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 11th day of June 2008 and the 16th day of October 2008, by the Coroner's Court of the said State, constituted of Mark Frederick Johns, State Coroner, into the death of Charles James Sweetland.

The said Court finds that Charles James Sweetland aged 28 years, late of Banfield Closed Ward, Glenside Campus of the Royal Adelaide Hospital, Fullarton Road, Eastwood, South Australia died at Eastwood, South Australia on the 27th day of August 2005 as a result of hanging. The said Court finds that the circumstances of his death were as follows:

1. Introduction and reason for Inquest

1.1. Mr Sweetland was 28 years of age at the time of his death on 27 August 2005. At that time he was detained pursuant to the Mental Health Act 1993 and was a patient at Glenside Campus in Banfield Closed Ward. A post-mortem examination was carried out by Professor Byard on 30 August 2005. Professor Byard gave the cause of death as 'attributed to hanging'. I find that his cause of death was hanging. As Mr Sweetland was detained at the time of his death his was a death in custody within the meaning of the Coroner's Act 2003 and this Inquest was held as required by section 21(1)(a) of that Act.

2. Background

2.1. Mr Sweetland had a long history of substance abuse including alcohol, heroin and cannabis. His upbringing was marked by episodes of abuse and abandonment and it is probable that his psychotic illness was developing for some years before he came to

the attention of mental health services whilst incarcerated at the Adelaide Remand Centre in 2000. It was apparent at that time that Mr Sweetland suffered from paranoid schizophrenia. His symptoms were characterised by auditory hallucinations in which multiple male voices said derogatory things about him and commanded him in various ways, in particular to harm or kill himself. He was not free of auditory hallucinations for even the briefest of moments after the commencement of his illness. In conjunction with his hallucinations Mr Sweetland had a variety of shifting paranoid delusions including fears that he was to be assaulted or harmed by others. This would sometimes lead to minor altercations with other people including other patients when he was in hospital.

2.2. Mr Sweetland also had an antisocial personality and was prepared to commit criminal offences, usually to obtain money for drugs. It was the opinion of a number of psychiatrists that some of these offences were not the product of his mental illness alone and that he was fit to stand trial for some of them.

2.3. According to Exhibit C36y which is a letter dated 5 August 2005 from psychiatrist, Dr Raeside, to the Deputy Registrar (criminal registry) District Court of South Australia, despite Mr Sweetland's generally poor mental health he was fit to plead in relation to a charge of an offence of attempted robbery. This followed an incident which allegedly occurred on 29 June 2004 at a hotel in Port Pirie. Mr Sweetland was particularly concerned in the period leading up to his death that the criminal charges pending against him would result in imprisonment for a lengthy term.

2.4. From the year 2000 until his death in 2005 there were comprehensive attempts at treating what Dr Hustig referred to as an illness that was quite refractory to medication[1]. This view was confirmed also by another treating psychiatrist, Dr Koopowitz[2]. Dr Koopowitz described Mr Sweetland's response to medication as being extremely poor. Dr Koopowitz said that the pattern of Mr Sweetland's illness had been that outside of structured institutional environments he had function for very limited periods before becoming involved in situations that then resulted in his readmission to institutions such as Glenside or James Nash House. However, once in those structured institutional environments, his anxiety would again increase. This paradoxical behaviour was confusing for carers and tended to confound medical

[1] See Exhibit C9a
[2] See Exhibit C25a

treatment. Once in an unstructured environment Mr Sweetland would seek admission to a structured environment. Then, after getting initial relief, he would seek to escape the structured environment thus behaving in a way which does not seem logical to the rational mind.

2.5. An overview was prepared by Dr Chris Branson. Dr Branson provided a written report dated 25 February 2008 which was admitted as Exhibit C35a. Dr Branson said that the medical records were replete with accounts of attempts to provide Mr Sweetland with various antipsychotic medications. He said that there was a general consensus even well before Mr Sweetland's death that none of these treatments had helped to any substantial degree. Dr Branson observed from the statements of Drs Hustig and Koopowitz that there had been some benefit from a prescription of clozapine but regrettably Mr Sweetland suffered unacceptable and dangerous side effects to clozapine to the extent that he could not be continued with it. No other medication appeared to have any substantial effect on his chronic psychotic symptoms.

2.6. Mr Sweetland spent much of the last five years either in hospital or in correctional custody. Despite this, Mr Sweetland seemed to be able to obtain supplies of cannabis which he continued to abuse claiming that it provided better relief for him than his prescription medications. However, as Dr Koopowitz pointed out, the relief from cannabis was short lived and the dangerous side effects of cannabis were extremely counterproductive.

2.7. On 11 June 2005 Mr Sweetland inflicted two lacerations to his neck whilst he was in a toilet cubicle at Glenside Campus. He used a razor blade which he had secreted for that purpose. He explained to staff that he had attempted to kill himself because 'the voices were telling him to'.

2.8. In an incident in early August 2005 Mr Sweetland was found in a bath submerged but holding his nose with his fingers. When the staff member who discovered him called out his name he opened his eyes and sat up in the bath in such a way that staff were unable to reach a clear conclusion as to whether this was a deliberate attempt at self-harm or simply a prank.

2.9. As Dr Branson noted, most of the treatment afforded to Mr Sweetland during this period was in a closed ward in order to protect him against the side effects of further

drug abuse and to protect the rest of the community. However, this essentially custodial environment would at times worsen Mr Sweetland's distress to the point that he would be given leave from the ward even though it was acknowledged that there was a significant risk of suicidal behaviour. According to Dr Branson:

> 'This is an extraordinarily difficult clinical situation to manage, but one which is fortunately relatively rare. However, it appears to have been the least bad of the several quite unattractive management options available to those attempting to treat Mr Sweetland.' [3]

3. The events of 27 August 2005

3.1. On the day of his death, Mr Sweetland slept most of the morning and requested leave. This was granted and he returned half an hour late at 3:40pm. He was surprised that staff had been worried about him. He was 'relaxed and enjoying pizza' in the evening according to a note made at 6:30pm by Enrolled Nurse Stanley Block. Mr Sweetland was found in his room in Banfield Ward at approximately 11:40pm by another patient, hanging from a bed sheet from the end of his upturned bed. He was unable to be resuscitated.

3.2. During the evening of 27 August 2005 Mr Sweetland's care was in the hands of two mental health nurses, Nurses Robinson and Davies. They were the only nurses on duty on Banfield Closed Ward that night. During the dayshift, there are four or five nurses on duty. There were eight patients in Banfield Closed Ward that night. Each patient had his own room.

3.3. At approximately 9pm Mr Sweetland asked Mr Davies for some fresh linen and was given a set of sheets, pillowcases and blankets. At about 10:30pm Mr Davies and Mr Robinson took medication to Mr Sweetland in his bedroom. Mr Sweetland was making his bed with the new linen. He was given 100mg of sodium valproate.

3.4. At approximately 11:15pm Mr Davies made a ward round and said in his statement that he saw the door to Mr Sweetland's room was partially open[4]. He did not enter the room but called out to Mr Sweetland who he said acknowledged him. He did not sight Mr Sweetland at that time.

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[3] Exhibit C35a
[4] Exhibit C7a

3.5. At about 11:40pm Mr Davies was alerted by another patient who had found Mr Sweetland[5].

3.6. The Director of Nursing at Glenside Campus, Mr Alan Scarborough, made a statement dated 30 June 2006[6]. He made reference to a number of policies including nursing observation policies[7]. The general effect of these policies is to establish a hierarchy of levels of observation from 'special' which requires a nurse to remain with a patient on a continual basis, to 'general' which requires two-hourly observations. On the night of 27 August 2005 Mr Sweetland's category was assigned as 'close' which requires checking to take place at 15 minute intervals. However, the Glenside Campus checklist for the patients on Banfield Ward on the night of 27 August 2005 did not make provision for 15 minute checking after 2130 hours. Thereafter, checking took place on the hour starting at 2200 hours and continuing through until 0700 hours the following morning. Thus, after 2130 hours the next check took place not after 15 minutes, but after half an hour and thereafter hourly rather than every 15 minutes. According to Exhibit C36ab, the last check upon Mr Sweetland occurred at 2115 hours. There is nothing to account for the other checks said to have been conducted by Nurse Davies. Certainly they are not corroborated by any tick on the check sheet for that night. Thus, there is a difference between the hospital policy in this regard and the documentation provided within the hospital for the policy to be effected.

4. Conclusions

4.1. As Dr Branson noted, it is debatable whether more frequent or intense observations of Mr Sweetland would have made a difference to the eventual outcome[8]. Dr Branson said that there was an inevitability that at some point Mr Sweetland would harm himself quite seriously at a time of increased stress. He said that the management of Mr Sweetland was 'an intensely difficult clinical dilemma' and Dr Branson was not critical of the balance which the staff caring for Mr Sweetland attempted to strike between close supervision and a certain small amount of independence. I agree with those observations.

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[5] Exhibit C36ae
[6] Exhibit C33
[7] See Exhibits C33g and C33h
[8] Exhibit C35a

5. Recommendations

5.1. I recommend, pursuant to Section 25(2) of the Coroner's Act 2003, that the Glenside Campus review the policy in relation to the frequency of checks, taking into account the checklists and staff practices so as to ensure that staff practices accord with hospital policy in the checking of patients, particularly during the night time hours.

Key Words: Death in Custody; Psychiatric/Mental Illness; Hanging

In witness whereof the said Coroner has hereunto set and subscribed his hand and Seal the 16th day of October, 2008.

State Coroner