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 15th, 16th, 17th and 18th days of May 2007,and 25th, 26th days of July 2007 and 3rd, 4th days of October 2007 and the 4th day of February 2008, by the Coroner's Court of the said State, constituted of Mark Frederick Johns, State Coroner, into the death of Thomas Ryan Keough.

The said Court finds that Thomas Ryan Keough aged 18 years, late of Room 7, 10 Baliol Street, College Park died at Room 7, 10 Baliol Street, College Park, South Australia on or about the 9th day of August 2003 as a result of methadone toxicity. The said Court finds that the circumstances of his death were as follows:

1. Introduction and reason for Inquest

Thomas Ryan Keough was born on 13 October 1984. He died on or about 9 August 2003, just short of his nineteenth birthday, at a supported residential facility known as Palm Lodge at 10 Baliol Street, College Park. A post mortem examination was conducted by Professor Roger Byard and a report was prepared by Professor Byard which was admitted as Exhibit C13a in these proceedings. In that report the cause of death was given as attributed to methadone toxicity. Mr Keough's body was not discovered until the evening of 11 August 2003. Mr Keough was not being prescribed methadone at or before the time of his death and his access to the substance was an issue which was explored at this Inquest.

2. Supported Residential Facilities Act 1992

2.1. Palm Lodge is licensed under the Support Residential Facilities Act 1992 ("the Act"). It is important to have an appreciation of the legislative framework under which such

a facility operates. A "supported residential facility" is defined in section 3 of the Act as being a:

> 'premises in which, for monetary or other consideration (but whether or not for profit), residential accommodation is provided or offered together with personal care services (other than for members of the immediate family of the proprietor of the facility).'

An intrinsic element of what constitutes a supported residential facility is the provision of "personal care services".

2.2. The expression personal care services is defined in section 3 of the Act and includes the provision of nursing care, assistance or supervision in bathing, toileting, dressing or undressing, and the consumption of food. It also includes the management of, or assistance with the management of, medication and the provision of substantial rehabilitation or developmental assistance.

2.3. One of the objects of the Act as set out in section 6 is "to recognise and protect the rights of persons who reside in supported residential facilities". The Act also sets out a number of "principles to be observed" (in section 7). Principle (b) is as follows:

> 'residents are, having regard to their needs and the type of service offered at the particular facility, entitled to receive reasonable levels of nutrition, comfort and shelter in a home-like environment;'

Principle (c) is as follows:

> 'services should be provided in a safe physical environment;'

Principle (d) is as follows:

> 'residents are entitled to be treated with dignity and respect and afforded reasonable degrees of privacy;'

2.4. Principle (e) sets out a number of resident's entitlements which include an entitlement to independence and freedom of choice in relation to such matters as the right to choose and pursue friendships and the right to participate in activities of a resident's choosing.

2.5. Principle (f) is as follows:

> 'residents are entitled to manage their own affairs (wherever possible) and must not be subjected to exploitation of their financial or other assets;'

2.6. A brochure explaining the services offered by the Palm Lodge facility describes it as "A facility for people who have a mental illness which impacts on their ability to maintain accommodation or move to independent living." In addition it states:

> 'Palm Lodge staff and care coordinators work with residents to develop skills and meet individual goals'

Palm Lodge also offers "hospital at home" treatment for patients who are seen to be manageable within with community rather than in an acute mental hospital environment.

2.7. The Act requires that a proprietor of a supported residential facility must prepare a prospectus containing prescribed information relating to the facility and the personal care services provided at the facility[1]. A proprietor of a supported residential facility must enter into a resident contract with a resident of the facility to whom personal care services are provided[2]. Section 38 provides that before a person enters into a resident contract they must be given a statement in the prescribed form. Section 38(4) provides that the contract will be taken to include a warranty on the part of the proprietor of the facility of the correctness of the information contained in the statement in the prescribed form.

2.8. The Palm Lodge casenotes were admitted in these proceedings as Exhibit C3. They contain a copy of the resident contract which was executed by Mr Keough and the prescribed form that accompanied it. The resident contract states that the Palm Lodge service is designed to be a stepping-stone to a more permanent place of residence. It states that Palm Lodge will give the resident an opportunity to develop the skills required with assistance from Palm Lodge staff and others. The contract states that the facility is licensed for up to twenty-four residents. The terms and conditions state that Palm Lodge is a community facility and residents are asked to respect the rights, safety and privacy of other residents. It states that each resident will have a negotiated rehabilitation focus during his or her stay in Palm Lodge which may require involvement in rehabilitation activities as agreed with staff and key-workers. The agreement states that "The consumption, sale or storage of illicit drugs on the premises will result in immediate termination of tenancy. Drunk and disorderly behaviour or aggressive, abusive and violent language or actions toward another

[1] Section 37 of the Act
[2] Section 38 of the Act

resident or Palm Lodge staff member will also result in immediate termination of tenancy". The agreement contains provision as to rent and stipulates provisions as to the termination of the contract.

2.9. The prescribed form contains a number of provisions which supplement the contract itself. In particular, the form states that the type of accommodation being made available is "hostel". It states under the heading "Services that may be provided to you" as follows:

> '3.1 You are to be provided with the following services by the facility: food and lodgings.
>
> 3.2 The following services will also be available at the facility: medical/clinical/admin.
>
> 3.3 The following equipment will be available to you at the facility: rec room/leisure etc'

2.10. In addition to the above documentation, there is contained in the notes another document headed "Rights and responsibilities of living at Palm Lodge" which was signed by Mr Keough. That documents sets out a number of rights and responsibilities for the residents. Of interest, the document lists as one of the responsibilities:

> 'To inform staff, for safety and security reasons, when leaving or returning to Palm Lodge.'

2.11. It further states:

> 'If you wish to go out overnight or over a weekend, please inform and negotiate with Palm Lodge staff.'

2.12. Before leaving the legislative framework I note that section 31(g) of the Act provides that a supported residential facility licence may be cancelled if the holder of the licence, or any person involved in the management of the facility or the provision of services within the facility, "has been guilty of negligent or improper conduct that has adversely affected the interests of a resident of the facility".

3. Ms Naomi Jolly

3.1. Naomi Jolly is a registered nurse and registered mental health nurse. She provided a statement which was admitted as Exhibit C9 in these proceedings and gave evidence at the Inquest. She had been working at Palm Lodge for approximately ten months prior to August 2003 and remained for some months after that time. She was the

Acting Clinical Nurse during that period. She was on day shift at Palm Lodge on Monday, 11 August 2003. She handed over responsibility for supervision of the hostel at approximately 7:30pm to registered nurse David Farrington who was working the night shift. She told Mr Farrington that Mr Keough was not at the hostel and that he had possibly been on leave for the weekend. She stated that she understood that Mr Keough was not within the premises at Palm Lodge because she had been so informed by the person who handed over to her that morning.

3.2. Ms Jolly stated that the staff at Palm Lodge monitored the mental state of the residents and their medications and attended to meals and cleaning. She said that to gain admission to Palm Lodge the resident had to have a "key-worker" working with that resident. A key-worker might be someone such as a mental health nurse or social worker or occupational therapist or other person working in the mental health sector.

3.3. Ms Jolly identified within the Palm Lodge notes for Mr Keough a community referral form which was his referral to the facility. The referrer was stated to be Jill Hicks, social worker of Fullarton Private Hospital. The referral states that Mr Keough was unable to live with either parent and that his parents' capacity to provide support was limited due to their relationship with Mr Keough as well as their life circumstances. It stated that he had been diagnosed with depression and gave background information of a long history of family dysfunction leading to depression. It referred to a lack of support from family members and that Mr Keough had experienced difficulties establishing and maintaining "satisfactory" lifestyle because of bouts of depression and withdrawal.

3.4. The notes also contain an initial interview with Mr Keough which was conducted on 2 April 2003. Ms Jolly explained that once the resident contract and other documents previously referred to had been completed, Mr Keough was allocated to a room, provided with a key to the room and a swipe card which would activate a particular gate giving access to the facility.

3.5. Ms Jolly described a whiteboard in the office area placed so that the staff but not residents could view it. She said that each of the rooms in the facility was represented upon the whiteboard by a square. The name of the new resident would be placed in the appropriate square according to the room he or she was allocated, together with

the name of the key-worker for that person. If the resident went "on leave" a magnetic strip would be placed across their name upon the whiteboard.

3.6. Ms Jolly stated that a handover would occur between night and day shift personnel. It was a verbal handover which covered any change in a particular resident's mental states, key-worker visits and whether the residents were on leave or not.

3.7. Ms Jolly identified two documents which were admitted as Exhibit C4 in these proceedings. One is headed July 2003 and the other August 2003. Each of them represents a table of a list of names of all residents at the facility during those months, and a column next to each of the names corresponding with each of the days of the month. A tick placed in an appropriate column indicated that the resident was present at the facility at midnight that night and the letter 'L' denoted that the resident was on leave at midnight that night. She stated that the purpose of the form was to gather statistical information to demonstrate how busy staff of the facility were by demonstrating how many bed days per month were recorded at the facility. Ms Jolly stated that there was only one person on duty at any one time and that staff thought that they were under "a fair bit" of pressure.

3.8. Ms Jolly stated that the policy of the facility was that illicit drugs and alcohol were not to be brought on or used on the facility. This is borne out by the rights and responsibilities document to which I have already referred, and the resident's contract.

3.9. Ms Jolly stated that most residents at Palm Lodge were taking prescribed drugs. This would be done under the supervision of staff at Palm Lodge. Once the resident reached a particular stage of reliability the staff would discuss with the key-worker the possibility that the resident could become self-sufficient in administering their medication.

3.10. In relation to Exhibit C4, the bed days document denoting whether a resident was present or absent, Ms Jolly stated that there was no system for checking to ensure that a particular person was present or absent. She said that a tick would be accorded to a person if they had been seen around at sometime that day. However no formal check was made.

3.11. Ms Jolly stated that there was a lot of drug dealing at Palm Lodge during her time there. When asked what sort of drugs were involved she stated "Obviously marijuana

but anything and everything, I mean there was one particular resident that was actually in Palm Lodge at the time that Tom died, who was a known drug dealer and had a very strong reputation and a huge user". Ms Jolly stated that no report was made to police about the person described as a "known drug dealer". She was able to provide one instance of a person having been evicted from Palm Lodge for being disruptive by reason of the influence of a drug suspected to be speed. It appeared that notwithstanding the drug policy referred to in the documentation, at least from Ms Jolly's point of view, it was not strictly enforced. If a resident was not disruptive of other residents, and simply went to their room although under the influence of drugs, or apparently under the influence of drugs, no action would be taken.

3.12. Ms Jolly stated that the forms which I have referred to, Exhibit C4, were never intended to be an accurate register of a person's presence at Palm Lodge overnight but merely to demonstrate to what she described as "the powers that be" the need of more staff.

3.13. Ms Jolly stated that there were occasions when no one with mental health qualifications would be present for a particular shift.

3.14. Ms Jolly acknowledged that it would be possible for a resident to bring methadone onto the premises without staff becoming aware of this. She also stated that visitors could bring in drugs or medications without staff becoming aware. She acknowledged that staff could not monitor what prescription or other drugs were on the premises at any given time. She stated that there were no regular searches conducted of resident's rooms.

4. Mr David Farrington

4.1. David Farrington is a registered psychiatric nurse and registered general nurse. It was he who discovered Mr Keough's body on the evening of 11 August 2003. He made a statement that same evening which was admitted as Exhibit C10 in these proceedings. He also gave evidence at the Inquest.

4.2. Mr Farrington was still working at Palm Lodge at the time of the Inquest and had been so working for approximately ten years. He remembered Mr Keough and gave evidence that the last time he saw Mr Keough alive was on the Thursday prior to his death.

4.3. Mr Farrington gave evidence which corresponded with that of Ms Jolly in relation to the handover process that existed between day shift and night shift staff. He stated that the bed statistic sheet (Exhibit C4) would only be filled in by him after he had made a specific check as to a particular resident's presence or absence. He stated that he would knock on the door of each resident and if no reply was forthcoming he would usually open the door. He stated that he would often find rooms with fans and heaters on but no resident in occupation. This represented a safety concern. He stated that he was told that Mr Keough was on leave by Ms Jolly at handover on the evening of 11 August 2003.

4.4. Mr Farrington stated that he always checked rooms before completing the bed statistic sheet (Exhibit C4) because "you never take anything for granted". He acknowledged that this practice was not followed by other staff. He said that he had not worked for the three nights prior to 11 August 2003.

4.5. Mr Farrington was not aware of any resident having been prescribed methadone at the time of Mr Keough's death.

4.6. On the subject of drug abuse, Mr Farrington stated that there might have been a minority of residents who did not comply with the system, but he did not consider that there was flagrant drug abuse. He was asked if he agreed with Ms Jolly's stated that there was a lot of drug dealing at Palm Lodge. He disagreed with that statement. He acknowledged that some residents did take illicit drugs, but this did not occur – for the most part – in the facility itself. He was not aware of any drug dealing in Palm Lodge.

4.7. Mr Farrington acknowledged that each of the different staff members had a different approach or policy in relation to the recording of the presence or absence of residents on the bed statistics form (Exhibit C4).

4.8. Mr Farrington stated that as a member of the staff he had a master key to all of the resident's rooms. When he would check whether a resident was present or not, he would knock on the resident's door several times, and if he did not receive a reply would enter the room by means of his master key. He stated that he never had any complaints about entering rooms in this manner. He stated that to his understanding, entry into rooms in these circumstances was a good and reliable practice. He never discussed his practice with other staff and never told them his views on how to go

about this process saying it was "not my place". It was clear that there is no forum that could be used amongst staff to share ideas of this nature. Mr Farrington at least regarded himself as authorised to enter rooms for the purposes of making such a check. This is supported by the fact that staff members were provided with a master key which would provide access to resident's rooms.

4.9. Mr Farrington described Palm Lodge as having three access gates. One of them is permanently closed. The other is capable of being operated by means of the swipe card issued to residents. Another one which he referred to as the kitchen gate or side gate was operated by means of a padlock and chain. Mr Farrington stated that he would lock it at night but that during the day it was usually open. He did not know who would open it in the morning. He stated that it was possible for residents to come and go unseen by staff by means of this kitchen/side gate anytime except at nighttime.

4.10. Mr Farrington said that he knew Mr Keough relatively well and that he was a very pleasant likeable lad. He was never a troublemaker and got on very well with the other residents. He described Mr Keough as quiet and reserved, and a relatively normal young man who had a mental illness. He occasionally noticed Mr Keough to be affected by alcohol but on these occasions he was never disruptive.

5. Mr David Hamilton

Mr Hamilton was, in August 2003, a resident of Palm Lodge. He may have been the last person to see Mr Keough alive. He made a statement which was admitted as Exhibit C2a in which he said that he was "almost certain" that he saw Mr Keough on Saturday 9 August 2003 between 9:30 and 10:00pm in the courtyard outside Mr Keough's room at Palm Lodge. They had a brief conversation before Mr Keough entered his room. That was the last that Mr Hamilton saw of Mr Keough. Mr Hamilton stated that he was not "100%" certain if this sighting occurred on the Friday night or the Saturday night, but was "almost certain" that it occurred on the Saturday. Having regard to that evidence, I find that the sighting did indeed occur on the Saturday night, Mr Hamilton was, therefore, the last person known to have seen Mr Keough alive.

6. Ms Sandra Matta

6.1. Sandra Matta is a social worker who holds the position of principal social worker with the Eastern Community Health Service. She was interviewed by Senior Constable Gross and the record of interview was admitted as Exhibit C12 in these proceedings. She also gave evidence at the Inquest. She did not have any management responsibility for Palm Lodge in August 2003, but she was the Acting Director of the Eastern Community Health Service for a period beginning in August 2004 and was aware of certain internal investigations carried out as a result of inquiries instituted by the Ombudsman. She was able to give an account of what she had found out in the course of that involvement.

6.2. Ms Matta said in evidence that a revised procedure regarding resident's leave came into being after the death of Mr Keough. She identified a written document entitled "Palm Lodge nursing staff procedure regarding residents leave" which was admitted as Exhibit C11 in these proceedings. This written document requires that if there is an unexplained absence or failure to return by a stated time nursing staff must check bedrooms at least once every shift and record in the resident's notes the date and time this has occurred. Further, if a resident has left contact details for where they were going to be, nursing staff should attempt to contact and clarify the expected date and time of the return of the resident.

6.3. Ms Matta also identified another policy which came into effect in the period after Mr Keough's death which is a policy for supporting grieving families following the death of a resident. That document was also produced and identified by Ms Matta and was admitted as part of Exhibit C11.

6.4. Ms Matta was asked whether any client at Palm Lodge was on a methadone program in August 2003 and responded that according to her inquiries no resident was on such a program at that time. She stated that if a resident had been on such a program she would have expected this fact to be recorded on the resident's nursing record at Palm Lodge.

6.5. Ms Matta acknowledged that she still does not know to what extent residents of Palm Lodge comply with the requirement that they provide staff at Palm Lodge with information as to their comings and goings. She acknowledged that there is not full compliance with this requirement.

6.6. Ms Matta understood that the present process at Palm Lodge is that room checks are made if a person is believed not to be on the premises, but no check is made if the person is believed to be present.

6.7. Ms Matta said that she recently discovered that the kitchen staff at Palm Lodge maintain a register of residents who are present or absent for lunch and dinner. She produced a copy of the register for the period 4 August 2003 to 17 August 2003. That register records that Mr Keough was present for lunch and dinner on Friday, 8 August 2003. It shows that he was not present at any time thereafter. A copy of the relevant pages of the register was admitted as Exhibit C12a in these proceedings.

6.8. Ms Matta was asked to comment upon Ms Jolly's remarks that there was a lot of drug dealing at Palm Lodge. Ms Matta stated that she thought Ms Jolly's description of the environment at Palm Lodge was exaggerated. It was Ms Matta's opinion that drug use was not so rife at Palm Lodge as suggested by Ms Jolly.

7. The view

In the course of the Inquest I took the opportunity to visit Palm Lodge for the purpose of conducting a view. I understand that Palm Lodge was the only facility of its kind in South Australia in August 2003. The premises were formerly a motel. They have been adapted to their present purpose. There are a number of rooms containing a bed and simple wardrobe and other furniture. There are men's and women's shower and toilet blocks and there is a common dining room, meeting room, recreation room with table tennis and billiard table and a general television and sitting room as well. There is a blue "pay phone" outside the resident's meeting room. The resident's dining room is serviced by a kitchen and servery area to which residents' have free access for the purposes of obtaining food even when kitchen staff are not present. As I have already noted, lunch and dinner meals are prepared and available for residents. The office area has a meeting room immediately behind it which contains the whiteboard mentioned earlier. I noted that there were four access gates, two of which are permanently locked. Of the remaining two, one is the gate by the office which is activated by means of a resident's swipe card. The final access gate is a service entrance which accommodates vehicles in addition to pedestrians. It is this gate which Mr Farrington said that he locks at night and which is generally open during the daytime. During the view I noted that the gate was closed.

8. Professor Roger Byard

8.1. I have already recorded that Professor Byard performed a post mortem examination upon the body of Mr Keough. He wrote an autopsy report dated 30 December 2003 which was admitted as Exhibit C13a. Professor Byard gave evidence at the Inquest and confirmed that he attributed Mr Keough's death to methadone toxicity, taking into account the results of toxicology tests of blood samples taken at post mortem. A toxicology summary report prepared by Joanna Rositano, Forensic Scientist was admitted as Exhibit C1a in these proceedings and it reported that the blood sample taken by Professor Byard contained:

> '(1) 0.010 % alcohol
> (2) approximately 0.04 mg methamphetamine per L. (non-toxic/therapeutic)
> (3) approximately 0.1 mg methadone per L. (non-toxic/therapeutic)
> (4) a non-toxic/therapeutic concentration of positively identified citalopram
> (5) a sub-therapeutic concentration of positively identified diazepam.
> (6) a non-toxic/therapeutic concentration of positively identified nicotine.'

8.2. In the post mortem report Exhibit C13a, Professor Byard stated as follows:

> 'Death was due attributed (sic) to methadone toxicity given the level of 0.1 mg/L in the blood. Although this is at the upper limit of the therapeutic range, it is possible that the deceased had a higher level which was metabolised over time before death occurred. As death occurs slowly from respiratory depression the levels measured may not represent the highest that had occurred. It is noted in the police statement that the only medications that the deceased was prescribed were Cipramil, Resperidal and Alprazolam, with the only medication being located within the room being Alprazolam. There is no mention of methadone. Individuals who are not habituated to methadone are far more sensitive than most who are taking it on an ongoing basis. There was no underlying organic diseases which could have caused or contributed to death. There was no evidence of trauma.'

8.3. In the autopsy report Professor Byard expressed the view that Mr Keough's date of death was on or about 9 August 2003. It will be recalled that his body was discovered on 11 August 2003. The date of the autopsy was 12 August 2003. Professor Byard stated that he estimated the date of death by reference to putrefactive changes which had occurred to Mr Keough's body and concluded that he had been dead for some time. Professor Byard acknowledged that this was an estimate only and its accuracy could be affected by the temperature in the room in which Mr Keough was found. Accordingly, the date of death could have been before or after 9 August 2003.

8.4. Professor Byard stated that there is a prolonged period of unconsciousness before respiratory depression reaches a point of irreversible brain damage. Professor Byard said that during at least some of this period it would have been possible for Mr Keough to be resuscitated. Professor Byard thought it was unlikely that Mr Keough could have been awakened by noise during that period. Professor Byard was a co-author of an article appearing in the American Journal of Forensic Medicine and Pathology in 2000 entitled "Methadone Maintenance Programs – A Two-Edged Sword?" A copy of the article was admitted as Exhibit C13b in these proceedings. I quote the following extracts which have particular relevance:

> 'Of the 35 cases, 8 victims (23%) not enrolled in a methadone maintenance program were found who had died after the use of "diverted" methadone.'
>
> 'Unfortunately, one consequence of releasing opioids to addicts in an unsupervised situation in the community is the potential for abuse by other individuals. This study clearly demonstrates the potential results of the use of "other people's" or "Diverted" methadone. Eight of 35 methadone-related deaths occurred in individuals who were not registered with a methadone maintenance program. Six of the victims had obtained the methadone from a partner, friend or family member who had been prescribed the drug through a program.'
>
> 'Methadone may be stored in home refrigerators by addicts, thus providing easy access to others in the house.'
>
> 'Because the respiratory depressant effects of methadone may last up to 48 hours, there may be a considerable time during which the victim appears to be asleep and snoring, although unrousable.'
>
> 'A solution to the problem of the use of other people's methadone would be to have daily releases, with the addict having to consume the drug under close supervision. This has been advocated by a number of authors and was instituted in Western Australia after a spate of methadone deaths, resulting in marked reduction in fatalities. Until such steps are taken in South Australia, further deaths from diverted methadone will undoubtedly occur, particularly with the increasing numbers of patients enrolling in programs.'[3]

8.5. Professor Byard stated in evidence that he continues to be concerned about methadone being passed on within the community. He pointed out that people who are not regular methadone users are more likely to be adversely affected by the drug than people who are tolerant to it from regular use. Professor Byard expressed the opinion that it is "highly unwise" to have people with drug use problems taking methadone into situations where they are accessible within the community. He stated that methadone syrup is easily ingested and does not require intravenous administration which is another factor which might encourage non-addicts to experiment with the

[3] I have deleted references to footnotes in the quoted passages.

drug. He stated that methadone gives the users a form of euphoria when first taken and this would also operate as an incentive for people to experiment with it.

9. Senior Constable Gross

9.1. Senior Constable Gross carried out an investigation in relation to Mr Keough's death at the request of the acting State Coroner in August 2005. He made a statement which was admitted as Exhibit C14 in these proceedings and also gave evidence at the Inquest.

9.2. Senior Constable Gross was asked to investigate this matter on 3 August 2005 and he gave evidence that he understood his investigation should cover how Palm Lodge was governed and run and where Mr Keough obtained the methadone which he must have ingested, and also Mr Keough's general movements over the weekend prior to his death.

9.3. Senior Constable Gross started his investigation by talking to Ms Matta. He made contact with Ms Matta to ascertain how the facility was run and set up. He interviewed Ms Matta at the Eastern Community Health Service on 25 August 2005. He had previously met Ms Matta at Palm Lodge for a view of the premises.

9.4. Senior Constable Gross stated that he was informed by Ms Matta that an agency nurse by the name of Schummacher was on duty for the night shift over the weekend of 9/10 August 2003. He made a number of efforts to ascertain the present whereabouts of Mr Schummacher including with the Nurses Board and South Australia Police. Senior Constable Gross stated that Ms Matta also mentioned a female person – I take this to be a reference to Mayia Charles who was mentioned at Line 301 of Ms Matta's record of interview[4]. Ms Charles was stated by Ms Matta to be on duty on the day shifts of 9/10 August 2003. However, Senior Constable Gross stated that his interest was in Mr Schummacher because it was he who informed Ms Jolly on the morning of 11 August 2003 that Mr Keough was thought to be on leave over the weekend. Senior Constable Gross wished to find out from Mr Schummacher how he came by that information which we now know was incorrect.

9.5. Senior Constable Gross did not interview two other persons mentioned by Ms Matta, namely Greg Calder who was Team Leader of Palm Lodge at the relevant time and

[4] Exhibit C12

Ann O'Donnell who was the Director of the Eastern Community Health Service at the time, although they were mentioned by Ms Matta. Senior Constable Gross said this was because of his interest in Mr Schummacher.

9.6. Senior Constable Gross interviewed Ms Jolly on 19 August 2005 at Palm Lodge. Her evidence has already been the subject of discussion in these findings and I will not repeat Senior Constable Gross' evidence about his interview with her. Senior Constable Gross was asked about information he obtained from Ms Jolly about Mr Keough's associates outside of Palm Lodge and whether he had made further enquiries in relation to them. Senior Constable Gross explained that he had no names and addresses in relation to those people and did not therefore pursue that line of inquiry.

9.7. Senior Constable Gross stated that he followed up a line of inquiry in relation to any person that might have fitted the description of the "known drug dealer" referred to by Ms Jolly. Inquiries were made in relation to a person who had lived at Murray Bridge. Senior Constable Gross arranged for Murray Bridge Police to follow this line of inquiry. However, this did not prove fruitful.

9.8. Senior Constable Gross interviewed another person who was a resident at Palm Lodge at the time Mr Keough was resident there. This person was the subject of an allegation that he had been seen giving Mr Keough some Valium by another resident. The person denied this allegation when interviewed by Senior Constable Gross. The person denied also that they were a methadone user and denied supplying Mr Keough with methadone. They also had no idea where Mr Keough obtained methadone from.

9.9. Senior Constable Gross stated that he obtained the bed statistic sheet[5] from Ms Matta and then attended the Drugs of Dependence Unit to make inquiries about whether any of the people recorded on the bed statistic sheet for 2003 were recorded as being on the methadone program for the period between 7 August 2003 and 11 August 2003. Mr Geoff Anderson of that Unit was able to identify three people whose names were similar to those on the Palm Lodge bed statistic sheet and were recorded as being on the methadone program during those dates. Senior Constable Gross contacted Ms Matta and asked her to confirm whether the two males identified by Mr Anderson were residents of Palm Lodge at the time of Mr Keough's death. She verified that one

[5] Exhibit C4

of the men who had been identified by Mr Anderson was a person recorded as being at Palm Lodge at the time of Mr Keough's death. Senior Constable Gross made arrangements for Detective Ellis of Adelaide CIB to pursue these lines of inquiry. She advised him that the female person referred to by Mr Anderson was now detained at Glenside Hospital. Detective Ellis was able to locate the male person who remained of interest and conducted an interview with him. A copy of the record of interview was admitted as Exhibit C14b in these proceedings. This person stated that he was a methadone user and a resident of Palm Lodge in August 2003. Senior Constable Gross did not know whether this person was permitted to take his methadone away from the chemist or other place at which it was provided, or whether he was required to consume it at the place at which it was provided to him. This person denied having provided methadone to Mr Keough. He acknowledged that he knew Mr Keough through being at Palm Lodge at the same time. He was asked if he knew where Mr Keough might have obtained the methadone and responded that he did not know. Senior Constable Gross formed the opinion that this person had not supplied Mr Keough with methadone and had no details as to where Mr Keough may have obtained it.

9.10. Senior Constable Gross summarised the position by stating that he was unable to ascertain where Mr Keough obtained the methadone which eventually caused his death.

9.11. Senior Constable Gross confirmed that he had not made any check of the electoral roll for Mr Schummacher. He could not remember if he contacted the agency through which Mr Schummacher was engaged by Palm Lodge. Senior Constable Gross had not been aware of the record which was admitted as Exhibit C12a in these proceedings recording the presence or otherwise of residents at Palm Lodge at meals during the relevant time. He stated that he was not informed about that document and did not know that it existed but agreed that it would have been useful for his purposes in 2005. He agreed that the fact that Exhibit C12a showed that Mr Keough was present at dinner on Friday night 8 August 2003 might tend to contradict the suggestion that he had been on weekend leave during the weekend of 9 and 10 August 2003.

9.12. Senior Constable Gross was asked whether he was alarmed by the allegation that there was a known drug user at Palm Lodge at the relevant time. He stated that it had

not alarmed him because it was an allegation which may or may not have been true. Having said that he commented that he would not have been surprised if drug dealing had occurred at Palm Lodge, because such behaviour occurs in the general community. He commented that without names it was difficult for him to investigate it further.

9.13. Senior Constable Gross was asked whether he was aware that Ms Matta was not aware that two persons at least who were resident at Palm Lodge in August 2003 were on the methadone program. Senior Constable Gross commented that he would not have thought that Ms Matta should have been aware of this because of the nature of the facility. Senior Constable Gross commented that the difficulty with the facility was that residents could come and go as they wished and with that in mind he knew that his investigation about how Mr Keough obtained the methadone was always going to be very difficult.

9.14. Senior Constable Gross could not remember whether he requested a copy of staff rosters for the weekend of 9/10 August 2003. He could not remember whether he ascertained for certain whether Ms Jolly was working over that weekend notwithstanding her statement to him in her record of interview that she could not remember this but that it could be ascertained by reference to the staff roster. Senior Constable Gross confirmed that he did not pursue an interview with Ms Mayia Charles because once he had established that Mr Schummacher was on the night shift and had handed over to Ms Jolly on the morning of 11 August, it was his view that it was only necessary to interview Mr Schummacher. Senior Constable Gross acknowledged that it would have been helpful to confirm who was working on the day shift during that weekend, but believed that he had no specific instructions to do so. This is somewhat perplexing given his understanding of the general nature of his inquiry, namely amongst other things to ascertain the movements of Mr Keough over that weekend. It would seem to me that it would have been most useful to have interviewed all staff working all rosters that weekend in order to achieve that investigational objective.

9.15. Senior Constable Gross stated that he conducted no checks for drug convictions or other criminal convictions of any of the residents on the bed statistic sheet of Palm Lodge for that period other than the persons known to be on the methadone program. Senior Constable Gross did not agree that it would have been a useful thing to check

the records of those persons. He stated that he eliminated those persons because in his opinion there would be no obvious benefit in interviewing them. With respect, I disagree. Senior Constable Gross acknowledged that he did not make any inquiries at Fullarton Private Hospital as to Mr Keough's associates there in the Adolescent Day Program, he did not make any inquiries as to the identity of Mr Keough's girlfriend and did not make contact with Mr Keough's father to ascertain the identity of Mr Keough's associates.

10. Dr John Brayley

10.1. Dr John Brayley gave evidence at the Inquest. He is a psychiatrist and holds qualifications in medicine, psychiatry and is a Master in health service management. In June 2005 he was appointed Director of Mental Health for the State of South Australia and in October 2006 became the Director of Mental Health Policy.

10.2. Dr Brayley referred to recommendations recently promulgated by the Social Inclusion Board in relation to mental health policy in this State. He explained that under the model proposed by the Social Inclusion Board facilities will have very clear roles and responsibilities. He stated that there would be a focus on earlier intervention and better coordination of care for people with very complex conditions and particularly with co-morbidities of mental illness and drug and alcohol dependency.

10.3. I gained the impression from Dr Brayley that it is unlikely that Palm Lodge will remain in its present configuration after the implementation of these recommendations. It will probably undergo some change in function.

10.4. Dr Brayley referred to a stepped approach to mental health care. He stated that there will be community rehabilitation centres and other facilities known as intermediate care centres. Community rehabilitation centres will have a full range of doctors and provide a clinical service as well as having care workers doing the day-to-day care for patients. The intermediate care facility will have clinical staff and will not have an accommodation focus but will be more of a treatment facility.

10.5. Dr Brayley agreed that he had a general understanding of the circumstances of Mr Keough's death having read staff interviews. However, he was not involved in the mental health service at the time of Mr Keough's death. He agreed that the misuse of prescribed and illicit drugs was not unusual with mental health patients. He stated

that the co-morbidities of drug and alcohol dependence and mental illness were certainly not uncommon. He said that it is quite common knowledge amongst professionals in this area that people with mental illness are also likely to be taking drugs. He stated that one problem of this is the admixture of illicit drugs and people's prescription drugs. Dr Brayley stated that the use of illicit drugs can precipitate a relapse or make a patient more unwell.

10.6. Dr Brayley stated that it is common for blood and urine testing for illicit drugs to be undertaken on a closed ward. On an open ward it is carried out if clinically indicated. He stated that in relation to a supported residential facility such as Palm Lodge it would be more likely that compulsory blood and urine testing would be conducted by external clinicians who were involved with patients and that it would not be consistent with the provisions of the Supported Residential Facilities Act for the owner of the facility to do that.

10.7. Dr Brayley stated that some consideration was given to the possibility of drug testing in the period after Mr Keough's death as a matter of a general review of policy. However it was decided that there would be no compulsory drug testing at Palm Lodge following that consideration notwithstanding Mr Keough's tragic death. Dr Brayley stated that if a member of staff of Palm Lodge were to suspect that a resident was using drugs, the appropriate thing would be to inform the clinician involved with that resident with the expectation that the clinician would then arrange for a drug test to be carried out.

10.8. Dr Brayley acknowledged that methadone can be a dangerous drug for persons who are not acclimatised to opiates. He stated that he believed that the staff at Palm Lodge would be aware if any of the residents at Palm Lodge were involved or registered with the methadone program run by the Drug and Alcohol Service Unit. He stated that he did not believe that it would be appropriate practice for methadone to be kept by a user in his or her room at Palm Lodge and in fact it would be preferable that it not be brought onto Palm Lodge at all.

10.9. Dr Brayley was questioned about the arrangements which exist for young people with mental illness once they achieve the age of eighteen and are no longer eligible for care by the Child and Adolescent Mental Health Service. Dr Brayley stated that the response in South Australia has been to arrange for the child and adolescent mental

health service and adult mental health services to work more closely together and that there have been major changes in recent years in this respect. Having said that, Dr Brayley stated that he was unable to draw the conclusion that Mr Keough needed more support from the services than he was getting at the time. Dr Brayley commented that there was key-worker involvement, that Mr Keough was a part of the adolescent program at the Flinders Private Hospital and was also seeing his private psychiatrist. He stated that Mr Keough's death came as a surprise and a shock to those at Palm Lodge because Mr Keough had been responding positively prior to this. Dr Brayley noted that Mr Keough was not taking his Risperidone at the time of his death however.

10.10. Dr Brayley was questioned about staffing levels at Palm Lodge. He responded that appropriate staffing levels should be determined against the background of the external support available to residents at the facility. He stated that he believes that Palm Lodge is now being operated diligently and that there is an appropriate mix of patients to staff levels. He stated that the adequacy of the level of staff depends on the mixture of residents and their requirements and the extent to which those requirements are being met by external supports.

11. Professor Jason White

11.1. Professor White is Professor of Addiction Studies and Head of the Discipline of Pharmacology at the University of Adelaide. He is a Director of Drug and Alcohol Services South Australia. He prepared a report in this matter which was admitted as Exhibit C19. He also gave evidence at the Inquest. In his report[6] which was dated 29 March 2007, Professor White states:

> 'The concentration in the sample from the deceased is within the concentration range from samples collected from cases where methadone or methadone in combination with other drugs has been the recorded cause of death. However, it is at the lower end of this range. Lower concentration tend to be found when the victim has consumed other drugs, particularly alcohol, and when the victim is not someone accustomed to taking methadone.
>
> The medical records of the deceased indicate that he was not prescribed methadone or other opioid drugs and could therefore be presumed not to have been tolerant to opioids. A low concentration of methadone could therefore have been fatal.
>
> Following consumption of a fatal dose of an opioid drug such as methadone, respiration is depressed and the person falls into a comatose state. The time to death can then vary

[6] Exhibit C19

considerably: from immediate to a number of hours. If it is immediate then the post-mortem methadone concentration reflects the fatal concentration. However, if there is a delay of some hours, then the post-mortem concentration may be lower than the concentration that initiated the events leading to death. In cases where there is such a delay, the post-mortem sample may show a relatively low methadone concentration.

In general, methadone concentrations reach a peak approximately three hours after oral consumption. The concentration falls rapidly for about 4 hours after the peak and then decreases more slowly. This last, slowly decreasing phase can be very long, as methadone has a half-life (the time taken for the drug concentration to decrease by 50%) of 24-30 hours.'

'Methadone is available in three forms in Australia. For the treatment of pain it is prescribed in the form of Physeptone tablets, each of 10mg. Methadone is widely prescribed for the treatment of chronic pain arising from a variety of conditions. It has a history of being relatively commonly used in South Australia. When prescribed for the treatment of chronic pain, patients normally are given an extended supply from the pharmacist and then are expected to regulate dosing themselves as occurs with other prescription medications.'

'The other form is a liquid containing methadone in a strength of 5 mg/mL. It is used for oral administration in the treatment of opioid dependence. Opioid dependent people may be offered methadone maintenance as one form of treatment of opioid dependence. When used in this way the dosing of methadone is more strictly controlled. The person normally starts with daily dosing under supervision of a pharmacist. If their treatment progresses well, then they may be allowed some unsupervised (take home) doses each week so that daily attendance at the pharmacist is not required. The number of unsupervised doses rarely exceeds four in a week. When not supervised, each day's dose is placed in a child-proof container and mixed to a volume of 100mL to reduce the risk of accidental consumption.'

11.2. Professor White stated that diversion of methadone is a potential problem both with methadone prescribed for the treatment of pain, and with methadone prescribed for the treatment of dependence. He said it is not possible to tell from the results of a blood test whether the methadone came from someone prescribed the drug for treatment of pain or for treatment of opioid dependence. Professor White referred in his evidence to an article entitled "Methadone related overdose deaths in South Australia, 1984-1994" of which he was a co-author. The article was admitted as Exhibit C19a in these proceedings. The article examined all deaths in which methadone was detected by blood assay during the period referred to in the title. The authors examined the casenotes containing the police investigation report and autopsy report for each death. The report found that for the year 1993 and 1994 deaths from methadone tablets accounted for sixty percent of all methadone related deaths in those

two years and in forty-six percent of the deaths the person had not been prescribed methadone. The authors stated:

> 'Police investigation reports specifically linked all methadone tablet overdose deaths to a prescription for chronic pain, either for the deceased person or for the suppliers of the tablets to the deceased person.'

The report also found that deaths related to illicitly obtained methadone syrup during 1993 and 1994 increased to an average of four per year, possibly reflecting the increased availability of take away doses and the increase in average dose.

11.3. Professor White made the point in evidence that it is not only addicts who pass on their methadone medication. Persons prescribed methadone for chronic pain have also been shown to do this, and that point is demonstrated by the article. Professor White commented that the relatively lower regulation in place for methadone prescribed to patients with chronic pain was a concern to him bearing in mind that diversion is occurring from that patient group.

11.4. Professor White commented that the consumption of alcohol can significantly increase the risk of respiratory depression after consumption of methadone. He stated that relatively small amounts of alcohol can potentiate the effects of methadone. Professor White acknowledged that the small amount of alcohol found in the post mortem blood samples taken from Mr Keough could not definitively be ascribed to alcohol consumed before death but could be attributable to the effects of putrefaction.

11.5. Professor White commented that diversion of methadone and similar opioids is increasing in Australia and other countries such as the United States. He stated that the problem of diversion probably cannot, in his opinion, be eliminated but merely minimised. Professor White stated that he did not realistically believe that it would be possible to eliminate deaths from opioids being handed on in the community.

11.6. Professor White was asked whether it would be feasible to ensure that persons prescribed methadone for opioid addiction were consuming their methadone. Professor White stated that it would theoretically be possible but that it would be extremely difficult and had never been tried. He pointed out that it would be necessary to conduct random testing to avoid manipulation.

11.7. Professor White referred to a new form of medication for opioid addiction known as buprenorphine which has been available since 2001. He stated that it is not presently

used for chronic pain but that there is less risk of diversion with buprenorphine than with methadone. Professor White stated that buprenorphine is now the first drug of choice for a new entrant to the program run by his unit. He stated that a total of approximately twenty-nine hundred people are on the program at the moment of which two thirds are on methadone and one third on buprenorphine.

11.8. Professor White was asked about the feasibility of introducing substitutes for pharmacies for the distribution of buprenorphine for participants in the program. He stated that bearing in mind that there are hundreds of pharmacies which presently participate in the program it would be extremely expensive and probably not feasible to introduce an alternative. He also stated that it is necessary for a pharmacist to dispense the medication. Of course, this is a result of present laws regulating the supply of methadone. No doubt the laws could be modified if a better system of distribution to persons involved in the program could be devised.

12. Dr Jon Jureidini

12.1. Dr Jureidini gave evidence at the Inquest. He is an Associate Professor of Psychiatry. He is Head of Child Psychological Medicine at the Women's and Children's Hospital. He stated that there has been an increasing recognition that the attainment of the age of eighteen years does not necessarily mean that a person is ready to take control of his or her life. He stated that the Child and Adolescent Mental Health Service has employed a transition psychiatrist to follow patients who have attained the age of eighteen years and facilitate their transition into the adult mental health system. He expressed the opinion that in general the adult mental health system is concerned with recovering lost skills but, by contrast, adolescents with psychiatric problems may never have acquired those skills in the first place. He stated that adolescents and young adults require a family based environment for their rehabilitation. The system which exists at the moment is geared towards what he described as a show of respect for autonomy. He pointed out that many of the young people in the greatest difficulty have dysfunctional families and therefore are expected to live independently. These are the very young people who require a family-like environment. He stated that the mental health system needs to provide for the creation of a family-like environment for young people in their late teens and early twenties.

12.2. Dr Jureidini expressed the opinion that it is not desirable for a young person such as Mr Keough to be in a place with older patients. He expressed the opinion that Mr Keough's age and emotional immaturity meant that he was not appropriately placed at Palm Lodge. Dr Jureidini qualified this by pointing out that Palm Lodge was not as detrimental to Mr Keough as many of the alternative places he might have found himself in would have been. He pointed out that Mr Keough might, like many other young people, end up in an ordinary boarding house, which would be a much more malignant situation than Palm Lodge. His point was that, in his opinion, although Palm Lodge was probably as good as was available for a person in Mr Keough's position at the time, much better is required if we are to seriously address the problems of young people in the position of Mr Keough. Dr Jureidini was asked whether it would be realistic to impose a system upon young people in Mr Keough's circumstances to ensure that they are taking their prescribed medication appropriately and not taking illicit medication to be required to submit to compulsory blood or urine testing. Dr Jureidini was unenthusiastic about this proposal. He stated that there was no evidence that compulsory testing would prevent deaths and that this proposal would be extremely resource intensive. The resources would be better utilised providing the sort of environment that he had already described as appropriate for young people in Mr Keough's position.

13. Dr Nicholas Ford

13.1. Dr Nicholas Ford gave evidence at the inquest. He is a Psychiatrist and he treated Mr Keough from February 2001 until his death. He said that his initial diagnosis of Mr Keough was major depression with extreme social phobia. Dr Ford was concerned that there may be an evolving psychotic process such as schizophrenia, bi-polar disorder or schizoaffective disorder.

13.2. Dr Ford gave evidence about a presentation of Mr Keough in January 2003 when he was admitted to Fullarton Private Hospital. At that time Dr Ford made a differential diagnosis of mania with dysphoric features and noted that Mr Keough was agitated and tearful and distressed on admission but at the same time was talking about starting up a band which according to Mr Keough would be bigger than the Beatles[7].

[7] Transcript, page 327

13.3. Dr Ford said that Mr Keough was again admitted to the Fullarton Private Hospital on 5 March 2003. On 11 March 2003 he was seen by Dr Ford who noted that Mr Keough felt that he had been reincarnated and was Jesus Christ. His conversation was rambling with abrupt changes in topic. Mr Keough was linking himself with Kurt Cobain and his mother with Mary. Dr Ford said this was a presentation of hypermania or certainly psychosis of which hypermania is a variant. During this period of hospitalisation, Dr Ford said that he was giving consideration to Mr Keough's eventual discharge and the environment in which he would need to be placed[8]. The admission to Fullarton Private Hospital on that occasion lasted from 5 March until 16 April 2003[9]. Dr Ford said that he was looking for a placement for Mr Keough upon his discharge that would have a homely environment with supervision and observation of his mental state and demeanour. He thought that it would be necessary for psychiatric nurses to be available and willing and able to administer medication[10]. Dr Ford said that the decision to place Mr Keough in Palm Lodge was made by him in consultation with Jill Hicks and Katie Phillips, an experienced psychiatric nurse from Fullarton Private Hospital who ran adolescent programs out of that hospital[11]. Dr Ford described Palm Lodge as the most suitable of the available alternatives for Mr Keough noting that there were not a lot of alternatives available for a young person who needed to have his mental state monitored while living semi-independently but with supervision of the administration of his medication[12]. Dr Ford gave evidence of the proposal for Mr Keough to attend certain programs including the Second Story, and the Fullarton Private Hospital AYEP program run by Katie Phillips. Dr Ford was to maintain contact with Mr Keough by outpatient appointments and Jill Hicks was to continue in the role of key worker[13]. Dr Ford said that his diagnosis of Mr Keough on discharge was that of hypermanic and depressive episode with a queried schizoaffective disorder[14].

13.4. Dr Ford said that from the period after Mr Keough left Fullarton Private Hospital in April 2003 through until August 2003 his compliance with medication had improved and his presentation had also improved[15]. In particular, Dr Ford stated that there was

[8] Transcript, page 333
[9] Transcript, page 335
[10] Transcript, page 336
[11] Transcript, page 337
[12] Transcript, page 340
[13] Transcript, page 341
[14] Transcript, page 343
[15] Transcript, page 355

nothing in Mr Keough's presentation in the months of June, July and August of 2003 that suggested to him that Mr Keough might be suicidal[16].

13.5. Dr Ford was asked about whether he would be concerned if Mr Keough was in an environment where illegal drugs were available. His response was that psychiatrists expect or anticipate that illicit drugs are an issue in any residential facility. He said that this is so at Glenside and that part of the business of psychiatric nursing is for the practitioners to have an awareness that illicit drugs are available and used. Dr Ford said that he has not spoken to a psychiatric nurse who is not aware of this and the need to constantly monitor the interactions between individual residents of such facilities. The nurses keep an eye on who is in the hospital, who has a history of drug use or is thought to be a dealer in drugs. They engage in what he described as "triangulation" by which he meant the sharing of information from a number of different sources in relation to a patient in order to assess the risks that they might be engaging in illicit drug use[17].

13.6. Dr Ford expressed the view that Mr Keough's use of methadone on the weekend of his death was a "one off episode" having regard to the low post mortem blood concentration of methadone[18].

14. The evidence of Ms Lana Lanco and Mr Geoffrey Nunn

During the course of the Inquest a person by the name of Lana Lanco contacted Mr Xenophon, solicitor for the father of Mr Keough, to provide information of relevance to the inquest. Ms Lanco provided a statement which was admitted as Exhibit C20. She also gave evidence. She stated that she was a resident of Palm Lodge on a number of occasions. She suffers from mental health problems. While she was resident in Palm Lodge in 2002 she was approached by one of the other residents who was being medicated with methadone because of chronic pain caused by a motor vehicle accident which resulted in a high level amputation of one arm. The presence of that person at Palm Lodge at the time referred to by Ms Lanco was confirmed by Palm Lodge records. Ms Lanco said that this resident had supplied her with methadone in Palm Lodge. Ms Lanco's carer, Geoffrey Nunn also provided a statement which was admitted as Exhibit C21. He gave evidence at the Inquest also.

[16] Transcript, page 361
[17] Transcript, page 382
[18] Transcript, page 394

He said that on the occasion that Ms Lanco obtained the methadone she told him what had happened. He said that he rang the Palm Lodge office on the day that Ms Lanco confessed to him. He advised the person in the office that Ms Lanco had bought methadone from the other resident.

15. Ms Susan Allen

15.1. Ms Susan Allen gave evidence at the Inquest. She is a Mental Health Nurse and was working at Palm Lodge in 2002. She gave evidence by reference to Palm Lodge casenotes[19] that she was the recipient of the telephone call from Geoffrey Nunn. She made a note of the phone call from Mr Nunn in Ms Lanco's casenotes and the notes record the incident in much the same terms as described by Ms Lanco and Mr Nunn. The note records that Ms Allen informed Mr Nunn that she would speak with the clinical team and the Team Leader about the matter. Ms Allen stated that, according to her note, a number of phone calls were made during the course of the day following Mr Nunn's communication. Ms Allen said that she could not specifically recall what action she took in relation to Mr Nunn's information but believed that she would have discussed the matter with the Team Leader, Mr Greg Calder, and that this would have occurred at a meeting at which Ms Jolly and the Palm Lodge Manager, Allan Johnson, would also have been present[20].

15.2. Ms Allen gave evidence that the person from whom Ms Lanco obtained the methadone was permitted to pick her methadone up in tablet form and return with it to Palm Lodge[21].

15.3. Ms Allen was asked whether there was a policy at Palm Lodge to involve the police when allegations of drug use or drug dealing are made. She responded in the negative and said that instead staff would inform the Team Leader:

> 'Palm Lodge falls into a very dodgy area. It's not an acute admission ward, it's not a community setting like the person's homes. Its this temporary residential facility and to my knowledge there are no written protocols about how we were meant to manage.[22]'

Ms Allen also said that staff of Palm Lodge were "often forced to accept people who we had concerns about"[23] as residents at the facility. She gave evidence that the staff

[19] Exhibit C22
[20] Transcript, page 443
[21] Transcript, page 452
[22] Transcript, page 453
[23] Transcript, page 455

used to call Palm Lodge "Dodgy Lodge", that there were no clear guidelines for staff and that the staff were "left in the lurch" without clear guidelines. Such direction as there was, was verbal from either Greg Calder or Ann O'Donnell[24]. She said that Palm Lodge still does not have guidelines at the time of her evidence[25].

15.4. However, Ms Allen balanced this evidence by acknowledging that Palm Lodge is a microcosm of society and that drug use is "everywhere". She said that drug use was certainly something which staff did not want in Palm Lodge and that they tried to protect people. She said that if they had suspicions about anybody they would do room searches and talk to the relevant key worker and request drug screens. However, she stated that unless staff actually found evidence there was little they could do[26].

15.5. Ms Allen gave evidence that she knew Mr Keough as a resident of the facility and worked with him. Although she was on holidays at the date of his death she was devastated to hear the news. She said that she felt that in the time that Mr Keough was in Palm Lodge he "blossomed" and that she had a great hope for him that he was getting on top of his problems and connecting with people and becoming more outgoing[27].

16. Mr Gregory Calder

16.1. Mr Calder gave evidence at the Inquest. He is qualified as a Mental Health nurse and has qualifications in health management. Mr Calder said that he had a number of areas of responsibility including that of Team Leader at Palm Lodge which involved full oversight of the day to day operations of Palm Lodge including resourcing and general oversight and welfare of the clients as well as the staff[28]. He gave evidence that Palm Lodge was covered by a number of policies and operational guidelines. He said that it came under the "jurisdiction" of the Royal Adelaide Hospital and that the overarching policies of that hospital applied to Palm Lodge. He also said that there were localised policies for Palm Lodge that were held in the nurses station for all to see and read. However, in relation to the matter of drugs, he stated that:

[24] Transcript, page 458
[25] Transcript, page 460
[26] Transcript, page 479
[27] Transcript, page 471
[28] Transcript, page 485

> 'But the drug policy was more around an observational aspect of the day to day running of the place. By that I mean that observation of a persons' behaviour, change of mental state, suspicion of perhaps using substances that interfered with their mental state, but there was certainly a direct policy in relation to reporting incidences (sic) where there was concrete evidence.'[29]

16.2. Mr Calder was questioned about the report that had been made by Ms Lanco that she had been provided with methadone by another resident. He was asked whether the police were called in to investigate the matter and conceded that they were not. He was asked what circumstances would have to exist for the police to be called in on such a matter and responded:

> 'At the time I really can't recall what would've triggered that. I can only assume, at the time, we didn't consider it to be a criminal offence.'

Later, he said:

> 'There was an allegation made. What I'm suggesting is that it wasn't me – my responsibility to determine criminality. But if there was an allegation made that there was a suspicion of such activity then we probably should've called the police in for them to determine that.'[30]

17. Conclusions as to monitoring and supervision at Palm Lodge

17.1. The Palm Lodge staff appear to have assumed that Mr Keough was on leave and absent from Palm Lodge over the weekend of 8, 9, 10 August 2003 and extending to Monday 11 August 2003. This was information that was passed onto Ms Jolly when she commenced her day shift on Monday 11 August 2003 and she passed the same information onto Mr Farrington when he commenced his night shift the same day. It will be recalled that it was Mr Farrington who found Mr Keough deceased in his room on the night of Monday 11 August 2003. Palm Lodge records show that Mr Keough was present in the dining room on Friday 8 August 2003 for dinner. I have found that the last person known to have seen Mr Keough alive was David Hamilton who believed that sighting to have taken place on Saturday 9 August 2003 between 9:30 – 10:00pm. There were no other sightings of Mr Keough after that time. I therefore find that on the balance of probabilities, Mr Keough remained in his room from approximately 9:30 or 10:00pm on 9 August 2003 until the discovery of his body in the evening of 11 August 2003. Professor Byard expressed the view that Mr Keough's date of death was on or about 9 August 2003. This estimate was based

[29] Transcript, page 489
[30] Transcript, page 520

on putrefactive changes which had occurred to Mr Keough's body that caused Professor Byard to consider that he had been dead for some time. However, Professor Byard acknowledged that the date of death could have been before or after 9 August 2003. Having regard to all of this evidence, it seems to me likely that Mr Keough had died some time before the evening of Sunday 10 August 2003. In my opinion, the time of death should be placed some time between 9:30 – 10:00pm on 9 August 2003 and the early evening of Sunday 10 August 2003.

17.2. It is clear that no search was made of Mr Keough's room at any time between 9:30 – 10:00pm on 9 August 2003 and the discovery of his body on the night of 11 August 2003, a period of approximately 48 hours.

17.3. Mr Farrington was the only member of staff who gave evidence who made a nightly room check. Of course, Mr Farrington was not on duty over the weekend of 9 – 10 August 2003.

17.4. The evidence showed that since Mr Keough's death, Palm Lodge has introduced a policy of room checking daily, although Ms Matta gave evidence that it is her understanding that room checks are only made if a person is believed not to be on the premises and that no check is made if the person is believed to be present. It appears that this matter still needs to be clarified further.

17.5. I referred earlier to the objects of the Supported Residential Facilities Act 1992. The objects that services should be provided in a safe physical environment and that residents are to be afforded "reasonable" degrees of privacy, could be seen to be at odds with one another. It is my view that the balance should be weighted in favour of safety when striking a balance between these objectives. There appears to be some acknowledgement of this in the change of policy regarding room checks.

17.6. It seems to me that, having regard to the evidence about drug use and the vulnerability of Palm Lodge residents, it was reasonable to expect, at the very least, that all rooms would be checked on a nightly basis at least once. Had this occurred on the weekend of 9 – 10 August 2003, it is possible that Mr Keough would have been discovered and action taken to prevent his death. The evidence as to the pharmacology of methadone showed that a person suffers respiratory depression following ingestion of an overdose of methadone. Such a person may appear to be asleep for many hours prior to death. Action can be taken to reverse the effects of the methadone at any stage

during that period. If Mr Keough had been sleeping or unconscious for a lengthy period prior to suffering respiratory arrest, it is possible that his condition may have been recognised and the process prevented or reversed. This is no more than a possibility; it is possible that Mr Keough succumbed quickly to the effect of the methadone, and if so, no measures would have been sufficient to prevent his death. However, I find that there was a possibility that his death might have been prevented had he been observed as part of a process of routine room checking during the relevant period.

18. Where did Mr Keough obtain the methadone?

Unfortunately this matter was not resolved at the Inquest. An earlier and more rigorous police investigation may have discovered the source of the methadone but the fact that Mr Keough's death was attributed to methadone toxicity was not known for some months after his death[31]. Apparently the relevant police officers did not consider it possible in the absence of a cause of death to undertake inquiries calculated to ascertain the source of the methadone in the immediate aftermath of Mr Keough's death. In my opinion it must remain a open question whether the methadone was procured from a source within Palm Lodge or external to Palm Lodge. Certainly Mr Keough had freedom to come and go from Palm Lodge as he chose; he was by no means confined to the precincts of Palm Lodge. It is possible that he procured the methadone outside of Palm Lodge and equally possible he procured it from another resident of Palm Lodge, or even a visitor to Palm Lodge.

19. Methadone in the Community

19.1. The evidence showed that methadone is used as a prescription drug in the community for two purposes: treatment of drug addiction and treatment of chronic pain. Methadone has a negative effect on the respiratory system and may induce a gradual or rapid cessation of breathing which deprives the brain of oxygen and can result in brain damage or death. The rate at which this occurs is dependent upon a wide variety of factors including the amount of the drug that has been taken, the concentration of the drug if in solution, whether the user is opiate naive or has developed a tolerance for opiates.

[31] Exhibit C1a is the toxicology summary report noting the presence of methadone in Mr Keough's blood. The report was dated 2 December 2003.

19.2. South Australia has a high per capita prescription for methadone tablets[32]. Patients in receipt of methadone for pain relief might receive a month's supply of tablets at one time[33]. Tragically, it is also a fact that methadone is prescribed for pain relief in the terminally ill. The evidence before the court does not suggest that there is any system for reconciling the remaining tablets in the possession of a palliative care patient when that patient dies. In my view that is a matter deserving of attention and I will return to it later.

19.3. The evidence showed that there are a limited number of pharmacies at which methadone can be provided on a daily basis. There are a number of factors to be considered in deciding whether persons should be permitted to take methadone away from pharmacies. They included the inconvenience that would result to pain management patients if they or a carer had to attend at a pharmacy every day, the potential that methadone prescribed for addiction might not be taken if the user had to attend at a pharmacy every day with the result that the user might revert to the use of illicit drugs, the benefits involved in "rewarding" patients who use methadone for treatment of addiction for demonstrating the responsibility to use it for "take home" purposes and many other factors. I note that an alternative to methadone, buprenorphine, has been introduced for treatment of addiction, and that for new people to the addiction program buprenorphine is the first choice[34]. Buprenorphine is seen as a safer alternative to methadone[35]. In the circumstances I am not prepared to make any recommendations in relation to the dispensing of methadone in the community.

20. <u>The involvement of Police when allegations of illicit drug use are made</u>

The evidence was surprising in this respect. Mr Calder admitted that the allegation by Ms Lanco should have been the subject of police involvement. There appeared to be a reluctance by Palm Lodge management to involve police in allegations of illicit drug use. There was some attempt by Mr Calder to explain this by suggesting that police were not interested in complaints unless there was "concrete evidence". However, that should not have been Mr Calder's concern. It is a matter for police to decide whether the evidence is sufficient or not, not for the Manager or staff of an

[32] Transcript, page 260
[33] Transcript, page 246
[34] Transcript, page 268-269
[35] Transcript, page 262

institution such as Palm Lodge. In my opinion, any allegation of a breach of the law should have been reported by staff to the appropriate authority, namely police. It is not a matter for the staff what happens thereafter provided they cooperate fully with a police investigation. I therefore propose to recommend that Palm Lodge and like institutions introduce a clear policy that allegations of illicit drug use and dealing be referred to police as expeditiously as possible.

21. Awareness of staff of methadone users at Palm Lodge

Both Mr Farrington and Ms Jolly believed that they would have been aware had there been methadone using residents at Palm Lodge. In fact there were such residents and neither Ms Jolly nor Mr Farrington was aware of that fact. I find this surprising given that Palm Lodge is meant to play a supervisory and monitoring role in relation to medications that are provided to residents. It is difficult to escape the conclusion that polices and protocols as Palm Lodge were not all they should be.

22. Polices and protocols at Palm Lodge

Ms Allen asserted that there were no policies and procedures at Palm Lodge. She used the expression "Dodgy Lodge" to describe the attitude of staff to the facility. On the other hand, Mr Calder suggested that the overarching polices and procedures of the Royal Adelaide Hospital were applicable to Palm Lodge. I do not regard that as a satisfactory state of affairs. The overarching polices of the Royal Adelaide Hospital may not be readily accessible to staff on the ground at Palm Lodge. Mr Calder said that there were local policies and that these were accessible to staff. However, he acknowledged that there were not such policies in relation to drug use nor in relation to the calling of police in relation to allegations of illicit drug use or dealing. In my opinion, whether there were polices and procedures as asserted by Mr Calder, or none as asserted by Ms Allen, on any view the polices and procedures were not adequate. I recommend that Palm Lodge polices and procedures be thoroughly reviewed.

23. The Police investigation

23.1. It was suggested that the initial police investigation in this matter was not adequate. Furthermore, there were deficiencies in the subsequent investigation conducted by Senior Constable Gross.

23.2. I have previously referred to the difficulties posed to a police investigation by the fact that blood toxicology information is not available for a considerable period after the discovery of a person in such circumstances as were applicable here. Nevertheless, in a sudden death of a young person in a facility such as Palm Lodge at which there was, according to all relevant witnesses, a likelihood of drug use and a vulnerable population of residents, the index suspicion that a drug overdose might have been involved was high. The Investigating Officer's statement, Exhibit C6a, was compiled in the early hours of Tuesday 12 August 2003 by a Constable of police. The author concludes the statement:

> 'There are no obvious signs of a cause of death at the moment, however the death of Keough does not appear suspicious'.

23.3. The initial investigation by police consisted of a statement of the last person to see Mr Keough alive[36], the Investigating Officer's statement to which I have already referred, a statement by a Senior Constable from Adelaide Criminal Investigation Branch made on 11 August 2003[37], a plan of Mr Keough's room and the position in which his body was found was made by another member of Adelaide Criminal Investigation Branch[38]. That was the extent of the preliminary investigation. No further attempts were made to ascertain whether Mr Keough had ingested a substance of unknown provenance or what his recent movements may have been. No effort was made to speak to persons who may have had relevant information in relation to Mr Keough's movements in the days prior to his death such as his girlfriend or other friends.

23.4. By the time Senior Constable Gross commenced his inquiries some two years had expired and the recollections of relevant witnesses were adversely affected. Certainly one of the officers from Adelaide Criminal Investigation Branch who initially attended deposed in his statement to having had a conversation with Professor Byard on the evening of 11 August 2003 in which Professor Byard referred to the likelihood of Mr Keough having taken a drug overdose. The relevant officers would not have known whether the overdose was of prescribed medications or some other drug. There was no suicide note. In my opinion the initial investigation was perfunctory. More could have been done. Mr Xenophon submitted that investigations in such

[36] Exhibit C2a
[37] Exhibit C7a
[38] Exhibit C8a

circumstances should be more thorough. I agree. In saying this I do not wish to be unduly critical of the individual police officers involved in the investigation on the night. They were doing no more than following the general standards of investigation applied by South Australia Police members generally in such circumstances. But I believe that more needs to be done to establish the source of drugs thought to be consumed in these cases. Senior Constable Gross said that the autopsy and toxicology results were not known for some time after Mr Keough's death. That is true, and it is unfortunate that autopsy reports and toxicology reports cannot be provided in a more timely fashion. I have commented on this in recent annual reports and in findings. But in this and many other cases, seasoned police officers often known from experience that a drug overdose is the most likely explanation for a sudden unexplained death in circumstances such as existed in Mr Keough's case. In Mr Keough's case, they also had the benefit of Professor Byard's preliminary view that there was a likely case of drug overdose. There is no need for police to put the case on hold for months while awaiting an autopsy report, for when it eventually becomes available the trail will be very cold indeed. Lines of inquiry that could usefully have been pursued in good time after the death will be less fruitful months later. Thus, police should proceed with those lines of inquiry while the event is fresh in people's minds.

23.5. I believe that South Australia Police should develop protocols which would ensure a more rigorous investigation of the cause and circumstances of death where drugs of unknown provenance may have been ingested by the deceased. In order to monitor the effectiveness of such protocols I believe that it would be sensible to instigate a system under which South Australia Police provide the Minister of Police with a report of all cases in which drugs are believed to be involved in a sudden unexplained death and the source of those drugs has not been ascertained within three months of the date of the death. The very disturbing circumstances of Mr Keough's death, and the involvement of methadone procured from an unknown source never identified by South Australia Police, make it necessary in my opinion that the public be kept informed of cases in which drugs of unknown provenance are believed to be involved. To that end, it is my view that all reports received by the Minister should be publicly available with appropriate protections for the identity of the deceased to prevent unnecessary distress to their relatives.

24. Recommendations

24.1. I recommend pursuant to Section 25 of the Coroners Act 2003 as follows:

1) That the Department of Health investigate the introduction of a system for reconciling the quantity of methadone or other opiate pain relief drugs that have been prescribed to palliative care patients as soon as convenient after their death, with appropriate sensitivity to the deceased's family.

2) I recommend that Palm Lodge and similar facilities institute a policy of reporting allegations of illicit drug use or dealing to police expeditiously upon receiving such allegations.

3) I recommend that Palm Lodge policies and procedures be thoroughly reviewed by the Department of Health.

4) I recommend that Palm Lodge carry out room checks daily, whether or not the resident is thought to be absent.

5) I recommend that South Australia Police introduce protocols to ensure a more rigorous investigation of the cause and circumstances of deaths suspected to have been caused by drug overdose, particularly with a view to ascertaining the involvement of drugs that are illicit or have been illegally obtained or provided.

6) I recommend that South Australia Police be required to report to the Minister of Police all deaths in which the deceased is believed by the initial investigating officers to have died as a result of ingesting an unknown drug and where South Australia Police has been unable, within three months of the date of death, to ascertain the source of the drugs involved.

7) I recommend that the Minister of Police make such reports publicly available, with appropriate protections for the identity of the deceased to prevent unnecessary distress to their relatives.

Key Words: Drug overdose; Methadone; Non-institutional care; Psychiatric/Mental illness.

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

Seal the 4th day of February, 2008.

State Coroner