



## **FINDING OF INQUEST**

*An Inquest taken on behalf of our Sovereign Lady the Queen at Adelaide in the State of South Australia, on the 8<sup>th</sup> day of June 2007, the 3<sup>rd</sup>, 4<sup>th</sup>, 5<sup>th</sup>, 6<sup>th</sup>, 7<sup>th</sup> and 11<sup>th</sup> days of March 2008 and the 6<sup>th</sup> day of June 2008, by the Coroner's Court of the said State, constituted of Mark Frederick Johns, State coroner, into the death of Richard Lesley Mann.*

*The said Court finds that Richard Lesley Mann aged 45 years, late of the Strathmont Centre, Grand Junction Road, Oakden, South Australia died at the Strathmont Centre, South Australia on the 30<sup>th</sup> day of May 2004 as a result of choking on food. The said Court finds that the circumstances of his death were as follows:*

### **1. Introduction**

- 1.1. Richard Lesley Mann was born on 12 December 1958. He was admitted to the Strathmont Centre on 25 November 1986, having suffered from an intellectual disability from birth. Mr Mann was found in a state of collapse in his room in the infirmary at the Strathmont Centre at approximately 6:25pm on 30 May 2004. The staff attempted resuscitation but unfortunately this was not successful.
- 1.2. When Mr Mann was well, he was a placid, friendly and polite person. He had reflux disease which was quite well managed. However, he had quite a severe psychiatric illness and every few months he would become psychiatrically unwell. The illness was variously described as being bipolar or manic depressive disorder, a psychotic illness of some description or possibly a schizophreniform illness. There was a difficulty in fitting Mr Mann within a diagnostic category because of his intellectual disability which meant that he could not communicate his symptoms, feelings,

emotions and thoughts effectively. Every few months or so he would become agitated, aggressive and disturbed. His behaviours would become more pronounced than usual and he would be withdrawn, depressed and uncommunicative. He was more psychiatrically unwell than usual in the months prior to his death<sup>1</sup>.

## 2. Cause of death

- 2.1. Dr Allan Cala gave evidence at the Inquest. He performed an autopsy upon Mr Mann and prepared a report, a copy of which was admitted as Exhibit C2a in these proceedings. Dr Cala said that people with intellectual disabilities are at higher risk of choking on food than other members of the community. Dr Cala found a large amount of vegetable material in Mr Mann's stomach and oesophagus and a bolus of food around the epiglottis and vocal chords. This formed the basis for his finding of choking on food as the cause of death.
- 2.2. Dr Cala noted that Mr Mann's history of ulcerative oesophagitis might be connected to the choking in that it had a tendency to make swallowing painful. Dr Cala also found that Mr Mann had healing rib fractures, a collapsed right lung and a considerable amount of fluid in the right pleural cavity. He also noted Mr Mann's clinical history of pneumonia in the weeks preceding his death and believed that the fluid in the right pleural cavity was more likely to be an organising blood clot consequent upon the rib fractures than a result of organising pneumonia<sup>2</sup>. Dr Cala was of the opinion that the rib fractures, having healed with a degree of callous, had been caused by an episode of trauma some weeks previously.
- 2.3. Dr Cala noted that no food had been aspirated into Mr Mann's lungs and that the airways below the vocal chords were clear of food. Dr Cala noted a reference in Mr Mann's casenotes to a possible fall on or around 18 April 2004. He believed, although acknowledging an element of speculation, that the fracture of Mr Mann's ribs may have occurred at or about that time.
- 2.4. The investigation did not reveal any details about the causes of Mr Mann's rib fractures. The evidence at the Inquest revealed nothing further in that regard. However, based on Dr Cala's evidence, it seems reasonable to assume that some trauma caused the fractures on or about 18 April 2004.

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<sup>1</sup> Transcript, page 52-53, Dr Nugent

<sup>2</sup> Transcript, page 13

- 2.5. At autopsy Dr Cala noted that Mr Mann had some injuries to the facial region, possibly resulting from a fall but he did not think that this injury played any part in Mr Mann's death. Dr Cala noted the toxicological findings of blood samples taken at autopsy which revealed toxic concentrations of Venlafaxine and Flecainide. Venlafaxine is an antidepressant and Flecainide is an antiarrhythmic medication. Dr Cala expressed caution in relation to the toxicological findings saying that they may have been attributable to post-mortem redistribution of these drugs which falsely elevates their levels after death. Dr Cala did not think that the presence of Venlafaxine or Flecainide played any role in relation to Mr Mann's death<sup>3</sup>. Dr Cala was asked to comment about the presence of two medications, Carbamazepine and Thyroxine, which had been administered to Mr Mann in error early on the day of his death and which were not prescribed for him as of that day. Carbamazepine is an anticonvulsant drug. Thyroxine is a treatment for an under active thyroid gland. Dr Cala thought it unlikely that either the Thyroxine or the Carbamazepine played any role in Mr Mann's death<sup>4</sup>, but acknowledged that this was a matter upon which expert pharmacological opinion should be obtained. I note that such an opinion was obtained, and that Professor White gave evidence at the Inquest. I will return to his evidence in due course.
- 2.6. Dr Cala did not think that the fractures to the ribs, the pneumonia and the presence of fluid in the pleural cavity contributed to Mr Mann's death because these were conditions which he had had for some time, indeed for many weeks<sup>5</sup>.
- 2.7. I heard evidence from Dr Michael Nugent who worked as a medical officer at Strathmont Centre in April and May 2004<sup>6</sup>.
- 2.8. Dr Nugent said that in the months immediately preceding his death Mr Mann had a number of admissions to Modbury Hospital in relation to his pneumonia. He moved between Modbury Hospital and the infirmary at Strathmont during this period. Dr Nugent gave an account of the medical history for this period which corresponded with the clinical picture as described by Dr Cala. Dr Nugent added that Mr Mann, when in an agitated state, would often eat food very rapidly, forcing it into his mouth

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<sup>3</sup> Transcript, page 28

<sup>4</sup> Transcript, pages 29-30

<sup>5</sup> Transcript, page 35

<sup>6</sup> Dr Nugent's record of interview was tendered at the Inquest as Exhibit C8

and swallowing without chewing properly. He said that this had caused some concerns about Mr Mann's ability to swallow<sup>7</sup>.

### **3. Circumstances surrounding the death of Mr Mann**

- 3.1. Sharon Cama was a Registered Nurse working at the Strathmont infirmary in 2004. She gave evidence at the Inquest that she was present in the infirmary on 30 May 2004. She said that morning, which was a Sunday, Mr Mann had smeared faecal matter upon himself and the floor and walls of his bedroom. She said that some carers and nurses walked him to the bathroom to have a shower. Mr Mann was agitated and being aggressive by hitting or kicking. Ms Cama said that in the shower there were two female nurses and two male support workers. The nurses were Trine Holst and Leanne Hamilton and the carers were Darrol Stott and Osvaldo Munoz. Ms Cama heard a lot of noise coming from the bathroom and went in to see what was going on. She said that one of the nurses, Trine Holst, was being very loud and that Ms Cama told her to lower her voice<sup>8</sup>. Mr Mann was trying to hit out and there was a lot of activity. According to Ms Cama, someone called out to her to request that Mr Mann be given what she described as PRN medication. Of course, PRN medication is medication which is prescribed for use on an 'as needed' basis. In Mr Mann's case, he was prescribed the antipsychotic medication, Haloperidol, on a PRN basis to manage aggressive behaviour. Ms Cama said that she was not prepared to give Mr Mann PRN Haloperidol that morning because he had not yet had his scheduled daily morning dose of medications which would have included a scheduled dose of Haloperidol. It was her view that the appropriate course was to give Mr Mann his scheduled dose of medications, including Haloperidol, rather than a PRN dose. Ms Cama spoke to another Enrolled Nurse, Marilyn Woodward, who was not involved in the situation relating to Mr Mann in the bathroom, and requested that she get Mr Mann's regular morning medications. Ms Woodward provided the medications to Ms Cama who then took them into the bathroom to administer them to Mr Mann. Ms Cama acknowledged that the appropriate protocol for dispensation and administration of medication is that the one person should dispense and administer the medication and thus there was a breach of the protocol in this case<sup>9</sup>. Shortly after Ms Cama administered the medication Ms Woodward called out to her not to administer it

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<sup>7</sup> Transcript, page 59

<sup>8</sup> Transcript, page 72

<sup>9</sup> Transcript, pages 76-77

saying that she gave Ms Cama the wrong medication. Ms Cama then ascertained what medications had been given to Mr Mann in addition to his standard medications and checked MIMS<sup>10</sup> as to possible side effects. She determined that there was no likely adverse side effect from the medications administered by mistake which, on the evidence, were Thyroxine and Carbamazepine. Ms Cama said that an incident report was completed as a result of this.

- 3.2. Ms Cama said that on the trip back from the bathroom to the bedroom Mr Mann fell on his face. She said that she saw that there was some blood on his face, although not a great amount, around his mouth and nose. His nose was slightly swollen but she felt that it was not broken<sup>11</sup>. Ms Cama said that she asked the enrolled nurse to keep an eye on Mr Mann following this incident<sup>12</sup>.
- 3.3. Ms Cama said that she took Mr Mann's dinner in to him sometime between 5pm and 5:30pm that afternoon. The dinner consisted of chicken nuggets and chips. Ms Cama put the plate down next to Mr Mann on the floor because he was lying on his mattress which was on the floor.
- 3.4. Ms Cama said that some time later one of the nurses, Leanne Hamilton, called out that Mr Mann did not look well. Ms Woodward called out that she thought Mr Mann had suffered a cardiac arrest. Ms Cama telephoned for an ambulance and then she, Ms Hamilton and Ms Woodward commenced cardiopulmonary resuscitation.
- 3.5. Ms Cama was asked whether she observed any restraints being used on Mr Mann and responded that she was not aware of any<sup>13</sup>.
- 3.6. Ms Woodward also gave evidence at the Inquest. She said that she was on light duties having suffered a work injury. She was on a 'return to work' program on 30 May 2004. Ms Woodward said that she did not go into the bathroom whilst Mr Mann was being showered. She recalled that Ms Cama asked her whether Mr Mann had been given his medications that morning and she confirmed that he had not. Ms Woodward then described picking Mr Mann's cup of medication off the top of a cabinet in the nurses' station and handing it to Ms Cama for her to take to Mr Mann in the bathroom. She said that shortly after this she realised that she had handed Ms

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<sup>10</sup> Medical Information Management System

<sup>11</sup> Transcript, page 81

<sup>12</sup> Transcript, page 82

<sup>13</sup> Transcript, page 88

Cama the wrong cup of medication<sup>14</sup>. Ms Woodward then informed Ms Cama that there had been an error in the administration of the medication. She confirmed that Ms Cama then consulted the MIMS drug guide for contraindications. Ms Woodward said that Ms Cama, having done that, decided that there was no question of adverse reaction<sup>15</sup>. She explained that the medications had been placed in individual cups for particular patients that day. Any cup might contain a number of different medications for a given patient. The cups were then placed on 'post-it' stickers with the patient's name written on them on top of the cabinet in the nurses' station. She confirmed that the proper protocols and policies in place at the Strathmont infirmary were breached in that the person who actually provided the medication to the patient should be the same person who prepared the medications. In this instance that did not occur<sup>16</sup>. Ms Woodward said that she received a letter of admonition from Mr Frank Walsh, the Manager of the Health Service, as a result of that breach<sup>17</sup>. Ms Woodward did not see Mr Mann fall but understood that Ms Cama requested that all of the staff keep a good eye on Mr Mann bearing in mind that he had ingested medications that he was not prescribed and also that he had suffered a fall<sup>18</sup>. Ms Woodward gave evidence in relation to the finding of Mr Mann and the resuscitation efforts that corresponded to the account given by Ms Cama.

- 3.7. Mr Darrol Stott gave evidence at the Inquest<sup>19</sup>. He is a carer in the employment of the Strathmont Centre and was familiar with Mr Mann. He said that on 30 May 2004 he and another carer attended at the infirmary to assist in the showering of Mr Mann pursuant to an arrangement that had been made the previous day<sup>20</sup>. The other carer was Mr Osvaldo Munoz. When they arrived at the infirmary they found that Mr Mann had already smeared himself with faeces and they made preparations to get him into the shower. They obtained a wheeled commode/showering chair and used that to wheel him into the bathroom. Mr Stott said that he thought there was one nurse in the shower at the same time but could not identify who the person was or whether she was a registered nurse or an enrolled nurse. He said that once in the bathroom Mr Mann started to lash out and behave aggressively. Mr Stott said that he then called

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<sup>14</sup> Transcript, page 109

<sup>15</sup> Transcript, page 110

<sup>16</sup> Transcript, page 111

<sup>17</sup> Transcript, page 112 and Exhibit C7b

<sup>18</sup> Transcript, page 113

<sup>19</sup> Mr Stott's record of interview was tendered at the Inquest as Exhibit C11

<sup>20</sup> Transcript, page 136

for two extra carers to come to the infirmary and to assist<sup>21</sup>. Mr Stott said that two additional carers arrived approximately five minutes later. They were Murray Humm and Hans Eggert. He said that before the arrival of the other two carers the nurse said that she wanted to restrain Mr Mann because he was lashing out. Mr Stott said that he was aware that restraint was only to be applied if in accordance with appropriate management protocols. He said to the nurse that it was her call as to whether Mr Mann should be restrained or not. He said that the nurse proceeded to restrain Mr Mann using what he described as a 'stretch bandage', tying his hands together behind his back and behind the back of the chair<sup>22</sup>. According to Mr Stott, when the other two carers arrived, one of them, (he thought Mr Humm), asked why Mr Mann was tied up<sup>23</sup>.

- 3.8. After Mr Mann was showered he was dried, but not dressed, and then wheeled back to his bedroom. At that point the bandage was removed from him using scissors to cut it off<sup>24</sup>. He said that it was removed by the same nurse that applied it. Mr Stott said that as soon as Mr Mann was free, he stood up immediately and then fell or collapsed onto his knees and from there onto his face giving himself a blood nose<sup>25</sup>. Mr Stott said that Mr Mann's commode chair was just outside the bedroom and that the staff were all around the chair outside the bedroom with the intention that when Mr Mann was released he would enter the bedroom with no staff member being therein. Mr Stott said that this was to prevent Mr Mann from attacking a staff member upon release. He said that the act of standing up and falling over caught the staff members by surprise because it happened so quickly<sup>26</sup>. Shortly after this, the carers departed.
- 3.9. Mr Stott said that he considered that the nurses 'outranked' the carers in relation to directions concerning patients<sup>27</sup>.
- 3.10. Leanne Hamilton gave evidence at the Inquest<sup>28</sup>. She was a nurse employed as an Enrolled Nurse at the Strathmont infirmary on 30 May 2004. She provided an account of the events of 30 May 2004, confirming that Mr Mann had smeared faeces in his room first thing in the morning. Ms Hamilton observed Mr Mann with the

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<sup>21</sup> Transcript, page 140

<sup>22</sup> Transcript, page 142

<sup>23</sup> Transcript, page 144

<sup>24</sup> Transcript, page 144

<sup>25</sup> Transcript, page 146

<sup>26</sup> Transcript, page 147

<sup>27</sup> Transcript, page 152

<sup>28</sup> Ms Hamilton's statement and record of interview were tendered at the Inquest as Exhibits C13 and C13a

carers through the open door. She said that the male carers were trying to help Mr Mann to sit and stay on the shower chair but that he was trying to get off it and was kicking out. Ms Hamilton said that the Enrolled Nurse, Trine Holst, was in the bathroom and that Ms Cama was also in there. Ms Hamilton recalled that at some point Ms Holst went down to the medical supply room and returned to the bathroom with medical tape. She then saw Mr Mann's hands tied behind his back with the medical tape. Ms Hamilton said that it was Ms Holst who taped Mr Mann's wrists together<sup>29</sup>.

3.11. After Mr Mann was returned from the bathroom, he was wheeled across the infirmary to the doorway of his room. Ms Hamilton said that the tape was then removed from his wrists and it was at this point that he took what she described as a 'big leap' and fell into his room through the doorway<sup>30</sup>. Ms Hamilton said that it was Ms Holst who removed the tape<sup>31</sup>. Ms Hamilton provided an account of the collapse of Mr Mann and the resuscitation attempts that corresponded with the other witnesses.

3.12. Mr Murray Humm gave evidence at the Inquest<sup>32</sup>. He was employed as a carer at the Strathmont Centre in 2004. He was one of the extra two carers called for by Mr Stott that morning. He said that he and Mr Eggert received a telephone call to attend the infirmary to assist and when they arrived at the infirmary Mr Mann was sitting in a commode chair within the infirmary. He had been brought from the bathroom at that stage. Mr Humm said that Mr Mann was just outside his room when he and Mr Eggert entered the infirmary. Mr Humm said that Mr Mann's hands were taped behind his back and behind the back of the chair as well. He said that he and Mr Eggert 'told them to get rid of it, to cut it off'. Mr Humm said that it was either he or Mr Eggert who removed the tape:

'... we got rid of it and told them, you know, that it wasn't supposed to be there in the first place.'<sup>33</sup>

Mr Humm acknowledged that it may not have been him or Mr Eggert but a nurse who removed the tape. He then described how Mr Mann fell shortly after getting out of the chair<sup>34</sup>.

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<sup>29</sup> Transcript, page 193

<sup>30</sup> Transcript, page 197

<sup>31</sup> Transcript, page 197

<sup>32</sup> Mr Humm's record of interview was tendered at the Inquest as Exhibit C14

<sup>33</sup> Transcript, page 216

- 3.13. Mr Hans Eggert gave evidence at the Inquest<sup>35</sup>. He was employed as a carer at the Strathmont Centre in May 2004. He confirmed that he was, with Mr Humm, called to assist at the infirmary on that morning to deal with Mr Mann. He said that Mr Mann was sitting in a chair within the infirmary upon their arrival. He said that it was unusual that Mr Mann had his hands tied behind his back with tape<sup>36</sup>. His recollection was that he and Mr Humm cut the tape but acknowledged that it may have been a nurse that did so. In general he confirmed the account given by Mr Humm.
- 3.14. Ms Trine Kennewell, formerly Trine Holst, gave evidence at the Inquest<sup>37</sup>. Ms Kennewell was working as a nurse at the Strathmont infirmary on 30 May 2004. Ms Kennewell's evidence was rather unsatisfactory. She stated that she would have to rely on her notes in giving evidence about the events of the day concerning Mr Mann<sup>38</sup>. When asked if she had any independent recollection of the events she stated that in giving her evidence she would be relying on her notes, her statement and her record of interview<sup>39</sup> entirely. Ms Kennewell said that she did not remember whether she was in the shower room with the carers and Mr Mann<sup>40</sup>. She was asked if she recalled Mr Mann having a fall after he was showered that morning and she responded that she remembered 'something along those lines'<sup>41</sup>. Ms Kennewell said that there was 'something about medication' but that she could not remember<sup>42</sup>. Ms Kennewell was asked if she recalled retrieving some medical tape from a medical supplies room and taping Mr Mann's hands together behind the shower chair that he was seated on. She stated that she did not remember doing that. When asked to clarify whether she simply did not recall doing it or suggested that she did not do it, she stated:

'I'm saying that it's something that I definitely wouldn't do, but I don't remember it.'<sup>43</sup>

- 3.15. I asked Ms Kennewell if she was scared of Mr Mann. She stated that she was very scared of him and that she thought that it may have affected her care for him. She

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<sup>34</sup> Transcript, page 217

<sup>35</sup> Mr Eggert's record of interview was tendered at the Inquest as Exhibit C15

<sup>36</sup> Transcript, page 227

<sup>37</sup> Ms Kennewell's statement and record of interview were tendered at the Inquest as Exhibits C16 and C16a

<sup>38</sup> Transcript, page 241

<sup>39</sup> Exhibits C16 and C16a

<sup>40</sup> Transcript, page 241

<sup>41</sup> Transcript, page 242

<sup>42</sup> Transcript, page 242

<sup>43</sup> Transcript, page 242

said she was reluctant to interact with him<sup>44</sup>. Ms Kennewell said that she had raised her fear of Mr Mann with the Nurse Manager, Janet Jones<sup>45</sup>.

- 3.16. It was put to Ms Kennewell that another witness had said that she, Ms Kennewell, had tied Mr Mann's hands behind his back. She responded:

'I don't know. What can I say? Someone's saying that I've done something that I know - I'm almost 100% sure that I didn't do, what can I say?'<sup>46</sup>

- 3.17. In my opinion Ms Kennewell was being less than frank in her evidence. I simply do not believe that she would not have a clear recollection one way or the other as to whether she tied Mr Mann's hands behind his back or not. She acknowledged that this would not be something that would occur on a regular basis and that it would be against appropriate practices and procedures. She acknowledged that if she were found to have done so she would be at risk of losing her registration as a nurse<sup>47</sup> and so she appreciated the seriousness of the allegation. In my opinion, Ms Kennewell would have a clear recollection one way or the other about such a serious matter. To respond that she was 'almost 100% sure that I didn't do it' seems to me to be an attempt to avoid a direct assertion under oath that she did not do so. In my view, the motivation for avoiding such an assertion was that, although she was not willing to admit it, Ms Kennewell was not willing to deny the allegation on oath.

- 3.18. Ms Rosalie Hodgson gave evidence at the Inquest<sup>48</sup>. She was working as a Float Shift Supervisor on the weekend of 29 and 30 May 2004 at the Strathmont Centre. She explained that the Float Shift Supervisor is one of the general shift supervisors at Strathmont who has an overall responsibility for the Centre during the weekends they are rostered for that purpose. Ms Hodgson said that she was physically present at the campus based in the after hours office. She said that she would go around and see the staff and the shift supervisors and this included the infirmary in relation to which she did not have supervisory responsibility but which she visited 'out of courtesy'<sup>49</sup>. Ms Hodgson said she visited the infirmary on the morning of 30 May 2004 at some time between 8:30am and 9am<sup>50</sup>. Upon her arrival she greeted the staff and went into Mr Mann's room to say hello to him because he was one of her clients in Bungoora Villa,

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<sup>44</sup> Transcript, page 252

<sup>45</sup> Transcript, page 254

<sup>46</sup> Transcript, page 260

<sup>47</sup> Transcript, page 260

<sup>48</sup> Ms Hodgson's record of interview was tendered at the Inquest as Exhibit C17

<sup>49</sup> Transcript, page 263

<sup>50</sup> Transcript, page 266

the villa within Strathmont Centre that Mr Mann resided in when not unwell. On seeing Mr Mann, Ms Hodgson became concerned because Mr Mann was lying on a mattress on the floor with his head tilted back. She picked up his hand but he did not show any recognition and did not respond when she squeezed his hand. Ms Hodgson said that Mr Mann looked very pale and ashen and that he had blood on his nose and that it somehow looked different from usual to her. She said his breathing seemed rather loud and that he had no blanket over him and because it was a cool morning that concerned her also<sup>51</sup>. Ms Hodgson assumed from the look of Mr Mann that the infirmary staff must have given him 'PRN medication' to sedate him. She went out to the nursing station and asked what was wrong with Mr Mann. One of the nurses responded by telling her that Mr Mann had fallen out of his chair during showering and had injured his nose. Ms Hodgson asked if he was going to be taken to a hospital. She said that the response was that the hospital would not be able to do anything in relation to Mr Mann's nose in any event<sup>52</sup>. Ms Hodgson remained concerned about the situation and spoke to the other member of the after hours team who was senior to her, Mr Malcolm Tulett, the after hours Service Coordinator. He was in the after hours office. Ms Hodgson contacted him and informed him of her concerns and asked if he might have a look at Mr Mann himself<sup>53</sup>.

3.19. Ms Hodgson also became aware as a result of speaking to Mr Tulett that he had received an enquiry from the infirmary asking about whether Mr Mann's management plan permitted the use of restraints. Mr Tulett mentioned that to Ms Hodgson and Ms Hodgson told Mr Tulett that the only restraint permitted in Mr Mann's management plan was a belt with padded cuffs to be used only on the bus taking Mr Mann to and from Glenside Hospital for his electro-convulsive therapy (ECT) treatment and that this form of restraint had been authorised by the Guardianship Board. Apart from that, Mr Mann's management plan also permitted that he be confined to his room with the door locked if necessary to calm him down. In those circumstances the door could be locked from the outside<sup>54</sup>.

3.20. Ms Hodgson was still on duty at Strathmont when she received a telephone call at approximately 6:30pm the same day from one of the nurses in the infirmary to advise

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<sup>51</sup> Transcript, page 268

<sup>52</sup> Transcript, page 269

<sup>53</sup> Transcript, page 270

<sup>54</sup> Transcript, page 271

that Mr Mann was choking. She attended the infirmary immediately and saw that ambulance officers were performing resuscitation upon Mr Mann<sup>55</sup>.

3.21. Mr Malcolm Tulett gave evidence at the Inquest<sup>56</sup>. He was employed as an Operational Services Officer in May 2004 and on Sunday, 30 May 2004 was on duty as the after hours Service Coordinator at the Strathmont Centre after hours office. He confirmed that he had received a telephone call from a member of the nursing staff at the infirmary enquiring about what forms of restraint might be available for Mr Mann if he was being difficult to manage<sup>57</sup>. He responded by directing the infirmary staff to Mr Mann's management plan and advising that as after hours Service Coordinator he himself could not authorise the use of any restraint<sup>58</sup>. During the conversation he became aware that the registered nurse on duty was an agency nurse and so he advised that he was happy to ring the on-call manager of the infirmary to obtain some advice about the matter. Mr Tulett proceeded to telephone the Manager of the infirmary, Mr Frank Walsh, who was on annual leave at that time and referred Mr Tulett to Janet Jones who was acting in his position. Mr Tulett informed Ms Jones of the contact which he had received from the infirmary and requested that she contact the infirmary to provide them with advice as to what action they might take<sup>59</sup>. This occurred at approximately 10:55am on 30 May 2004, which was some three hours after the time at which, according to the evidence previously referred to, Mr Mann had been showered, restrained by tape, returned to his bedroom and fallen over hurting his nose. Mr Tulett thought that the call from the infirmary about restraint was a general query about the forms of restraint that could be used with Mr Mann rather than a specific query about something which could be done in relation to behaviour being exhibited by Mr Mann at the time of the phone call<sup>60</sup>.

3.22. Later in the day Mr Tulett attended at the infirmary at the request of Ms Hodgson. He observed Mr Mann lying on his mattress in his room and spoke to the infirmary staff about Mr Mann. They advised that everything was fine and that Mr Mann was quiet and not causing any problems but that he had been aggressive and agitated and had had a fall after his shower. Mr Tulett asked if they had taken any action or had considered whether Mr Mann should be taken to Modbury Hospital. The infirmary

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<sup>55</sup> Transcript, page 275

<sup>56</sup> Mr Tulett's record of interview was tendered at the Inquest as Exhibit C18

<sup>57</sup> Transcript, page 290

<sup>58</sup> Transcript, page 290

<sup>59</sup> Transcript, page 292

<sup>60</sup> Transcript, page 296

staff advised him that it was their view that no purpose would be served by taking Mr Mann to Modbury Hospital and that he was to be observed within the infirmary itself<sup>61</sup>.

- 3.23. Mr Tulett explained that as the after hours Service Coordinator he had no authority to direct staff of the infirmary as to how they might go about their duties. He explained that the infirmary was managed by its own manager, to whom the nursing staff were responsible. He said that there was little communication and coordination between the residential services at Strathmont and the infirmary service<sup>62</sup>. When asked what advice he would have provided if told that Mr Mann had been aggressive and violent towards staff whilst he was showering, he stated that he would have recommended that the staff withdraw from the area until Mr Mann had calmed down<sup>63</sup>.
- 3.24. Mr Tulett was asked whether it was part of the policies and procedures of Strathmont Centre to use physical restraints or shackles to tie people's hands. He said that at Strathmont Centre staff never used any form of physical restraint and that the use of shackles or tying people's hands 'was never, never authorised'<sup>64</sup>. He said that if a request had gone to him or to any other senior person for Mr Mann's hands to be tied behind his back 'it would have been refused and staff counselled as that would have been inappropriate'<sup>65</sup>.
- 3.25. Mr Tulett said that he knew of no senior officer or manager at Strathmont who would have approved the notion of tying a client's hands behind the shower chair. He said clients at Strathmont Centre were never shackled or tied down and that he himself, having worked in Adelaide and also London, had never seen or been involved in a situation where a client was taped using medical tape<sup>66</sup>.
- 3.26. Ms Janet Jones gave evidence at the Inquest<sup>67</sup>. She is a Nurse Manager employed by Disability SA. She was working at the Strathmont Centre and on 30 May 2004 was relieving Mr Frank Walsh as the Acting Manager of Health Services at Strathmont which included the infirmary. She said that she received a call from Mr Tulett that day after he had first attempted to contact Mr Walsh. She said that Mr Tulett asked

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<sup>61</sup> Transcript, page 294

<sup>62</sup> Transcript, page 299

<sup>63</sup> Transcript, page 299

<sup>64</sup> Transcript, page 301

<sup>65</sup> Transcript, pages 301-302

<sup>66</sup> Transcript, pages 307-308

<sup>67</sup> Ms Jones' record of interview was tendered at the Inquest as Exhibit C19

her to contact the infirmary nurses who had contacted him in relation to ‘behaviour practices’ for Mr Mann. She said that following her conversation with Mr Tulett she contacted the nurses within the infirmary and spoke with Leanne Hamilton. Ms Jones directed the nurses to consult Mr Mann’s behaviour support plan which could be found either within the infirmary or at the villa in which Mr Mann usually resided. She said that she was told nothing to indicate that there was an emergency but that Mr Mann had settled following his shower<sup>68</sup>. The staff informed Ms Jones that there had been a problem in that Mr Mann had smeared faeces but she was not told anything about the fact that Mr Mann had been restrained in the shower<sup>69</sup>. Ms Jones said that she did not tell the person to whom she spoke that the infirmary staff could restrain Mr Mann<sup>70</sup>. She said that she was not informed about the fact that Mr Mann had fallen after his shower until after the following day when she received an incident report<sup>71</sup>. A copy of that incident report appears at page 199 of Exhibit C25 which is Mr Mann’s Strathmont Centre notes. The report states that Mr Mann fell face first onto the floor and hurt his nose after having had a shower. It states that prior to this Mr Mann had been very agitated and extremely physically violent towards staff. In response to the question on the form about whether there was a current authorisation for the use of restrictive practice that related to this incident, the person completing the form circled the letter N for no. The name of the witness was given as Trine Holst and I think it is more than likely that the form was completed by her. It is noted as having been sighted by Janet Jones the following day, 31 May 2004. Ms Jones said that she was not aware of the fact that Ms Kennewell (nee Holst) was afraid of Mr Mann and said that she could not recall, and indeed denied, that Ms Kennewell had raised her fear of Mr Mann with Ms Jones on a number of occasions as asserted by Ms Kennewell in evidence<sup>72</sup>.

- 3.27. Ms Jones said that the enrolled nurses who work within the infirmary did not have the skills to handle people with ‘behaviour management issues’ and that there was always a question about whether such people should be managed in the infirmary<sup>73</sup>. Ms Jones questioned whether Mr Mann should have been ‘specialled’ by a support worker who knew him or whether he should have been nursed within his villa with a nurse

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<sup>68</sup> Transcript, page 321

<sup>69</sup> Transcript, page 322

<sup>70</sup> Transcript, page 322

<sup>71</sup> Transcript, page 324

<sup>72</sup> Transcript, page 328

<sup>73</sup> Transcript, page 331

attending at the villa to attend to his health needs as required<sup>74</sup>. Ms Jones conceded that although she was in charge of the health service at the time, she was never entirely happy with accommodating aggressive or violent residents within the infirmary<sup>75</sup>. Ms Jones was asked about a note which, according to Trine Holst, had been placed upon Mr Mann's file to the effect that female staff were not to have anything to do with him. Ms Jones stated that she was not aware of any such note and that if such a note had existed she would have been aware of it<sup>76</sup>.

- 3.28. It became apparent during the course of Ms Jones' evidence that no satisfactory policy or procedure existed within the infirmary to determine, in the situation where nurses and carers were working together to manage a resident such as Mr Mann, who was ultimately in charge. The effect of her response was that the nurses were responsible to their line managers and the accommodation staff were responsible to their line managers. I find this very concerning and quite unsatisfactory. There should have been a clear understanding between medical and residential staff as to who was ultimately in charge.
- 3.29. Ms Jones said that she was not advised on 30 May 2004 as to the fact that Mr Mann had been administered Thyroxine and Carbamazepine by mistake. In fact she was not advised of this until three days after Mr Mann's death<sup>77</sup>.
- 3.30. Mr Frank Walsh gave evidence at the Inquest<sup>78</sup>. His substantive position in May 2004 was Manager of Health Services at Strathmont which included the infirmary<sup>79</sup>. Mr Walsh was overseas on 30 May 2004 and Janet Jones was acting in his place at that time. Upon his return from leave he spoke with Ms Jones about the events surrounding Mr Mann's death. Mr Walsh said that Ms Jones told him about the administration of the incorrect medications and that Mr Mann had been in a room in the infirmary when he was found to have collapsed. He said that in familiarising himself with the notes he became aware that there had been a gap in the observations of Mr Mann during that afternoon<sup>80</sup>. Mr Walsh said that following his review of the matter Ms Cama and Ms Woodward were both provided with formal warning letters about inappropriate practices. The letter to Ms Woodward was to confirm that she

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<sup>74</sup> Transcript, page 331

<sup>75</sup> Transcript, page 332

<sup>76</sup> Transcript, page 322

<sup>77</sup> Transcript, page 336

<sup>78</sup> Mr Walsh's record of interview was tendered at the Inquest as Exhibit C23

<sup>79</sup> Transcript, page 370

<sup>80</sup> Transcript, page 373

had breached the medication policy and that she was provided with a formal warning. A copy of that letter was admitted as Exhibit C7b. Ms Cama was provided with a similar letter to confirm that there had been a breach of the medication policy but also that she had failed to ensure that proper observations were conducted in relation to Mr Mann. A copy of that letter was admitted as Exhibit C7c in these proceedings. Mr Walsh did not write any similar letters to Ms Kennewell or Ms Hamilton as they were agency nurses<sup>81</sup>.

- 3.31. Mr Walsh did not become aware of information about the fact that Mr Mann had been restrained on that day for approximately two years after the fact<sup>82</sup>. Mr Walsh was asked to explain the division of roles and responsibilities between nursing and accommodation staff, and particularly who would lead and take charge when they were working together. He was unable to provide any clear answer to that question<sup>83</sup>. Mr Walsh had never heard about nursing staff complaining that they were afraid of Mr Mann<sup>84</sup>. Mr Walsh was not aware of a note having been placed on Mr Mann's file within the infirmary suggesting that female staff should not attend to him<sup>85</sup>.
- 3.32. Mr Walsh said that the infirmary is no longer open at the Strathmont Centre<sup>86</sup>.
- 3.33. A report was obtained on behalf of the Court from Professor Jason White, Head of the Discipline of Pharmacology at the University of Adelaide. The report was admitted as Exhibit C24 of these proceedings. Professor White also gave evidence about the possible impact of the drugs found in Mr Mann's blood upon autopsy. Professor White expressed the opinion that the Carbamazepine and Thyroxine given to Mr Mann by mistake on the morning of 30 May 2004 were, to use his words, probably not very dangerous<sup>87</sup>. Professor White added however that against a background of a person such as Mr Mann with a number of concurrent disorders who is on a number of medications, it would be appropriate that a dosing error should have been followed up by careful monitoring<sup>88</sup>. On the subject of the high concentrations of Venlafaxine and Flecainide found in the post-mortem blood samples, Professor White said that those two drugs are two of the drugs for which there can be a change in the

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<sup>81</sup> Transcript, page 374

<sup>82</sup> Transcript, page 381

<sup>83</sup> Transcript, page 383

<sup>84</sup> Transcript, page 388

<sup>85</sup> Transcript, page 390

<sup>86</sup> Transcript, page 377

<sup>87</sup> Transcript, page 407

<sup>88</sup> Transcript, page 407

concentration of the drug in the blood after death<sup>89</sup>. This was the phenomenon of post-mortem redistribution referred to by Dr Cala in his evidence. Professor White said the high levels found in the post-mortem bloods were attributable to that effect rather than having been very high at the time of death<sup>90</sup>.

#### **4. Concerns relating to the treatment of Mr Mann by carers**

- 4.1. In addition to the witnesses referred to above, evidence was also taken from three witnesses employed on the nursing staff at Modbury Hospital about statements provided by them to police concerning Mr Mann's treatment by carers from the Strathmont Centre - who could not be identified - when they were collecting Mr Mann after he had been admitted to Modbury Hospital on various occasions in April 2004. The witnesses were Susan Niedeck, Discharge Coordinator, Christine Stewart, Patient Services Assistant and Lisa Raftery (nee Noonan), Registered Nurse. Their evidence disclosed two particular incidents. The first occurred on 14 April 2004. One of the witnesses described the behaviour of two male carers who came to collect Mr Mann on that day to return him to the Strathmont Centre. Mr Mann was sitting in a chair with his feet up on a bed when the carers arrived. One of the carers told him to remove his feet from the bed and then kicked his legs off the bed without giving him a chance to remove them himself. Later the same day, Mr Mann was readmitted and brought back to the Modbury Hospital by the same two carers. On this occasion Mr Mann was sitting on the edge of a bed and sucking his fingers. The carer who had kicked his legs off the bed earlier that day told him to get his hands out of his mouth and then slapped his hands out of his mouth. In a further incident on 19 April 2004, Mr Mann was collected from Modbury Hospital by carers for return to the Strathmont Centre. A witness described an incident in which two carers escorted Mr Mann from Modbury Hospital into a van to convey him to the Strathmont Centre. Mr Mann was able to put one foot into the van but was unable to pull his other foot up. One of the carers pushed Mr Mann in the back with the result that he fell across the seat inside the van. He was then told to get up but was unable to do so. One of the carers helped him onto the seat and put his seatbelt on.
- 4.2. The three witnesses were interviewed by police officers in 2004. They told the police officers at that time that they thought they would be able to recognise the carers again

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<sup>89</sup> Transcript, page 404

<sup>90</sup> Transcript, pages 404-405

if they saw them. However, by the time of the hearing of this Inquest, none of the witnesses felt that they could identify the persons concerned any longer.

- 4.3. These episodes are clearly disturbing and distressing. It is possible that Mr Mann's fractured ribs were caused on the second mentioned occasion (19 April 2004 when Mr Mann was pushed into the van). However, I am unable to make any positive finding to that effect. In view of the evidence of Dr Cala that the rib fractures were unlikely to be causative of Mr Mann's death, I do not consider it necessary to give further consideration to these events, other than to note them and to record my concern. The three witnesses from the Modbury Hospital were clearly truthful witnesses. I have no reason not to accept their accounts of events. In those circumstances it seems plain that some persons, apparently employed at the Strathmont Centre, abused Mr Mann on the occasions described. Needless to say this is a very serious matter.

## 5. **Conclusion**

- 5.1. On the morning of 30 May 2004, Mr Mann was administered the wrong medication. The system, if I can call it that, that was employed without management approval in the infirmary at that time, was to place medications in cups on post-it-notes with the name of the patient written thereon. The method that was being employed by staff, apparently without management authority, for dispensation of medicine as described was clearly dangerous and unsatisfactory and in breach of protocols and procedures and proper nursing practice. Those protocols, procedures and practices were designed to prevent exactly what happened on the morning of 30 May 2004 - the inadvertent provision of another patient's medication to Mr Mann. It was fortunate that the medications which were wrongly prescribed to Mr Mann did not have any adverse effect or adverse interaction with his other medications. The error should have led to much closer observation of Mr Mann for the remainder of the day. That did not occur.
- 5.2. I have found that on the morning of 30 May 2004 Mr Mann was restrained by Ms Kennewell who tied his hands behind his back and behind the chair with medical tape. Again, that event by itself did not cause Mr Mann's death. However it was part of the circumstances leading up to his death and I have felt obliged to refer to it in this Finding.

- 5.3. Shortly after showering, Mr Mann, when released from his bindings, rose quickly from his chair and almost immediately fell to the ground hurting his nose. This was a head injury, and warranted close neurological observations for the rest of the day. Those did not occur.
- 5.4. Had close observations been maintained on Mr Mann, the fatal choking episode which took place in the late afternoon may quite likely have been avoided.

**6. Recommendations**

- 6.1. Pursuant to section 25(2) of the Coroner's Act 2003 I am empowered to make recommendations that in the opinion of the Court might prevent, or reduce the likelihood of, a recurrence of an event similar to the event that was the subject of the inquest.
- 6.2. I recommend that these Findings be considered by the Nurses Board of South Australia.
- 6.3. I recommend that these Findings be considered by the Strathmont Centre and the Department of Health to ensure that the protocols are formulated to establish clear roles and responsibilities when nursing and residential staff are working together.

*Key Words: Psychiatric/Mental Illness; Choking (Food); Nursing Care; Restraint*

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

*Seal the 6<sup>th</sup> day of June, 2008.*

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*State Coroner*