CORONERS ACT, 2003

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 1st, 2nd, 3rd and 8th days of November 2006, and the 21st day of December 2006, by the Coroner's Court of the said State, constituted of Elizabeth Ann Sheppard, Coroner, into the death of Renato Dooma.

The said Court finds that Renato Dooma aged 36 years, late of Cramond Clinic, Woodville Road, Woodville died at the Royal Adelaide Hospital, North Terrace, Adelaide, South Australia on the 7th day of October 2004 as a result of multi organ failure due to consequences of multiple injuries. The said Court finds that the circumstances of his death were as follows:

1. Introduction

1.1. On 20 September 2004, Mr Dooma was an inpatient of Cramond Clinic at The Queen Elizabeth Hospital (TQEH) and was subject to a Continuing Detention Order issued by the Guardianship Board on 3 June 2004. Mr Dooma was suffering from chronic paranoid schizophrenia. By 20 September 2004 he had been treated in Cramond for approximately 4½ months without any significant improvement in his condition. Mr Dooma's psychotic symptoms were so pervasive and resistant to conventional antipsychotic medication that the Consultant in charge of his management, Dr Rohan Dhillon considered that he required an extended period of hospitalisation in a closed facility at Glenside Hospital to see whether he would respond to Clozapine[1]. Clozapine is an alternative medication which requires careful supervision. There was no suitable facility available in South Australia, other than at Glenside, to manage Mr Dooma. The acute setting at Cramond was regarded as unsuited to Mr Dooma's

[1] Exhibit C16a

management, partly because of the high level of stimuli in the wards. An application to transfer Mr Dooma to the extended care facility at Glenside was rejected in July 2004. A trial period in the community in August failed after only four days and Mr Dooma was brought back to Cramond for closed ward management.

1.2. Mr Dooma was well known to be at high risk of absconding, having absconded from the hospital four times during this episode of illness. By 20 September 2004, his treating team decided that the principal reason Mr Dooma was being kept in the closed ward was because of his high absconding risk, rather than because of any perceived risk to himself or others. On this day, there were seven admissions to the five bed closed ward at Cramond. The treating team transferred Mr Dooma to the open ward in Cramond on 20 September 2004 to make his bed available for one of the new acute patients[2].

1.3. Around lunchtime on 20 September 2004, Mr Dooma was given some medication by his allocated mental health nurse, William Emerton after Mr Dooma requested medication for the 'voices in his head'. By approximately 1:00pm that day, Mr Dooma had absconded from the open ward, unnoticed by staff. He made his way to Findon Road, where he was seen dashing across the road, narrowly missing some vehicles before he grabbed hold of the bull bar of a prime mover which then ran over him, causing multiple fractures and a closed head injury. There is no suggestion in the evidence that the driver of the prime mover was at fault in any way. I accept that he had no opportunity to take evasive action.

1.4. An ambulance conveyed Mr Dooma to the Royal Adelaide Hospital (RAH) where he underwent surgery for injuries to his legs. He was then transferred to the Intensive Care Unit where he remained unconscious on life support for the following 17 days. Mr Dooma's management was complicated by multi-resistant staphylococcal aureus sepsis and he succumbed to multi-organ failure shortly after life support was withdrawn on 7 October 2004 at 4:00pm[3].

[2] Exhibit C16c
[3] Exhibit C2

1.5. Because the cause of Mr Dooma's death arose while he was being detained in Cramond Clinic, his death is to be regarded as a 'death in custody' in which case, an Inquest is mandatory[4].

2. Post Mortem Examination

2.1. A post mortem examination was conducted by Forensic Pathologist Dr Allan Cala at the Forensic Science Centre in Adelaide on 8 October 2004. In Dr Cala's report, he summarised his findings as follows:

> 'Post mortem examination confirmed the injuries described although these were in a state of healing. There were multiple areas of debridement on the lower limbs particularly the left leg, many of which appeared purulent. The lungs were consolidated. The heart showed mild coronary atherosclerosis. The brain was essentially normal. No skull fractures were present.
>
> I believe the deceased died as a result of multiorgan failure due to consequences of multiple injuries following a motor vehicle collision.'[5]

2.2. Dr Cala observed signs of a closed head injury, thoracic and lumbar spine fractures and a 'fractured left knee with vascular compromise.' There were extensive lower limb lacerations and abrasions and diffuse alveolar damage.

2.3. I accept Dr Cala's opinion concerning the cause of death.

3. Toxicology

3.1. Samples of Mr Dooma's blood were analysed for the presence of alcohol, amphetamines, benzodiazepines, cannabinoids, opiates and common basic drugs. According to a report by Janice Gardiner, Forensic Scientist at the Forensic Science Centre, Adelaide, none of those substances were detected, although there is no indication in the report concerning when the sample was taken for analysis.

4. Interpretation of Mr Dooma's actions

4.1. Having considered the circumstances surrounding Mr Dooma's actions in the light of the evidence concerning his psychiatric illness, I am unable to find that Mr Dooma made a conscious decision to end his life when he entered Findon Road and was run over by the prime mover. If Mr Dooma was agitated shortly before absconding, he

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[4] Section 3, section 21(1)(a) Coroners Act 2003, Section 19 Mental Health Act 199
[5] Exhibit C3a

may have been restless and desperate to leave the hospital.[6] Whilst Mr Dooma was given medication to reduce his agitation shortly before absconding, there may have been very little time for the medication to take effect. Given the severity of Mr Dooma's illness, I consider that his judgment may have been so impaired that one could not safely conclude that he acted consciously to end his life.

5. Mr Dooma's psychiatric history

5.1. Mr Dooma was born in the Philippines in 1967. He engaged in substance abuse which precipitated an admission to hospital, with psychosis, in Blacktown, New South Wales in 1998. In 2002, he had two admissions to the Royal Prince Alfred Hospital where he was diagnosed with schizophrenia. Records of these admissions by way of discharge summaries were obtained from New South Wales after Mr Dooma came to the attention of the South Australian Mental Health Service in April 2004. He was referred to the Eastern Acute Crisis Intervention Service (ACIS) by the Salvation Army in Whitmore Square where he was noticed to be behaving in a bizarre fashion. Mr Dooma was said to be floridly psychotic and he was detained in Brentwood closed ward at Glenside Hospital and treated with anti-psychotic medication. About a week later he was transferred to Cramond open ward, where he absconded on 8 May 2004.

5.2. After police located Mr Dooma in the community on 13 May 2004, he was admitted to Cramond closed ward, where he was detained pursuant to a 21-day order[7]. Management of Mr Dooma was made more difficult because he was guarded, markedly thought disordered and un-co-operative with interviews. He denied having any previous psychiatric problems or any contact with Mental Health Services and although it was later discovered that Mr Dooma's parents resided interstate, Mr Dooma told his doctors that he had no family in Australia[8]. According to Dr Dhillon, Mr Dooma was a very difficult historian and without collateral information, there remained gaps in his history. To illustrate how Mr Dooma presented to his treating practitioners in South Australia, I refer to a passage in Dr Dhillon's report concerning an interview with Mr Dooma on 26 May 2004:

> 'Mr Dooma presented as a short man of Asian appearance with a goatee beard, moustache and looking older than his stated age. He was quite unkempt in his appearance and malodorous. His appearance was of someone who had neglected his self care for some time. He also had long grown nails which he had not cut for

[6] Transcript, page 256
[7] Section 12(5) of the Mental Health Act, 1993
[8] Exhibit C16a

several months. He appeared quite agitated and irritable during the interview with constant teeth grinding. He on occasions muttered to himself in an incoherent way. There were numerous odd stereotypic movements and ritualistic behaviours noted. He would gesture in a particular way and repeat this action several times during the interview. This included touching himself in particular way and folding and unfolding his arms several times during the interview. He would on occasions draw circles in the palm of his hands and repeat this action several times during the interview. Other occasions, he would stop in mid sentence and stare into space and place his hands between his knees and then in his pockets. These odd ritualistic behaviours were quite striking during the interview.'[9]

5.3. Mental Health Nurse William Erskine looked after Mr Dooma in Cramond. He regarded Mr Dooma's psychosis as 'extreme' and illustrated his behaviour as follows:

> 'Even receiving a meal tray caused him great anxiety. He would sit in front of the tray and continually rearrange knives, forks and plates due to his OCD. Even showering was a problem for Renato. He seemed an extremely tortured man as a result of his illness.'[10]

5.4. When the discharge summaries from New South Wales became available to the treating team at Cramond, it was clear that Mr Dooma had a non-compliance history and had chronic lack of insight. A trial of Clozapine was said to have commenced in New South Wales, but Mr Dooma absconded and was lost in the system until he turned up in South Australia. Whilst there were documented thoughts of self harm, the evidence indicated that Mr Dooma had never acted on these thoughts[11].

5.5. On 28 May 2004, Mr Dooma absconded again, this time from the closed ward at Cramond[12]. He was located three days later by police and conveyed to Brentwood overnight before being transferred back to Cramond closed ward. Mr Dooma was proving to be a very challenging patient as indicated in a report by Dr Dhillon, dated 31 May 2004:

> 'His treatment over the last few years has been complicated by various factors including his chronic lack of insight and poor compliance with medical treatment and follow up. Mr Dooma is a man who evades the mental health system by living an itinerant lifestyle and having numerous aliases. He has mostly been homeless over the last few years. This has provided difficulties for the Mental Health Team to assertively follow him up in the community. There is also a history of substance abuse problems which is difficult to quantify at this particular time because of there being limited history. He was prescribed the atypical antipsychotic Clozapine in 2002 because of the treatment refractory nature

[9] Exhibit C16a, page 5
[10] Exhibit C8a, page 2
[11] Transcript, pages 22-25
[12] Exhibit C17, page 74

> of his psychotic illness. Again, he has been commenced on this treatment and we are yet to see a response. He is only in the early stages of treatment.'[13]

5.6. In Dr Dhillons' view, Mr Dooma had probably been floridly psychotic in the community for the previous two years. During this time he had come to the attention of police for offences concerning theft and had been incarcerated on four occasions. Similar charges initially prosecuted in South Australia were dropped following the disclosure of Mr Dooma's psychiatric condition.

5.7. By late May 2004 Mr Dooma was not responding to treatment at Cramond and remained floridly psychotic[14]. He was also a high absconding risk. On one occasion, when escorted to the open ward by a mental health nurse, Mr Dooma asked if he could play the guitar. When the nurse was distracted for a few seconds, Mr Dooma absconded over the courtyard fence[15]. In Dr Dhillon's view, Mr Dooma required an extended period in hospital with a properly supervised trial on Clozapine. He recommended that an application be made to the Guardianship Board for a Continuing Detention Order for between six and twelve months. Dr Dhillon's reasoning was documented as follows:

> 'It is likely that his response to this medication will be slow because of the chronic nature of his illness. It is important for Mr Dooma to remain in a closed setting because of being a high absconding risk. If he is released into the community or transferred to an open facility, there is a strong likelihood he will abscond and evade psychiatric treatment.'[16]

5.8. An order was granted by the Guardianship Board on 3 June 2004 for Mr Dooma's detention for a period of six months[17].

6. Application for Extended Care Bed at Glenside

6.1. According to Dr Dhillon, Mr Dooma needed a closed in-patient facility for an extended period where the chance of absconding was minimal. The only extended care facility was at Glenside Hospital. That remains the case today. In Dr Dhillon's view, Cramond was unsuitable for Mr Dooma because it was an acute facility and it was unrealistic to expect Mr Dooma to recover quickly. The demand for beds in the

[13] Exhibit C16a
[14] Transcript, page 45
[15] Exhibit C8a
[16] Exhibit C16a
[17] Exhibit C13b

extended care facility is said to be so great that patients often have to wait up to six months before being accepted.

6.2. The system in 2004 and currently, requires a medical practitioner to fill out forms setting out the basis of the application for an extended care bed. A psychiatric nurse typically processes the application by looking at the medical notes, interviewing the patient and then discussing his or her assessment with the Glenside Team. Whilst a Psychiatrist from Glenside is involved in the final determination, that person does not assess the patient. In Dr Dhillon's experience, he is rarely consulted by the nurse who conducts these assessments[18]. He was not consulted concerning Mr Dooma's application and had no control over the process, yet in his considered opinion, his patient required this type of long-term management. It is said to be a time consuming and frustrating process to try to get the Glenside Team to reverse its decision once a patient has been rejected[19].

6.3. Dr Tony Davis, a senior Psychiatrist with over 20 years experience in Psychiatry at the RAH, was requested to review the psychiatric management of Mr Dooma and to provide a report. Dr Davis agreed with Dr Dhillon that Mr Dooma needed an extended care bed in a closed facility. In his experience, the demand for extended care beds is such that it means that patients who need them are either staying in acute wards or being released into the community[20]. In his view it was 'highly unlikely that Mr Dooma would have made any significant gains in an acute psychiatric unit or in the community'[21] According to Dr Davis, Cramond was unsuitable for Mr Dooma because of the high level of stimulation in the ward. The combined foot traffic from 35 patients in the open ward, medical practitioners, nurses, social workers, students, and support staff is said to create an unsuitable environment for patients with chronic unstable psychotic illness. According to Nurse Erskine, Mr Dooma was very distressed by the high stimulus environment in Cramond[22]. Dr Davis agreed with Dr Dhillon that the closed ward extended care facility at Glenside had a quieter environment with lower turnover and was more suitable than the acute facility at Cramond[23]. In Dr Davis's view, South Australia has inadequate facilities to provide

[18] Transcript, page 39
[19] Transcript, page 39
[20] Transcript, page 236
[21] Exhibit C21
[22] Exhibit C8a
[23] Transcript, pages 238-240

the type of supervision and assertive management required for patients like Mr Dooma. He elaborated as follows:

> 'I think if you're post-acute and really stabilised you can be managed by the community teams, but it's that interim phase, and in South Australia we just have not got adequate facilities'[24]

6.4. Dr Dhillon explained that in a response to the high demand for extended care beds, the criteria for admission has tightened in recent years. Practitioners are required to demonstrate that their patient has the potential to be rehabilitated back to the community following treatment. With a patient like Mr Dooma, this was an unrealistic expectation[25].

6.5. The application was made by Mr Dooma's psychiatric team on 24 June 2004[26]. In a short letter dated 2 July 2004, the treating team was informed that the application was rejected as follows:

> 'Thank you for referring your client to Rehabilitation Services, Glenside Campus. The referral was discussed at the referral round on Wednesday 30/6/04.
>
> The Referral Team understands that Mr. Dooma may require extended hospitalisation. However, the service offering extended care for chronic clients no longer operates within the confines of Glenside Campus Rehabilitation Service. We now offer a Rehabilitation and Recovery model of Service that does not incorporate facilities for long term closed care and maintenance for chronic clients.
>
> The waiting list for a closed or secure bed in Rehabilitation Services is extremely lengthy and our lack of available resources and facilities make admission for this man unsuitable.
>
> We would consider re-referral once Mr. Dooma is stabilised and is able to be maintained in an open ward setting.' [27]

6.6. The letter was signed by Suzanne Ecclestone, Occupational Therapist, Banfield Referral Team, Glenside Campus. When commenting upon the way in which the system operated and continues to operate, Dr Dhillon elaborated as follows:

> 'It is a major problem as far as I am concerned. I mean, there is an unrealistic expectation that people with chronic mental health disorders should make a recovery within, you know, two, three weeks, even a month. I mean, it is very clear from my 19 years experience now in the area of psychiatry that people with more chronic illnesses actually take weeks, to months, or even longer to recover. We used to have such sort of services in place, you know, 15, 20 years ago, and 20 years ago in 1989, when I started

[24] Transcript, page 238
[25] Transcript, pages 35-44
[26] Exhibit C17a, page 28
[27] Exhibit C17a, page 26

> my training, it was much easier to keep people in hospital much longer and for them to go to a step-down facility for months, and they actually even had long-stay patients at the Hillcrest Hospital, but really it's been a bit of a struggle over the last five years to actually have a person accepted for extended care. Numerous letters have been written officially and I have had dialogues with the director of the services on numerous occasions, but we are basically told that "Look, you have got to do everything and even try the person out in the community to see if they are successful or not, you know, before they might be sometimes considered for a bed at extended care".'[28]

6.7. Having reflected on the evidence on this topic, I consider that the process which has evolved regarding access to extended care beds is an insult to senior Psychiatrists in this State who are trying to act in the best interests of their patients.

7. Trial in the Community

7.1. Following rejection of the application for an extended care bed, Mr Dooma was transferred to the open ward at Cramond on 27 July 2004 and a month later, was released for trial leave in the community, in hostel accommodation. He was unable to cope and after collapsing at Afton House he was taken to the RAH on 31 August 2004.

8. Further episodes of absconding

8.1. The Emergency Department assessment at the RAH almost resulted in Mr Dooma's discharge, however, when he requested admission to the psychiatric ward, a psychiatric assessment was arranged after which Mr Dooma was transferred back to Cramond. Whilst waiting for assessment by the Acute Crisis Intervention Service at TQEH, Mr Dooma absconded. Eight hours later, he presented to the RAH again and was transferred to Cramond open ward on 1 September 2004. When assessed by the psychiatric Resident Medical Officer, Mr Dooma was agitated and complained about hearing voices and feeling dizzy. The plan adopted was to keep Mr Dooma under 'close observation'[29].

8.2. According to consultant psychiatrist Dr Tarun Bastiampillai, when he assessed Mr Dooma during this period, Mr Dooma "appeared very anxious displaying distressing audio hallucinations telling him to harm himself". Mr Dooma was indicating that he wanted to remain in hospital for treatment, which suggested to Dr Bastiampillai that his attitude was improving, although his symptoms persisted,

[28] Transcript, page 39-49
[29] Exhibit C17a, pages 58 and 59

notwithstanding the administration of intramuscular Zuclopenthixol and oral supplements, Clopixol and Lorazepam[30].

8.3. On 16 September 2004, Mr Dooma absconded again after snatching his key card during an escorted walk at TQEH, but returned eight hours later intoxicated and distressed. Amongst Mr Dooma's posessions, staff located a train ticket to Melbourne (for 18 September 2004) and a booking for motel accommodation. After disclosing to staff that he was hearing voices and wanted help, Mr Dooma was admitted to the closed ward at Cramond[31]. His treating team planned to make a fresh application for an extended care bed highlighting the fact that he now had auditory hallucinations with 'suicidal reference', he was resistant to depot anti-psychotic medication, was a high absconding risk and was itinerant[32].

9. Assessment of Mr Dooma's risk of suicide

9.1. In Dr Dhillon's view, because Mr Dooma appeared to have made plans for the future, evidenced by his train ticket and motel booking, together with the fact that he had not acted on any of his command auditory hallucinations in the past, Mr Dooma was not regarded as an acute suicide risk[33]. Dr Davis regarded this assessment of Mr Dooma's suicide risk as 'reasonable, given the clinical observation and knowledge of the patient at that stage'[34]. I accept the opinions of both Psychiatrists concerning the assessment of Mr Dooma's suicide risk, although I acknowledge that such an assessment is very difficult to make in some cases. What is clear, is that Mr Dooma was a high absconding risk and he required on-going treatment in hospital.

10. Final transfer to Cramond open ward

10.1. Mr Dooma remained in the closed ward for a few days before his treating team decided that he could be transferred back to the open ward on Monday 20 September 2004, at which time it was intended to commence a trial of a new drug, Risperidone Consta. Apart from Mr Dooma's high risk of absconding, there was said to be no clinical basis for keeping him in the closed ward at Cramond. There was also a

[30] Exhibit C7a
[31] Exhibit C7a
[32] Exhibit C17a, page.65, Transcript, page 58
[33] Exhibit C16c, Transcript, page 53
[34] Exhibit C21

demand for Mr Dooma's bed by new patients admitted over the weekend with more acute 'risk issues' than Mr Dooma appeared to have[35].

10.2. At approximately 11:45am on 20 September 2004, Mr Dooma was transferred into the open ward at Cramond. Clinical Nurse Roberta Airy was responsible for the transfer[36]. After a formal handover, Mr Dooma was settled into the open ward by his allocated Mental Health Nurse, William Emerton[37]. Mr Emerton had thirteen years experience as a mental health nurse. He was familiar with Mr Dooma from previous occasions when he cared for him in Cramond[38]. Mr Emerton explained that he adopted a respectful approach with Mr Dooma to encourage his co-operation[39]. He knew that Mr Dooma was an absconding risk[40]. He was also aware that it was relatively easy for patients to abscond from the open ward at Cramond either by walking through the front door when someone was entering the ward, or by scaling the fence along the courtyard.

10.3. At around lunch time, Mr Dooma is said to have approached Mr Emerton to ask him for some 'good medicine' for the 'voices in his head'. Mr Dooma was noted to be pacing the office area and reporting auditory hallucinations[41]. Mr Emerton gave Mr Dooma oral Clopixol 20mg and Lorazepam 1mg which were medications prescribed on an 'as needs' basis. Whilst Mr Emerton recorded in Mr Dooma's medical notes that he administered the medication at 1330 hours, it is now clear that this entry is incorrect. It must have been given no later than approximately 12:45pm, because other evidence which I accept, indicates that Mr Dooma was seen running onto Findon Road at about 1:00pm. According to Mr Emerton, when he last saw him after administering the medication, Mr Dooma was walking back towards his room after agreeing to rest on his bed to let the medication take effect. Meanwhile, Mr Emerton went about other tasks and did not notice that Mr Dooma was missing until after his tea break at 5:00pm at which time, senior staff were alerted[42].

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[35] Exhibit .C16c
[36] Exhibit C6a
[37] Exhibit C6a
[38] Transcript, page 83
[39] Transcript, page 139
[40] Transcript, page 85
[41] Exhibit C17a,page 68
[42] Exhibit C19, Transcript, page 90

11. Observation policy and practice in Cramond

11.1. According to Mr Emerton, all patients in the open ward at Cramond were subject to a policy that they be sighted every half hour. This level of observation is described as Category R observations. The various categories of observation were set out in a document inside a large policy manual kept in the nurses station at Cramond. When patients were in the closed ward, they were assigned Category C observations which meant that patients were to be sighted every fifteen minutes. Whilst the policy stipulated that patients subject to Category R observations were to be sighted half hourly, it also stipulated that "appropriate records must (sic) maintained on the half hourly checks chart'[43]. Notwithstanding this policy, the evidence establishes that in September 2004, night shift nurses in the open ward at Cramond documented hourly observations of all patients on a clip board, and during the day, any observations which might have been made, were not documented at all[44].

11.2. Whilst it is not entirely clear, it appears that Mr Emerton is likely to have had his normal allocation of five patients for whom he was responsible on 20 September 2004. I accept that nurses would normally be quite busy when working in Cramond open ward[45]. When questioned about his failure to follow the half-hourly observation routine concerning Mr Dooma, Mr Emerton was unable to give any satisfactory explanation[46]. He stated that between 7:00 and 8:00am that day, he had encounters with two aggressive patients, leaving him somewhat shaken for the remainder of the day[47]. On one occasion, Mr Emerton stated that at about 1:45pm he left the ward to take a female patient to have an ECG and returned about 45 minutes later to continue with his other duties. There was no evidence of any staff shortage or excessive workload during Mr Emerton's shift which might have explained why he was unable to turn his mind to Mr Dooma for over four hours. Mr Emerton made no request of any other nurse to take over his observation duties in his absence.

[43] Exhibit C13h
[44] Transcript, page 125
[45] Transcript, page 86
[46] Transcript, pages 93-94
[47] Transcript, page 82 and page 138

11.3. In a statement concerning these events, given on 8 December 2004, Mr Emerton explained the situation as follows:

> 'Renato was what we call a category 'R' patient which means he is supposed to be checked every thirty (30) minutes. No register is kept with regards to these observations it is just supposed to be done.
>
> I do not know who checked Renato every thirty (30) minutes, I was busy with other patients. There is no formal method for keeping observations on category 'R' patients. So many patients come and go it is hard to keep track of them. Most of the patients are category R patients.
>
> No one knows how Renato escaped. The ward gets so busy and with the large volume of traffic it's hard to keep up with patients'[48]

11.4. It is a serious concern that a mental health nurse with Mr Emerton's experience, failed to keep a close eye on Mr Dooma when he realised that he was an absconding risk and must have realised that he remained unwell and needed ongoing treatment in hospital. Mr Emerton conceded that in practice, the half hourly observations of his patients were carried out subject to other more pressing tasks[49].

11.5. Clinical Nurse Roberta Airy described the difficulty nurses had in adhering to the observation policy as follows:

> 'Many times during our shifts, nurses find that they are distracted by other responsibilities such as telephones, individual patient care, enquiries and appointments. Due to staffing numbers it is impossible at times to adhere to the Category R checking cycle.' [50]

I acknowledge that even if Mr Emerton attempted to sight Mr Dooma 30 minutes after giving him his medication, it may already have been too late to prevent what ultimately occurred. Yet Mr Emerton's inattention for four hours reflects poorly upon him as well as the Cramond Clinic.

11.6. No doubt when Mr Emerton realised that he had not given Mr Dooma any attention for over four hours and was missing from the Ward, he would have felt responsible and very concerned. At 6:00pm, before staff at Cramond had learned about what had happened to Mr Dooma, Mr Emerton made a nursing entry in Mr Dooma's medical notes, suggesting that he last noticed Mr Dooma at approximately 1540 hours, after giving him the medication and that there were 'nil signs of sedation'[51]. There can be

[48] Exhibit C19
[49] Transcript, page 93
[50] Exhibit C6a, page 4
[51] Exhibit C17a, page 68

no doubt that this entry is factually incorrect. When Mr Emerton was questioned about this entry, he denied that it was a fabrication[52]. I found his evidence on this topic to be most unimpressive. Mr Emerton explained in evidence that after leaving work that evening, he felt fatigued and questioned whether he could keep doing that type of work. He said that he took sick leave the following day[53]. I have not been provided with any evidence to suggest that the circumstances leading to Mr Dooma's death has affected Mr Emerton in a way which might explain his unusual demeanour when giving evidence. I am prepared to make some allowance nevertheless, on the assumption that his work in mental health and this experience in particular, has traumatised him.

12. Official response from The Queen Elizabeth Hospital concerning the Applicable Observation Policy

12.1. Neville Phillips is a nursing director for the early intervention acute services for the Central Northern Adelaide Health Service, covering TQEH and Cramond Clinic. He occupied a similar role in 2004. Mr Phillips explained that he was responsible for the development and review of policies for nurses and other staff. He was involved in the development of the policy on nursing observations for the Lyell McEwin and TQEH Mental Health Divisions. Whilst he has nursing qualifications, he has not worked in a clinical position since 1994. Mr Phillips claimed that he knew the Cramond Clinic well although he had never worked there[54]. According to Mr Phillips, nurses were expected to be familiar with the policy and procedures for observation of patients in Cramond. He stated that he trusted the Unit Team Leaders to update the policy manual with new issues of policy documents and to implement the policies.

12.2. When questioned about the implementation of the observation policy, Mr Phillips was unable to say how it operated in the Cramond Clinic in September 2004 despite claiming that he spoke with 'staff' about it following the tragic events concerning Mr Dooma[55]. Mr Phillips later conceded that he did not realise that records were not being kept of nursing observations during day time shifts in September 2004. He

[52] Transcript, pages 103, 109, 110
[53] Transcript, page 111
[54] Transcript, page 147
[55] Transcript, page 159

emphasised that the policy of half-hourly observations and documentation was now operating. He claimed that he knew that because he had inspected the check lists[56].

12.3. Subsequently, during a visit to Cramond Clinic during the Inquest, the Court discovered that the day time check charts in the open ward recorded hourly observations, rather than half hourly, contrary to Mr Phillip's assertions.

12.4. Evidence was called from former Acting Clinical Nurse Consultant, Christine Edwards concerning an internal memorandum which she circulated to staff in Cramond Clinic on 17 June 2005 concerning the implementation of a day time checklist for patients in the open ward. The memo reads as follows:

> 'We need to implement a checklist similar to the night duty one in which we can monitor client's whereabouts throughout the day. You will see that it is an hourly check as we would all agree that half hourly on a unit as big as ours is impossible to maintain. If staff have a client that they have concerns about especially within 24 to 48 hours of admission it is their responsibility to be more vigilant with their checks. We will also be looking at being more aware of our risk categories and updating them on a more regular basis'.[57]

12.5. Ms Edwards explained that her memo came about to provide a record of patient movement as an extra safety check in addition to the half hourly requirement of individual nurses to sight their allocated patients. Ms Edwards confirmed that the day time hourly check chart system is still used today. According to Ms Edwards, who currently works on day time shifts, the hourly checks take about 20 to 25 minutes to complete and are often complicated by interruptions. She explained that all nurses are required to share this task in an unstructured fashion after checking the chart on the clip board in the nurses station[58].

12.6. Ms Edwards was unsure whether these and other charts used by staff were shredded at the end of each shift or were retained as a permanent record[59]. In my view, it would be prudent to ensure that at least one copy of any charts used by nursing staff in Cramond to record observations, medications and other relevant matters should be kept as a permanent hospital record.

12.7. When Mr Phillips was shown a copy of Ms Edward's memo, he stated that he had not seen it before. He expressed concern that a practice was introduced which departed

[56] Transcript, page 158
[57] Exhibit C19a
[58] Transcript, page 305
[59] Transcript, page 309

from the official policy without being consulted about it[60]. It is difficult to understand how Mr Phillips could have been so ill informed about this critical topic when he came to give evidence at the Inquest.

13. Review of Mr Dooma's Psychiatric Treatment at Cramond

13.1. After reviewing the medical notes concerning Mr Dooma's psychiatric management, Dr Davis concluded that the treatment provided was appropriate and that the medications which were administered were 'most suitable for the management of a chronic psychotic illness'[61]. His concerns centred around the inadequacy of supervision of Mr Dooma in Cramond and the rejection of the treating team's application for an extended care bed at Glenside.

13.2. I accept the opinions expressed by Dr Davis in his report and in his evidence as to the appropriateness of Mr Dooma's psychiatric management whilst in Cramond Clinic.

14. Security Concerns in Cramond Open Ward

14.1. As far as nursing observations are concerned, Dr Davis did not have a strong view about whether half hourly or hourly observations were made and recorded, as long as Mr Dooma was kept under reasonable scrutiny[62]. Dr Davis acknowledged that it was a dilemma to provide a secure environment for people at risk in a therapeutic setting[63]. Just because a person is subject to a Continuing Detention Order, Dr Davis emphasised that this does not necessarily mean that the person must remain in hospital. I accept that when a patient subject to this type of order is deemed safe to be returned to the community, they may be released and yet be brought back into hospital under their continuing order if they deteriorate. In Mr Dooma's case, however, his treating team were strongly of the view that he was unable to cope in the community and needed an extended period of hospitalisation. In these circumstances, I find that it was necessary for staff to ensure his safety and keep him in the ward.

14.2. The open ward in Cramond is said to have a range of different patients, some of whom are admitted on a voluntary basis. Dr Davis expressed a serious concern that to increase the security in this ward by way of higher fencing, increased surveillance at

[60] Transcript, page 162 and page 176
[61] Exhibit C21
[62] Transcript, page 241
[63] Transcript, page 244

the entrance, security guard presence or closed circuit camera surveillance, would be detrimental to the health of patients in the ward[64]. Dr Dhillon expressed similar views about the negative therapeutic effect which increased security measures would have on many patients[65].

14.3. Evidence was called from Phillip Tasker, security services coordinator at TQEH, concerning the potential role his service might play in improving security in Cramond. To gain access to the ward, persons are either buzzed in remotely after being recognised on a monitor by a person at the nurses station, or they use a swipe card to activate the door. Mr Tasker was in favour of having a security guard in Cramond[66]. The major security concerns at TQEH are said to be in the Emergency Ward and to a lesser extent in Cramond. According to Mr Tasker, the hospital has one patrolling security guard between 6am and 6pm, one guard permanently stationed in the control room, and one in the emergency room overnight between 6pm and 6am. Voluntary staff members have been recruited to form emergency response teams when a Code Black is called for security support in the hospital. The evidence suggests that the security arrangements overall are quite stretched, however, because this issue is not directly relevant to the circumstances in which Mr Dooma absconded, I consider that it would be inappropriate to pursue this topic in any detail, other than to suggest that consideration be given to having a security presence adjacent Cramond Clinic to enable rapid response to Code Black emergencies and to pursue patients who have absconded.

14.4. I accept the professional opinions of Drs Davis and Dhillon concerning the dilemma between security concerns and therapeutic management. Yet it must be recognised that staff at Cramond were ultimately responsible for Mr Dooma's welfare. On balance, I consider that because Mr Dooma was regarded as a high absconding risk and remained unwell, when he was transferred to the open ward to make way for a more acutely unwell patient in the closed ward, special arrangements should have been made by Senior Nurses in Cramond to ensure that Mr Dooma would be kept under very close scrutiny. If Mr Emerton was unable to provide the degree of scrutiny required because of his competing tasks, then a suitable option may have been to have an enrolled nurse brought onto the ward to help him.

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[64] Transcript, page 250
[65] Transcript, page 60
[66] Transcript, page 224

15. Mr Dooma's death was preventable

15.1. I find that the shortage of extended care beds in a closed ward facility at Glenside between June and September 2004, resulted in a situation where Mr Dooma was required to stay in an acute facility which was ill equipped to manage his high absconding risk and long term treatment. If Mr Dooma had been admitted to Glenside in a timely fashion, following Dr Dhillon's application for an extended care bed, it is likely that his death could have been avoided.

16. Recommendations

16.1. In accordance with the provisions of section 25(2) of the Coroner's Act 2003, the following recommendations are made in anticipation that they might prevent or reduce the likelihood of or recurrence of an event, similar to the events, the subject of this Inquest.

16.1.1. That provision be made to increase the number of closed ward extended care beds available at Glenside Hospital (or a suitable alternative facility), for persons with chronic mental illness who have not responded sufficiently to treatment in an acute facility and who are deemed unsuited to management in the community.

16.1.2. That administrators and senior nurses in acute psychiatric facilities examine their observation policies and practices to ensure that patients who have been detained in these facilities and have not been granted leave in the community, are adequately supervised.

Key Words: Psychiatric/Mental Illness; Death in Custody

In witness whereof the said Coroner has hereunto set and subscribed her hand and Seal the 21st day of December, 2006.

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Coroner