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 4th, 5th and 6th days of August 2004 and the 10th day of September 2004, before Wayne Cromwell Chivell, a Coroner for the said State, concerning the death of Peter Henry Cornish.

I, the said Coroner, find that Peter Henry Cornish aged 43 years, late of 6 Worthington Road, Elizabeth East, South Australia died at Elizabeth Railway Station, Elixabeth, South Australia on the 25th day of September 2001 as a result of aspiration of vegetable matter.

1. Introduction

1.1. On 25 September 2001 at around 2:30pm a man now known to have been Peter Cornish was seen at the Elizabeth Railway Station running along the platform and yelling. A witness noted cuts and grazes on his face (Exhibit C4a, p1).

1.2. Mr Cornish was carrying a green plastic shopping bag. He turned and ran to the edge of the platform, jumped down and ran across the tracks towards the western fence.

1.3. Mr Cornish ran straight into the fence, and flipped over it so he was lying on his back on the ground on the other side. He was punching himself in the head, kicking his legs and writhing on the ground, while continually yelling.

1.4. Mr Cornish then ran towards a small creek and 'belly-flopped' into the water. He was seen to be shoving something into his mouth while kicking his legs.

1.5. Police officers attended at about 2:45pm and found Mr Cornish almost completely submerged in the creek. They dragged him out and tried to clear his airway, but they were unable to.

1.6. An ambulance arrived, and did not undertake resuscitation in view of Mr Cornish's condition. He had been in the water for 10 to 15 minutes before the police arrived.

2. Cause of death

2.1. A post-mortem examination of the body of the deceased was performed by Professor R W Byard, Forensic Pathologist, on 26 September 2001. Professor Byard found that the cause of death was aspiration of vegetable matter. He commented:

> 'Death was due to aspiration of vegetable matter with occlusion of the upper airway by a matted mass of apparent grass. Although it appeared that the grass had been chewed, grass was not present in the stomach but only in the oesophagus, with the bulk being inhaled into the upper airway. Hyperinflation of the lungs was more in keeping with upper airway obstruction than possible drowning. While there was evidence of superficial injuries to the face and limbs with bruising and healing abrasions, no significant life-threatening injuries were present. No underlying organic diseases were present which could have caused or contributed to death.
>
> The alleged erratic behaviour of the deceased prior to death indicates either a psychiatric disturbance with psychosis or a reaction to drugs or volatile substances. The results of head space analysis for volatile substances, blood alcohol level and blood drug screening were not available at the time of this report. These will be the subject of a separate report.'
>
> (Exhibit C2a, p1)

2.2. A toxicological analysis of Mr Cornish's blood was performed by Mr D N Sims, Principal Forensic Scientist at Forensic Science SA. Mr Sims found:

> 'RESULTS:
>
> 1. The blood contained:
>   (1) approximately 5 ug tetrahydrocannabinol (THC) per L (see interpretation).
>   (2) 11-nor-9-carboxy-THC.
> 2. None of the drugs alcohol, amphetamines, benzodiazepines, methadone, tricyclic antidepressants, opiates or other common drugs were detected in the blood.
> 3. No volatile chemicals were detected in the blood.
>
> INTERPRETATION:
>
> Cannabinoids are a group of compounds found in Cannabis. Tetrahydrocannabinol (THC) is a cannabinoid and the major psychoactive constituent of Cannabis. Blood THC concentrations reach a maximum a short time after Cannabis use and then decrease

> rapidly. Low concentrations of THC may be detected for up to a day following Cannabis use depending on dose and frequency of use.
>
> 11-nor-9-carboxy-THC is the major metabolite of THC in blood. It may be detected for several days after Cannabis use.'
>
> (Exhibit C3a)

2.3. Volatile substances were searched for because police officers viewed a surveillance videotape of the interior of the train on which Mr Cornish had been travelling, and said that he was holding a shopping bag over his lower facial area for some time, either inhaling the contents or preventing himself from breathing.

2.4. Further to that, one of the witnesses, Ms Natasha Franke, said that she had seen Mr Cornish about a week earlier, at the Elizabeth Railway Station, sniffing paint or glue from a plastic bag (Exhibit C6a, p3).

2.5. Although no volatile chemicals were detected in Mr Cornish's blood, the possibility remains that he may have been inhaling a volatile substance previously. This may have led to or contributed to the erratic behaviour which culminated in his death.

3. Background

3.1. Mr Cornish had a long history of mental illness.

3.2. I requested an overview of Mr Cornish's treatment from Dr Craig Raeside, Consultant Forensic Psychiatrist. In his report, (Exhibit C25), Dr Raeside said that Mr Cornish suffered from chronic bipolar affective disorder with recurrent manic episodes (p12).

3.3. Dr Raeside said that such a condition can be triggered by using cannabis, as Mr Cornish did regularly. Alternatively patients often use cannabis in an attempt to alleviate their symptoms, but only succeed in making it worse (T188).

3.4. Mr Cornish's family were familiar with his symptoms, particularly during episodes of mania, which occurred every three to four years, according to his brother Andrew. Mr Cornish said that his brother became 'overly religious'. He said:

> 'Peter was a normal sort of a bloke but sometimes when he became very stressed, instead of drinking, he became overly religious. He saw a lot of things as evil and would burn things that represented other religions other than Christianity. On one occasion about 17 years ago he was put in Hillcrest Hospital when he was having relationship difficulties with the mother of his two eldest boys. He has two children from another relationship. At this time he was living apart from her but had the custody of his two boys. His behaviour became that irrational that the mother of the two boys with her new boyfriend

> came around and took the children away from Peter one night. Peter came around to my parent's house that night and began behaving irrationally taking his clothes off and burning things. We called the police and they took him away under the Mental Health Act to Hillcrest Hospital. He was in Hillcrest for about a month and he just slowly got better because he would have been having rest and taking medication. I think he was diagnosed with manic depression. Instead of getting down when he was depressed, Peter would be on a manic high and behave irrationally. I don't think Peter had any follow up treatment and if it was offered he wouldn't have wanted it anyway.'
>
> (Exhibit C22a, p1)

3.5. The incident to which Mr Andrew Cornish referred occurred in 1986. Mr Cornish was detained and admitted to Hillcrest Hospital:

> 'He was noted to have become 'preoccupied with religious ideas, started to wear odd bits of clothing tied around his wrists. He spoke in tongues and was preoccupied with possession and sacrifices.''
>
> (Exhibit C25, p3)

3.6. Mr Cornish was noted to have a history of heavy use of marijuana, and recent exposure to LSD and amphetamines.

3.7. Mr Cornish absconded from Hillcrest Hospital after the detention order expired and was re-admitted several days later. Treatment with antipsychotic medication led to some improvement in his mental state.

3.8. Mr Cornish was admitted to Hillcrest Hospital again in 1987 with depressive symptoms and was treated with antidepressants. He discharged himself after a few days, and was not considered detainable.

3.9. In 1988 Mr Cornish was admitted to Hillcrest Hospital under detention. He was described thus:

> 'extremely irritable and restless with prominent disorder in the form of thought and religious, grandiose and paranoid delusions. His affect (mood) was angry and irritable, there were suggestions of auditory hallucinations of God's voice and insight was limited.'
>
> (Exhibit C25, p4)

3.10. It was noted that Mr Cornish 'masked' his symptoms and was discharged when the three day order expired. He became non-compliant with medication and his mental state deteriorated again. He had two further admissions and each time his lack of insight led him to cease medication and deteriorate again. He was eventually treated with long-acting injectable antipsychotic medication, and significant improvement occurred.

3.11. Mr Cornish had further admissions to Hillcrest Hospital in 1991 and 1993 with manic relapses. He was relatively stable after that, until 1998 when he saw Dr Rajan Nagesh, a Consultant Psychiatrist, concerning problems with neighbours, and a request for priority housing.

3.12. First contact with ACIS

On 18 February 2000, Mr Cornish telephoned Northern Assessment and Crisis Intervention Service ('ACIS') and spoke to Mr John Provis. Mr Provis is very experienced in mental health, having worked in the area since 1989. Mr Cornish told Mr Provis that he had a history of manic depression, and that he had been non-compliant with medication for two years. He said he did not wish to go back to Dr Nagesh because he owed him money. He said he wanted an ACIS review in order to restart his medication. Mr Provis made an appointment to see Dr Karen Elsdon on 22 February 2000, four days later.

3.13. Dr Elsdon saw Mr Cornish on 22 February 2000. She noted:

> 'Referred himself here because his General Practitioner would not complete the TDR (Treating Doctor's Report) for his pension application.'
>
> (Exhibit C15)

3.14. Mr Cornish described some obsessive behavioural problems, chronic sleep disorder and some other social problems such as gambling, drinking and drug-taking. Dr Elsdon found 'no clear cut Axis 1 diagnosis'. She had telephoned Dr Nagesh who confirmed that Mr Cornish had a diagnosis of bipolar mood disorder and had been in hospital in the 1980s. She said:

> 'There is no sign of depression or mania at present and he has never been helped by medications.'
>
> (Exhibit C15)

3.15. Dr Elsdon gave Mr Cornish a prescription for Thioridazine for his sleeping problem, and referred him for counselling for his social problems. She declined to issue a TDR.

3.16. Mr Cornish was seen by his General Practitioner, Dr Charles Ling, in July and August 2000 with symptoms of depression, alcohol dependence and bronchial asthma. He prescribed antidepressants and Ventolin (Exhibit C8a).

4. Events of 5 September 2001

4.1. On 5 September 2001 Mr Cornish was behaving strangely in the company of his sons Shawn and Adam. Mr Cornish had not slept properly for about a week, and was not eating properly. He had injuries to his face from a bicycle accident.

4.2. Adam was rather circumspect about what happened. He did say that at one stage Shawn was holding his father (Exhibit C10a, p2). Andrew Cornish, Mr Cornish's brother, said that there had been a fight, and that Mr Cornish and Shawn had been wrestling (Exhibit c22a, p2).

4.3. Adam Cornish telephoned the police and they attended and detained Mr Cornish pursuant to Section 23 of the Mental Health Act 1993 ('the Act'). He was conveyed to the Lyell McEwin Hospital.

4.4. At Lyell McEwin Hospital, Mr Cornish was seen by Dr Sadarangani in the Emergency Department, who noted that Mr Cornish alleged that he was at home drinking a cup of coffee when the police arrived and detained him. The story provided by the police was that he had been aggressive to the extent that he needed to be restrained, throwing things around the house and 'pulling earrings from ears' (Exhibit C15).

4.5. Dr Sadarangani referred Mr Cornish to the Community Mental Health Nurse, Mr Michael Merritt. Mr Merritt is a very experienced Registered Psychiatric Nurse, having been qualified since 1980.

4.6. Mr Merritt took extensive notes of his consultation with Mr Cornish. Mr Cornish denied the allegations of aggressive/violent behaviour. Mr Merritt noted some pressure of speech and thought disorganisation. He noted the previous consultation with Dr Elsdon, the history of bipolar disorder and admission to Hillcrest Hospital in 1994. He also noted that he had seen Dr Nagesh previously.

4.7. Mr Merritt noted as part of his assessment that Mr Cornish was denying his behaviour which be assessed as a perceptual anomaly. He also described his insight as only 'fair', in that he 'does not believe has a problem and surprised (at/by) police'. It cannot be argued on the basis of those comments that Mr Merritt unquestioningly accepted Mr Cornish's denials for the purposes of his assessment.

4.8. Mr Merritt's assessment was:

> '43 yr old man referred by Police s23 after ? aggression at home - denies this, denies current problems. Some mild pressure & disorganisation in speech, not obviously psychotic. Not requiring Ψ (psych) admission - not detainable, not suicidal. Given previous bipolar diagnosis - this may be precursor to further episode.'
>
> (Exhibit C20a, p1)

4.9. Mr Merritt's treatment plan was as follows:

> 'Plan: 1) D/C home.
> 2) Request ACIS to follow-up - make contact via phone & reassess situation & further follow-up as needed.'
>
> (Exhibit C20a, p2)

He explained that his intention was that ACIS would contact Mr Cornish and follow-up with a more formal and extensive mental state examination. Unfortunately, this did not occur.

4.10. ACIS contacted Mr Cornish on 6 September 2001, and a home visit was arranged on 12 September 2001. When Mr Christopher Randells and Ms Linda Nobes attended, Mr Cornish was evasive and uncommunicative. He would not let them into the house, so they attempted to interview him in the car. Mr Randells' notes of the consultation were:

> "Slightly built man wearing silver grey suit and running shoes, shaved head, multiple healing lesions on scalp, superficial, each approximately 1 to 2 - 1 to 3 sq cm. Anxious manner, speech mildly pressured, unwilling to give any information that may indicate active symptoms. Unable to think of any reason for police taking him to Lyell McEwin last week. Evasive re sleep, appetite and energy. Denies the existence of problems, not currently on medication. He terminated the interview after less than 10 minutes although he did agree to further contact at unspecified date. Assessment incomplete. Plan for further discussion in ACIS meeting, repeat first - repeat visit may be more productive, booked for 17th of September 2001' and I've signed it.'
>
> (Exhibit C21, pp3-4)

4.11. Mr Randells said that he did not get the impression that Mr Cornish was psychotic, although the assessment was incomplete (Exhibit C21, p4).

4.12. At 4:30pm that afternoon, Mr Cornish's father, Mr Ernest Cornish, telephoned Mr Randells. Mr Randells noted:

> "…call from father, dissatisfied with the above plan and requesting repeat visit tomorrow rather than the 17th. He expressed his concern that Peter may start a dangerous fire, drive in a dangerous manner or harass him at home. Plan ACIS please discuss

> further and consider assessment prior to the 17th and father to contact the police as necessary'.'
>
> (Exhibit C21, p6)

4.13. Mr Cornish's case was discussed between Ms Nobes and Dr Penelope Roughan, Consultant Psychiatrist, the next day, 13 September 2001. Ms Nobes' note reads:

> ''Discussed with Dr Roughan, psychiatrist with Northern ACIS, she suggested we offer a doctor's review to Peter also if Mr Cornish Senior, that's Ernest would like to discuss this further, Dr Roughan is willing to speak to him. Planned first doctor's appointment available 19th of September, 2.30 p.m'.'
>
> (Exhibit C21, pp6-7)

4.14. Consequent upon that meeting, Mr Randells telephoned Mr Cornish on 14 September 2001. His translation of the notes of the several calls he made are as follows:

> "Call to advise Mr Cornish of available appointment. Son Shawn answered the phone, line went dead after I introduced myself as part of Mental Health Service. I repeated the call and I could hear a second voice in the background, possibly Mr Cornish himself. Shawn's response this time "Didn't you get the message first time fuckhead" then he hung up.' I remember, he was quite vitriolic, there was a lot of passion in that. I waited a short time and called again, and on the third call that evening I spoke to Mr Cornish. He was amiable and apologised for his son. He couldn't see any reason for an appointment with Dr Roughan and politely declined it. He expressed concern about his brother Chris and his father Ernest and their relationship, and he suggested the Mental Health Service could profitably direct our energies in their direction rather than his, and that the father was the cause of many difficulties within the family, including this particular episode. He denied any psychiatric problems and stated he only wanted a quiet life in his own house. He was prepared to accept home visits, but couldn't see a need for them. He expressed pleasure that Dr Roughan was willing to speak to his father if he calls, and gave verbal approval for that to happen. This conversation was calm and coherent, thoughts clearly and politely expressed. So the plan on that occasion was to cancel the appointment with Dr Roughan at his request, discuss it again with ACIS and I've also written that he had agreed to contact ACIS if he thought it necessary.'
>
> (Exhibit C21, p8)

4.15. It would appear that the decision to cancel the further home visit and the appointment with Dr Roughan was made in ignorance of information provided by Mr Chris Cornish, brother of deceased, in a telephone call to Mr Jeff Jensen, the duty Combined Regional Triage Officer on 12 September 2001 at 11pm. Mr Jensen's note of the conversation is as follows:

> 'Unwell for several weeks, has been setting fire to objects in the house over past week, believing they have evil spirits. Has been chanting religious songs, aggressive manner to people. Tried to get into Chris's and his parents home tonight, reasons unclear. He was

> refused access and left. His son (aged 17) then came challenging refusal of access, said he himself felt suicidal, and left with friends in car. Chris believes his brother has BPAD. Was taken to LMHS by police on Thursday due to aggression, and discharged after review in am because he 'talked his way out of it'.
>
> Has evidently not been eating or sleeping.
> Uses considerable amounts of marijuana.
>
> P) Follow up by Northern ACIS
> Chris wishes to be kept informed'
>
> (Exhibit C15)

4.16. Mr Randells said that he was unaware of that information at the time (T84).

4.17. The clinician should have been aware of this information. It indicates that Mr Cornish was probably entering another manic phase of his illness, and urgent assessment was required.

4.18. On 23 September 2001 at 9:30pm, Adam Cornish telephoned Mr John Provis, to whom I have previously referred, in connection with the telephone call from Mr Cornish on 18 February 2000. Mr Provis' translation of this note of the telephone call is as follows:

> 'At that point Adam stated that he was concerned about the father's odd behaviours, and I've put those in inverted commas. For example, riding a bike recklessly without a helmet; falling requiring stitches etc. He also went on to say that his father was - his way of saying it - speaking in tongues. Burning objects in the house, consequently little in the way of ornaments left. He also went on to say that he thought his father was vague and confused, had no insight into why the family should be concerned about that sort of behaviour perhaps.'
>
> (Exhibit C23, p3)

Mr Provis also noted that Adam Cornish was unaware of the 12 September 2001 home visit, and the subsequent cancellation of Dr Roughan's review. His note continued:

> '… the son requesting additional psych review, and I've put in brackets, in spite of father's obvious reluctance. Family worried that Peter may harm himself and/or others, and I've put question marks after that. And the plan was at that time to discuss with the team, which would have been the next morning, and another question mark, offer another medical officer review.'
>
> (Exhibit C23, p4)

4.19. At 9:45pm on 23 September 2001, Mr Provis received a telephone call from Mr Christopher Cornish. Mr Provis described him as 'extremely intoxicated'. He

advised Mr Cornish of the plan to discuss his brother's case at the ACIS meeting the next day.

4.20. On 24 September 2001, Mr Cornish's case was discussed at the team meeting at which various clinicians including psychiatric consultants, registrars and medical officers are routinely present. Mr Provis' notes of the outcome of the meeting read:

> 'Discussed with team → option of another booked medical review? (But declined previously, won't engage)
>
> → respond in crisis?
>
> Plan await recontact from Peter or family.'
>
> (Exhibit C15)

I accept Mr Provis' evidence that this was a decision of the team as a whole, and not his alone (Exhibit C23, L255).

4.21. Mr Provis said that he did not regard this as a crisis. He said that it had never been documented that Mr Cornish was suicidal. He said:

> 'I mean we deal with these sorts of issues on a daily basis, many times during the day where … there may be an issue of self-harm … and its not reflected that he stated that.'
>
> (Exhibit C23, L295)

4.22. It would appear that the telephone call between Mr Cornish and Mr Randells on 14 September 2001 was the last contact between Mr Cornish and South Australian Mental Health Service before he died.

4.23. While the above events were taking place, Mr Cornish had been to see Dr Ling on a continual basis. On 5 September 2001, the day he was detained, he saw Dr Ling for infected sores and insomnia. On 13 September 2001 he complained of tinea in both feet. On 24 September 2001, the day before he died, he saw Dr Ling in relation to multiple sores on his face caused by a fall from his bicycle (this had occurred on 22 September 2001 and he had received treatment at Lyell McEwin Hospital including sutures to several injuries). Dr Ling said:

> 'I never did a mental state examination during these examinations. He seemed to me to be a happy go lucky man. He never expressed to me any suicidal ideation and I had no suspicion that he was having psychiatric problems. Peter Cornish's family never advised me of any concerns they had.
>
> I was unaware during September 2001 that any Mental Health Agencies were involved in his care. I am not aware if Mr Cornish was seeing any other General Practitioners.

I was surprised to hear that he had died. He appeared to be quite normal to me.'
(Exhibit C8b, p2)

5. Issues arising at inquest

5.1. I received a report (Exhibit C25) from Dr Craig Raeside, a very experienced Forensic Psychiatrist, in which he provides an assessment of the treatment provided to Mr Cornish. When he gave evidence, it is fair to say that Dr Raeside modified his views in light of further information put to him during the course of his evidence.

5.2. As I have already mentioned, Dr Raeside agreed with the diagnoses made during Mr Cornish's various hospitalisations at Hillcrest Hospital during the 1980s and 1990s, that of bipolar affective disorder, now known as bipolar disorder, which he shortly described as a 'severe mood disorder and may or may not have psychotic features associated with it' (T187).

5.3. Dr Raeside said that Mr Cornish was a frequent user of cannabis, and this can aggravate a psychotic disorder or a mood disorder and can produce relapses of illness such as mania or florid psychosis (T188).

5.4. I also heard evidence from Dr Daryl Watson, Director of Clinical Services, Mental Health Division, Lyell McEwin Health Service, who gave a similar description of Mr Cornish's illness and the complicating tendencies of cannabis, alcohol and other substances (T162).

5.5. Dr Elsdon's diagnosis

Dr Raeside disagreed with Dr Elsdon's conclusion on 22 February 2000 that Mr Cornish had no clear Axis 1 (ie. psychiatric disorder) diagnosis. He said that Mr Cornish's diagnosis of bipolar disorder was well established in past episodes and that Dr Elsdon did not appear to have been aware of that (Exhibit C25, p6)

5.6. In fact, Dr Elsdon had spoken to Dr Nagesh before she wrote to Mr Cornish's General Practitioner, and was aware that there had been a previous diagnosis of bipolar disorder. It may well be the case that by the time Mr Cornish attended upon Dr Elsdon, he was no longer seeking treatment, as he had been in his telephone call to Mr Provis on 18 February 2000. He had impaired insight into his illness, and could have been masking his symptoms. However, the fact remains that Dr Elsdon saw no sign of depression or mania when she saw Mr Cornish on that day, and there is no evidence that she was in error in forming that conclusion.

5.7. Mr Merritt's assessment

Dr Raeside suggested that Mr Merritt relied solely on information received from Mr Cornish when he decided that he was not detainable on 5 September 2001 (Exhibit C25, p7). He also suggested that Mr Merritt was unduly influenced by Dr Elsdon's assessment in February 2000 that Mr Cornish had no Axis 1 diagnosis.

5.8. Mr Merritt rejected these criticisms, saying that he had information from Dr Sadarangani, and from the police officers who had detained Mr Cornish earlier that day. He said he also telephoned Northern ACIS, and was told about previous contacts with Mr Cornish. I accept this information was reflected in Mr Merritt's entries in the clinical record.

5.9. Dr Raeside acknowledged that since Dr Nagesh had not seen Mr Cornish for a substantial time, Mr Merritt could not have been expected to have telephoned him on 5 September 2000 (T201).

5.10. Dr Raeside thought that Mr Cornish's history, and some presenting symptoms (pressure of speech, disorganised thought), when coupled with the evidence of a disturbance earlier that day, would have justified a 24 hour detention. He said:

> 'My comment is that, in general, a 24-hour admission tells you a lot about someone's current psychiatric state. It's almost impossible to - well, it would be impossible to hide a manic phase over 24 hours with direct supervision, or direct assessment and observation by nursing staff and doctors in an in-patient ward, and I think in this particular case that had he been in hospital for 24 hours that would have become evident or the converse would be that staff would be much more confident that he is settled and there is no, you know, acute psychiatric episode at that point.' (T202)

As to detention, Dr Raeside said:

> 'Well, obviously the legislation indicates that the person must have a mental illness, that they must be considered to be an immediate risk of danger to themselves or others and that there is treatment available in hospital. It's also important to recognise that Mr Merritt couldn't detain Mr Cornish, being a nurse, only a medical practitioner could do so and that would require either one of the other doctors that was in the hospital or the psychiatry registrar or psychiatrist who was on call. So there would have had to have been another step which would be Mr Merritt would have had to refer Mr Cornish to see whoever was on call from the psychiatric service before that ultimate decision could be made. I think, though, that on the history that's available there's enough there to suggest that he would have been detainable, that if we accept that he's got a mental illness, we accepted there's been an episode of aggression and he's even noted to be verbally aggressive in hospital, I think that would come under the interpretation of being a danger

> to others, or a risk of danger to others, and obviously he's got a condition that is potentially treatable.' (T203)

5.11. When cross-examined, Dr Raeside conceded that the issue facing Mr Merritt was not clear-cut. Mr Merritt recognised that Mr Cornish had a history of bipolar disorder, wondered whether his behaviour on 5 September 2001 was a 'precursor' to a relapse of his illness, and arranged a more comprehensive follow-up by the Community Team, an approach Dr Raeside accepted was appropriate (T216).

5.12. The outcome of the home visit

Dr Raeside said that when Mr Randells visited Mr Cornish on 12 September 2001, he was evasive and uncooperative, and in those circumstances it is often difficult to elicit information from the person upon which to base a mental state assessment. Dr Raeside was not critical of Mr Randells' decision to consult further with the team before taking more urgent action. I agree, particularly in light of Mr Cornish's 'amiable and apologetic' telephone conversation with Mr Randells on 14 September 2001.

5.13. Events of 23 September 2001

Dr Raeside said that the contact from Adam Cornish and later from Christopher Cornish was well recorded in the clinical record. He said that the ACIS team were assertive in following up with Dr Roughan.

5.14. However, Dr Raeside said that he thought Mr Provis' response to Adam Cornish's telephone call was not adequate, although he acknowledged that his opinion has been formed with hindsight of the outcome. He said that, in his opinion, Mr Cornish's behaviour towards his sons that night was a 'clear cut severe manic episode' which, had it been identified, would have led to more urgent intervention (T210).

5.15. Mr Provis rejected the suggestion that he should have taken urgent action that Sunday night. He could have organised a medical officer to do a home visit, but this would have required police assistance having regard to the time of night and the emotional state of Adam Cornish and Christopher Cornish. He said that this might have been difficult to arrange in view of the inconclusive outcome of the police intervention on 5 September 2001 (T127).

5.16. Dr Watson explained at length the very limited options available to Mr Provis that night (T174-176). He agreed that, ideally, the service should have been able to take

more assertive action in the form of arranging for a medical officer, a mental health worker and the police to attend at Mr Cornish's house and assess him. However, even today he is unable to say that a medical officer would be available at that time on a Sunday evening (T178).

5.17. Mr Provis said that he was particularly influenced by the fact that neither Adam Cornish nor Christopher Cornish knew about Mr Randells' home visit on 12 September 2001, nor the offer to see Dr Roughan, nor Mr Randells' telephone call with Mr Cornish on 14 September 2001. In those circumstances, he argued that he was justified in awaiting the outcome of the team meeting next day. I accept that.

5.18. Outcome of team meeting, 24 September 2001

Dr Watson was more critical of his own service when considering the outcome of the team meeting next day, 24 September 2001, namely to take no action and await further contact from Mr Cornish or his family. He said:

> 'Me sitting here now, how do I consider that? I think we should have been more assertive in our intervention at that point in time, and many of the impediments that we're talking about there were removed by that time and I don't think that passively dealing with that information was the right thing to do at that time.' (T179)

5.19. Dr Watson's statements echoed those of Dr Raeside:

> 'In my opinion, there are certainly cases in which someone may be suffering from mental illness, such that they lack insight or are unable to make appropriate decisions about their own well being, where mental health services need to be assertive, rather than simply taking a passive stance such as that if the person declines involvement then they are left to themselves.'
>
> (Exhibit C25, p14)

5.20. Mr Cornish's mental state on 25 September 2001

Dr Raeside was in no doubt that, at the time he died, Mr Cornish was suffering an acute relapse in his condition. He said:

> 'More recently, Mr Cornish appears to have suffered a relapse in his mental state, with a two month decline in his mental health prior to his death, with what appears to be a fairly obvious manic episode of a Bipolar Affective Disorder. However, it should be noted that this is only 'fairly obvious' when taking into consideration the longitudinal history, the history of various symptoms typical of mania provided by the family members, and the ultimate death itself.
>
> In my opinion, had Mr Cornish been appropriately and correctly diagnosed, with appropriate treatment instituted, then his acute relapse would probably have resolved and his ultimate death been prevented.' (Exhibit C25, p12)

He explained a ‘manic episode’ as follows:

> 'Manic, if you look at it in the traditional way of it, if you have a line on the left is depression, on the right is mania with in the middle being normal as far as your mood is concerned. Depression is obviously low mood but maybe accompanied by agitation and irritability. Mania involves not just an elevated mood but also a number of other features as well. Just on the mood it doesn't always mean high, happy mood, although that might be the beginning of it, but in the more severe cases it's usually not a happy mood but agitation, irritability, aggression. There's increased movement, the person's hyperactive, have a less need for sleep, they may display pressured speech, flight of ideas and florid psychotic symptoms, other symptoms such as delusional ideas, often grandiose or paranoid in nature, very bizarre ideas sometimes and they often have this driven quality to them, that is that they're, it's almost sort of unstoppable type of thing and invariably they come into conflict with other people, the law at the severe end of the scale. So again it's on a spectrum but a manic phase would mean a change from their normal baseline. Some people can remain sort of chronically manic, but not usually - you can't usually remain severely manic for long because you just physically wear out and end up in hospital or dead. So the manic phase I'm referring to outside of his chronic state, but this is what I refer to as an acute relapse, so there's a more severe spiking if you like of that mood disorder.' (T226-227)

Dr Watson gave a similar description (T157-158)

5.21. Dr Raeside was unable to say how long Mr Cornish had been in a manic phase at the time he died (T228). Dr Watson argued that if Mr Cornish had been manic in preceding days, this would have been obvious to Dr Ling who saw him several times for relatively minor ailments, and to Dr Woodroffe the Emergency Department doctor who sutured him on 22 September 2001 after the bicycle accident (T161). Dr Raeside accepted that, but said that Mr Cornish’s mania was probably waxing and waning as it was progressively getting worse over the period (T231).

5.22. Dr Raeside acknowledged that use of cannabis, particularly during the period in which Mr Cornish’s condition was deteriorating (and the onset of symptoms may have induced him to use more cannabis to try and self-medicate), may also have been a factor which contributed, together with his mental illness, to the ‘final behavioural disturbance’ (T234).

5.23. Dr Watson give similar evidence, although he was prepared to say that Mr Cornish’s behaviour on 25 September 2001 could have been the result of mental illness, intoxication or both:

> 'I'd say it's consistent with a severe psychiatric disturbance. That disturbance may be a manic episode, severe manic episode. There's other possibilities there including a gross

> intoxication with substances such as cannabis and as I've mentioned briefly, a potential confounder of those two things in combination.' (T167)

On the whole of the evidence, it seems more likely that there was a combination of factors operating, rather than one in isolation.

5.24. There is also the possibility that inhalation of a volatile substance may also have been a factor, although, as I have stated earlier, that can not now be established with any certainty.

5.25. Conclusions

On the basis of this evidence, I find that Mr Cornish died on 25 September 2001 while he was suffering from a severe psychiatric disturbance. On the balance of probabilities it was a manic episode, in the course of his bipolar disorder which had been deteriorating since at least 5 September 2001.

5.26. I find that if a more assertive approach had been taken by the Northern ACIS team on 24 September 2001 towards providing treatment for Mr Cornish's illness there was a chance that this tragic outcome might have been avoided. This is by no means certain, however, having regard to the unpredictable nature of his illness, and his lack of insight and resistance to treatment.

6. Recommendations

6.1. It is very unfortunate that this inquest has been held almost three years after Mr Cornish's death. Such delays reduce the efficacy of the inquest both as a fact finding process, and as a means of preventing similar deaths.

6.2. Northern ACIS

I heard evidence from Dr Watson about the very considerable changes which have taken place in community mental health since 1991. Many of these changes were initiated during the tenure of Dr Margaret Tobin as Director of the South Australian Mental Health Service, prior to her tragic death on 14 October 2002.

6.3. For example, Dr Watson produced two examples of written State-wide policies which have been developed. They are entitled 'Emergency Demand Management - ACIS' (Exhibit C24) and 'Mental Health Emergency Demand Management - Best Practice for South Australia' (Exhibit C24a). These are detailed policies which give clear

guidance to ACIS workers faced with a situation such as that faced by Messrs Merritt, Randells and Provis in this case.

6.4. Dr Watson also produced a new four-page form entitled 'Mental Health Assessment and Crisis Intervention Service - Triage Telephone Record'. This is designed to provide a clear mechanism to assist ACIS workers to perform a risk assessment whenever they receive a telephone call concerning a potential client of the service.

6.5. Dr Watson said that there had been several senior appointments to the service, including his own (Director of Clinical Services, Mental Health Division, Lyell McEwin Health Service), and a full-time consultant psychiatrist whose principal responsibilities concern emergency issues. Both positions provide a degree of clinical leadership that was formerly lacking.

6.6. In addition, Dr Watson told me that their resources in terms of psychiatric registrars, medical officers and medical officer/mental health worker teams, have been increased.

6.7. This greater level of professional resources means that clinicians such as Mr Merritt or Mr Provis can seek professional guidance from experts up to and including Dr Watson if faced with such a situation again. The risk of a death such as that of Mr Cornish is thereby reduced, in my opinion, and these improvements are to be commended.

6.8. In view of the substantial changes that have been made since the death of Mr Cornish, the opportunity to make recommendations concerning Northern ACIS has passed.

6.9. <u>Detention</u>

One issue which arose during the course of submissions of counsel was the perceived inadequacy of the Mental Health Act in relation to detention of acutely ill patients.

6.10. It will be recalled that after Mr Cornish was detained by police pursuant to Section 23 on 5 September 2001, he was seen by Dr Sadarangani, and referred to Mr Merritt who is a senior clinician but not a medical practitioner, and it was Mr Merritt's decision to discharge him rather than recommend detention to Dr Sadarangani.

6.11. This case demonstrates that the decision <u>not</u> to detain can be just as professionally challenging as a decision to detain. The initial period of detention provided for in

Section 12(1) of the Act is up to 3 days, and can be ordered by a medical practitioner. During the first 24 hours, or as soon as practicable, the detention must be reviewed by a psychiatrist (Section 12(3)). Such a period provides a good (but not necessarily ideal) opportunity to carry out a proper mental state assessment by a psychiatrist.

6.12. In this case, Mr Merritt thought that Mr Cornish might have been suffering a relapse of a psychiatric illness which needed treatment (bipolar disorder), and indeed he thought he had developed a 'precursor' to that state which required further assessment. He thought that, since the present requirements of the Mental Health Act for detention were not present, such an assessment had to be done in the community. Unfortunately, that did not happen. In my opinion, the decision made by Mr Merritt should have been made by a psychiatrist after a proper assessment of the patient's condition.

6.13. In my opinion, where police officers exercise their powers pursuant to Section 23 of the Act, an automatic 24 hour detention of the patient should follow so that a proper assessment of the patient by a psychiatrist can occur, and the order can be either confirmed or revoked.

6.14. I <u>recommend</u> that the Minister for Health consider such an amendment to the Mental Health Act 1993.

Key Words: *Suicide; Suicide Risk - Assessment Of; Psychiatric/Mental Illness; Bipolar Disorder*

In witness whereof the said Coroner has hereunto set and subscribed his hand and Seal the 10th day of September, 2004.

Coroner