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 6th, 7th and 8th days of April 2009 and the 1st day of October 2009, by the Coroner's Court of the said State, constituted of Anthony Ernest Schapel, Deputy State Coroner, into the death of Antonio Rodriguez.

The said Court finds that Antonio Rodriguez aged 49 years, late of 21/52A Henry Street, Stepney, South Australia died at Stepney, South Australia on the 16th day of September 2006 as a result of hanging. The said Court finds that the circumstances of his death were as follows:

1. Introduction and cause of death

1.1. Mr Antonio Rodriguez, aged 49 years, lived alone at 21/52A Henry Street, Stepney. Mr Rodriguez's body was found at his unit shortly before 5pm on Monday 18 September 2006. He was located by his nephew and his wife Wendy Rodriguez, from whom he was separated. Members of Mr Rodriguez's family had been concerned about his welfare since his release from a psychiatric ward at the Royal Adelaide Hospital (RAH) on the morning of Saturday 16 September 2006. Mr Rodriguez had hung himself with a belt that had been used as a ligature. When Mr Rodriguez's body was examined during the course of a post-mortem examination conducted by Dr Allan Cala, a forensic pathologist, it was noted that there were moderate to marked decompositional changes. Dr Cala's stated cause of death as set out in his post-mortem report[1] is hanging. I find the cause of Mr Rodriguez's death to be hanging.

[1] Exhibit C2a

1.2. Dr Cala states in his post-mortem report that in his opinion the date of Mr Rodriguez's death was on or around 16 September 2006. Mr Rodriguez had been discharged from the RAH at about 10:45am on that day. His last known communication with any person following his discharge and prior to the discovery of his body was a telephone conversation between himself and his wife, Wendy. Although Wendy Rodriguez did not supply a formal witness statement to the police, on the day Mr Rodriguez was discovered she told Constable Andrew Jones of SAPOL Norwood Patrols[2] that she had last spoken with Mr Rodriguez on the telephone between 11:30am and midday on Saturday 16 September 2006. An examination of Mr Rodriguez's mobile phone call register reveals that there were a number of missed telephone calls that day but that the last call made from the phone was to 'Wendy' at 11:39am on the Saturday[3]. This would accord with what Wendy Rodriguez told Constable Jones. Constable Jones also records in his statement that Mr Rodriguez's sister, Anna Maria Cuevas, told him that she had been trying to call Mr Rodriguez on the Saturday and the Sunday after learning from staff at the RAH that Mr Rodriguez had been discharged.

1.3. A number of attempts to telephone Mr Rodriguez after his discharge from the RAH were made by staff of the Eastern Acute Crisis Intervention Service (Eastern ACIS or EACIS), an arm of the Central Northern Adelaide Health Service. The first such attempt was made at 7:45pm on Saturday 16 September 2006, the day of Mr Rodriguez's discharge. The attempts were made both to Mr Rodriguez's home landline and his mobile phone with no response. The EACIS phone number was left on an SMS text message with a request that he ring EACIS. At 8:30pm that same evening attempts were again made to call Mr Rodriguez in the same manner, again with no response. On 17 September 2006, the Sunday, a further attempt was made at 11:25am by phone to both Mr Rodriguez's home telephone and his mobile. There was no response. At 3pm on the Sunday an attempt was made to contact Mr Rodriguez on his landline. He did not answer and another message was left for him to ring EACIS. The plan at that stage as noted by EACIS staff in their records was that they would await contact from him that day and, failing that, to make another attempt to contact him on the Monday.

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[2] Exhibit C6a
[3] Statement of Constable Heath Joseph Wright, Exhibit C5a, page 5

1.4. When Mr Rodriguez was discharged from the RAH an appointment had been made for him to see his general practitioner, Dr Kate Oaten, of the Klemzig Medical Centre. The appointment time was for 11:30am. The appointment was not kept.

1.5. I note that there is no evidence that any person, including any member of Mr Rodriguez's family, nor any member of the EACIS staff, actually attended at Mr Rodriguez's unit at Stepney over the weekend of Saturday 16 September and Sunday 17 September 2006.

1.6. Given the lack of communication with Mr Rodriguez in spite of a number of attempts to contact him over the weekend and having regard to the state of decomposition of his body as well as Dr Cala's unchallenged opinion that Mr Rodriguez died on or around 16 September 2006, it is my opinion that it is more likely than not that Mr Rodriguez died on Saturday 16 September 2006 and I so find. Further, while there is no doubt that Mr Rodriguez was alive at about 11:39am on the Saturday, it is quite possible that he took the steps to hang himself sometime before the first attempted calls were made to his landline and his mobile phone by EACIS at 7:45 that evening.

1.7. Mr Rodriguez had been suffering from depression. This had accounted for his recent episode of hospitalisation in the RAH. At one point the concern about Mr Rodriguez's frame of mind was so acute that the authorities removed a firearm from his premises. It appears that this had taken place on Saturday 2 September 2006. Mr Rodriguez's depression had at times been accompanied by suicidal ideation. I return to the details of this in due course but it all supports the conclusion which I reach that Mr Rodriguez's hanging is explained by an intention on his part to end his own life. There is no evidence of the involvement of any other person in Mr Rodriguez's hanging and I find that there was no such involvement.

2. Reason for Inquest

2.1. Mr Rodriguez had undergone a period of hospitalisation for his depression earlier that year in May. On this occasion he had been admitted to Ward B8 at the RAH which is a psychiatric ward. He had been discharged on medication in that instance. He had re-presented again to the RAH on 1 September 2006, again with depression, and on that occasion had made it plain that he was suicidal and just wanted to kill himself. On this occasion, having been examined psychiatrically within the RAH Emergency Department, he was again admitted to Ward B8 where he remained until the day of

his discharge on Saturday 16 September 2006. Mr Rodriguez was discharged in less than ideal and indeed questionable circumstances that I will describe in this finding. In this Inquest I examined the issue as to whether in all of the circumstances Mr Rodriguez had been accorded proper psychiatric evaluation and treatment during the course of his admission in September 2006. Also examined was whether his discharge had been appropriate in the circumstances as they existed on the day of his discharge, having regard to what was known about his potential in respect of suicidal behaviour. Mr Rodriguez's treatment within Ward B8 of the RAH has been examined by an independent clinical and forensic psychiatrist, Dr Chris Branson. Dr Branson is critical of the way in which Mr Rodriguez's case was handled. I evaluated the legitimacy or otherwise of those criticisms. The other issue that I will discuss concerns the lamentable failure of the public health system to accommodate Mr Rodriguez's psychiatric needs as they existed during the two week period of his hospital admission in September 2006.

3. The Mental Health Short Stay Unit - Ward B8 at the Royal Adelaide Hospital

3.1. I have already alluded to the fact that in both May and September of 2006 Mr Rodriguez was accommodated in the ward at the RAH that was known as B8. The ward, which was on the top floor of the hospital building and was reasonably remote from such services as the Emergency Department of the hospital and security, was established in 2005 as a mental health short stay unit. For ease of reference in these findings I will refer to the unit as B8.

3.2. Documentation that was tendered to the inquest[4] indicates that B8 was established as a short stay unit in August 2005. Within this documentation there are a number of internal memoranda and what appear to be guidelines in which the purpose of B8 is defined. The definitive documents consist of an internal memorandum dated 23 August 2005 from Dr Shane Gill, the Director of Clinical Services, and a document that purports to be 'Guidelines for assessing a patient's need for admission and determining which ward is the most appropriate', which is a document under the banner of the RAH Eastern Community Mental Health Service. This document is dated 22 August 2005. As of the date of operation of this documentation, all patients admitted to general wards under a psychiatry bed card were to be transferred to B8 for further care until discharged or transferred to a psychiatric ward.

[4] Exhibit C11a

3.3. It is clear from the documentation that, except in the short term, B8 was not intended to accommodate patients who ought to have been admitted to an acute inpatient ward. It was said to be more or less a 'holding' ward, the length of stay in which was anticipated to be less than 3 days. The covering memorandum of Dr Gill stated that the unit had the capacity to act as a 'brief overflow unit for patients waiting admission to an acute inpatient ward or to Hospital at Home'. I explain Hospital at Home in due course. The short stay unit was established as a dedicated psychiatric facility that was not meant to accommodate patients who also had presented with a medical issue as well as a psychiatric issue. According to the guidelines to which I have referred, B8 was a unit that was intended to provide an opportunity for efficient management of patients requiring brief, targeted psychiatric intervention.[5] Alternatively, when acute psychiatric wards were full, B8 was also intended to provide a capacity to hold patients for up to 3 days while a bed was located for them in an acute ward. B8 thus served at least two identifiable purposes in general. Firstly, to provide brief psychiatric intervention or secondly, as a holding facility for patients prior to their transfer to an acute ward established for the purpose of delivering acute but more prolonged intervention. During the course of Mr Rodriguez's admission in September 2006, Mr Rodriguez fell into that second category, but in the event was at no point transferred to an acute ward because of a lack of beds.

3.4. The guidelines to which I have referred go on to make it very plain that whatever the criterion for admission to B8 was, the expectation was that the patient would have a length of stay of 3 days or less. For patients who required and were waiting for admission to an acute ward or Hospital at Home, but where the acute beds were full, the expectation was that following admission to B8 a bed would become available within 3 days. The guidelines also suggested that B8, insofar as it was intended to hold patients prior to an acute bed becoming available, was akin to, but preferable to, holding patients within the Emergency Department of the hospital. So, rather than psychiatric patients who needed inpatient care being held within the Emergency Department before a bed became available, these patients could be held within B8 but for a period no longer than 3 days. The guidelines also explained that admission to B8 should not be regarded as the patient already having a bed in an acute ward. In other words, the patient was not meant to remain in B8 if that patient required acute psychiatric care within a psychiatric ward, or alternatively in Hospital at Home. It

[5] Exhibit C11a, page 2

was not meant to be a substitute for proper psychiatric care. Accordingly, patients held within B8 who were awaiting transfer to an acute ward were regarded as having a high priority for transfer to an acute ward. However, there was in practice a triaging exercise as between those patients.

3.5. As to the criteria that might render a patient suitable for an acute ward they encompassed, but do not appear to have been limited to, patients in whom a risk assessment indicated high to very high (but not extreme) risk of self-harm or harm to others and those patients who might be best observed in an acute inpatient facility.

3.6. According to the guidelines, Hospital at Home provided acute care to patients in their own home. The anticipated length of stay in the Hospital at Home program was of the order of 10 to 20 days. Suitable patients were said to include most patients who were suitable for acute ward care. It is said that consumers with suicidal ideation have been successfully managed by the Hospital at Home program. However, one stated contraindication to participation in Hospital at Home was said to have been triggered where, due to issues of high immediate risk, the patient required close ward care or intensive psychiatric care. Another negatively worded guideline was that it was best if the consumer's psychiatric condition was not especially complex, treatment resistant or in need of close observation as part of diagnostic appraisal.

3.7. The acute wards that were relevantly in place at the time with which this inquest was concerned were Ward C3 within the RAH itself and Cleland House at the Glenside Campus of the RAH. It was within either of those two facilities that Mr Rodriguez was intended to be admitted after his period within B8.

3.8. The theory behind the use of B8 as identified in the guidelines to which I have referred was quite different from reality and Mr Rodriguez's admission and stay within B8 in September of 2006 was a case in point. Mr Rodriguez was never admitted to an acute ward when the same was clearly indicated. This was due to the fact that there were no beds available. Hospital at Home was also unable to accommodate him. He remained within B8 for 15 days and by any measure this was wholly unsatisfactory, non-therapeutic and in any case outside all of the B8 guidelines.

3.9. Dr Johannes Van Den Bos, a consultant psychiatrist, was Mr Rodriguez's treating psychiatrist at B8. In 2006 Dr Van Den Bos was a visiting medical specialist at the

Department of Psychiatry at the RAH. He had clinical responsibilities in relation to the Emergency Department as well as in B8. Dr Van Den Bos in fact was the only consultant psychiatrist attached to B8. He worked at the hospital five mornings per week. Psychiatric registrars, nursing staff and social workers were also attached to the unit. Dr Van Den Bos provided the Court with his perceptions of the purpose of B8. He described it as a '*holding bay*'[6]. He said it was created as a temporary facility to accommodate patients for up to 3 days pending the availability of beds in other mental health wards. In those 3 days staff of B8 were expected to find beds for the patients in the appropriate mental health units, namely Ward C3 at the RAH and Cleland at the Glenside Campus. According to Dr Van Den Bos B8 had 12 beds.

3.10. Dr Van Den Bos made no secret of the fact that as a psychiatric ward B8 left much to be desired in terms of its ability to deliver effective psychotherapeutic treatment. There was no privacy, very limited facilities for consultation, no examination room and no facilities for confidential interaction with patients or for physical examination. Dr Van Den Bos described it as '*a very spartan ward*'[7]. All of the doors to the ward were locked. By comparison, Ward C3, the acute psychiatric ward at the RAH, had a much larger area and bed capacity with facilities for occupational therapy and diversional activities. Ward C3 accommodated and delivered care to patients who were acutely ill. This ward could deliver medication regimes and, as well, there was a much greater ability within the ward to engage patients and be therapeutically involved in their treatment. Ward C3 was a proper psychiatric ward, as was Cleland. It was accepted during the inquest that the services that could be provided by either ward was what Mr Rodriguez in reality required, at least in the initial stages of his admission in September 2006 and in my view arguably all along.

3.11. To begin with there was a screening process within the RAH that enabled unsuitable patients to be screened from admission to B8. However, in the mid 2006, between Mr Rodriguez's two admissions that year, instructions were received that patients were no longer to be screened. This had the result that B8 was forced to admit patients with histories of severe aggression, patients who had not settled in Accident and Emergency and patients with medical co-morbidities. Dr Van Den Bos told me that this new and unwelcome development rendered it very difficult to look after patients in B8. There was at times an atmosphere of hostility within the ward such that staff

[6] Transcript, page 14
[7] Transcript, page 18

had to barricade themselves into the nursing station at night. This was complicated by the fact that it took a long time for security staff to come to the ward because of its relative remoteness. There was difficulty finding nursing staff to work at B8.

3.12. Dr Van Den Bos told me that B8 was '*not an appropriate environment to have patients for longer periods of time*'[8]. The reasons for this were that there was no support for patients, no diversional activities and owing to the fact that there was such a high turnover of admissions in any given year, there was a limited ability for patients to interact with staff and to obtain the necessary support. By way of contrast, in wards like C3 or Cleland, clinical staff would gain some familiarity and rapport with patients and there was a much more effective therapeutic environment. In other words, they were proper, dedicated psychiatric facilities. Dr Van Den Bos, being the consultant psychiatrist, was not able to see every patient at B8 on a daily basis. Much of what Dr Van Den Bos may from time to time have known about a patient was derived not from his own observations of him or her, but from descriptions gleaned from the psychiatric registrars and nursing staff.

3.13. I was informed during the course of the evidence that psychiatric care is generally the more effective when a combination of medication and psychotherapy is delivered to the depressed patient. This is the regime of treatment that Mr Rodriguez required. B8 was not set up for the delivery of psychotherapy in a patient such as Mr Rodriguez. It was a holding ward with the expectation that a patient such as Mr Rodriguez would be transferred to an acute psychiatric facility that could deliver the necessary medical and psychotherapeutic services. Mr Bonig who appeared on behalf of the Central Northern Adelaide Health Service which encompassed the RAH invited me to find that B8 was not designed to provide, nor was it able to provide any more than the most 'primitive therapeutic treatment'. For my part it is hard to disagree. This is not to criticise B8. It was never intended to provide the kind of services that Mr Rodriguez required. According to the guidelines, he should have been out of there in 3 days.

3.14. Quite apart from the intrinsic limitations of B8, there was generally great difficulty experienced in transferring patients to other more appropriate units. This meant that patients such as Mr Rodriguez remained within B8 for many days in excess of the stipulated 3 days. Dr Van Den Bos told me that one of the factors that led to the

[8] Transcript, page 21

increase in the length of stay of some patients was the change in policy that allowed patients with medical co-morbidities also to be admitted to the ward.

3.15. Ms Karen Howell is a Registered Mental Health Nurse who worked within B8. She gave evidence in the Inquest. When she was asked to give a description of the ward, she said in plain terms '*it wasn't a very nice place at all*'[9]. In particular there was no privacy, complicated by the fact that both men and women occupied the ward. There were inadequate interview facilities. She said:

> 'I mean we couldn't provide any therapeutic atmosphere really for the patients because it was just everybody was on top of each other.' [10]

Nurse Howell said that patients stayed longer than was stipulated in the guidelines because of the frequent bed blocks in the units to which they should have been transferred. I was told in evidence that there were times when patients were transported from B8 to one of the acute facilities only to discover that there was no bed for the patient there. This would mean that on occasions the patient had to be subjected to the potentially demoralising experience of being returned to B8. In May 2006, during his first presentation at the RAH Mr Rodriguez underwent this very experience.

3.16. Such was the environment in B8 at the time of Mr Rodriguez's September admission. Ironically, by the time Mr Rodriguez had spent just over two weeks in B8 he did not want to leave. He was nonetheless discharged albeit with certain structures in place. It is reasonably evident that Mr Rodriguez would not have wanted to stay because of the unit's ambience. It appears to have been more a case of Mr Rodriguez fearing the consequences of his returning home. More of this later.

3.17. B8 as a psychiatric unit has been closed since these events.

[9] Transcript, page 108
[10] Transcript, page 108

4. Mr Rodriguez's admission in May 2006

4.1. Mr Rodriguez first presented on 15 May 2006 at the RAH Emergency Department. I know of no previous psychiatric diagnosis. He appears to have been thoroughly evaluated by a Dr Radulescu. Dr Radulescu has noted that Mr Rodriguez had said that he could not function anymore and was coming to the end of the road. He said there was nothing left for him and he was in such pain because he was unable to do anything. He described certain social issues such as the loss of his job. In addition, it appears that Mr Rodriguez had given up smoking marijuana about 3 weeks previously and this had added to his general depression. He also apparently stated that he had seen a general practitioner who had prescribed zoloft and temazepam with no improvement. There were also issues in regard to the separation from his wife that he was not coping with. It was recorded that this was Mr Rodriguez's first presentation to psychiatric services due to severe depression, anxiety and suicidal ideation. He was diagnosed as suffering from severe depression, anxiety and also withdrawal from THC, which is the active component of marijuana. As far as Mr Rodriguez's risks were concerned Dr Radulescu noted:

> 'suicide → (has no access to firearms)' [11]

It became apparent later that year that Mr Rodriguez did have access to a firearm.

4.2. Mr Rodriguez was admitted to B8 on 15 May. A nursing admission note of the same day described Mr Rodriguez as having 'thoughts of fleeting suicidal ideas (by overdosing)'[12].

4.3. Both Dr Van Den Bos and a Dr Gunapu treated Mr Rodriguez during the course of this admission. Dr Gunapu also gave evidence at the inquest.

4.4. In keeping with B8's stated purposes, it appears that Mr Rodriguez was admitted to the ward with his transfer to an acute facility in mind. On 18 May 2006, which is exactly 3 days after Mr Rodriguez's admission to B8, the ward staff were contacted by a representative of EACIS who stated that there was a bed available for Mr Rodriguez at Cleland House. It is recorded that Mr Rodriguez left the ward at 11:20am on that day and upon arrival at Cleland it was discovered that the bed had

[11] Exhibit C8
[12] Exhibit C8

been given to someone else. Mr Rodriguez was then immediately returned to B8 for re-admission. In the event, he remained in B8 until his discharge on 20 May 2006.

4.5. Dr Van Den Bos told me that in the meantime Mr Rodriguez was prescribed certain medication including olanzapine which is normally used as an antipsychotic but can also be used to reduce anxiety and agitation in a patient. It was administered for that latter purpose in Mr Rodriguez's case. Dr Van Den Bos told me that olanzapine was frequently used in patients who are suicidal as it has a mood stabilising and anxiolytic effect. Dr Van Den Bos said:

> 'It's a medication that's very helpful in people who are suicidal to help that feeling of being aroused, being agitated - to help it settle.' [13]

Mr Rodriguez was also prescribed lorazepam and cipramil. Lorazepam is an anti-anxiety medication and cipramil is an antidepressant.

4.6. An examination of Mr Rodriguez's progress notes reveals that when examined by Dr Van Den Bos on 17 May 2006, Mr Rodriguez had no suicidal ideation at that time. Dr Gunapu has noted upon his examination on 19 May 2006 that Mr Rodriguez was better than before, was more reactive and had no active suicidal ideas. He recorded that Mr Rodriguez was 'still anxious about going home'. It appears that Dr Gunapu advised Mr Rodriguez to call ACIS and to come to the Emergency Department if he felt he could not cope. The plan noted on this day was that Mr Rodriguez would be discharged on 20 May 2006 which in fact occurred. On 20 May 2006 it is noted in the nursing notes that when Mr Rodriguez was discharged, he was flat in mood but keen to go home. It is recorded that he possessed the phone numbers of a number of support services.

4.7. Mr Rodriguez's discharge summary records his principal diagnosis as 'Depression with psychotic symptoms'[14] with complications of self-harm ideation. The clinical synopsis records inter alia:

> 'On assessment was depressed and non reactive. He was commenced on antidepressant and antipsychotic. In view of good response he was dischrged (sic) from the ward.'

The discharge summary refers specifically to Mr Rodriguez's commencement on olanzapine with a trial of discontinuation to be administered in 3 to 4 months.

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[13] Transcript, pages 30-31
[14] Exhibit C8, page 57

4.8. Dr Gunapu told me that in his view Mr Rodriguez had shown improvement during the course of his admission in May 2006. Dr Gunapu put his improvement down to his reaction to the cipramil which he described as a faster acting antidepressant. Dr Gunapu told me that he was not surprised that a shift in Mr Rodriguez's mood was seen. Dr Gunapu's attitude towards Mr Rodriguez's prognosis was as follows:

> 'I personally felt that he was - like I mentioned before he was quite open and he was very keen on getting help and treatment, especially someone who just gave up cannabis use after long, prolonged use and somehow made the connection that cannabis use was perhaps maintaining his depression and adding to a lot of his problems, as someone who looked keen and motivated, so I thought - I didn't think that would be a problem, compliance or him not engaging would be an issue. And he had already gone and established a link with his GP prior to him coming as well, so I didn't think that would be an issue because often if it's a new GP it's a problem but he's already known the GP from before so I thought - I didn't think compliance would be an issue.' [15]

In the event, Mr Rodriguez was to re-present to the RAH in September and one of the features of that presentation was that he had not been compliant with medication since his discharge in May.

4.9. As far as this first admission is concerned there does not appear to have been any kind of psychotherapy delivered to Mr Rodriguez. The treatment for the most part seems to have consisted of prescription of antidepressant and antipsychotic medication and a monitoring of Mr Rodriguez's mood and suicidal ideation.

5. Mr Rodriguez's admission in September 2006

5.1. Mr Rodriguez again presented to the RAH Emergency Department on 1 September 2006. On this occasion he was seen by a psychiatric registrar by the name of Dr Dharani. Again Mr Rodriguez appears to have been thoroughly evaluated within the Emergency Department.

5.2. Mr Rodriguez's social difficulties were unaltered for the most part, insofar as he reported having lost his job and was separated from his wife and was feeling sad and depressed with symptoms of a duration of about four months. On this occasion he also mentioned financial troubles and the fear of losing his home.

5.3. Mr Rodriguez reported that due to their side effects he had stopped taking his prescribed medication of olanzapine and cipramil approximately 1 month previously.

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[15] Transcript, pages 191-192

5.4. It is clear from Dr Dharani's note of 1 September 2006 that Mr Rodriguez was depressed with ideas of helplessness and hopelessness as well as anxiety. He also said that he was feeling overwhelmingly sad, anxious and fearful. A diagnosis is recorded as 'major depression – agitated type (mod – severe intensity)' and 'cannabis abuse'[16].

5.5. Of particular note are the references within this Emergency Department assessment to Mr Rodriguez's suicidal ideation. The following references are pertinent:

- That he was feeling very suicidal, wanted to shoot himself with a gun and had a gun at home[17];
- That Mr Rodriguez entertained intense death wishes;
- That Mr Rodriguez had suicidal thoughts and plans:

  'Wants to shoot/kill himself with a gun. Has been putting a gun at his head in the middle of the night almost every other day, but doesn't have the guts to pull the trigger.' [18]
- That Mr Rodriguez took an overdose of sleeping tablets, olanzapine and cipramil 1 month ago and went to sleep. When he woke up in the morning he did not tell anyone and did not seek help in a hospital;
- That Mr Rodriguez had at his home a .22 rifle that he used to use to hunt animals. There is further reference to the recent pointing of the gun to his head with the intention of killing himself;
- There is reference within the notes again to Mr Rodriguez's suicidal thoughts and positive plans and his desire to shoot himself.

5.6. Dr Dharani has noted that Mr Rodriguez should be admitted to B8 and may need a long admission on a voluntary basis. However, it was recommended that he should be detained if he was non-compliant with treatment.

5.7. I understand that as a result of this presentation on 1 September 2006 clinical staff notified the Registrar of Firearms about the possibility that Mr Rodriguez had access

[16] Exhibit C8
[17] Exhibit C8, page 122
[18] Exhibit C8, page 122

to a firearm. I also understand that police attended at Mr Rodriguez's unit in Stepney on 2 September 2006 and there located and seized a firearm[19].

5.8. Mr Rodriguez was admitted to B8 on 1 September 2006 and it was noted by nursing staff upon his admission that Mr Rodriguez had said that he was suicidal and just wanted to kill himself. It is noted that although he had no definite fixed plans in relation to self-harm, his potential to overdose or to use the rifle was noted. Also of note are his assertions that his medications, with which he had lacked compliance, did not help.

5.9. There are references in Mr Rodriguez' clinical notes that in the first 3 days of his admission he experienced increasing anxiety and agitation as well as him being highly emotive and feeling suicidal. There are also descriptions of him wanting to be isolated and it is recorded that he kept to himself.

5.10. Dr Van Den Bos saw Mr Rodriguez on 4 September 2006. Dr Van Den Bos noted that Mr Rodriguez appeared quite depressed, angry and concerned about his financial situation. He noted 'fleeting' suicidal ideation. Dr Van Den Bos formed the view that Mr Rodriguez was suffering from major depression. He ordered certain medication and also ordered that Mr Rodriguez be placed on the Eastern bed list with the intention that he be transferred to a psychiatric ward being C3 or Cleland. Of course by this date Mr Rodriguez had already spent 3 days within B8 and, in accordance with the guidelines, would have required immediate transfer. But there were no beds. A nursing note of 4 September 2006 timed at 4:30pm describes Mr Rodriguez's presentation as 'very low in mood' and that he described himself as 'very depressed and anxious'.

5.11. As I understood the evidence, the efforts to secure a bed within a psychiatric ward continued on a daily basis without success.

5.12. There are nursing notes within Mr Rodriguez's progress notes on 5, 6 and 7 September 2006 in which his demeanour is recorded in terms of his lack of activity, his anxiety and flat mood as well as his isolative behaviour.

5.13. On 7 September 2006 at 5:50pm a nursing note records that Mr Rodriguez continued to voice feelings that he was flat and lethargic and that he did not feel any

[19] Exhibit C9

improvement since his admission. Dr Gunapu saw Mr Rodriguez on the same day and described him in the progress notes as 'psychomotor retarded'. Dr Gunapu gave evidence that Mr Rodriguez told him that there had been no improvement in his symptoms. Dr Gunapu himself opined that Mr Rodriguez objectively presented in the same fashion as he had at the start of that current admission[20]. Dr Gunapu explained that psychomotor retardation was an impression of slow thinking and slow movement. Dr Gunapu has attributed the following statement to Mr Rodriguez:

> 'I tried to suffocate myself with a plastic bag last night.'

Dr Gunapu told me in evidence that Mr Rodriguez said that he had taken a small shopping bag and had tried to put it around his face. His impression was that Mr Rodriguez had experienced a '*compulsive need*' to do this[21]. When Dr Gunapu enquired of Mr Rodriguez as to whether this had been accompanied by an intent to kill himself, Mr Rodriguez had said '*he was so distressed he couldn't think of anything*'[22]. Dr Gunapu interpreted this incident as Mr Rodriguez actually showing some intent, albeit not strong intent, to self-harm. There was some indication from Mr Rodriguez that this incident had occurred in the presence of others. In any case, the incident prompted Dr Gunapu to increase Mr Rodriguez's antidepressant medication and to consider the possibility of electro-convulsive therapy (ECT). Dr Gunapu said the following about this incident:

> 'I would say it was a more direct sort of thing. It happened on the spur of the moment, seconds, and he aborted it immediately. It was in the presence of people. One could argue about the potential of that causing immediate death. On the balance I thought it was moderate risk but still I thought he needed more antidepressant, so I made the decision at that stage.' [23]

and, with regard to ECT:

> 'The reason I thought of that is again the shift of someone who was just having suicidal ideology to actually showing some intent, if not high intent. I thought what are the treatment options I have here. Obviously adjusting antidepressant is one of them. Second option, is he someone who is ready for or needs electro convulsive treatment? I wasn't very sure myself so I put '??'. I wanted to discuss that. That is why I wrote 'Discuss with consultant about that'.' [24]

[20] Transcript, page 199
[21] Transcript, page 199
[22] Transcript, page 199
[23] Transcript, page 200
[24] Transcript, page 201

5.14. Dr Gunapu discussed this incident with Dr Van Den Bos during the ward round of the following day, namely 8 September 2006. Dr Van Den Bos reviewed Mr Rodriguez and noted within the progress notes that Mr Rodriguez remained severely depressed, withdrawn and with ongoing suicidal ideation. He considered Mr Rodriguez to be 'at risk'[25] and he noted this accordingly. Clearly this assessment was made both in the light of Mr Rodriguez's presentation and also the events as had been described to Dr Gunapu the day before. Dr Van Den Bos formulated a plan that if Mr Rodriguez was to discharge himself he should be detained under the Mental Health Act 1993. It will be noted that detention under the Mental Health Act is undertaken, in the context of a presentation such as that of Mr Rodriguez, in the interests of the health and safety of the patient. On that same day, namely 8 September 2006, nursing staff also recorded that Mr Rodriguez claimed that he was still feeling suicidal and that it was 'his business if he lives or dies'. It is thus somewhat surprising that on 8 September 2006 at 5pm the mental health risk assessment would record Mr Rodriguez's risk of harm to himself as only 'moderate' and not 'high' given that high risk by definition included a presentation involving current suicidal thoughts with some plans, but not immediate intent. In any event, whatever his risk classification, it was clear that clinical staff rightly would have regarded Mr Rodriguez as wholly inappropriate for release in the light of his potential to self-harm.

5.15. On 8 September 2006 Dr Van Den Bos altered Mr Rodriguez's medication. Dr Van Den Bos told me that on 8 September 2006 Mr Rodriguez was '*significantly depressed and at risk*'[26]. He added a prescription of venlafaxine as a second antidepressant, the idea being to make the working of the first antidepressant stronger. He also prescribed olanzapine on this day in order to 'reduce agitation and anxiety and suicidal ideation'. It will be remembered that Mr Rodriguez had been prescribed olanzapine in May for similar reasons and in fact had been discharged with olanzapine on that occasion. Mr Rodriguez had become non-compliant with that medication after his May discharge. Dr Van Den Bos explained that his approach on 8 September 2006 was to reduce Mr Rodriguez's risk with a view to commencing him ultimately in an outpatient phase of treatment working on psychotherapeutic issues. To Dr Van Den Bos the psychotherapeutic phase of Mr Rodriguez's treatment was

[25] Exhibit C8, page 134
[26] Transcript, page 52

not available within B8. He said '*it was simply impossible*'[27]. He repeated that there was no facility available for such treatment to occur and in any event the atmosphere within the ward was totally non-conducive to establishing a psychotherapeutic relationship between patient and clinician.

5.16. As well as Dr Van Den Bos' plan regarding possible detention and alteration in his medication, Mr Rodriguez also remained on the Eastern bed list in the expectation and hope that he would be transferred to Cleland or C3. Dr Van Den Bos told me that he would have viewed Mr Rodriguez as having very high priority in that regard, but everything indicates that as of 8 September 2006 there were still no beds available.

5.17. The nursing note of 9 September 2006 records Mr Rodriguez as having experienced a quiet day with no expression of suicidal thoughts but with a mood that remained flat.

5.18. On 10 September 2006 the nursing staff have recorded that there was little change in Mr Rodriguez. He remained flat and unmotivated. There were no expressed suicidal thoughts or any desire to leave.

5.19. On 11 September 2006 Mr Rodriguez was seen by Dr Gunapu and was noted to be still depressed and unmotivated but with no active suicidal ideation. The plan on that occasion was to continue with his current medication and for Mr Rodriguez to perform a self-mood test and to compile a problem list.

5.20. On 12 September 2006 Dr Van Den Bos saw Mr Rodriguez. On this day it was considered that Mr Rodriguez would be suitable for the Hospital at Home program as by then it is recorded that his risk of self-harm was 'low'. This characterisation of his risk was recorded in a note made of Dr Van Den Bos' examination by Dr Gunapu. I return to this description of risk below. The other consideration that was recorded as supporting the Hospital at Home plan was the need for Mr Rodriguez to have a more structured environment insofar as his home environment would be more suitable for him. The plan therefore was to refer Mr Rodriguez to the Hospital at Home program administrators.

5.21. On the same day Nurse Howell contacted the Hospital at Home staff and it was indicated that Mr Rodriguez would be accepted for referral. It was arranged that

[27] Transcript, page 53

Hospital at Home would contact them and advise of an appointment to see Mr Rodriguez.

5.22. Nurse Howell has noted that at about 6:25pm on that same day, 12 September 2006, Mr Rodriguez 'continued' to voice his concern about going home. However, it is also noted that he listened to assurances about the Hospital at Home system.

5.23. On Wednesday 13 September 2006 a plan was contemplated whereby Mr Rodriguez would be assessed for Hospital at Home the following day. On that day he was recorded as being of 'very flat effect'[28]. On 14 September 2006, the day upon which Mr Rodriguez was meant to have been assessed for Hospital at Home, the assessment was deferred as it was ascertained that there was no current vacancy within the system. This is revealed in the EACIS progress notes in Exhibit C9, page 28. Also within those same notes is a reference on 14 September 2006 to Dr Van Den Bos' instruction regarding detention of Mr Rodriguez were he to indicate a desire to go home. There is a reference in this note to Dr Van Den Bos' opinion that the patient was at high risk of suicide. In conjunction with that note is another note to the effect that Hospital at Home administrators believed that the staff of B8 held a different opinion to Dr Van Den Bos and that Mr Rodriguez was comfortable being in hospital. To my mind this notation does not necessarily reflect Dr Van Den Bos' view about Mr Rodriguez as of 14 September 2006. Certainly that was Dr Van Den Bos' beliefs as of 8 September 2006, but it will be remembered that on 12 September 2006 Dr Van Den Bos and Dr Gunapu formulated the plan to refer Mr Rodriguez to Hospital at Home on the basis that his self-harm risk was then low. In my view the Hospital at Home note of 14 September 2006 is not a true reflection of the psychiatric opinion that was held at the time about Mr Rodriguez's risk of self-harm. Whether that opinion was accurate or not is another matter entirely.

5.24. As it transpires, Mr Rodriguez's frame of mind on 14 September 2006 was something that ought to have been regarded as a matter of significant concern. In a note timed at 6pm on 14 September 2006, which is less than 48 hours before his eventual discharge, it is recorded that Mr Rodriguez was insecure, blaming his illness for everything and was struggling to understand what had happened to him. It is recorded that he was feeling guilty about his past and was disgruntled with himself. He was insecure and miserable and, specifically, terrified about his future.

[28] Exhibit C8, page 138

5.25. The next entry in the notes is a nursing note to the effect that Mr Rodriguez indicated that he felt maybe it was time for him to go home. That entry is timed at 5:40am on 15 September, but the terms of the entry suggest that he may have given that indication the night before on 14 September 2006. It appears from these last two entries that Mr Rodriguez may have had mixed feelings about staying in the ward. While acknowledging that it might have been time for him to go home, he said things from which it could be deduced that his frame of mind was on the whole quite negative. His statement that he was terrified about his future was clearly a matter of some concern and not in any sense ameliorated by equivocation on his part that he might have thought it a good idea to go home.

5.26. On 15 September 2006 it appears that for the first time a plan was formulated that would among other things involve Mr Rodriguez being discharged the following day, namely Saturday 16 September 2006. The plan that was formulated as recorded in the social worker's note of 15 September 2006 at 1:50pm was that Mr Rodriguez would in the first instance be discharged and be referred to EACIS for phone support over the ensuing weekend. He would then be followed up by the Brief Intervention Service (BIS) during the following week. As I understood the evidence, the BIS is a mental health service that involves the patient being treated at home and receiving short term follow-up to settle their illness before GP or private psychiatric intervention. Dr Gunapu discussed this plan with Dr Van Den Bos during the handover. A conclusion was reached that Mr Rodriguez was not deriving any further therapeutic benefit from remaining in hospital and the plan involving EACIS and the BIS was endorsed, as was his discharge the following day. Dr Gunapu for the last time examined Mr Rodriguez on 15 September 2006 and recorded that Mr Rodriguez still felt occasionally anxious but that when the plan was explained to him, Mr Rodriguez was 'agreeable'[29]. It is difficult to determine whether Mr Rodriguez was genuinely agreeable or had agreed because his imminent discharge had been presented to him as a fait accompli. As will be seen, he left the ward only with reluctance.

5.27. The nursing note of 15 September 2006 timed at 5:30pm records that Mr Rodriguez spent all day on the ward, mostly in bed, and when approached appeared quite anxious about his life and the 'issues' that he had, saying that he 'can't cope'.

[29] Exhibit C8, page 139

5.28. On 15 September 2006 there are a number of references in the B8 progress notes that suggest that the support that was contemplated and which would be provided by EACIS was going to be limited to telephone support over the weekend and not necessarily by way of home visitation.

5.29. Mr Rodriguez was discharged on the morning of Saturday 16 September 2006. Nurse Howell spoke to Mr Rodriguez prior to his discharge. It being a Saturday neither Dr Van Den Bos nor Dr Gunapu saw Mr Rodriguez before he left the ward. Nurse Howell records that at 10:30am Mr Rodriguez continued to voice his concern about his discharge and expressed the belief that he was not ready to go home. It is recorded that he 'reluctantly left the unit around 1045 hrs'.

5.30. The plan as recorded by Nurse Howell was that EACIS, whom she contacted that day, were to make a 'follow-up visit' over the weekend. I am not satisfied that any such arrangement was made with EACIS or that any understanding was reached that EACIS would necessarily conduct a home visit. The only reference to the possibility of an actual visit to Mr Rodriguez's home is this notation by Nurse Howell. There is no corresponding information or notation within EACIS' own records[30] for 16 September 2006. What notes there are reveal that B8 had requested telephone support from EACIS. There is a notation to this effect timed at 8:55pm on 15 September 2006. There is an earlier reference in the EACIS notes of the same day timed at 5:10pm which suggests that they were advised by SAPOL that any home visits should be conducted in company with police[31] given the history of Mr Rodriguez' possession of a firearm. Apart from Nurse Howell's note, there is no evidence to suggest that EACIS had unequivocally agreed to visit Mr Rodriguez over the weekend. I note that the formal referral from B8 to EACIS[32] dated 15 September 2006 requests only phone support on the weekend. Another document compiled by a B8 social worker and faxed to EACIS on 15 September 2006[33] also requested phone support from EACIS. There is a document within EACIS' own records that confirms the need for a home visit to be accompanied by police. This is a fax dated 15 September 2006[34] from EACIS to the Adelaide Police Station confirming that EACIS would request police support in the event of a need to visit Mr Rodriguez at home. All of this leads me to

[30] Exhibit C9
[31] Exhibit C9, page 11
[32] Exhibit C9, page 17
[33] Exhibit C9, page 29
[34] Exhibit C9, page 23

conclude that all along it was contemplated that the contact in the first instance would be restricted to phone contact and that a visit would not occur unless something unforseen happened, and then only with SAPOL involvement.

5.31. The other pertinent features of the discharge plan were that the BIS would begin their involvement with Mr Rodriguez from Monday 18 September 2006 and that Mr Rodriguez would see his general practitioner, Dr Kate Oaten, at 11:30am on the same day. An appointment was made for him to that end.

5.32. In the event we know that there was no home visit made by EACIS either on Saturday 16 September or Sunday 17 September 2006. I have already referred to the phone calls that were made on both days to Mr Rodriguez's mobile and home telephone numbers. It is entirely possible that by the time the first phone call was made by EACIS at 7:45pm on the Saturday Mr Rodriguez was already deceased.

6. The evidence of Dr Chris Branson

6.1. Dr Branson is a clinical and forensic consultant psychiatrist who has had many years experience in providing psychiatric medico-legal opinion to courts at all levels. He has a Bachelor of Medicine and a Bachelor of Surgery from the University of Adelaide and has been a Fellow of the Royal Australian and New Zealand College of Psychiatrists since 1986. Dr Branson works in private practice in Adelaide. The majority of his time is spent consulting with general adult patients for treatment purposes while the remainder of his time is spent performing assessments for forensic matters.

6.2. Dr Branson provided a report about this matter to the State Coroner[35]. He also gave evidence in the inquest.

6.3. Dr Branson explained the therapeutic milieu that should exist in a dedicated psychiatric ward. As seen, it is common ground that it did not exist in B8. As had been recognised by Drs Van Den Bos and Gunapu, Dr Branson speaks in his report and in his evidence of the need of a dual approach to psychiatric treatment that is provided by both medication and psychotherapy and the establishment of a psychotherapeutic relationship with clinicians. In particular he spoke of the need for a strong therapeutic relationship with hospital staff, the need for in-depth therapeutic

[35] Exhibit C12a

consultation and general interaction with medical staff. He said that all psychiatric inpatient units should provide a certain amount of psychotherapy as well as medication and other therapies[36]. In Dr Branson's experience within the public hospital system, psychotherapeutic treatment might vary according to the patient and their needs but there is a need to do more than simply provide medication treatment for virtually any patient in this setting. This requires one or more staff members to develop a therapeutic alliance with the patient, to spend time talking with them about their problems, getting to understand their problems from a psychological point of view and providing them with outlets to attempt help them solve those problems as best they can[37].

6.4. While Dr Branson was quite critical of Mr Rodriguez's management in September 2006, he acknowledged that Mr Rodriguez's first admission to B8 at the RAH had been relatively successful, insofar as his mood had improved, but he still had a low mood at the time of his discharge. However, overall Dr Branson acknowledged that there had been some practical, positive steps achieved at that time.

6.5. Dr Branson voiced two principal areas of criticism in respect of the September 2006 admission. Firstly, Dr Branson was critical of the lack of psychotherapeutic intervention within B8 during Mr Rodriguez's admission. He saw little evidence of the establishment of any psychotherapeutic rapport or relationship between Mr Rodriguez and the clinical staff. Mr Rodriguez' treatment for the most part had been driven by a strictly medical approach exemplified by changes to medication. Secondly, Dr Branson held the clear opinion that in any case Mr Rodriguez had been discharged prematurely and inappropriately on 16 September 2006.

6.6. As to the first of these criticisms it should be pointed out that when Dr Branson prepared his report he did not have a complete understanding of the purpose and nature of B8. He did not know that B8 was a short stay unit that had been set up to manage patients for a period of 3 days before their transfer to a more appropriate acute psychiatric ward. While acknowledging all of that in his evidence, Dr Branson said that it did not alter the fact that what had been lacking in Mr Rodriguez's treatment was a therapeutic environment that B8, as he now understood it to be, did not provide. Dr Branson did not resile from his view that Mr Rodriguez, having been

[36] Transcript, page 248
[37] Transcript, page 249

in B8 for just over 2 weeks, did not receive a great deal of therapeutic input other than by way of his commencement on medication. Dr Branson suggested that there had not been much effort in reaching an understanding about Mr Rodriguez and his feelings, which could only be achieved by spending significant amounts of time speaking with him. Dr Branson suggested that the psychiatric registrar would normally be the leader in this kind of work but it could be performed by a psychologist or social worker or even a nurse, any of whom should have the skills to perform that kind of work. Given that there appears to have been simply no intention in B8 to provide that kind of therapy, it was:

> 'An entirely inadequate environment for him to have been in.' [38]

To Dr Branson, B8 '*couldn't provide any therapeutic care of any sort*'[39]. He was of the clear view that Mr Rodriguez should have been in a place where he could receive that care. Dr Branson acknowledged that the efforts of some members of the B8 staff that had been designed to assist Mr Rodriguez and his personal problems from a practical point of view had been useful, but he would not call it psychotherapeutic.

6.7. While agreeing with the proposition that seems to have been universally held in this inquest that B8 was an inappropriate place for a person with depression to remain in long-term[40], and that it was unlikely that Mr Rodriguez would receive any significant or meaningful psychotherapeutic benefit from remaining in B8, Dr Branson suggested that whether Mr Rodriguez received any such benefit in B8 would depend on whether the staff there decided to do something about that[41]. In this regard, Dr Branson still appeared to direct a measure of criticism towards B8 staff in failing to deliver appropriate care notwithstanding the accepted fact that the unit was not really geared for the same.

6.8. As to Dr Branson's second criticism that concerned the timing of Mr Rodriguez' discharge, there were two areas of note. Firstly, Dr Branson believed that there had been insufficient time for any meaningful therapeutic effect to have been delivered by way of anti-depressant medication. Secondly, he was discharged at a time when the risk of self-harm was not insignificant. Notwithstanding the fact that B8 was unable to provide an appropriate level of psychotherapeutic assistance, it was at least a safe

[38] Transcript, page 266
[39] Transcript, page 270
[40] Transcript, page 288
[41] Transcript, page 288

place for Mr Rodriguez to remain in, having regard to his suicidal ideation. In short, Dr Branson did not believe that Mr Rodriguez should have been assessed as appropriate for discharge.

6.9. Dr Branson suggested that Mr Rodriguez's suicide, occurring very shortly after his discharge from hospital, was in retrospect not surprising. In his evidence Dr Branson also suggested that even without the benefit of hindsight, there was reason to believe that the decision to send him home even with the support that was contemplated was not a reasonable one in all of the circumstances[42]. In addition, Dr Branson suggested that Mr Rodriguez was still quite depressed and suicidal and, if that was the case, he needed to be in hospital[43].

6.10. In answer to Dr Branson's criticisms, Dr Van Den Bos suggested that it was not always necessary for a patient to remain in a ward for 3 or 4 weeks once antidepressant medication was commenced. He said that Mr Rodriguez required a second phase of treatment, namely the psychotherapeutic phase which was not possible to be undertaken in B8. Notwithstanding the fact that there had been no beds available in an acute ward and that Hospital at Home had also been unable to accommodate Mr Rodriguez, in his view there had been a huge improvement in Mr Rodriguez since he had seen him on 8 September 2009, the day that he had contemplated detaining Mr Rodriguez under the Mental Health Act[44]. Dr Van Den Bos told me that the improvement was consistent with the course of olanzapine that had been administered to Mr Rodriguez. He said that olanzapine had a positive effect in people who are severely depressed and suicidal. Dr Van Den Bos thought that by 12 September 2006 when Hospital at Home was first contemplated, the need for admission to an acute ward had been overtaken by Mr Rodriguez' improvement to the extent that by then he did not think that he would have transferred Mr Rodriguez to C3 or Cleland House in any event. He suggested that transfer by then would have been a retrograde step. He had believed that by 12 September 2006 it was better that Mr Rodriguez go home to his own environment[45]. He said:

> 'Well, that you have reached a stage that the patient's mental state has improved, the direct risk is not there anymore, you really need to or you ought to then go - switch to the

[42] Transcript, page 285
[43] Transcript, page 261
[44] Transcript, page 56
[45] Transcript, page 57

second phase of psychotherapy and support. In this case Mr Rodriguez was in an environment that was totally unsuitable for long-term inpatient care.' [46]

Thus Dr Van Den Bos did not believe that Mr Rodriguez had not been discharged prematurely or inappropriately. He had been of the view that the intervention of ACIS and BIS would be more in line with his needs. He also believed that if Mr Rodriguez had stayed in hospital without any positive psychotherapeutic impact, and in a very hostile environment, he might become more unwell, become quite depressed and become even more suicidal and remain at risk[47]. Dr Van Den Bos believed that the factors that led to Mr Rodriguez's discharge were his improved mental state, his low risk and the need for a therapeutic alliance. He believed that he needed to be provided with a supportive community nursing environment where staff regularly attended and where the patient would come to trust staff members. His plan of discharge, involving as it did EACIS and BIS support, was explained as follows:

'A. The Brief Intervention Service was intensive community nursing support as well, that would start soon after the patient being discharged. Again, focusing on psycho-education, providing support, providing encouragement with commencing activities of daily living, helping the patients to get on with their life.

Q. And the reference to weekend ACIS support.

A. Weekend ACIS support, ACIS support would often be arranged when a patient was discharged to the Brief Intervention Service to provide an interim arrangement. We were never sure when exactly the brief intervention would start, ideally straightaway, but in case it would be the next day or the day after, you would ask the ACIS team to have regular telephone contact with the person, to support them, to make sure that they would settle in at home, to feel that they were not forgotten, and you know, to provide a support till the Brief Intervention Unit would get involved.' [48]

6.11. Dr Van Den Bos did not believe that Mr Rodriguez had been released with no care. He said that the BIS provided quite intensive community nursing support and also believed that the referral to EACIS for telephone support would have been quite adequate.

6.12. Dr Van Den Bos disagreed with Dr Branson's opinion about Mr Rodriguez's level of risk given that Mr Rodriguez's mental state had improved especially during the period from 8 to 12 September 2006.

[46] Transcript, page 58
[47] Transcript, page 60
[48] Transcript, page 61

6.13. In cross examination by Ms Kereru, counsel assisting, Dr Van Den Bos pointed to the improvement in Mr Rodriguez's level of socialisation between 8 and 12 September from which a conclusion could be drawn that his mental state had improved. He said:

> 'I mean somebody with profound depression doesn't socialise.' [49]

The difficulty with this observation was that on and following 12 September 2006 Mr Rodriguez expressed concern to nursing staff about going home, had spent all day in bed on 13 September 2006 and attempts to engage him in conversation were positively rejected. Mr Rodriguez also made the worrying observation on the late afternoon of 14 September 2006 about being terrified of the future. He also slept for most of the day on 14 September 2006. Dr Van Den Bos acknowledged that this would indicate that he felt less well than he had felt on 12 September 2006.

6.14. Dr Van Den Bos and Dr Gunapu did not see Mr Rodriguez on the day of his discharge. He was spoken to by Nurse Howell that morning. It is recorded that in the conversation with Nurse Howell he continued to voice his concern about discharge and made it plain that he was not ready to go home. Nurse Howell told me that it did not occur to her that the concern that Mr Rodriguez entertained about his going home may have arisen out of fear as to what he might do to himself. She said that she would have called the doctor and asked Mr Rodriguez to remain in the ward if that had crept into her thinking. While there was no express suggestion on the day of his discharge of any suicidal ideation, there is no notation that any conversation about that subject occurred during that morning.

6.15. To my mind the precise nature of Mr Rodriguez' concerns and in particular his level of suicidal ideation was an obvious line of enquiry to have been made immediately prior to his discharge from B8. Dr Van Den Bos himself suggested that one possible line of thought at the time was that one of Mr Rodriguez's concerns might have been the prospect of self-harm[50]. If so, it was a subject that ought to have been raised with medical staff.

6.16. In the event, it is not known what Mr Rodriguez's particular concerns were on the morning of 16 September 2006, the day of his discharge, except that he obviously held the firm belief that he was not ready to go home. But in hindsight it is likely that

[49] Transcript, page 86
[50] Transcript, page 96

Mr Rodriguez had contemplated the prospect of suicide even before he left the ward. It is not unreasonable in my view to suggest that it would have been highly appropriate for Mr Rodriguez's concerns to have been explored by one of the medical staff as opposed to it merely being footnoted by a nurse. Medical evaluation of Mr Rodriguez' difficulties did not take place because medical staff were not on duty. It appears that to all intents and purposes the plan that had been formulated to discharge Mr Rodriguez on 16 September 2006 was set in concrete when it should have been assessed and reassessed on an ongoing basis.

6.17. It is worthwhile observing here what Dr Van Den Bos' expectation had been in respect of contact by support groups following Mr Rodriguez's discharge. As far as the EACIS weekend intervention was concerned, Dr Van Den Bos told me that he would have expected regular contact between that agency and Mr Rodriguez over the ensuing weekend. He would have expected contact very soon after discharge as well as regular contact throughout that day and the next until the BIS commenced its management early in the following week[51]. He said that he would have expected EACIS to have contacted Mr Rodriguez maybe 1 or 2 hours after his discharge in order to ascertain how Mr Rodriguez was coping, how he was settling in, what was taking place at his home and what kind of support he had in place. Such issues as to how he was feeling, how he was coping and mundane issues such as whether there was enough food at his premises were matters that he expected would have been the subject of general enquiry by EACIS. He expected that there would have been telephone contact that would have involved Mr Rodriguez being called on a regular basis. In the event we know that EACIS endeavoured to contact Mr Rodriguez for the first time on the Saturday evening and so it is clear that Dr Van Den Bos' expectations were not met.

6.18. In Dr Gunapu's evidence at the inquest he also opined that B8 had become simply unable to provide the structured intervention that Mr Rodriguez required. He said that Mr Rodriguez's discharge to the Hospital at Home program was contemplated because his risk had been perceived as having diminished[52]. Dr Gunapu also referred, as did others, to the possibility of Mr Rodriguez becoming dependent upon the ward environment within B8. Dr Gunapu's thinking behind Mr Rodriguez's discharge plan was, for the most part, identical to that of Dr Van Den Bos.

[51] Transcript, page 97
[52] Transcript, page 211

6.19. Dr Gunapu suggested that Mr Rodriguez had responded very quickly within ward B8 and had shown some signs of reversal of his depression. He believed, as did Dr Van Den Bos, that EACIS and the BIS were capable of providing the necessary psychotherapeutic structure for Mr Rodriguez.

6.20. Dr Gunapu suggested that at one point Mr Rodriguez was '*keen, happy to go home*'[53]. But, interestingly, Dr Gunapu had this to say:

> 'Discharge planning from B8 was often prompted by patients. If they continued to say or they're reluctant or they said 'I just don't want to go home' or anything like that or they're completely against the idea, it wouldn't have been initiated because, like I mentioned, we're not a unit which were doing that. We were more of a triaging role and things like that. If someone is being sent off from that stage itself, the client or the patient had to be completely comfortable with that idea.' [54]

I took Dr Gunapu there to be saying that a patient's reluctance to be discharged from a ward was a matter to be seriously taken into account. It will be remembered that on the Saturday morning of Mr Rodriguez's discharge any prior indication that Mr Rodriguez may have given to staff that he thought it might be time for him to go home was overtaken by his clear reluctance to leave the ward that morning. That being the case it is difficult to reconcile his discharge with what Dr Gunapu said in the above passage. Suffice it to say, Dr Gunapu was not advised on the Saturday morning of Mr Rodriguez's concerns and he did not know about them[55]. If he had known about that, he told me that he would have gone up to the ward and spoken to Mr Rodriguez to see what was taking place. Mr Rodriguez' reluctance may not have changed the decision in respect of his discharge, but Dr Gunapu said that one would have to take all of the circumstances into account including a risk assessment and then evaluate whether the patient was simply being ambivalent about discharge, whether there was separation anxiety at work or whether there was a real issue involving safety that needed to be assessed[56]. The point to be made here is that there was no opportunity given to any of the medical staff for such an assessment to be made on 16 September 2006.

6.21. The only other matter that I need mention about Dr Gunapu's involvement was that he agreed with Dr Van Den Bos that, as of 12 September 2006 when Hospital at Home

[53] Transcript, page 214
[54] Transcript, page 216
[55] Transcript, page 218
[56] Transcript, page 220

and discharge was being considered for the first time, he believed that Mr Rodriguez was at low risk.

6.22. Unlike Mr Rodriguez's discharge in May 2006, there was no discharge summary compiled in respect of Mr Rodriguez on 16 September 2006 as Dr Gunapu was not on duty that day. Thus it was that there was no documentation that Mr Rodriguez could have shown to his general practitioner or the BIS first thing on the Monday morning even if he had survived until then.

6.23. When Dr Branson had regard to all that was said in respect of Mr Rodriguez by Drs Van Den Bos and Gunapu and by Nurse Howell, Dr Branson was still of the firm view that Mr Rodriguez's discharge had been quite inappropriate and premature. He did not believe that Mr Rodriguez had improved in any significant way throughout the course of his admission. He also suggested that he would not have assessed his risk of self-harm as being low. Dr Branson's assessment of Mr Rodriguez was as follows:

> 'My impression from the notes is that Mr Rodriguez's mental state did not change very much during that admission. He remained depressed and withdrawn, apparently very concerned about his future and how he was going to cope, and there were fluctuating levels of him expressing suicidal ideas or feelings of hopelessness at different times; sometimes that had seemed to improve, at other times it was worse.' [57]

Dr Branson suggested that limited weight could be placed on Mr Rodriguez's own assertions that he was not suicidal and, in any event, there were entries within the notes that suggested that he was still very distressed and at quite significant risk of suicide, particularly when regard was had to the note of 14 September 2006 in which he had indicated his insecurity and terror about the future. Dr Branson suggested that when people speak of feeling guilty about their past and refer to self loathing, insecurity and being miserable they are symptoms that have to be given considerable weight '*because it is those sorts of feelings which frequently does cause people to consider killing themselves*'[58].

6.24. Dr Branson was of the view that it was difficult to place reliance upon any assertion that Mr Rodriguez may have made that he felt it was maybe time to go home. One thing that had to be considered was whether or not he wanted to go home because he had given up all hope. Dr Branson said the last thing that should have happened at

[57] Transcript, page 254
[58] Transcript, page 259

that point was for Mr Rodriguez to be discharged. Even if B8 was not the most desirable environment from a therapeutic point of view, with the degree of supervision and oversight that it could have undoubtedly provided, it was at least safe.

6.25. Dr Branson disagreed that any significance could be placed on Mr Rodriguez's rapid response to medication. He said that the administration of olanzapine, whilst having a good effect as a tranquiliser, was in itself not necessarily liable to reduce the level of suicidal thinking.

6.26. As to Mr Rodriguez's alleged dependence upon the ward, Dr Branson suggested that such would not be surprising. He said that in any case many sick people do require treatment for periods of time of up to 15 or 16 days. He suggested:

> 'It's not much help to simply describe him as institutionalised or dependent without working out why that might be or what might be done about it.' [59]

6.27. Dr Branson also suggested that the plan involving EACIS and the BIS was inadequate insofar as all that may have been planned was a phone call from ACIS. Dr Branson would not have described that as adequate and observed that it was very likely that Mr Rodriguez was dead before the phone call was made. While Dr Branson acknowledged that EACIS intervention by way of telephone support does not necessarily mean that it is limited to one phone call, in his experience that may well have been the case in practice.

6.28. Dr Branson suggested that the absence of notations concerning suicidal ideation since 8 September 2006 was of limited relevance. Although Mr Rodriguez did not in terms tell B8 staff that he had suicidal ideation, Dr Branson believed that he had done so indirectly and, in particular, by his references on 14 September 2006 to feelings of guilt, insecurity and terror about the future. He did not believe that Mr Rodriguez's suicidal ideation was all that hidden[60]. Dr Branson said:

> 'You know, that really should have raised serious concerns about his suicidal ideation, even though it doesn't appear to have been explicitly addressed and even though perhaps he might have denied it if he was asked. It doesn't mean though that there shouldn't have been strong suspicion about it.' [61]

7. Conclusions

[59] Transcript, page 264
[60] Transcript, page 286
[61] Transcript, page 286

7.1. Mr Rodriguez presented to the RAH Emergency Department twice in 2006. On both occasions he was admitted to Ward B8 which was intended to act as a holding ward for patients' eventual transfer to acute wards for psychiatric treatment.

7.2. Mr Rodriguez was diagnosed with depression on both occasions. In May 2006 he spent a number of days in Ward B8 before his discharge. He was discharged on antidepressant and antipsychotic medication. He became non compliant with that medication.

7.3. He re-presented on 1 September 2006 and on this occasion made various statements that indicated quite pointedly that he was at a significant risk of suicide. He was again admitted to Ward B8. It was intended that he would be transferred to an acute ward, being either Ward C3 at the RAH or Cleland House at Glenside. There were no beds available in either ward for Mr Rodriguez and so he was kept for the duration of his admission in Ward B8 at the RAH. B8 was essentially unable to cater for Mr Rodriguez' psychotherapeutic needs.

7.4. On 8 September 2006 clinical staff of Ward B8 became so concerned about Mr Rodriguez's frame of mind and ongoing suicidal ideation that they decided that if Mr Rodriguez were to attempt to discharge himself he would be detained in the interests of his own safety under the Mental Health Act 1993.

7.5. Following 8 September 2006 there does not appear to be any further specific references to suicidal ideation. On 8 September 2006 Mr Rodriguez had again, for the second time that year, been prescribed with olanzapine.

7.6. On 12 September 2006 a view was formed by Dr Van Den Bos and Dr Gunapu that Mr Rodriguez psychiatric condition had improved and that his risk of self-harm was low. On that day a plan was formulated to refer Mr Rodriguez to the Hospital at Home program but it was soon revealed that there was no vacancy for him within the program.

7.7. The assessment of 12 September 2006 that Mr Rodriguez' risk of self harm was low seems to have been a long bow to draw, especially if that view had simply been based upon his response to medication and a lack of expressed suicidal ideation over a handful of days within a lengthy and complex longitudinal history. He had entered B8 in a suicidal frame of mind. His firearm had to be confiscated. On 7 and 8 September he had confirmed his suicidal ideation when he spoke of the plastic bag

incident. It was understood on 8 September that he would be detained for his own safety if he tried to leave the ward. He had on the very day that his risk of self harm had been assessed as low expressed concerns about going home. When Mr Rodriguez' longitudinal history from May to September of 2006 is considered in its entirety, it is not easy to understand how in a matter of a few days he could progress from a frame of mind in which he was acutely suicidal to the point where he would have been detained, to one in which his risk of self harm could be considered as low and where he was being actively encouraged to go home against his own better judgment.

7.8. On 15 September 2006 the referral to the Hospital at Home program was withdrawn. A plan was then formulated to discharge Mr Rodriguez from Ward B8 to his home with EACIS support over the weekend and BIS support after the weekend. In my view it is not entirely clear as to whether this plan was created because the Hospital at Home program was unavailable for Mr Rodriguez or whether it was considered to be an appropriate measure in any event. Suffice it to say, it would have been highly appropriate for Mr Rodriguez to have been admitted to Ward C3 or Cleland House should that opportunity have arisen. That was unavailable to him, so was the Hospital at Home program and the end result was that he was kept for an unduly prolonged period within the inappropriate and non-therapeutic environment that was ward B8.

7.9. The plan to discharge Mr Rodriguez with the support that I have identified was made notwithstanding the fact that on 12 September 2006 Mr Rodriguez had voiced concerns about going home, concerns that do not appear to have been noted in any detail. However, on 14 September 2006 Mr Rodriguez told nursing staff in plain terms that he was experiencing feelings of guilt, insecurity and misery and was terrified about the future. A conclusion is available, which I reach and which is supported by the evidence of Dr Chris Branson, that this ought to have been interpreted as an indication that Mr Rodriguez was not ready for discharge from hospital owing to the risk of self-harm.

7.10. On 15 September 2006, the day before Mr Rodriguez's discharge, Mr Rodriguez again indicated that he was not able to cope and spent most of the day in bed. On that day a decision was made to discharge him from B8.

7.11. It is difficult to discern anything from Mr Rodriguez' presentation or from the circumstances as they existed between 14 September and 16 September that would have inspired confidence in the correctness of the decision to discharge him from B8.

7.12. On 16 September 2006 Mr Rodriguez was discharged from B8. Immediately before he left the ward he expressed to nursing staff his ongoing concern about his discharge and reiterated his belief that he was not ready to go home. He reluctantly left the ward and went home. His concerns and his reluctance to leave the hospital were not communicated to either of Mr Rodriguez' doctors. All of that should have been communicated to them. If it had been so communicated it conceivable that he would have been kept within the ward.

7.13. While the decision to discharge Mr Rodriguez from Ward B8 on 16 September 2006 was made by well meaning clinicians and was based on what were at the time genuinely believed to be sound reasons, I agree with Dr Branson that the risks of his leaving the safety of the ward were such that he should not have been released and discharged on 16 September 2006. The need to protect Mr Rodriguez from himself manifestly outweighed the need to discharge him from the ward notwithstanding that the ward was unable to cater for his treatment. One cannot discount the possibility that Mr Rodriguez in due course may have taken the same fatal decision even if he had been kept on the ward on 16 September. What can be said with some degree of confidence is that he would not have taken his own life on that day.

7.14. I find on a balance of probabilities that Mr Rodriguez took his own life later that day at a time before EACIS staff could contact him by telephone.

7.15. Mr Rodriguez manifestly should have been accommodated in an acute psychiatric ward where psychotherapy as well as medication could have been administered. That he was not so accommodated was contrary to the relevant guidelines that governed the utility of ward B8. If he had been transferred to an appropriate psychotherapeutic environment it is likely that he would have received more appropriate care. His chances of survival if that care had been made available to him can never be known with certainty. All that can be said is that he would have been given a better shot at survival had that been the case.

7.16. This court finds it difficult to comprehend how in these so-called enlightened times a patient like Mr Rodriguez who clearly required and deserved intensive psychiatric evaluation and care in a proper therapeutic environment could be so poorly served by

a modern public mental health system. He was firstly denied access to acute psychiatric care in an appropriate facility and was then denied access to the Hospital at Home program. The reason for that in both instances was that there were insufficient available resources to cater for his needs. He was therefore kept in an environment that was totally unsuited to those needs. That such a circumstance could be allowed to develop in a sophisticated society such as ours borders on the scandalous and should never be repeated.

8. Recommendations

8.1. I was told during the course of this Inquest that Ward B8 no longer exists as a psychiatric facility. I was also told during the Inquest that short stay psychiatric beds have now been established in Ward C3 and within the Emergency Department of the Royal Adelaide Hospital. There no longer appears to be any dedicated short stay unit like Ward B8. To my mind the facts and circumstances surrounding Mr Rodriguez's death should be seen as a reminder that the care that is provided by a short stay unit such as Ward B8, in cases such as Mr Rodriguez's, is a very poor substitute for the acute and proper psychiatric care that is delivered in a facility established for that purpose. I agree with Mr Bonig, counsel for and on behalf of the Central Northern Adelaide Health Service, that it would be inappropriate to stigmatise wards such as B8 as intrinsically misconceived. Nobody would doubt that there is a clear purpose to be served by such a facility. The difficulty was that it did not serve Mr Rodriguez' purposes. I also agree with Mr Bonig that if another unit akin to Ward B8 were to be established, that appropriate procedures would need to be in place to ensure that patients are moved on from the unit so that they do not remain within the unit any longer than the stipulated length of time and are, in any event, placed into the appropriate care that is relevant to their clinical circumstances.

8.2. The only other comment that I would make about facilities such as Ward B8 is that if any situation such as Mr Rodriguez's were ever to be repeated, it would be difficult to resist the suggestion that the patient ought to be found accommodation within the private hospital system even if the same were to result in added public expense.

8.3. The other topic of recommendation concerns the desirability of patients who have exhibited suicidal ideation during the course of their admission being psychiatrically evaluated and cleared on the day of their discharge. This did not happen in Mr Rodriguez's case.

8.4. I make the following recommendations:

1) That the circumstances of this case be drawn to the attention of the wider medical community as an example of the pitfalls that are to be encountered in maintaining psychiatric patients in facilities and environments that are unsuited to their needs. I direct the attention of this recommendation to the Minister for Mental Health and the Medical Board of South Australia;

2) That if a facility such as a short stay unit is ever again created that checks, balances and protocols be established to ensure that patients do not remain in the facility in circumstances where their clinical needs are not met. I direct the attention of this recommendation to the Minister for Mental Health;

3) That in future cases involving an inability to properly accommodate a psychiatric patient within an appropriate therapeutic environment in the public hospital system, that consideration be given to placing the patient within the private hospital system with the expense of the same being met by Government;

4) That the Minister for Mental Health design and promulgate protocols to ensure that patients who have exhibited suicidal ideation during the course of a hospital admission are psychiatrically evaluated by a psychiatrist or psychiatric registrar on the day of their discharge and that their suitability for discharge be carefully assessed immediately prior to the patient leaving the hospital.

Key Words: Psychiatric/Mental Illnes; Suicide

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

Seal the 1st day of October, 2009.

Deputy State Coroner