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 15, 16th, 17th and 18th days of March 2005 and the 24th day of May 2005, before Wayne Cromwell Chivell, a Coroner for the said State, concerning the death of Candice Mackenzie Wallace-Mohlmann.

I, the said Coroner, find that Candice Mackenzie Wallace-Mohlmann aged 30 years, late of Malberry Lande, Mirrabooka, Western Australia died at the Royal Adelaide Hospital, North Terrace, Adelaide, South Australia on the 27th day of October 2001 as a result of hypoxic brain injury due to mixed drug toxicity. I find that the circumstances of her death were as follows:

1. Reason for inquest

1.1. On 22 October 2001 an order was made pursuant to Section 12(6) of the Mental Health Act 1993 by Drs B McKenny and B Kelly, both Psychiatrists, that Ms Wallace-Mohlmann be detained to the Glenside Campus of the Royal Adelaide Hospital for a period of 20 days and 12 hours. Ms Wallace-Mohlmann had previously been the subject of orders detaining her pursuant to the same Act.

1.2. Also on 22 October 2001, Dr McKenny made an order pursuant to Section 16 of the Mental Health Act 1993 transferring Ms Wallace-Mohlmann to the North Terrace campus of the Royal Adelaide Hospital, on the grounds that it was 'better equipped to provide for the care and treatment' of the patient. The justification given for that conclusion was:

> 'They have open beds.'
> (Exhibit C27, p1)

1.3. Accordingly, on the date of her death on 27 October 2001, Ms Wallace-Mohlmann was 'detained in custody pursuant to an Act or law of the State' within the meaning of Section 12(1)(da) of the Coroners Act 1975, and an Inquest into her death was therefore mandatory by virtue of Section 14(1a) of the said Act.

2. Introduction

2.1. At about 10pm on Tuesday 23 October 2001, Registered Nurse Catherine Schutt entered a store room which was part of Ward B4 of the Royal Adelaide Hospital. Ward B4 is the Cardiothoracic Surgery Recovery Unit, and is one floor above Ward C3, the Psychiatric Unit in which Ms Wallace-Mohlmann was detained.

2.2. When Ms Schutt entered the storeroom, she noticed a door into a subsidiary storeroom was locked from the inside. She obtained the keys from the nurses' station and entered the room to find Ms Wallace-Mohlmann lying on the floor and unresponsive. She called for help and began performing cardio-pulmonary resuscitation.

2.3. Three syringes were found on a cupboard, and two had apparently been used. One had blood in it. A cigarette was found nearby. Ms Wallace-Mohlmann had six ampoules of adrenaline in her pockets. A 'transportation backpack', a medical emergency kit which was carried when patients were being transferred, was noted to have been opened and the following items were found to be missing:

- 1 ampoule of vecuronium;
- 1 ampoule water;
- 6 ampoules of adrenaline;
- 1 ampoule of lignocaine;
- 1 ampoule of atropine.

2.4. An emergency team quickly arrived and continued resuscitation efforts. A cardiac output had been obtained by then but Ms Wallace-Mohlmann remained unresponsive to stimuli.

2.5. Ms Wallace-Mohlmann was transferred to the Intensive Care Unit, where it was found that she was suffering from severe hypoxic encephalopathy. Unfortunately, despite the best efforts of the clinicians, her condition continued to deteriorate, until

27 October 2001 when Drs J Gilligan and P Whyte diagnosed complete brain death (see Exhibits C2a and C19a respectively). Further efforts to prolong artificial ventilation were discontinued, and circulatory death soon followed.

3. Cause of death

3.1. A post-mortem examination of the body of the deceased was performed by Dr J D Gilbert, Forensic Pathologist, at the Forensic Science Centre, Adelaide on 30 October 2001. Dr Gilbert concluded that the cause of Ms Wallace-Mohlmann's death was hypoxic brain injury due to mixed drug toxicity (Exhibit C4a, p1).

3.2. A toxicological analysis of blood taken upon Ms Wallace-Mohlmann's admission to the Intensive Care Unit on 23 October 2001 was analysed by Mr P Harpas, Senior Forensic Scientist, on 17 February 2003. Some delay had been experienced because the Forensic Science Centre did not initially have the capacity to analyse vecuronium and suxamethonium

3.3. The analysis conducted by Mr Harpas revealed the presence of the following:

> '1. The admission blood numbered 6516728 contained:
>
> (1) 6 μg vecuronium per L (see interpretation)
>
> (2) 8 μg atropine per L (see interpretation)
>
> (3) 0.07 mg zuclopenthixol per L (excess but not fatal)
>
> (4) approximately 33 mg valproic acid per L (non-toxic/therapeutic)
>
> 2. The drugs vecuronium, atropine and zuclopenthixol were present in the admission urine numbered 6551691.
>
> 3. Alcohol was not detected in the blood.
>
> 4. None of the drugs suxamethonium, chlorpromazine, amphetamines, benzodiazepines, methadone, tricyclic antidepressants, morphine, cannabis and other common basic and acidic drugs were detected in the blood.'
>
> (Exhibit C6b, p1)

3.4. Dr Gilbert commented:

> '1. Death was due to severe hypoxic brain injury resulting from cardiac arrest following apparent self-injection with non-prescribed medication. It is believed that the deceased injected herself intravenously with atropine and vecuronium obtained from a storeroom in the Royal Adelaide Hospital where she was being held on a 21-day detention order for a psychiatric illness. Vecuronium is a skeletal muscle-paralysing agent used during anaesthesia to achieve muscle relaxation and permit artificial ventilation. Shortly after being administered intravenously it would cause paralysis of all skeletal muscles including the muscles of respiration.

> This would cause profound hypoxia and death unless artificial ventilation was instituted promptly.
>
> …
>
> 2. There were no injuries or other markings on the body to indicate the involvement of another person in the death.
> 3. No natural disease that could have caused or contributed to the death was identified at autopsy.'
>
> (Exhibit C4a, p4)

3.5. I accept Dr Gilbert's conclusions, and find that the cause of Ms Wallace-Mohlmann's death was hypoxic brain injury due to mixed drug toxicity.

4. Background

4.1. Candice Wallace-Mohlmann was born on 26 February 1971. At the time of her death she was 30 years old.

4.2. In a statement given to police, Ms Wallace-Mohlmann's mother Rhonda stated that she was one of non-identical twins. Both her father and grandfather had a history of mental illness and had taken their own lives. Mrs Mohlmann said:

> 'Between the age of 12 and 13 Candy started using marijuana. This resulted in a noticeable change in her behaviour. She became suspicious, aggressive, and she showed an inclination towards the super-natural; ouija boards, devil marks in black ink on her hands, giving demon 'hex' hand gestures and so on.'
>
> (Exhibit C1a, p2)

4.3. Records obtained by the Social Worker at Glenside Campus disclosed that Ms Wallace-Mohlmann's first admission to a psychiatric institution was in 1987 at the age of 16 years. She had many subsequent admissions to various institutions in Western Australia. Her diagnoses included schizophrenia, borderline IQ, and borderline personality traits. It was suggested in the records that she had been disturbed since the age of 3, and that her behaviour was characterised by impulsivity, substance abuse, and high risk sexual behaviour.

4.4. Mrs Mohlmann said that in about 1986 or 1987, her daughter went to Sydney by herself. She said:

> 'She told me she was going shopping one afternoon and would be 'back by five', but she actually hitched a ride from Perth across the country to Sydney. I reported her as a

missing person. She contacted me almost six months later and told me she would be getting a bus back to Western Australia, which she did soon after.

When she got back she showed marked improvement over her former state, but this quickly deteriorated and resulted in her returning to Graylands as an in-patient. She was forcibly detained for at least a year, but she was given regular leave. At this stage I understood her drug use to be marijuana. She also could not be relied upon to take her medication to control schizophrenia. I surmised that Candy had supported herself in Sydney by prostituting herself.

…

Throughout this era I understood Candy's drug use to be marijuana, progressing to amphetamines and heroin. In the early 1990s my younger children reported to me that they'd seen Candy sticking a needle into her arm while she was in the toilet at home; they even described a tourniquet though not in those words. Right up to when she left my house destined for Sydney about six months ago, I would find syringes in Candy's room while tidying up.

Candy could live without drugs, but she would get the idea into her head that she needed them, and she would go down to Fremantle, prostitute herself then go and buy drugs, namely speed or marijuana. On my birthday this year she stole money given to me for my birthday ($65 in total) and a ring valued at $1,250 which I assume she pawned. When she was in a state where she needed drugs I would describe her as desperate. I once saw two large and heavily built police officers struggle to restrain her during one of these episodes.'

(Exhibit C1a, p3)

4.5. In about March or April 2001, Ms Wallace-Mohlmann went back to Sydney by train. Sometime later she was in trouble for shoplifting and assault but was subsequently released. Mrs Mohlmann said she did not hear further from her daughter until around August 2001 when she heard that she was in hospital in Adelaide (Exhibit C1a, P5).

4.6. Ms Wallace-Mohlmann had been the subject of limited Guardianship Orders in Western Australia since 18 March 1999. These orders were reviewed in March 2000 and were to be further reviewed in March 2001, but by that time she had left for Sydney and so the proceedings were adjourned. She had also been the subject of a Community Treatment Order in relation to her psychiatric medication since December 1999. She had previously attempted suicide by overdose, when facing criminal charges, in October 2000. She had also attempted to jump in front of a train in December 2000.

5. First admission to Royal Adelaide Hospital

5.1. On Friday 28 September 2001 Candice Wallace-Mohlmann was apprehended by uniformed police officers on the northern bank of the River Torrens in Adelaide, not far from the University footbridge. She was dressed skimpily and was barefoot. She was behaving in a bizarre manner, seeming over-cheerful and child-like. She was conveyed to the Royal Adelaide Hospital.

5.2. Ms Wallace-Mohlmann was seen in the Emergency Department at around 3pm, and was found by the Psychiatric Registrar, Dr Tai, to be 'significantly thought disordered, psychotic and agitated/restless'. He diagnosed a psychotic relapse of '? schizophrenia, ? schizo-affective disorder, ? substance induced'. He commented:

> 'Requires psychiatric admission - if behaviour settles, may be able to manage her in C3 Ward with security special. Otherwise, needs closed ward management.'
>
> (Exhibit C30)

5.3. At 3:30pm, Ms Wallace-Mohlmann was detained by Dr Paul De Ieso pursuant to Section 12(1) of the Mental Health Act 1993. As there were no beds available in Ward C3, the psychiatric unit, she was kept in Ward S3, shackled to the bed and guarded by a security officer.

5.4. Ms Wallace-Mohlmann was seen during the morning of 29 September 2001 by Professor R J Barrett, and he made an entry in the clinical record as follows:

> 'Candice Mohlmann suffers from schizophrenia. I suspect that underlying this she is intellectually retarded. She is thought disordered, quite grossly. She has disorganized delusions of a grandiose nature. She is disinhibited and agitated.
>
> I am concerned that she is being managed in a setting which, in spite of the best efforts of the nursing staff, is quite inappropriate for her care.
>
> I am deeply concerned that she is shackled for treatment of acute psychosis. Again this is the only resource available to the nursing staff under these extreme circumstances, and they are to be commended for removing them as soon as possible. However the use of shackles is unethical. It could be construed as a form of malpractice which places the Royal Adelaide Hospital at risk of medico-legal action.
>
> To deal with the immediate situation we must:
>
> 1. increase the dose of olanzapine
> 2. maintain the security guard
> 3. continue the consistent, calm, nursing input
> 4. arrange transfer to Brentwood as a matter of urgency.'
>
> (Exhibit C30)

5.5. Professor Barrett confirmed Dr De Ieso's detention order pursuant to Section 12(4) of the Mental Health Act 1993, and transferred her to the Glenside Campus pursuant to Section 16 of the Mental Health Act 1993 on the following grounds:

> 'It has an Intensive Care Unit designed to manage such patients.'
> (Exhibit C30)

5.6. Following Professor Barrett's consultation, there are no further entries in the clinical record until after 7:10pm. It was not until 10:15pm that evening that Ms Wallace-Mohlmann had arrived and could be assessed at Glenside Campus. She was seen and admitted immediately and spent 30 September 2001 uneventfully.

5.7. On 1 October 2001, Ms Wallace-Mohlmann was seen by Dr Geoffrey Seidel, Consultant Psychiatrist, for the purpose of reviewing her detention order. Once again, Dr Seidel found her to be grossly thought disordered and thought blocking, probably hallucinating, loud, animated and threatening. He diagnosed that she was suffering from schizophrenia which was probably severe and drug resistant. He commented:

> 'Should be in locked ward but manageable with special + prn (as required) medication.'
> (Exhibit C27)

5.8. Dr Seidel made an order pursuant to Section 12(5) of the Mental Health Act 1993 detaining Ms Wallace-Mohlmann for 21 days.

5.9. On 2 October 2001, Ms Wallace-Mohlmann was transferred to Brentwood North, a closed ward. On admission, she was seen by Dr Maria Cominos, Psychiatric Registrar, who diagnosed that she was suffering from a 'severe exacerbation of chronic treatment resistant schizophrenia'. Dr Cominos noted that 'she may require seclusion', and that 'close observation may be needed'.

5.10. Ms Wallace-Mohlmann remained in Brentwood North until 22 October 2001. Some improvement was noted throughout this time. For example:

- On 9 October 2001, Drs McKenny and Cominos observed that she was 'beginning to settle - marginally';
- On 16 October 2001, Drs McKenny and Cominos noted that she 'remained psychotic';

- On 19 October 2001, Dr Cominos noted that she was 'slowly improving - there has been a significant overall improvement but she remains very unwell'.

5.11. On 22 October 2001, Ms Wallace-Mohlmann was seen by Dr McKenny and Dr Cominos for a detailed assessment in the context that her detention orders required further review. Dr Cominos noted that she was wearing 'bizarre eye makeup', that she was cooperative, her speech was pressured, her thoughts remained disorganised, she was expressing bizarre persecutory sexual/sematic delusions, that her affect was labile, and that her insight and judgment were impaired.

5.12. Despite these observations, Dr McKenny observed:

> 'However she is sufficiently settled to warrant a trial in an open unit. The longer term prospects for future care are still problematic. She is resistant to the idea of returning to Perth where there are orders in place. She wants to return at some point to New South Wales to face charges. Today she expressed the wish to stay in Adelaide.
>
> → Trial open unit
>
> → Depot today'
>
> (Exhibit C27)

The reference to 'Depot today' indicates that although Ms Wallace-Mohlmann was not due to receive a further injection of zuclopenthixol decanoate, a long-acting psychotic medication, until a further four days had passed, she should receive the medication earlier because of her continuing psychosis.

5.13. Following this assessment, Dr McKenny wrote the order pursuant to Section 12(6) of the Mental Health Act 1993, co-signed by Dr Kelly, and the transfer order to the Royal Adelaide Hospital to which I referred earlier in these findings. It is noteworthy that the transfer order reads:

> 'I am of the opinion that the Royal Adelaide Hospital (approved treatment centre) is better equipped to provide for the care and treatment of the above patient, and that the patient should be transferred to that centre, for the following reasons:
>
> They have open beds.'
>
> (Exhibit C27)

I will discuss the issues arising from this decision later in these findings.

6. Further admission to Royal Adelaide Hospital

6.1. Ms Wallace-Mohlmann was seen by Dr Jacqueline Symon, Psychiatric Registrar, at about 8pm on 22 October 2001. Dr Symon read the discharge summary prepared by Dr Cominos which concluded, after a detailed analysis of her history, presentation and progress at Brentwood North:

> 'Overall fair improvement in mental state during the course of admission, however remained delusional, with some thought disorder, mildly excited, pressured speech, labile mood. Requesting open ward, expressing preference to stay in Adelaide for a while, hoping to have a flat of her own, with community case management.
>
> Form 4 completed. Risk of absconding remains. Reasonable to trial on an open ward and consider all discharge planning options.'
>
> (Exhibit C27)

6.2. Dr Symon prepared a very detailed note in the clinical record, covering seven pages. Her impression was as follows:

> 'Woman with history of schizophrenia, presents disorganised and psychotic following 3/52 admission to psychiatric intensive care ward. Appears to have improved since admission, but remains very unwell. Candice does not represent a risk to self or others in terms of actual physical harm. However, she is at risk of absconding, due to level of disorganisation, and would be very vulnerable in the community.'
>
> (Exhibit C30) (my underlining)

6.3. Dr Symon said that she specifically made those notes for the consideration of the clinicians present at the 'intake meeting' which she knew would be conducted the following morning (T79).

6.4. At 9am on 23 October 2001, an intake meeting took place at which Dr Les Koopowitz, Consultant Psychiatrist, Dr Felicity Ng, Psychiatric Registrar, and Ward C3 nursing staff including the Nurse Manager, were present. Dr Ng read Dr Symon's note to the meeting. When Ms Wallace-Mohlmann attended the meeting her behaviour was noted as irritable and hostile, she was verbally abusive, her thought was disorganised and speech was loud and pressured. Dr Ng described her presentation as 'floridly psychotic with severe thought disorder'.

6.5. As part of her treatment plan, Dr Ng wrote:

> 'Close observation of mental state.'
>
> (Exhibit C30)

6.6. Having regard to Ms Wallace-Mohlmann's continuing psychosis, she was given 200mg of zuclopenthixol acetate (Clopixol-Acuphase), a short-acting antipsychotic medication, as well as 400mg of zuclopenthixol decanoate, a longer-acting psychotic medication, as had been directed by Dr McKenny the day before.

6.7. At 12:10pm, Ms Wallace-Mohlmann was given 100mg of chlorpromazine and 5mg of lorazepam, both 'prn' medications, presumably given after she absconded from the ward and then returned. The note of Registered Psychiatric Nurse Alexander Mitchell at 12:30pm includes the following:

> 'Has been off the ward needing to be retrieved from A4, running up and down corridor, smell of incense in her room. Wants to spent $2,000 in her bank account. Wearing make-up excessively and poorly applied …' (Exhibit C30)

6.8. Another note made on 24 October 2001, after Ms Wallace-Mohlmann's collapse, was written by Dr Daryl Catt, a Consultant Physician in the Intensive Care Unit. The note reads:

> 'Patient seen wandering a number of times in B4 by staff (including Ward Clerk). Assistance was offered; patient apparently muttering 'I'm going to kill her': during 23/10/2001.'
>
> (Exhibit C30)

6.9. It is unclear whether Ms Wallace-Mohlmann absconded from Ward C3 more than once. The reference by Mr Mitchell to Ward A4 and the reference by Dr Catt to Ward B4 is not contradictory, since those two wards are next to each other on the same floor.

6.10. The reference to Ms Wallace-Mohlmann muttering 'I'm going to kill her' may be consistent with Dr Ng's impression that she had been hostile to her and refused to talk to her because she had written the order for Acuphase earlier that day. Because of her attitude, Dr Ng did not think it would be the best strategy to 'push her' (T122).

6.11. Ms Wallace-Mohlmann received a further 100mg of chlorpromazine and a further 5mg of lorazepam at 4pm on 23 October 2001. There was no entry in the clinical record to indicate why the further 'prn' medication was administered.

6.12. Registered Nurse Nita Clifton was the Clinical Nurse on Ward C3 for the afternoon of 23 October 2001. She commenced duties at 1:30pm. She had not met Ms Wallace-

Mohlmann before, but said that she spent about an hour with her helping her to tidy up her room and attend to her clothing.

6.13. It was Ms Clifton's role to allocate patients to the nursing staff on duty that day. She allocated Ms Wallace-Mohlmann to Registered Mental Health Nurse Andrew Grant, whom she described as the best nurse on duty that day (T137).

6.14. Ms Clifton said that if it had been apparent to her that Ms Wallace-Mohlmann needed special nursing (ie a full-time one-to-one nursing), this could have been arranged (T139). As it was, Ms Wallace-Mohlmann was one of five patients allocated to Mr Grant that afternoon.

6.15. Mr Grant commenced duties at 2:30pm. He told me that he attended an oral handover from Mr Mitchell. He said that during the handover, the nurses complete a sheet on which various notes are made about the particular patient. As this is not an Royal Adelaide Hospital approved document, the sheets are not retained in the clinical record. As it is, no record exists of what took place in the handover. This is a most unsatisfactory system.

6.16. Mr Grant told me that he was not informed about Ms Wallace-Mohlmann absconding from the ward earlier that morning.

6.17. Surprisingly, neither Ms Clifton nor Mr Grant read Dr Symon's note that Ms Wallace-Mohlmann may need special nursing, nor did they read Dr Ng's note directing 'close observation of mental state', nor did they read Mr Mitchell's note that she had been off the ward that morning needing to be retrieved from A4. I find it extraordinary that experienced nurses would rely on an oral handover of patients rather than reading the clinical record concerning a patient with such high needs as Ms Wallace-Mohlmann.

6.18. Mr Grant told me that he formed the view that Ms Wallace-Mohlmann was the most needful of his five patients that afternoon and so he spent most time with her. He resolved to sight her every 15 minutes. He was concerned that she might 'wander off' (T187), and because she was 'over aroused' he gave her the 'prn' medication at 4pm. He did not make an entry in the clinical record that he had done so.

6.19. On several occasions he escorted Ms Wallace-Mohlmann outside for a cigarette and noted that she was very agitated and abusive while he was with her, although he did not find her threatening (T169).

6.20. Both Ms Clifton and Mr Grant noted that by about 9pm that evening, Ms Wallace-Mohlmann's condition had settled. She was calmer and more organised in her speech. She had attended to a shower by herself, and was now dressed and groomed appropriately.

6.21. The apparent inference to be drawn from this evidence, is that even if Ms Wallace-Mohlmann had needed special nursing earlier in the afternoon when she was still highly agitated, this would no longer have been necessary by about 9pm that evening. One would hope, however, that if special nursing was to cease, the Psychiatric Registrar, Dr Ng, would have been consulted, and would have performed an appropriate Mental State Examination prior to any such change being made. In the event, no such assessment was performed.

6.22. Mr Grant told me that at about 9:45pm that evening, he heard Ms Wallace-Mohlmann request a cigarette from another nurse. The smoking room had closed at 9:30pm, and so the request was denied. Mr Grant said that he expected her to react badly to this refusal, but instead he heard her mutter something to herself and walk away. At around 10pm that evening, he asked the student nurse to do a count of the patients and it was reported back that Ms Wallace-Mohlmann was missing. At about 10:10pm, he was advised that she had been found in Ward B4 upstairs, and that she had suffered a cardiac arrest (T178).

7. Issues arising at inquest

7.1. Mixed drug toxicity - accidental or deliberate?

Drue Wallace-Mohlmann who is about 13 years younger than his sister, said that, in his opinion, his sister did not commit suicide. He said:

> 'I don't believe that she did commit suicide, I believe that she took these drugs to feel good. She always wanted to feel good and would take any drug to make her feel this way.'
>
> (Exhibit C7a, p2)

7.2. In an addendum to his statement, Mr Wallace-Mohlmann added:

> 'During out stay at the RAH, I was informed that Candice had been over sedated in order to control her as she was acting aggressively upon admission. I imagine Candice took the drugs that killed her with the intent of pulling herself out of the stupor that the drugs she had been over administered put her in.'
>
> (Exhibit C7a, p3)

7.3. I do not accept that there is any evidence that Ms Wallace-Mohlmann was 'over sedated' at the Royal Adelaide Hospital. Indeed, as I will presently discuss, there have been criticisms that her medication was insufficient to control her very severe psychosis. However, I can readily accept that Ms Wallace-Mohlmann might have resented any sedation which she may have felt as a result of the medication she was given, and may have sought stimulant medication to counteract that. It is noteworthy that there were six ampoules of adrenalin found in her clothing after her collapse. She may have felt that the atropine and vecuronium may also have counteracted the sedatives.

7.4. Dr Koopowitz also suggested that Ms Wallace-Mohlmann was looking for excitement and stimulation rather than self-harm when she took the drugs. He said:

> 'In my experience of dealing with people such as Candice, they have what I term excitement-seeking brains. The world can be a very dull and boring place and they need … stimulation and we put them in a position where we take away that stimulation by trying to dull their brains with medication and impose restrictions on them. It had appeared, from what I could see, from my reading of the situation, that at some stage during her time in C3, she had left the ward, whether that was before the meeting or after the meeting or sometime during the day, she had been brought back. She'd been reined in; that the nursing staff had worked very hard in terms of trying to help her contain her behaviour but that she was seeing no reward. She wasn't getting the excitement she was seeking. By about 9.30, 9.45 that evening, she felt she deserved a cigarette or some - and we know nicotine does give - it acts on what we call the nicotinic - the collogenic nicotinic receptors which give that immediate relief and it's a very addictive substance. With the rules of the institution as they are, the smoking room at C3 - because there was no outside facility - had been closed. The exit door had been locked and I think that or my speculation is that Candice used that medication time as a window of opportunity then to, in a moment of frustration, to sort of say 'Okay, I've played the game' - not necessarily reasoning this consciously but to say 'They won't give me a cigarette. I've done what's been expected of me. Stuff this type of thing. I'll just go see what else I can get hold of' and wandering about. Maybe she'd seen the emergency trolley in A4 during her earlier reconnaissance or earlier time up in the ward but what we did, having spoken to, as I had noted although it wasn't later documented, we did conduct an internal audit. I did speak to the staff at the other ward. On the emergency trolley, one of the big letters that was written there was 'Adrenaline' and we all know about an adrenaline rush and it

> could have been that Candice thought 'I'll get some reward or get a high from injecting myself with this stuff' but didn't realise there was the muscle relaxant and the other toxins associated with it and was she perhaps looking for a high? Was she perhaps looking for the reward that had been denied to her by not allowing her access to the smoking room because it had been shut for the night? That's the speculation that I possibly thought about during that time; that the possibility of escaping into the parking area had been denied her.' (T113-T114)

7.5. I accept the evidence outlined above, and find that Ms Wallace-Mohlmann did not ingest atropine and vecuronium with a view to taking her own life, but rather as a form of recreational drug use in order to achieve excitement and stimulation in the context of psychiatric treatment she was receiving.

7.6. Medication

I received a report from Professor R D Goldney who has had extensive experience in academic and clinical psychiatry in general and mental hospital and private practice settings for many years. He is a part-time Professor of Psychiatry at the University of Adelaide.

7.7. Professor Goldney drew attention to two aspects of the medication administered to Ms Wallace-Mohlmann, namely the antipsychotic medication flupenthixol, and the mood stabiliser sodium valproate.

7.8. As to sodium valproate, Professor Goldney referred to entries in the clinical record that established that on 10 October 2001 the level of sodium valproate was 280 umol/L, and on 23 October 2001 they had dropped even further to 96 umol/L. Professor Goldney pointed out that the therapeutic range for sodium valproate is 300-600 umol/L. Ms Wallace-Mohlmann was receiving doses of 500mg, twice per day. The ‘rule of thumb’ is that a dose of 20mg to 25mg per kilogram of body weight is usually required. On the basis that Ms Wallace-Mohlmann weighed more than 80kg, a dose of between 1500mg to 2000mg was called for.

7.9. Clearly, Ms Wallace-Mohlmann’s mood had not been successfully stabilised when she was transferred from Glenside Campus to the Royal Adelaide Hospital, and nor was it stabilised after she arrived there. One would have thought that the first step might have been increasing the level of sodium valproate to ascertain whether that might have made a difference.

7.10. Dr McKenny acknowledged that the sodium valproate levels were inadequate, and said that in retrospect Ms Wallace-Mohlmann should have been receiving 1500mg per day, although he had reservations about whether that would have affected the outcome (T44). It will never be known if he is right about that.

7.11. As to flupenthixol decanoate, Professor Goldney noted that Ms Wallace-Mohlmann had been receiving doses of 800mg by intramuscular injection every fortnight, whereas the dose was only 400mg fortnightly when she was admitted to Glenside Campus.

7.12. It was argued by the clinicians that 400mg was the appropriate dose, as specified in MIMS (see for example the evidence of Dr Kelly at T27).

7.13. Professor Goldney argued that MIMS is an extremely conservative prescribing guide, and that specialist clinicians are used to following their professional judgment of the clinical response to medication dosage, rather than regarding themselves as bound by prescribing guides (T238).

7.14. Dr McKenny argued that there is also a debate in the professional literature about the usefulness of large doses of flupenthixol, and wondered whether the high dose Ms Wallace-Mohlmann was receiving in Western Australia may have been the reason why she left Western Australia and went to Sydney. With respect, I think that is drawing a rather long bow, since I note no evidence in the Western Australian material that indicated that she objected to the medication she received there.

7.15. Again, the plain fact is that Ms Wallace-Mohlmann was still floridly psychotic, and it is surprising that the clinicians did not consider increasing flupenthixol medication in view of the fact that there were aware of the dosage she was receiving in Western Australia. It is noteworthy that she received both an intramuscular injection of flupenthixol decoanate as well as the shorter-acting flupenthixol acetate on 23 October 2001 but it would appear that neither medication had time to reach its full effect by the time she collapsed.

7.16. I accept Professor Goldney's evidence that Ms Wallace-Mohlmann's medication levels were inadequate, and should have been monitored more closely, both at the Glenside Campus and at the Royal Adelaide Hospital.

7.17. Continuity of care

Professor Goldney was particularly critical of the transfer of Ms Wallace-Mohlmann's care between institutions. He said:

> 'It is also evident that there was a lack of continuity of care, with her having been assessed initially at the Royal Adelaide Hospital and then transferred to Cleland House, following which she went to North Brentwood, a secure area, before she was transferred back to the Royal Adelaide Hospital, where she was seen by a duty doctor after transfer in the evening (admission recorded as occurring at 19:56 hours), before seeing a new primary therapist the following morning. It is difficult for patients to have therapeutic relationships when there is such lack of continuity of care. That is particularly the case when a patient has a very active and severe continuing psychotic condition, as was the case with Ms Wallace-Mohlmann. Indeed, her psychotic illness was such that she refused to be assessed by the psychiatric registrar, Dr Ng, and therefore one is not in a position to take any risks at all in regard to her safety.'
>
> (Exhibit C36, p8)

7.18. In particular, Professor Goldney said that it would have been better if Ms Wallace-Mohlmann stayed in a closed ward environment until her condition was stable, but if that was not possible then:

> 'I could be persuaded to modify this view if in fact Ms Wallace-Mohlmann had been placed in an open ward with very careful monitoring of her symptoms and behaviour within Glenside Hospital. In my view the transfer from a secure ward at North Brentwood at Glenside Hospital, in a person whose condition clearly has not settled, to an open ward at another hospital without very careful supervision is not appropriate.'
>
> (Exhibit C36, p10)

7.19. As for the suitability of Ward C3 at the Royal Adelaide Hospital to care for a patient such as Ms Wallace-Mohlmann, Professor Barrett commented in his interview:

> 'And what I have observed is that there's been an enormous change in the open wards of general hospitals. This has occurred right across Australia, in fact it's right across the world. And C3 is no exception. That what has been expected of these wards, these open wards, especially in the last five years in South Australia, is that they manage patients, of what we call higher and higher acuity. Patients of higher and higher risk. And there is a reason for that, there's a structural reason for that and the reason is that the massive mental hospitals that we used to know have been wound down, Hillcrest for example, Glenside, and so patients aren't treated there in the same way as they used to be in the same numbers. So where do they go? Well a lot of then end up in prison, actually. That's where they go. A lot of them end up in open wards, where I have no doubt in my mind ten years ago, we would have said, straight back. This is dangerous. But what's happening is that the nursing staff and the medical staff and the psychiatrists on the open ward, are being placed under increasing pressure to treat patients who are at increasing levels of risk, because of these institutional changes and so, I mean, the end, if I was to

> speak in the abstract, I would say that ten years ago this would have been an outrage for, to have her re-admitted. But you have to take it in terms of the context, the context and the time. These days it is being asked of nursing staff time and time again to manage patients who are very, still very much at risk, who are still quite a danger to themselves and perhaps to others, and so I think we live in very risky dangerous times. My own opinion is that the nursing staff in particular, psychiatric staff, do an extraordinary job in so far as they live on a knife edge.'
>
> (Exhibit C9a, p9)

That interview was given on 27 November 2001. In case it might be argued that it does not represent the current situation, I sought Dr McKenny's comments on these issues and he said:

> 'I accept Professor Barrett's observation that the open wards are certainly a lot more acute places to work than they were ten years ago, and I think my previous comment about the percentage of detained patients is a reflection of that. Certainly the levels of physical risk that the nursing staff are placed under, and psychological stress that nurses and doctors are placed under, this is significant and I think is an ongoing factor in terms of problems with staffing, the age of nursing staff, the propensity for my colleagues to leave the public system for private practice and so on and so forth. As to the … opening premise about the benefits of hospitals, the downside of the large hospitals, of course, is that they consume large amounts of resources and Professor Barrett doesn't really have time, in that discussion, to go into the benefits of community care and the amount of money that's gone into community care or lack of it in South Australia by comparison to the eastern States which then, can hopefully prevent some of these problems getting to this point. That's one issue. I think the other issue I mentioned was the substance abuse increasing the level of risk because those who are affected by substance in combination with a mental illness pose significant challenges to us all at the moment.' (T53-T54)

7.20. These opinions, coming as they do from senior clinicians in the public mental health system, are cause for great concern. The clear implication is that a patient whose condition is as acute as Ms Wallace-Mohlmann's was, should be treated in a more 'intensive care' environment. The pressure for beds in the Intensive Care Unit (North Brentwood) led to a rather uncoordinated and unplanned transfer and less than intensive treatment in Ward C3 at the Royal Adelaide Hospital. The extent to which this is a resourcing issue for the mental health system is not clear.

7.21. I suspect the fact that both the Royal Adelaide Hospital and Glenside Campuses are part of the same organisation has led to an attitude where transfer between the two is regarded as an internal issue, without regard to the risks inherent in any institutional transfer of a high-risk patient.

7.22. These issues have been addressed in changes to the regime in Ward C3, made since Ms Wallace-Mohlmann's death, as I will presently outline.

7.23. Nursing care

I have already recounted the evidence of Mr Grant, who told me that although there were no specific instructions to this effect, he had formed the conclusion that Ms Wallace-Mohlmann was a 'high needs' patient and had decided to see her every 15 minutes.

7.24. There are several grounds upon which it can be concluded that Ms Wallace-Mohlmann's needs were even higher than that identified by Mr Grant. Taking into account Dr Symon's suggestion that 'ward staff may need to consider a special nurse', and Dr Ng's direction that Ms Wallace-Mohlmann required 'close observation of mental state' following the intake meeting, Professor Goldney said that, in his opinion, special nursing (ie. one-to-one) would have been 'ideal' (T242).

7.25. Dr Koopowitz said that he considered whether special nursing should have been specifically directed when he assessed Ms Wallace-Mohlmann during the intake meeting, and said that if he had known about her tendency to abscond, this would have 'tipped the balance' in favour of special nursing (T102).

7.26. By the time he gave evidence, Dr Koopowitz was under the mistaken impression that Ms Wallace-Mohlmann had absconded prior to the intake meeting, whereas it seems clear from the clinical record that this happened afterwards. Dr Koopowitz should have been aware, however, of Ms Wallace-Mohlmann's tendency to abscond from Dr Symon's note from the night before.

7.27. Registered Nurse Alison Charlesworth, Clinical Nurse Consultant now in charge of Ward C3, told me that, in her long experience in nursing, an instruction to conduct 'close observation' on a patient would require special nursing, and should be recorded in the clinical record (T202).

7.28. As to the clinical record, it is noteworthy, as Professor Goldney pointed out, that there is not a single contemporaneous entry for the balance of 23 October 2001, following the intake meeting in the morning. The only substantial entry is that of Mr Mitchell at 12:30pm. Dr Ng's note was made at the end of the shift at about 9pm, and Mr Grant's note was made the following day in retrospect.

7.29. This is a completely unsatisfactory method of maintaining a clinical record. None of the observations made by the clinicians were noted contemporaneously. Particular issues, such as the reason why 'prn' medication was administered, have not been noted.

7.30. Even worse, a culture seemed to have developed in Ward C3 that it was not necessary to read the entries in the clinical record from the previous shift, but rather to rely on the verbal handover from the nursing staff of the previous shift. As a result of this, important information was either not transferred, or if it was, it was not noted by the incoming shift. I have not heard evidence from Mr Mitchell, and I make no finding about whether the particular information about Ms Wallace-Mohlmann's absconding was handed over verbally or not. There was a perfectly adequate and informative note in the clinical record which, in my opinion, Ms Clifton and Mr Grant should have read and noted. I find it extraordinary that they would rely upon a verbal handover as a substitute for reading the clinical record.

7.31. As a result, neither nurse was aware that Ms Wallace-Mohlmann had absconded during the morning of 23 October 2001 until the next day, after she had absconded and collapsed. This was important information which should have had a significant bearing upon the level of care she should have received.

7.32. I agree with the evidence of Ms Charlesworth that the information should have been handed over, it should have been noted, and it should have been read (T195-T196).

7.33. <u>Security of drugs</u>

It is noted that the drugs which Ms Wallace-Mohlmann found in the Ward B4 storeroom were 'Schedule 4' drugs within the meaning of the Controlled Substances Act 1984. The licence to possess such drugs (Exhibit C37) provides:

> 'The Health Service must provide appropriate storage for drugs to ensure efficacy, stability and security.'

It is noteworthy that these were not 'drugs of dependence' which would be subject to 'Schedule 8' of the Controlled Substances Act, and which would have required an even higher degree of security.

7.34. It seems clear that the 'security' with which the atropine and vecuronium was stored was virtually non-existent. The staff of that ward were aware that Ms Wallace-

Mohlmann had been wandering in the area that morning, and yet she was able to walk into the storeroom undetected and lock the door from the inside and administer the drugs to herself.

7.35. I note the evidence of Ms Schutt that the storeroom is now locked and nursing staff are able to access the room only with the use of a 'swipe card' (T215). I also note the statement of the Director of Nursing, Ms Kathleen Read (Exhibit C20a), to the same effect. This level of security is much more appropriate for potentially dangerous drugs.

7.36. Security in Ward C3

A major cause for concern arising out of this case is how it could be that a person who had been described, only hours earlier, as 'floridly psychotic', could have been able to leave Ward C3 undetected, and enter the storeroom of another ward, still undetected, and administer lethal drugs to herself.

7.37. I have already recounted Professor Goldney's opinions about the appropriateness of Ms Wallace-Mohlmann's containment in an open ward. Unless she was nursed on a one-to-one basis, the lack of physical security in Ward C3 meant that it was always possible for her to abscond undetected.

7.38. Dr Shane Gill, the Director of Clinical Services of the Royal Adelaide Hospital's Community Mental Health Service, supplied a statement (Exhibit C21a) describing the changes which have taken place in Ward C3 since Ms Wallace-Mohlmann's death:

- All patients undergo a formal risk assessment (as per the Emergency Demand Management Protocols released by DHS) which includes an assessment of absconding risk, risk of aggression and risk of self harm, conducted on admission and daily during admission;
- Level of nursing observation (from Special Nurse to 15, 30, 60 and 120 minutely frequency observations) are linked to the risk assessment;
- The entry door to Ward C is kept locked (with key card access for staff) if the number of patients with high risk, or any one patient with a very high absconding risk exceeds the capacity of ward staff to sufficiently observe them. In practice this is almost all of the time, so it is rare for the ward not to be locked;

- There is a seclusion room available if patient behavioural disturbance needs to be contained for brief periods.

Dr Gill added:

> 'With these measures in place there is no requirement for security staff to man the entry door to Ward C3.
>
> The impact of these security arrangements has to some extent sacrificed the therapeutic milieu of the ward in order to provide a more custodial environment that provides a physical barrier to absconding.
>
> However, as a result of these changes the risk of a repeat of or similar incident to the one involving Ms Mohlmann is substantially reduced. '
>
> (Exhibit C21a, pp1-2)

7.39. Ms Charlesworth gave a statement which is substantially similar to that of Dr Gill, with the following additional information:

- Digital photographs of patients are now taken on admission which can be used to assist if patients abscond and for patient identification for administering medication;
- The position of Shift Coordinator has been established, whose responsibility it is to coordinate both early and late shifts rather than having a complete break in the middle of the day;
- The expectation is now that any administration of 'prn' medication should be accompanied by an entry in the clinical record, a signature in the drug chart, and an entry in the progress notes;
- The 'unofficial' observation record kept at Ward C3 at the time Ms Wallace-Mohlmann collapsed has been abolished, and a new revised patient visual observation chart for both day and night time observation has been introduced;
- A checklist of nursing duties governing the admission and discharge of a patient has been developed;
- The smoking room times have been altered so that it is now open at a later hour when patients might reasonably be expected to use it (9:30pm was considered too early);
- A staff orientation package has been developed;

7.40. A number of other changes have been introduced which clearly have significantly altered the way in which Ward C3 operates, particularly now that it is closed.

7.41. I accept the force of Ms Charlesworth's evidence that the deficiencies in care provided in Ward C3 to Ms Wallace-Mohlmann during her stay are unlikely to reoccur. The evidence before me does not suggest that other measures should be taken to ensure that they do not. Only time will tell if her optimism is justified.

7.42. This is a particularly significant matter, since I have read recently in the print media that a decision has been taken to close Glenside Campus and to establish more inpatient facilities such as that which exists in Ward C3 at the Royal Adelaide Hospital at other hospitals, notably the Flinders Medical Centre, the Repatriation General Hospital, the Lyell McEwin Hospital and the Noarlunga Hospital.

7.43. Certainly, a very high degree of vigilance will need to be exercised in relation to patients with an illness as acute as that of Ms Wallace-Mohlmann if a tragedy such as her death is to be avoided in future.

8. Recommendations

8.1. In view of my comments in the preceding section, I have no recommendations to make pursuant to Section 25(2) of the Coroners Act, 1975.

Key Words: *Death in Custody; Psychiatric/Mental Illness; Hospital Treatment; Drug Overdose*

In witness whereof the said Coroner has hereunto set and subscribed his hand and Seal the 24th day of May, 2005.

Coroner