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 18th day of January and the 22nd day of December 2011, by the Coroner's Court of the said State, constituted of Anthony Ernest Schapel, Deputy State Coroner, into the death of Simon Christopher Hynes.

The said Court finds that Simon Christopher Hynes aged 41 years, late of 3 Threlfall Avenue, Norwood, South Australia died at Black Hill Conservation Park, Montacute, South Australia between 7 June 2007 and 5 July 2007 as a result of acute neck compression due to hanging. The said Court finds that the circumstances of his death were as follows:

1. Introduction and reason for Inquest

1.1. On Thursday 2 August 2007 at approximately 11am the body of Simon Christopher Hynes, 41, whose whereabouts had been unknown for some time, was located hanging from a tree in the Black Hill Conservation Park. His body was discovered by a teacher who was conducting a school excursion. Naturally, police were immediately notified. It is apparent that Mr Hynes' body had been in this location for some time, probably weeks. He was in a state of advanced decomposition and, in the event, was positively identified as Simon Christopher Hynes by way of fingerprint comparison with police records. As far as is known, the last reliable sighting of Mr Hynes alive occurred on 31 May 2007. On that day he had been discharged from the Royal Adelaide Hospital (RAH) where he had been detained under the Mental Health Act 1993 (MHA). Indeed, on that day Mr Hynes had been granted leave of absence from detention under the MHA and was taken to new accommodation at 3 Threlfall Street, Norwood which was a guest house. A nurse and a social worker from the

Eastern Mobile Assertive Care team had conveyed Mr Hynes to that address. It had been expected that regular contact would thereafter be made with the mental health authorities for the purpose of administering Mr Hynes' fortnightly medication pursuant to an ongoing community treatment order. When mental health staff attended at the Norwood premises on 12 June 2007, Mr Hynes was absent and it is apparent that by then he had for all intents and purposes left that address. However, during the Inquest I was informed by Mr Hynes' aunt, Ms Ann Tillsley, that after Mr Hynes' body had been located some of his possessions were found at the Norwood premises.

1.2. The precise date of Mr Hynes' death cannot be established with absolute precision. It is apparent that Mr Hynes had written a note sometime prior to his death. The note was located in a tobacco packet that was found at his feet when his body was located in the Conservation Park. Unfortunately the note was not dated. Although it is written in very cryptic terms, it seems clear enough that it was written by Mr Hynes with his imminent suicide in mind. For instance, it refers in part to his leaving behind evidence on a 'hanging rope' and urges his finder to do whatever was required in respect of his corpse. While this note gives no hint of when it was that Mr Hynes died, in my view it signifies that Mr Hynes hanged himself, probably without the involvement of any other person, and certainly with an intent to end his own life. I so find.

1.3. Mr Hynes' body was subject to an autopsy that was performed by Dr Cheryl Charlwood, a specialist forensic pathologist at Forensic Science South Australia. Dr Charlwood found no evidence of trauma other than that associated with suspension from the neck. No natural disease processes were identified. She formed the opinion that the cause of Mr Hynes' death was acute neck compression due to hanging[1]. I find that to have been the cause of Mr Hynes' death.

1.4. Dr Charlwood noted at the post-mortem examination that there were advanced decompositional changes in Mr Hynes' body with variable wet decomposition and mummification affecting the body. She expressed the date of Mr Hynes' death as on or around 31/05/07. However, it is clear that this date was a reference to the date on which he had last been reliably seen alive and was not intended to be definitive as to

[1] Exhibit C3a

the precise or even approximate date of death. In an addendum statement[2] Dr Charlwood indicates that following her post mortem examination she gave further consideration to the question of the date of Mr Hynes' death. In that statement Dr Charlwood indicates that she reviewed the post-mortem file, the photographs and the history of the matter. Taking into account the weather conditions preceding his discovery, she estimates that Mr Hynes' occasion of death was between 4 to 8 weeks prior to his discovery on 2 August 2007. Further, she states that it is possible that Mr Hynes' death occurred in the days shortly after last being seen alive on 31 May 2007. The period of 4 to 8 weeks prior to 2 August 2007 spans the period between 7 June 2007 and 5 July 2007. Thus the mental health workers' failure to locate Mr Hynes on 12 June 2007 when they attended at the Norwood address is possibly explicable by Mr Hynes' death having taken place by that time. However, this cannot be known for certain. On Dr Charlwood's analysis it is possible that Mr Hynes was still alive until sometime in mid July 2007.

1.5. For the purposes of the preamble to these findings I recite the date of death as between 7 June 2007 and 5 July 2007, but it will be clear to the reader that these dates are also premised on an estimation.

1.6. In this Inquest the Court explored the circumstances surrounding Mr Hynes' death insofar as they can be established, including the circumstances in which he was detained and then released on leave of absence from detention under the MHA.

2. Cause of death

2.1. Following Mr Hynes' death, a post-mortem examination was conducted by Dr Cheryl Charlwood, a forensic pathologist at Forensic Science South Australia. In her post-mortem report dated 19 March 2008[3], Dr Charlwood expresses the opinion that the cause of death was:

> 'a) Acute Neck Compression
> b) Hanging' [4]

In light of Dr Charlwood's report, I find that the cause of Mr Hynes' death was acute neck compression due to hanging.

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[2] Exhibit C17
[3] Exhibit C3a
[4] Exhibit C2a, page 1

3. Background

3.1. Mr Hynes became mentally unwell in about 1987 at the age of 22 years and was subsequently diagnosed with schizoaffective disorder, an extremely debilitating disability. A report was obtained by the Court from Dr Chris Branson[5], a consultant psychiatrist, on a range of matters associated with Mr Hynes mental illness. Dr Branson was not involved in the clinical management of Mr Hynes, but has provided his report based upon his review of Mr Hynes' clinical notes and statements provided to the Court. I accept Dr Branson's analysis of the situation.

3.2. Dr Branson stated that the characteristics of Mr Hynes' illness seemed to remain a constant throughout his life. His episodes of illness would be characterised by paranoid delusions, thought disorder, grandiosity, agitation and frequently aggressive, or even actively violent behaviour. He outlined that Mr Hynes had five psychiatric inpatient admissions within the first two years of his illness, and that it was clear even at that early stage that long term antipsychotic treatment would be required. Mr Hynes appeared to have limited insight into his illness and would tend not to comply with his medication regime when not in hospital. Dr Branson illustrated that illicit drug abuse was also a feature of Mr Hynes' illness, particularly with marijuana, LSD and 'magic mushrooms'. In the latter years of Mr Hynes' life it appears that relapses in his illness were precipitated by marijuana usage, limited compliance with medication, despite often being on community treatment orders, and being elusive to follow-up from Mental Health Services staff, often because of itinerancy and homelessness. Dr Branson pointed out that, due to Mr Hynes' level of insight into his illness, there were times that he either evaded follow-up or was permitted not to take his antipsychotic medication and that both of these methods invariably resulted in significant relapses of his condition leading to psychiatric hospitalisation. The longest period that Mr Hynes remained well without medication was a few months at most. In contrast to this when Mr Hynes was complying with medication, which usually only occurred whilst he was under a Community Treatment order, he could remain reasonably well for lengthy periods, provided he also abstained from illicit drugs such as marijuana.

3.3. Dr Branson stated that toward the end of his life, Mr Hynes was significantly affected by his schizoaffective disorder to the extent that he had a number of mild continuing

[5] Exhibit C10a

delusional ideas at the best of times. Mr Hynes suffered from a large number of negative symptoms of schizophrenia and its related illnesses, such as social withdrawal, poor interpersonal relationships and a significantly decreased level of ability to care for himself in various ways. Dr Branson pointed out that the problem was not a lack of efficacy of the antipsychotic medication that Mr Hynes was taking, but lack of compliance. This was combined with the effects of marijuana which would destabilise his illness, even when being treated, which Mr Hynes appeared to have little or no insight into.

3.4. Notwithstanding Mr Hynes' disability, at Inquest I was told by Mr Hynes' aunt, Ms Tillsley, that Mr Hynes had a number of relationships during the period of his mental illness. He had a daughter, now aged approximately 18. Ms Tillsley told me that Mr Hynes' daughter had been a very important component of his life. When he was well his daughter was constantly in Mr Hynes' thoughts.

3.5. At the time of his death Mr Hynes was subject to a community treatment order issued by the Guardianship Board of South Australia[6] pursuant to Section 20(1) of the Mental Health Act 1993[7]. These orders were granted on the grounds that the Guardianship Board was satisfied that Mr Hynes had a mental illness amenable to treatment and that Mr Hynes had refused or failed, or was likely to refuse or fail, to undergo this treatment, and that Mr Hynes should be given treatment in the interests of his health and safety or for the protection of other persons. These orders could last up to 12 months.

3.6. Mr Hynes had been on community treatment orders sporadically since 1989, but remained on them continuously from 1998, albeit there was a brief moment when the Guardianship Board allowed Mr Hynes to take control of his medication regime in 2001, which was eventually followed by a hospital admission with florid psychosis in 2002.

3.7. The Guardianship Board records[8] contain a full history of Mr Hynes' treatment orders. In particular the records contain a written submission from Mr Hynes' family in support of a community treatment order dated 8 May 1996 which sets out a compelling history. The submission detailed their observations of Mr Hynes' struggle

[6] Exhibit C13
[7] Now replaced by the Mental Health Act 2009
[8] Exhibit C13

with his illness since 1987 and how he appeared mentally stable when subject to community treatment orders. Additionally, the transcript of the Guardianship Board hearing dated 24 April 2002 provides further insight. At the time of Mr Hynes' death he was subject to a community treatment order granted on 2 May 2007 which was due to expire on 2 May 2008.

4. Mr Hynes' continuing detention orders

4.1. Mr Hynes was subject to two continuing detention orders issued by the Guardianship Board on 28 February 2006. The first order was for 6 months' detention at the Royal Adelaide Hospital (RAH). During the course of that order Mr Hynes was discharged to a mental health hostel, Palm Lodge, on 15 March 2006 but was readmitted to Glenside Hospital on 19 March 2006 following a disagreement with another resident. Mr Hynes was discharged from Glenside Hospital on 5 March 2006. Mr Hynes was then lost to follow up but was readmitted to the RAH on 30 June 2006 having been detained by SAPOL pursuant to Section 23 of the Mental Health Act for being located near a school behaving strangely with rambling conversation and responding to auditory and visual hallucinations. On this occasion Mr Hynes was discharged on 22 August 2006.

4.2. Dr Branson stated[9] that it seems that there was no real intention on the part of the treating staff that Mr Hynes would stay in hospital for the entire duration of the continuing detention order, but that it was considered reasonably routine that he would be released on extended leave when accommodation was found for him, provided that he appeared well enough.

4.3. A further 12 month continuing detention order was issued by the Guardianship Board on 15 August 2006[10] and this was the order that Mr Hynes was subject to at his death. Dr Branson pointed out that Mr Hynes was discharged from the RAH on 22 August 2006[11] and from this time onwards his admissions as an inpatient were brief. Mr Hynes left the RAH on 22 August 2006 for accommodation at the Afton Hotel on South Terrace. He next presented at the RAH on 11 October 2006 and was admitted for 5 days as he had left his accommodation after an altercation with another resident and was homeless. On 24 February 2007 Mr Hynes was admitted to the RAH having

[9] Exhibit C10a, page 4
[10] Exhibit C13
[11] I point out that a search of the RAH files has not located a leave form for this time period, nor for 16 October 2006

lost contact with Mental Health Services in January 2007. On this admission he presented with suicidal ideation which turned out to be secondary to his homelessness. Mr Hynes absconded after 2 days. On 1 March 2007 Mr Hynes was located and taken to Glenside Hospital in a florid state. He was discharged on 20 March 2007 to a boarding house in Kilburn.

4.4. I note here that at the time of Mr Hynes death, he was subject to two Guardianship Board orders; both the continuing detention order due to expire on 15 August 2007 and the community treatment order due to expire on 2 May 2008.

4.5. The final period of hospitalisation for Mr Hynes commenced on 2 May 2007 when he was detained at the Lyell McEwin Health Service having been brought in by the police. Mr Hynes had become agitated at a hostel as he was suffering from a thought disorder, was responding to internal stimuli and refusing assessment which was again precipitated by lack of compliance with medication. This is recorded on the Form 1 detention that was completed upon his arrival at the Lyell McEwin Health Service[12]. On presentation he refused to inform staff of his identity and referred to himself as 'Shivers'. The Lyell McEwin Health Service then completed a Form 2 and then transferred Mr Hynes to the Modbury Hospital where Mr Hynes' actual identity was eventually discovered by a staff member who recognised him from previous dealings in the mental health system. The Modbury Hospital completed a Form 3 on 5 May 2007 instigating a further 21 day detention. Mr Hynes was transferred, appropriately on a Form 8, to the RAH on 23 May 2007 so that he was in the catchment area in which he wanted to live, as soon as a bed became available.

5. Mr Hynes' leave from RAH

5.1. On 31 May 2007 at the RAH, after a period of apparent wellness, Mr Hynes was granted leave pursuant to his continuing detention order until 15 July 2007. Mr Hynes was involved extensively with social work and his mental health team.

5.2. Two mental health nurses, Ms Meagan Wellington[13] and Ms Marilyn Schuster[14], collected Mr Hynes from the RAH and transported him to his newly obtained accommodation in Norwood. They variously describe Mr Hynes as reactive, pleased

[12] Exhibit C11, Volume 5
[13] Exhibit C7a
[14] Exhibit C6a

to be out of hospital and happy about his new housing. Ms Schuster, who was Mr Hynes' main mental health worker, then commenced 3 weeks annual leave.

5.3. An alternative mental health nurse returned to Mr Hynes' accommodation on 12 July 2007 in order to provide him with his antipsychotic depot injection, but was informed that he had left that accommodation.

5.4. Mr Hynes' leave pursuant to his continuing detention order expired on 15 July 2007. Pursuant to Section 23(3) of the Mental Health Act 1993. This meant that if Mr Hynes was still alive, he was now 'unlawfully at large' for the duration of his period of detention and as such be liable to apprehension and return to the RAH.

6. Mr Hynes is declared a missing person

6.1. On Friday 27 July 2007 Ms Schuster read in Mr Hynes' notes that a nurse had gone out to his accommodation on 12 July 2007 and had found nobody at home. On that day she travelled to Mr Hynes' accommodation and spoke with the landlord and was advised that Mr Hynes had moved out. As the landlord experienced difficulty in speaking English, Ms Schuster was unable to ascertain when Mr Hynes had left the accommodation. As seen earlier, it is said that after Mr Hynes' body was discovered, his things were found there by his family. On the same day Ms Schuster called SAPOL and filed a missing persons report at 1:24pm[15].

6.2. The Missing Persons Investigations Diary[16] details the subsequent actions of SAPOL following receipt of the report:

- Sunday 29 July 2007 SAPOL realise the telephone numbers they have for the reporting person are incorrect so they ask a for call to be made to Assessment and Crisis Intervention Service.
- Monday 30 July 2007 calls are made to ACIS to ascertain the reporting person and a message is left to call SAPOL back.
- Tuesday 31 July 2007 the reporting person still has not returned the call and a further message is left.

[15] Exhibit C9b
[16] Exhibit C9c

- Wednesday 1 August 2007 a further call is placed and a message is left for the reporting person. At 11:30am the reporting person, Ms Schuster, contacts SAPOL.

The document further reveals that Ms Schuster provided the following information to SAPOL:

- Mental Health Services have no record of family contacts;
- Mr Hynes has friends in Salisbury and Kilburn;
- Ms Schuster is not willing to provide the details of those friends to police and she will make enquiries herself;
- Ms Schuster cannot provide SAPOL with any follow up addresses or contacts for Mr Hynes;
- Ms Schuster is happy for Mr Hynes simply to be listed as missing in case SAPOL come across him and Mental Health Services will make follow-up inquiries;
- Mr Hynes is subject to a continuing detention order which expires on 15 August 2007;
- Mr Hynes is also subject to a community treatment order which does not expire until 2 May 2008. This means that Mr Hynes has a treatable mental illness. If he resists or does not show up for treatment, police and Mental Health Services may use reasonable force to ensure treatment is received;
- If Mr Hynes is not located by 15 August 2007 Mental Health Services will likely remove him as their client and he will no longer be missing.

7. Conclusions

7.1. According to reliable reports, Simon Christopher Hynes was last seen alive on 31 May 2007 when he was discharged from the RAH and placed in accommodation at Norwood. On 2 August 2007 his body was discovered hanging from a tree in the Blackhill Conservation Park. I find that Mr Hynes deliberately ended his own life and that no other person was involved.

7.2. It is not possible to ascertain the date on which Mr Hynes died other than by saying that the most likely period during which it occurred was between 7 June 2007 and 5 July 2007.

7.3. An attempt was made by mental health workers to visit Mr Hynes on 12 June 2007 at the Norwood premises. However, Mr Hynes was not present. It may well be that Mr Hynes was deceased by that time. Certainly that possibility has not been excluded. Thereafter I do not understand there to have been any further attempts to administer Mr Hynes with his mandatory antipsychotic medication in accordance with a still existing community treatment order. The fact that Mr Hynes was missing was reported to police on 27 July 2007. According to Dr Charlwood, the forensic pathologist, in her view Mr Hynes had probably been deceased for the four weeks prior to the discovery of his body. Police do not appear to have received any meaningful information as to Mr Hynes' possible whereabouts as of 27 July 2007 and in the opinion of Dr Charlwood, which I accept, Mr Hynes was probably deceased by that time in any case.

7.4. Dr Branson reports that at the time of Mr Hynes' discharge from hospital on 31 May 2007 there appeared to be no reason at all to believe that he was imminently suicidal. He was reasonably psychiatrically well and expressed pleasure and satisfaction at his new accommodation. In respect of the issue as to whether it was appropriate for Mr Hynes to be discharged on 31 May 2007 having regard to the fact that he was on a continuing detention order, Dr Branson says at follows:

> 'In fact it seems clear from his history that there was no intention that he would be in hospital for the whole of his Continuing Detention Order, and as I have outlined it is quite apparent that he was not. At the time of his discharge, Mr Hynes seemed relatively well and seemed satisfied with the accommodation that had been found for him. In these circumstances, it seems to me that it was quite reasonable to discharge him from hospital at the time that he was.' [17]

The Court has no reason to conclude otherwise.

7.5. Between 12 June 2007 and 27 July 2007, when Mr Hynes was reported as a missing person, there was no attempt made by mental health authorities to locate Mr Hynes despite the fact that he was on a community treatment order, that he was obliged to receive fortnightly administrations of his antipsychotic medication and, if not

[17] Exhibit C10a, page 8

deceased already, that he was unlawfully at large when his leave of absence from MHA detention expired on 15 July 2007. This may be due in part to an inability to even begin to work out where Mr Hynes may have been in that period. Also, I note again that he may well have been deceased even by 12 June 2007 which was the first time that mental health workers attempted to located him at the Norwood premises. Accordingly, in the circumstances it is not possible to say whether or not Mr Hynes' death could have been prevented by more stringent attempts to locate him.

8. Recommendations

8.1. I have no recommendations to make in this matter.

Key Words: Death in Custody; Missing Person; Suicide

In witness whereof the said Coroner has hereunto set and subscribed his hand and Seal the 22nd day of December, 2011.

Deputy State Coroner