all those items set out in that entry to be inappropriate items for Mr Richardson to have in his possession.
- A. Yes definitely, definitely.
- Q. And was your reaction to that, can you recall, did it make you extra vigilant to whether he had such items in his possession from that time.
- A. I think you'd always be more aware. I think I would be more aware that was the issue with anybody. That he was a detained client that had been there for quite a while was steadily improving, and while you have those sort of things in the back of your mind all the time you keep it an obvious overall look out around. There wasn't anything to indicate that it was an issue at that point in time. Things were improving. He was heading for leave. He was going to go out with the family and time out on his own.
- Q. That's your recollection of it from that around that time things were improving and there was no need, say extra concerned about these things.
- A. Well I think you always try to be extra concerned. There was no indication that there was anything untoward.' (T133-134)

However, there was little reason to suppose that the vague assurances that he would try to keep off 'the substances' would always be honoured. To my mind an improvement in his psychotic state would not necessarily imply any lessening of his desire to acquire and use substances of abuse.

- 4.14. The deceased's death occurred within a week of the State Coroner's findings in an inquest into the death of Sandra Jane Sanders (inquest 2/2000) who died while under detention pursuant to the Act in Woodleigh House, an open environment. She had absconded from that facility and had committed suicide by drowning. In his finding the state Coroner said this:

'I think it should be emphasised that where a patient has been detained pursuant to the Mental Health Act, a statutory duty has been imposed upon the institution to which that patient has been detained to ensure his or her own health and safety and the protection of other persons. Where a consultant psychiatrist has determined that the safety of such a patient is so clearly at risk that the very serious step of detention, with all the concomitant loss of human rights which that entails, is justified, then that duty is a very clear and a very high one.'

The remarks of the State Coroner bear repetition, in my view.

5. The issue of suicide

- 5.1. There is no evidence before me that indicates that the deceased entertained any suicidal ideation. I have already referred to the fact that the deceased's father had not observed any suicidal tendency. In addition, the Glenside medical notes with respect to the deceased reveal that from time to time the deceased was asked as to whether he had any suicidal thoughts and they were consistently denied. Dr Fielke told me that 'depression did not emerge as a feature throughout his entire admission'. He did not leave a suicide note.
- 5.2. The inhaling of butane in a confined space is a recognised form of substance abuse and Dr James told me that deaths occasioned thereby have invariably occurred in circumstances where such deaths have been accidental as opposed to deliberately caused. Dr James told me from his experience that in the absence of any corroboration of suicide, for example the leaving of a suicide note or an expressed suicidal ideation, deaths from butane inhalation should be regarded as accidental. Although such considerations are matters for me, rather than matters of forensic pathology, I can understand such an approach.
- 5.3. Although the deceased had on 20 April 2000, the day before his death, unsuccessfully applied to the Guardianship Board for the lifting of the detention order, the evidence suggests that this did not have any adverse effect on his mood. He was observed that evening to be in a jocular frame of mind and there is simply no evidence to conclude that he deliberately took his own life. In fact Dr Lawry on 20 April 2000 had signed forms granting permission to the deceased to have accompanied leave over the imminent Easter period.
- 5.4. I am certain that what happened in this case was that whilst the inhalation of the butane by the deceased was a deliberate act, in all the circumstances his death was accidental.

6. The detention of the deceased under the Act

- 6.1. The deceased was originally apprehended on 22 March 2000 by Constable John Gardner in circumstances I have already described. His statement verified by affidavit (Exhibit C31a) reveals that he exercised his power of apprehension for the deceased's own safety. The deceased had been very slow and disjointed, was

sometimes incoherent and did not make sense. He was confused about where he was and what he had done. Gardner established that the deceased had a history of mental illness. I find that his apprehension in those circumstances was authorised by Section 23(1) of the Act.

- 6.2. Dr Penna, a medical practitioner at the Berri Medical Centre examined the deceased and in his statement verified by affidavit (Exhibit C4a) describes the deceased on 22 March 2000 as being quite delusional, was seeing things and hearing voices. He assessed the deceased as having schizophrenia. The deceased remained agitated throughout the night, and in the morning he remained psychotic. Dr Penna, in the interests of his health and safety and for the protection of other persons, ordered that the deceased be admitted and detained in an approved treatment centre. He did so at 8:30am on 22 March 2000. I find that he lawfully did so by virtue of powers conferred by Section 12(1) of the Act.
- 6.3. The deceased was conveyed to Glenside on 22 March 2000 and admitted. Pursuant to Section 12(3) of the Act, it was mandatory for a psychiatrist to examine the deceased within 24 hours of his admission. Dr McKenny, a psychiatrist, made this examination at 11:40am on 23 March 2000 which was within 24 hours of the deceased's admission to Glenside. He recorded thought disorder, bizarre delusions, visual hallucinations and a perplexed effect (Exhibit C6a). He confirmed the detention order of Dr Penna under Section 12(4) of the Act. I find that he lawfully did so.
- 6.4. Dr Litt, another psychiatrist at Glenside, made an order pursuant to Section 12(5) of the Act that the deceased be detained for a period of 21 days from the expiration of Dr Penna's original 3 day order. Dr Litt examined the deceased on 25 March 2000 and he assessed him as vague, puzzled and with poor insight. Dr Litt thought that he was probably schizophrenic and needed ongoing hospital care. I find that Dr Litt lawfully made his Section 12(5) order that day.
- 6.5. Drs Fielke and Seidel, both psychiatrists at Glenside, examined the deceased on 14 April 2000. Both doctors concluded for the reasons stated in their orders that the deceased required further treatment and they jointly made a further 21 day detention order on 14 April 2000 pursuant to Section 12(6) of the Act. This further order was still extant on the day of the deceased's death. I find that this order was lawful.

- 6.6. The deceased had unsuccessfully challenged this order in the Guardianship Board on the day before his death. The Board had ruled that the detention order remain in place in the interests of the deceased's health and safety and for the protection of other people. The deceased was thus lawfully detained at the time of his death.

7. **Recommendations**

- 7.1. There are two separate issues that might properly be the subject of recommendation. The first concerns the steps that might be taken to prevent the recurrence of a death by butane or another hydrocarbon inhalation. The second issue concerns practices at Glenside that might be modified so as to prevent the recurrence of a detained patient gaining access to harmful material.

7.2. Butane inhalation

I have delivered a public warning as to the potentially fatal consequences of butane inhalation. The continuing education of the public in this regard also needs to be addressed. In this regard I recommend that legislation be introduced that renders it mandatory for all aerosol products that contain hydrocarbon propellants to bear a prominent warning as to the inherent dangers of the deliberate inhalation of the concentrated product.

- 7.3. I have given consideration as to whether the sale of these products ought to be restricted, in particular to minors. The types of aerosol products that are propelled by hydrocarbon gases are many and varied. It would arguably be inappropriate to restrict the sale of many of those products to minors merely on the basis of a potential for abuse where contact with such products is otherwise not harmful. Moreover, I do not have sufficient evidence to enable me to conclude whether such restriction would be feasible. That is a matter that the relevant authority should consider. I do recommend, however, that particular consideration be given to restricting the sale of pure butane, propane, methane and ethane to minors. I would also recommend that consideration be given to the implementation of a program of education, to be directed at minors, as to the deleterious effects of the inhalation of butane and other hydrocarbon propellants.

7.4. Practices at Glenside

I make the following recommendations:

- 1) That the administration of the Rural and Remote Ward at Glenside institute a review of procedures with a view to addressing the issues that have been considered in this inquest, including:
 - A re-evaluation of the appropriate degree of observation, scrutiny and restriction of movement of a detained psychotic patient;
 - A re-evaluation of the questionable practice of allowing detained patients to associate with voluntary patients;
 - A re-evaluation of the circumstances in which detained patients should be permitted to have access to cash during the course of their detention;
 - Consideration of the need for a separate facility for detained patients that might involve a degree of openness but falling short of enabling patients' physically to leave the grounds of Glenside;
 - Whether random searches, with or without the consent of the patient, ought to be conducted with respect to a detained patient's personal environment, especially in circumstances where the patient has demonstrated a propensity to acquire and retain contraband items.

*Key Words: Death in Custody; Detention Order; Inhalation of Butane;
Substance Abuse; Psychiatric/Mental Illness; Public Warnings*

*In witness whereof the said Coroner has hereunto set and subscribed his hand and
Seal the 29th day of November, 2002.*

Coroner