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 30th day of January 2007, and the 22nd day of February 2007, by the Coroner's Court of the said State, constituted of Mark Frederick Johns, State Coroner, into the death of John Culo.

The said Court finds that John Culo aged 44 years, late of Unit 4/21 Caroona Avenue, Hove died at Glen Osmond Road, Frewville, South Australia on the 29th day of April 2004 as a result of multiple injuries. The said Court finds that the circumstances of his death were as follows:

1. Introduction and reason for Inquest

1.1. John Culo was 44 years old at the time of his death on 29 April 2004. He died as a result of injuries that he sustained after being hit by an Australia Post semi-trailer at approximately 7:30am on that day on Glen Osmond Road, Frewville in the State of South Australia. At that time Mr Culo was a patient at the Patterson East Ward of the Glenside Campus.

1.2. Mr Culo was detained pursuant to the Mental Health Act at the time of his death, and accordingly his death was a death in custody within the meaning of Coroner's Act 2003.

2. Background

2.1. The circumstances of Mr Culo's death were investigated by Detective Senior Constable De Zilwa. The investigation was comprehensive.

2.2. Mr Culo had a history of mental illness dating from 1985.

2.3. On 16 April 2004 Dr Annita Paull, Senior Consultant Psychiatrist at the Flinders Medical Centre working at the Marion Community Care Team ordered that Mr Culo be detained pursuant to the Mental Health Act. On that day she diagnosed that Mr Culo had a Major Psychotic Depression. She also considered that he was at a significant risk of suicide. Mr Culo was keen to be hospitalised at Flinders Medical Centre, but as there were no beds available there he was taken to Glenside Campus. According to Dr Paull, Mr Culo was willing to be admitted as a voluntary patient. However, she thought that she could not rely on him not to change his mind and decided instead that a Detention Order was necessary.

2.4. Mr Culo was treated and assessed by a number of doctors at Glenside Campus, including Doctors O'Moore, Narielvala and Short. The clear diagnosis was that he was suffering a severe depressive episode as part of his Chronic Bipolar Disorder. Dr Narielvala reviewed Mr Culo on 19 April 2004 and confirmed the Detention Order.

2.5. According to Dr O'Moore, Senior Psychiatric Registrar, Mr Culo was ruminating about a letter that he had written. He was expressing concern that the recipient may wish to harm him. These ruminations were persistent. Dr O'Moore discussed electroconvulsive therapy treatment with Mr Culo and he agreed to consent to undergo such therapy.

2.6. Dr O'Moore saw Mr Culo again the following day, 28 April 2004, and discussed the electroconvulsive therapy treatment once more. Mr Culo confirmed his agreement to consent to the therapy. However, Mr Culo was continuing to ruminate about the letter he had sent. Dr O'Moore explained the therapeutic benefits that might be available from electroconvulsive therapy treatment and commenced Mr Culo on Chlorpromazine, an antipsychotic medication. Her purpose in that treatment was to assist Mr Culo with his ruminations concerning the letter.

2.7. Another doctor, Dr Short also reviewed Mr Culo at about that time. His view was that Mr Culo's ruminations about the letter were bordering on being delusional and Mr Culo was unable to accept any reassurance about the irrational nature of his concerns.

2.8. The electroconvulsive therapy was scheduled to occur on 30 April 2004.

2.9. A statement provided by Mr Culo's brother, Mr Proepster, which was admitted in evidence as Exhibit C6b in these proceedings, reveals that Mr Culo informed him that he was concerned both about the letter, and the ECT or "shock treatment" that was due to start in two days. Mr Proepster stated that he discussed these issues with Mr Culo and talked about them with him. He also discussed the matter with staff at the Glenside Campus and was satisfied that the staff fully recognised the extent of Mr Culo's illness and that the proposed treatment was designed to target that illness appropriately.

2.10. The medical records from Glenside Campus, and statements from the nurses who were on night shift duty on the night of 28/29 April 2004, Ms Green and Mr Jones, show that Mr Culo was extremely distressed and agitated on the evening before his death and in the early hours of that morning. Mr Culo was provided with 100mg of Chlorpromazine at 9:15pm on 28 April 2004 and another 100mg at 2:00am on 29 April 2004.

2.11. The night shift staff handed over to the day shift staff at about 7:00am on 29 April 2004. At the handover, Nurses Green and Jones handed over to Nurses Yeung, Karran, Hill and Proeve.

2.12. Probably the best description of what I might describe as Mr Culo's disappearance from the ward at approximately 7:30am that morning is to be found in the account of Nurse Hill whose statement was admitted as Exhibit C8a in these proceedings. Nurse Hill stated that Mr Culo was one of the six patients for whom she had responsibility during that day's shift. She said that she saw Mr Culo walking down the corridor towards her from the direction of what she described as the "smoking enclosure". She greeted Mr Culo and advised him that she would be his nurse for the day. She asked him if he was okay and how he was feeling, to which he replied "Alright". She described him as having a slouched carriage, slow sluggish movements and as being "really softly spoken". However he was polite and gave her good eye contact.

2.13. She said that as a result of this brief contact she decided that she would get Mr Culo's medication which had to be provided to him at approximately 7:30am. She went to the nurses' station and recorded on the medication chart the medication that she intended to give him. She knew that it was 7:30am as she was doing this because she recalled checking the clock on the wall. She stated that she was only there for two to

three minutes at the longest. When she returned to the corridor where she had previously seen Mr Culo, he was no longer there. She checked the foyer and could not find him. She spoke with Nurse Yeung and he said that he had not seen Mr Culo out the front. Nurse Hill then checked Mr Culo's room, the bathroom and the smoking area but could not find him. She then alerted other staff of the fact that she could not find Mr Culo. One of those staff members was Nurse David Karran, and Nurse Karran undertook to use his private motor vehicle to search for Mr Culo on the nearby streets. Nurse Yeung went to walk throughout the grounds to see if he could find Mr Culo there. Nurse Hill contacted the switchboard and asked that they contact security. Security was called shortly after this and Nurse Hill explained to them that Mr Culo was a very high suicide risk, his description, and the fact that he needed to be found.

2.14. Nurse Yeung was interviewed by Constable Clarke on the day of Mr Culo's death. From notes recorded by Constable Clarke, a statement was prepared. Nurse Yeung refused to swear to the accuracy of the contents of his statement, albeit some two and a half years after the event, because he could not accurately remember the events. The notes made by Constable Clarke of her interview with Nurse Yeung provide a slightly different account to that provided by Nurse Hill. Nurse Yeung told Constable Clarke that he was approached by Mr Culo who asked Nurse Yeung if the latter could open the door for him so that he could have a cigarette. Nurse Yeung allowed Mr Culo to exit from the ward and stated that no other person walked out with him at the time. According to Nurse Yeung, within less than a minute he walked out of the ward to see if he could find Mr Culo but could not. According to his account he then walked back into the ward to see if he could find Mr Culo and could not do so. According to the notes of Constable Clarke, Nurse Yeung stated that he then came back into the ward and asked Nurse Hill where Mr Culo was.

2.15. Nurse Hill's sworn account does not refer to an approach being made by Nurse Yeung to ascertain the whereabouts of Mr Culo. According to Nurse Hill's account, it was she who instituted the search for Mr Culo and who made an enquiry of Nurse Yeung.

2.16. On either account, Mr Culo was only missing for between one and three minutes before a further check was made. It therefore seems to me that although concerning, this discrepancy may not be significant as a period of two minutes was unlikely to

afford an opportunity for the institution of an earlier search. In any event, I prefer the version of Nurse Hill.

2.17. I now turn to the account of Nurse Karran for what took place next. Nurse Karran's statement was admitted as Exhibit C11a in these proceedings. He stated that he was approached by Nurse Hill at approximately 7:30am to advise him that she could not find Mr Culo. Nurse Karran stated that he offered to use his own vehicle to drive around outside the hospital. He said that Mr Culo normally told the staff where he was going, but Nurse Karran thought it was as well to check the main roads for Mr Culo's safety. Nurse Karran got into his vehicle and drove straight out of the main entrance of Glenside Campus onto Fullarton Road. He travelled south along Fullarton Road and then turned left into Glen Osmond Road travelling east. As he turned onto Glen Osmond Road he saw orange flashing lights on a utility parked approximately 50 metres up the road. Nurse Karran parked his vehicle and walked to where the utility was parked. He stated that he saw a body lying on the road near the front of the utility. It had been covered with a blanket but Nurse Karran realised that it was the body of Mr Culo because Nurse Karran recognised Mr Culo's Colorado sandals and could recognise Mr Culo's bare legs.

2.18. Nurse Karran stated that Mr Culo was a "pretty big bloke and I could tell it was him". According to Nurse Karran, an ambulance arrived soon after and then police arrived as well. He informed the police that Mr Culo was a detained patient and returned to the hospital shortly afterwards.

2.19. Statements were obtained from the driver of the Australia Post semi-trailer and a passenger in that vehicle. Those statements were admitted in evidence in these proceedings. It is sufficient to observe that there is no suggestion that the manner of driving the semi-trailer had any bearing on this tragic episode. It appears quite clear that Mr Culo was intent upon throwing himself in the path of the oncoming vehicle, and neither the driver nor any other witness had any reason to suspect that Mr Culo was going to behave in what for them was an entirely unexpected and unpredictable manner.

2.20. The Major Crash Investigation Unit investigated the circumstances of the accident and there is nothing in that investigation which causes me to doubt that the accident

was a result of Mr Culo's own actions, and not the responsibility of the driver of the semi-trailer.

3. Mr Culo's treatment

3.1. The treatment of Mr Culo was the subject of a report to the Court by Dr Tony Davis, Psychiatrist. Dr Davis reviewed the material that was available including all of the material produced as a result of Detective Senior Constable De Zilwa's investigation.

3.2. Dr Davis' report was admitted as Exhibit C5a in these proceedings and in it, Dr Davis states that in his opinion Mr Culo had a severe form of mental illness, namely Bipolar Disorder with recurrent depressive and manic episodes. At times of mania, Mr Culo became psychotic and required treatment in hospital. Some of his admissions were compulsory while others were voluntary. Mr Culo had access to comprehensive treatment through the Marion Outreach Team with backup from Glenside Campus, the Repatriation Hospital and Flinders Medical Centre at times of crisis or more acute mental disturbance. Dr Davis considered that Mr Culo was treated with appropriate medication and psychological therapies over time and that a considerable amount of effort was made by many clinicians to provide him with comprehensive care for his severe mental illness.

3.3. Dr Davis was of the opinion that the treatment provided in Patterson East Ward at Glenside Campus was most appropriate for Mr Culo's condition. Dr Davis found that Mr Culo was treated with a combination of mood stabilising, antidepressant, antipsychotic and anxiolytic medication. He found that the staff were alert to the possibility that Mr Culo might have suicidal thoughts or plans and that they appreciated the risk of suicide. Dr Davis considered that given Mr Culo's history and mental state, the decision to manage him in an open ward such as Patterson East, was a reasonable decision. This view was reinforced by Mr Culo's apparent cooperation and adherence to treatment in the past. Staff members were alert to the risk of suicide and took appropriate precautions and communicated clearly about that matter. There were suggestions in the notes that Mr Culo be considered for a closed ward if his agitation persisted beyond 29 April 2004, and Dr Davis considered this to be most appropriate. It was his view that up until the time of Mr Culo's death it was reasonable that he remain in an open ward with regular observations. Dr Davis also commented that the benefits of closed ward management must be weighed against the

possible adverse effects of such management, and that it is important that acutely ill psychiatric patients have access to a therapeutic hospital environment while being managed in a way that guarantees their safety without undue restriction of liberty. He considered that the Detention Order made in Mr Culo's case did ensure that he was observed and monitored closely, and allowed for the possibility that he could be transferred to a closed ward environment if his behaviour were to escalate.

4. Conclusions

4.1. I conclude that Mr Culo's treatment, care and management were appropriate, and that the staff of Patterson East Ward could not by any reasonable measure have prevented him from absconding from Patterson East Ward on the morning of 29 April 2004.

4.2. A post mortem examination was conducted on the body of Mr Culo by Professor Roger Byard. A post mortem report prepared by Professor Byard was admitted as Exhibit C3a in these proceedings. The cause of death given by Professor Byard was multiple injuries and I so find. I further find that Mr Culo's death was a result of an act of suicide on his part. I do not believe that it is necessary to make any recommendations in relation to this matter.

Key Words: Bipolar disorder; Death in custody; Detention Order; Psychiatric/Mental illness; Suicide.

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

Seal the 22nd day of February, 2007.

State Coroner