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 29th day of June 2010 and the 26th day of August 2011, by the Coroner's Court of the said State, constituted of Anthony Ernest Schapel, Deputy State Coroner, into the death of Michael David Rex.

The said Court finds that Michael David Rex aged 41 years, late of 11/10 Celeste Court, Glandore, South Australia died at Flinders Medical Centre, Flinders Drive, Bedford Park, South Australia on 2nd day of November 2008 as a result of mixed drug toxicity (methadone, valproate, zuclopenthixol). The said Court finds that the circumstances of his death were as follows:

1. Introduction and cause of death

1.1. Mr Michael David Rex, aged 41 years, died on Sunday 2 November 2008. At that time Mr Rex was an inpatient at the Margaret Tobin Centre, Ward 5H. The Margaret Tobin Centre, which consists of a number of wards, is the psychiatric facility of the Flinders Medical Centre (FMC). Mr Rex's body was discovered by Margaret Tobin Centre staff at approximately 1:10pm on the day in question. Mr Rex was still in bed at that time. Mr Rex occupied his room alone. Mr Rex had last been seen alive and awake by staff at approximately 11:30pm when he retired to bed. He was observed throughout the course of the night on an hourly basis and was recorded as having been asleep on all of those occasions. I was told in evidence that normally a patient such as Mr Rex would be given his or her medication between 8am and 9am. However, latitude was given in relation to the administration of some medications with the result that on weekends patients were generally permitted to sleep in. Mr Rex was allowed to sleep in on this particular morning.

1.2. At approximately 1:10pm Mr Rex was observed still not to be up and about. One of the facility's nurses entered his room. While standing at the door the nurse looked for signs of Mr Rex breathing but no movement could be detected. On closer observation it was established that Mr Rex was deceased. Even at that point Mr Rex appeared to be in a normal sleeping position within the bed and his bed clothes remained undisturbed.

1.3. There was at that point in time no obvious cause of Mr Rex's death. Naturally the police were brought into the matter, as was the forensic pathologist, Dr John Gilbert of Forensic Science South Australia. Dr Gilbert attended at the Margaret Tobin Centre at 4:30pm that day. Mr Rex's body was still situated on the bed. From the ambient room temperature and the deceased's rectal temperature, and taking into account his body weight and other relevant factors, Dr Gilbert formed the opinion that Mr Rex's approximate time of death had been 10am that day plus or minus 3 hours. This would mean that Mr Rex probably died sometime between 7am and 1pm that day. The possibility remains that he died at a time before he would normally be woken to have his medication administered. Equally, his time of death could have been relatively close to the time he was found deceased.

1.4. Dr Gilbert performed a full autopsy in respect of Mr Rex on the morning of Monday 3 November 2008. Dr Gilbert's report, which cites the cause of death as mixed drug toxicity (methadone, valproate, zuclopenthixol), is dated 11 March 2009[1]. The cause of Mr Rex's death was in fact known for the first time on or about 20 January 2009 which is the date borne on the toxicology report of Mr Timothy Scott[2]. Mr Scott's report revealed that in Mr Rex's bloodstream there were three substances detected. They were methadone, valproate and zuclopenthixol. Zuclopenthixol is an antipsychotic agent that had been prescribed for Mr Rex. Mr Scott reports that the concentration of Zuclopenthixol in this case was a high therapeutic concentration. Valproate (sodium valproate) is used as an anticonvulsant drug. The concentration of valproate in Mr Rex's blood was considered to be within the therapeutic range. There is nothing surprising about the presence of zuclopenthixol and valproate in Mr Rex's bloodstream, nor in the quantities detected, as he had been prescribed both medications and he had recently been administered with both. On the other hand, the

[1] Exhibit C2a
[2] Exhibit C3a

methadone found in Mr Rex's system was not something that he had ever been prescribed, and certainly had not been prescribed it or legitimately administered with it while in the Margaret Tobin Centre. Methadone is a potent analgesic used for the relief of all types of severe pain where morphine might otherwise be indicated. It is also used for substitution therapy in persons dependent on heroin and morphine. Its distribution and administration is tightly controlled. Methadone is available in both tablet and syrup form. The experience of this Court is that individuals may consume methadone recreationally in circumstances where it has not been prescribed for them. It is said variously within the evidence that was presented to the Court that Mr Rex was a user of marijuana and amphetamines, but there is no evidence that Mr Rex had ever been an abuser of methadone. I have seen no reference to him using methadone in any circumstances, legitimate or otherwise.

1.5. According to Mr Scott's toxicology report[3], the concentration of methadone in Mr Rex's blood may indicate a potentially lethal concentration depending upon previous drug history. I take that to be a reference to whether or not Mr Rex was naïve to the consumption of methadone as. For the reasons set out in the preceding paragraph, I assume he was so naïve.

1.6. In his post-mortem report Dr Gilbert states as follows:

> 'Analysis of a specimen of blood obtained at autopsy reportedly showed a methadone concentration of 0.28 mg/L and therapeutic levels of valproate (mood stabiliser) and zuclopenthixol (antipsychotic). The methadone was evidently not prescribed and further investigation will be required to determine its source. The methadone level was potentially lethal for an individual not tolerant to opiates and additive CNS depressant effects would be expected in combination with valproate and zuclopenthixol. Deaths associated with methadone toxicity are often preceded by a prolonged period of unconsciousness with snoring, thus resembling deep sleep.
>
> In the absence of any other apparent cause, death has been attributed to mixed drug toxicity (methadone, valproate, zuclopenthixol).' [4]

1.7. I accept Dr Gilbert's evidence. I find the cause of Mr Rex's death to have been mixed drug toxicity (methadone, valproate, zuclopenthixol).

1.8. The principal issue in the Inquest was the means by which Mr Rex came into possession of methadone. Unfortunately the precise means have not been identified, but there a number of possible ways in which it may have occurred.

[3] Exhibit C3b
[4] Exhibit C2a, page 2

2. Background

2.1. Mr Rex had a long history of chronic, treatment resistant paranoid schizophrenia with his first diagnosis being made when he was 17 years of age. There were admissions to Glenside Hospital between January 2004 and August 2007.

2.2. In 2008 Mr Rex was receiving depot medication for his psychosis. This was administered in the community. Although Mr Rex was under a Guardianship Board Administration Order and a Community Treatment Order, for the most part he was able to live independently. The most recent orders had been made in February 2008. It became apparent that Mr Rex continued to suffer from debilitating delusions the details of which I do not need to recite. It is also believed that while living in the community Mr Rex associated himself with other mental health patients some of whom unfortunately were illicit drug users. I have already mentioned the use of cannabis and amphetamines, although there was no evidence of the use of methadone. A Mr Robert Fitch, who is a registered psychiatric nurse most recently working with the Mobile Assertive Care Unit in Marion, gave a statement to police[5] in which he asserted that he had known Mr Rex as a patient at Glenside Hospital when Mr Fitch attended there to see other patients. He describes occasionally seeing Mr Rex in the grounds of Glenside Hospital and would notice that he was 'stoned'. He had heard it through other staff at Glenside that Mr Rex was buying drugs from within the grounds of the hospital.

2.3. By virtue of the Community Treatment Order, Mr Rex was ordered to undergo fortnightly the administration of 400mg of zuclopenthixol decanoate, an injectable depot antipsychotic. When Inner South Mobile Assertive Care (ISMAC) staff endeavoured to administer that medication on 21 October 2008, Mr Rex indicated that he did not wish to have his depot medication anymore. Two ISMAC workers again visited Mr Rex at his home on 22 October 2008. He again refused his medication and levelled various delusional accusations at ISMAC staff. Later that day Mr Rex agreed to meet Dr James McLachlan who is a psychiatrist for Southern Area Mental Health. That day Dr McLachlan interviewed Mr Rex. During this encounter Mr Rex demonstrated bizarre and persecutory delusions of abuse and altered self identity. He was agitated and threatening and so Dr McLachlan detained him under the Mental Health Act 1993 (MHA). In doing so Dr McLachlan recommended observation and

[5] Exhibit C20a

review of medication in a closed secure ward. Mr Rex was conveyed to the Margaret Tobin Centre where he was initially placed in Ward 5J which is a closed ward. This would mean that he was not permitted to leave the ward. There is no question but that this initial detention was perfectly appropriate and lawful.

2.4. By virtue of the provisions of the MHA Mr Rex's detention, which initially operated for a period of 3 days only, required confirmation within the first 24 hours of Dr McLachlan's originating order having been made. On 23 October 2008 Dr Allan Nelson who is a consultant psychiatrist at the Margaret Tobin Centre and who had no past involvement in the care of Mr Rex prior to meeting him at this facility, reviewed Mr Rex's detention order. He examined Mr Rex's past psychiatric history. He conducted a full interview of Mr Rex during which the latter appeared highly distressed, tearful and pleading. Mr Rex expressed his customary bizarre beliefs as well as other grandiose delusions. Dr Nelson believed that Mr Rex was experiencing a relapse of his chronic schizophrenia and that this created a danger to himself as well as to others. On this basis he confirmed the detention order. There is no question but that this confirmation was both appropriate and lawful.

2.5. As alluded to a moment ago, the initial detention was for a maximum period of 3 days. For the detention to be extended it required further consideration by a psychiatrist. That further consideration was given by Dr Georgina Cheng who is a psychiatric consultant in the Noarlunga Emergency Mental Health Services. From time to time she has the responsibility to review mental health detentions under the MHA. As it happens she had previous knowledge of Mr Rex during her work as a senior registrar at Glenside Hospital in 2003 and 2004, although she had not seen Mr Rex since. On 25 October 2008 Dr Cheng examined Mr Rex in Ward 5J of the Margaret Tobin Centre. During this review Mr Rex expressed the usual delusional beliefs. Mr Rex was pleasant and cooperative but his delusional themes dominated his presentation. Dr Cheng felt it necessary to impose a 21 day detention order and she completed the necessary documentation to bring that into effect. There is no question but that this order for further detention was both appropriate and lawful.

2.6. Between 22 October and 31 October 2008 Mr Rex was accommodated under detention within a closed ward of the Margaret Tobin Centre. During that period Mr Rex was seen by Dr Nelson. Dr Nelson reviewed his medication.

3. Ward 5H of the Margaret Tobin Centre

3.1. By 30 October 2008 Dr Nelson considered it would be appropriate to begin discharge planning as Mr Rex was now back on his depot medication and he was less distressed with no specific management problems within a closed ward. He was therefore transferred to the open ward, Ward 5H, on 31 October 2008.

3.2. Mr Rex occupied Room 11 within that ward. His room was occupied alone.

3.3. Upon his arrival in Ward 5H Mr Rex was observed initially not to be settled and had to be medicated shortly after arrival. There was an expectation that Mr Rex might be taken back to Ward 5J due to his behaviour but his attitude appeared to settle.

3.4. Ward 5H accommodates both detained and voluntary mental health patients. It accommodated 15 patients approximately 80% of whom were detained patients. The detained and voluntary patients can and do co-mingle. Although detained patients are kept within the Margaret Tobin Centre as a whole, strictly speaking as a matter of law their detention is maintained within the whole of the approved treatment centre which is the entire FMC. Mr Evert Regter, who is the Nurse Management Facilitator for the Margaret Tobin Centre, told me in evidence that this meant that detained patients could leave the ward and go to other parts of the approved treatment centre being the entire FMC. However, in order to leave the ward a detained patient was required to seek and obtain what he referred to as 'ground leave'[6]. Once ground leave was granted the detained patient could have access to other parts of the FMC that included the grounds. In those circumstances patients might meet random members of the public or meet them by prior arrangement.

3.5. Detained patients within the open ward 5H were permitted to receive visitors who were not required to identify themselves to staff.

3.6. Attached to Ward 5H was a recreational outdoor courtyard area that had a number of benches as well as a basketball ring. There was lighting, shrubs and trees. Patients within the ward, both detained or otherwise, were permitted to take visitors into this area. The courtyard was surrounded by a fence that from photographs appears to be approximately 6 feet high. The fence was comprised of slats through which small objects could conceivably be passed. Beyond the fence was an area that was

[6] Transcript, page 63

accessible to the general public. There was nothing preventing a member of the public from looking through the fence into the courtyard. There was nothing to physically prevent a member of the public inserting any small object through the narrow gaps in the fence, or indeed throwing something over the fence into this enclosure.

3.7. Patients within Ward 5H, both detained and voluntary, were not permitted to possess or use mobile telephones. One of the reasons for this was to prevent both still and video photography being conducted by patients. The patients did have access to a landline within the ward, and thus a meeting could be arranged between a patient and a member of the public. As well, there was nothing to prevent an arrangement being made between patient and a member of the public to meet at the fence and to exchange objects. The only deterrent to this happening would be the prospect of detection by an observant member of staff.

3.8. There were a number of CCTV cameras within the ward, all of which were capable of making video recordings. One such camera was trained on part of the area within the outdoor courtyard. Mr Regter told me that it could capture approximately 90% of the courtyard. There was also a camera that was trained upon the entry / administration area leading into Ward 5H. There was a camera that covered the entry point of the building proper and there was a camera situated along a linkway that joined the Margaret Tobin Centre to the rest of the hospital. Unfortunately the video recordings made by these four cameras were not obtained during the course of the police investigation.

4. Mr Rex's admission within Ward 5H

4.1. Mr Rex arrived at Ward 5H late on Friday afternoon, 31 October 2008. According to the statement of Sally-Anne Crane (formerly Cooke)[7], Mr Rex was given 2mg of lorazepam, which is a sedative, at 5:15pm. Ms Crane completed her duty at 6pm that day. There is no evidence that Mr Rex left the ward after his arrival and, having regard to his presentation when he arrived, as described by Ms Crane, and the need for sedation, it seems unlikely that he would have been granted permission to leave the ward and go to other parts of the hospital. This is not to say that he did not have access to the courtyard area that afternoon or evening.

[7] Exhibit C23a

4.2. The events of the following day, Saturday 1 November 2008, are described in a number of witness statements supplied by Mr Andrew McGregor who was a mental health care nurse at Ward 5H of the Margaret Tobin Centre[8]. Mr McGregor did not work on the Friday, which was the day of Mr Rex's arrival on the ward. He saw Mr Rex on the Saturday morning. Mr McGregor had known Mr Rex for a number of years through some of Mr Rex's previous hospital admissions. During the Saturday morning Mr Rex asked Mr McGregor if he could be taken to the shops. Mr McGregor agreed. At about 2:30pm that afternoon they both left the ward and travelled to Castle Plaza at Edwardstown. Mr Rex had stated to Mr McGregor that he wanted to purchase a wig because he was self-conscious about his baldness. Ultimately Mr Rex was able to find and purchase a wig. They returned to the facility later in the afternoon. Mr Rex wore the wig for the remainder of the day. Mr McGregor in his witness statement[9] states on his oath that during the shopping expedition Mr Rex was constantly in his presence and he had not purchased or acquired anything other than the wig. Accepting Mr McGregor as I do, this means that Mr Rex did not acquire the methadone at castle plaza. In any event this would seem unlikely because, as I understand Mr McGregor's statement, the time at which they attended Castle Plaza would not have been known to Mr Rex in advance. Thus Mr Rex would not have been able to arrange a meeting with anyone for the purpose of acquiring a substance.

4.3. Mr McGregor states that when they returned to the ward from Castle Plaza, Mr Rex was in a very good mood and was very pleased with his wig. Mr McGregor completed his shift at 7:42pm and did not see Mr Rex again until he personally discovered his body at 1:10pm. Checks in respect of Mr Rex were carried out by other staff members overnight and during the following morning and the records relating to hourly observations indicate that he was checked hourly until 12:30pm on the day of his death. He was obviously in bed during all of those checks and no person, at any point, detected that he had passed away or was otherwise in extremis.

4.4. It appears that there is no evidence that once Mr Rex was returned to the ward after his visit to Castle Plaza on the Saturday that he left the ward, at least to anyone's knowledge. He did, however, have access to the outdoor enclosure. He appeared to the nursing staff to be in good spirits that evening. With the exception of Mr

[8] Exhibits C22a, C22b, C22c and C22d
[9] Exhibit C22c

McGregor, the nursing staff could not recall any visitors. Ms Linda Green, a nurse, gave him a Panadol tablet for a headache at about 8:40pm and she provided him with his normal valproate medication at 9pm. According to Ms Green, Mr Rex went to bed at about 11:30pm and remained asleep. As alluded to earlier, this was the last occasion on which he was seen to be alive and awake.

5. The source of the methadone

5.1. The source of the methadone that Mr Rex undoubtedly ingested has not been in any way established. There was only one patient on the ward whose prescribed medication included methadone, a Mr Wilson. Mr Wilson himself had been transferred from the closed ward to Ward 5H the night before, 31 October 2008. The statements on oath of both Mr McGregor[10] and Sally-Anne Crane[11] have satisfied me that they administered that particular patient with his methadone dose at 11am that morning. The practice is that the drug is ordered on a DDA[12] form and that the order is usually placed the day before it is required on the ward. It is supplied by the FMC pharmacy and is generally administered when it arrives on the ward. If it is not immediately administered it is stored in a locked metal DDA cabinet which is only accessible by way of a key. The room in which the DDA cabinet is situated is accessed only by way of a secure keypad. According to the relevant records, Ms Crane discerns that the drug was given to Mr Wilson immediately upon its arrival in the ward. The methadone is administered in liquid form and the practice is to observe the patient consume it. There is no evidence of the existence of any other methadone within the ward at any other time during Mr Rex's occupancy. To my mind it is highly unlikely that Mr Rex obtained the methadone from a static source within the ward itself.

5.2. Having regard to the fact that the fence surrounding the outdoor area was adjacent to a location to which the public had access, the possibility that the methadone was passed through or over the fence to Mr Rex undetected cannot be wholly discounted.

5.3. The fact that no record is kept of visitors on the ward would fail to negate the possibility that Mr Rex received the methadone from a visitor.

[10] Exhibit C22 and attachments
[11] Exhibit C23a
[12] Drug of Dependence Administration

5.4. There is also the question as to whether or not a person who might have had access to methadone within the hospital as part of their duties may have supplied it. There is no evidence of this.

5.5. Negating the possibility that Mr Rex sourced the methadone through a visitor or through some person who had a connection with FMC was somewhat hampered by the fact that the cause of Mr Rex's death was not immediately understood. As indicated earlier, there was no outward sign immediately available to establish Mr Rex's cause of death. The toxicology result was not known until January 2009. The investigating officer, Detective Senior Constable Andrew Hewlett-Parker, told me in evidence that the lateness of the toxicology had the indirect consequence that CCTV footage was no longer available. The recordings had not been retained by the hospital but had been over-written. As well, observations that may have been made by staff of persons associating with Mr Rex on or about the day of his death would have gone from their memories. As an example of this, although Mr McGregor could remember that Mr Rex had been in the presence of an unknown male person some time during the evening prior to his death, he could give very little detail about that person other than, one assumes, that the person was not another male patient on the ward. The identity of that person cannot be established.

5.6. Mr McGregor made a statement to police at the time of Mr Rex's death. Mr McGregor did not mention the existence of this visitor to police until a further statement was taken from him in March 2009[13]. Then, Mr McGregor identified a bench seat within the outdoor area on which he had seen Mr Rex seated beside the unknown male person, apparently a visitor, during the course of the evening prior to Mr Rex's death. It appears that the position of this particular bench would have been captured by the CCTV camera that was trained on the majority of the outdoor area. I do not criticise Mr McGregor for not mentioning this to police in the first instance because it appears that he was not asked about contacts that Mr Rex may have had with persons in the period leading up to his death. Detective Senior Constable Hewlett-Parker told me in effect that Mr Rex's contacts in that period did not become a live issue until the toxicology report was available which established that Mr Rex had died from the ingestion of a substance that had not been prescribed for him and which he must have obtained from some extraneous source. If the fact that Mr Rex had been seen speaking to an unknown person the night before his death had been

[13] Exhibit C22d

revealed on the day of his death or shortly thereafter, it may very well be that that person would have been depicted in CCTV footage and possibly identified. In the event, the CCTV footage was only kept for a maximum of approximately 30 days and so it was no longer available by the time Mr Rex's cause of death was established.

5.7. I do not wholly agree with the position explained by police that their investigations were hampered by not knowing the toxicology result before January 2009. While such a time lapse is not ideal, one would have thought that in an unexplained death such as this, occurring as it did in a hospital and against a background of drug abuse, that a toxicological cause of death was very much on the cards. It would not have been difficult to consider, at least as a working possibility, that the cause of death might ultimately be revealed as involving the ingestion of a substance that had not been prescribed for the deceased person. Accordingly, Mr Rex's contacts in the period leading up to his death would have been a matter worthy of investigation from the outset. If that had been appreciated then I have little doubt that CCTV footage from all of the relevant cameras would have been obtained before destruction.

5.8. In March 2009 a statement[14] was taken from Ms Lisa Robertson who is the Senior Specialist Pharmacist - Dispensing Services, Division of Pharmacy, FMC. Her statement deals with the question as to whether or not the source of the methadone could have been the hospital itself. According to Ms Robertson's statement, the DDA form relating to the administration of methadone to the patient Mr Wilson establishes that the appropriate dosage of methadone was administered to him on the morning of 1 November 2008. This accords with the evidence of Mr McGregor and Ms Crane to which I have already referred. The statement also makes the bald and unsubstantiated assertion that the stock levels of the pharmacy as they relate to methadone syrup did not suggest any discrepancy, with all requisitions accounted for. I understood from Detective Senior Constable Hewlett-Parker that this evidence represents the extent of the checking of FMC stocks. In future, in circumstances such as these it would be preferable if police insist on sighting evidence of a full stock take and reconciliation.

[14] Exhibit C8a

6. Conclusions

6.1. Mr Michael David Rex died as a result of mixed drug toxicity (methadone, valproate, zuclopenthixol) during the morning of 2 November 2008. The approximate time of death is 10am but it may have occurred 3 hours either side of that time.

6.2. Mr Rex's deceased body was located at 1:10pm on the afternoon of 2 November 2008. Hourly checks during the course of the morning and early afternoon had established no more than that he was in bed. To my knowledge none of those checks established whether at any given point in time Mr Rex was actually alive. That said it may well be that having regard to Dr Gilbert's estimate as to the time of death and the leeway that he has described, the time of death may have been not long before 1pm. Nevertheless it is fair to assume that in the period leading up to Mr Rex's death there would have been difficulty rousing him from the sedating effects of what he had ingested. It may well be that closer inspection of Mr Rex during the course of the morning and early afternoon could have revealed that he was in extremis and that the necessary measures to reverse that may have been attempted.

6.3. The practice of allowing a patient to sleep in to the early afternoon without making a close inspection of the person to ascertain their welfare is manifestly undesirable. However, in fairness it has to be borne in mind that there was no suggestion that Mr Rex was suffering from any physical condition that might have signified risk of sudden death.

6.4. The source of the methadone that Mr Rex ingested has not been established. There are a number of possibilities including the following:

a) That Mr Rex was in possession of methadone when he first arrived at the Margaret Tobin Centre. This seems unlikely in light of the fact that according to the evidence of Mr Regter Mr Rex's possessions would have been inspected upon his arrival at the facility[15];

b) That Mr Rex met an unknown person in the grounds of the hospital and received the methadone from that person. In this regard it will be noted that Mr Rex was accommodated within the closed ward of the Margaret Tobin Centre from 22 October to 31 October 2008. It is therefore unlikely that he had an opportunity to

[15] Transcript, page 24

meet anyone within the hospital grounds in that period. There is no evidence that Mr Rex left Ward 5H, the open ward, at any time after his admission to that ward except when he went on the shopping excursion with Mr McGregor. For the reasons I have already mentioned I do not believe that he obtained the methadone during the course of that excursion;

c) That Mr Rex obtained the methadone from a source within Margaret Tobin Centre, be it from a static position such as a medicine room or from another patient. There is no means of establishing whether or not Mr Rex may have received something from another detained or voluntary patient, but it is unlikely that Mr Rex obtained methadone from a static source within the ward such as the medicine room;

d) That Mr Rex received the methadone from an unknown visitor. This to my mind is the most likely explanation having regard to the fact that he was visited by an unknown person the night before his death;

e) That a member of the public passed the methadone through the fence of the outside enclosure. This possibility has not been eliminated.

7. Recommendations

7.1. By virtue of section 25(2) of the Coroners Act 2003 the Court may add to its findings any recommendation that might, in the opinion of the Court, prevent, or reduce the likelihood of, a recurrence of an event similar to the event that was the subject of the Inquest.

7.2. There was much debate during the course of the Inquest about the means by which a death such as Mr Rex's might be prevented in the future. Detective Senior Constable Hewlett-Parker set out a number of recommendations at the conclusion of his comprehensive report[16]. I reproduce them as follows:

'1. Review of physical nature of fencing to rear garden area of Ward 5H of the Margaret Tobin Centre. As identified this fence is not constructed in a fashion to prevent items such as illicit drugs being passed through the fence.

2. Implementation of policy to govern the access of visitors to Ward 5H including the introduction of visitor guidelines for the benefit of staff and a record book to include visitor / patient interaction. This policy should further include a requirement

[16] Exhibit C19a

of duty staff to note in patient records, any visitor interaction they may have had that day.

3. Review of routine guidelines and reassessment of the manner in which patients are checked during the night and when asleep during the day. Reassessment of timeliness of administration of medication and re-fresher training provided to staff as necessary.

4. Introduction of guidelines to determine minimal course of action by ward staff upon finding of deceased detained persons. These guidelines should included securing of scene, identification of staff as possible witnesses and provision of all records pertaining to the deceased. Also to be included is the requirement for any CCTV of the ward to be made available to investigators as soon as practicable after any death requiring the attendance of police.

5. Review of timely manner in which toxicology results are made available by Forensic Science SA. In cases where no suspicious circumstances exist at the scene, and no cause of death can be given following autopsy, emphasis must be placed on securing a toxicology result as soon as possible. This would hopefully lead to establishing a cause of death and assist investigators in identifying a clear direction for their investigation.' [17]

7.3. The wisdom and feasibility of implementation of these recommendations was debated during the course of the evidence of Mr Regter. The principal objection to the implementation of these recommendations is that the measures contemplated might well impair the therapeutic environment that exists within Ward 5H of the Margaret Tobin Centre. In the opinion of the Court there are a number of matters that are the subject of appropriate comment in this regard.

a) There does not appear to be any reason why the fence surrounding the open area should enable members of the public to see into that area, or provide an opportunity for members of the public to pass objects through the fence to a known recipient;

b) Detective Senior Constable Hewlett-Parker suggests that a detained patient's ability to move around the grounds of the FMC ought to be reviewed. There is a case for arguing that if detained patients are permitted to move about the hospital grounds as a whole, there is a need for procedures to be in place that would prevent the patient from bringing contraband items back into the ward;

[17] Exhibit C19a, pages 19 and 20

c) The objections to the implementation of a requirement that visitors to Ward 5H should identify themselves in the case of detained patients are difficult to understand;

d) As to recommendations 4 and 5 as drafted by Detective Senior Constable Hewlett-Parker, investigating police should not wait for witnesses to provide relevant information. Police should take a proactive role in identifying the possible issues for investigation and not rely on witnesses coming forward with information that the witness may not even consider relevant at that point in time. In addition, investigating police should seriously consider the possibility of a toxicological component in the cause of death in these circumstances and do so at a time before toxicology results become available.

7.4. I make the following recommendations:

1) That the principal administrative officer or equivalent of the Margaret Tobin Centre give further consideration to the implementation of SAPOL recommendations 1 to 4 as set out in paragraph 7.2 herein;

2) That the principal administrative officer or equivalent of the Margaret Tobin Centre take the necessary steps to ensure that upon the death of a patient within the Centre, all CCTV footage is retained and not overwritten until permission to do so has been obtained form the State Coroner or SAPOL.

Key Words: Death in Custody; Psychiatric/Mental Illness; Drug Overdose

In witness whereof the said Coroner has hereunto set and subscribed his hand and Seal the 26th day of August, 2011.

Deputy State Coroner