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 20th, 23rd, 24th, 26th and 27th days of April 2012 and the 24th day of April 2013, by the Coroner's Court of the said State, constituted of Mark Frederick Johns, State Coroner, into the death of Andrew David Hollonds.

The said Court finds that Andrew David Hollonds aged 37 years, late of 23 Stone Road, Elizabeth Downs, South Australia died at Elizabeth Downs, South Australia on the 19th day of November 2009 as a result of compression of the neck consistent with hanging. The said Court finds that the circumstances of his death were as follows:

1. Introduction and reason for Inquest

1.1. Andrew David Hollonds died on 19 November 2009. He was aged 37 years. At the time of his death Mr Hollonds was the subject of a detention order under the Mental Health Act and his death is therefore a death in custody within the meaning of that expression in the Coroners Act 2003 and this Inquest was held as required by section 21(1)(a) of that Act.

2. Cause of death

2.1. Mr Hollonds was found to have hanged himself at his home address. An autopsy was performed by Dr Langlois who provided a post-mortem report[1] giving the cause of death as compression of the neck consistent with hanging, and I so find.

[1] Exhibit C1a

3. Background

3.1. Mr Hollonds was one of five children. He spent his early childhood years in Alice Springs. When Mr Hollonds was in his early 20s his father became aware that Mr Hollonds had been taking drugs for some years. Over the next 15 years Mr Hollonds came into contact with the criminal justice system and this related largely to problems that he had with his partners. Unfortunately, Mr Hollonds was the subject of restraining orders for domestic violence. He had two children from the two significant relationships that he had. At times he had difficulty accessing these children due to his behaviour.

4. Mr Hollonds' first admission to the Lyell McEwin Hospital

4.1. In April 2008 Mr Hollonds was admitted to the Lyell McEwin Hospital for a period of two weeks with an episode of psychosis. Casenotes for this admission reflect that Mr Hollonds was using cannabis heavily at the time and was drinking alcohol daily in large quantities. He also gave a history of having used methamphetamine but had not done so recently and this was confirmed by a urine drug screen carried out during that admission. After discharge Mr Hollonds was monitored by the Northern Community Health Team and his general practitioner. He was treated with risperidone and paroxetine[2]. These medications appeared to have good effect although Mr Hollonds continued to smoke cannabis regularly.

5. The events leading to Mr Hollonds' death

5.1. On 18 November 2009 Mr Hollonds presented at the Lyell McEwin Hospital with his father. Mr Hollonds had taken an overdose of temazepam and consumed a large quantity of alcohol. Mr Hollonds' father had been informed by his son's flatmate that Mr Hollonds had taken a bottle of sleeping pills and had washed them down with six cans of Bundaberg and coke. This had occurred following an altercation between Mr Hollonds and another worker at his workplace which had resulted in Mr Hollonds being dismissed from his employment.

5.2. Mr Hollonds was driven to the hospital by his father. During the journey Mr Hollonds informed his father that if he was not taken to the hospital and kept there he would be found hanging from a tree in the backyard. He repeated this a number of times to his father during the journey to the hospital.

[2] Paroxetine is an antidepressant

5.3. Mr Hollonds arrived at the hospital at approximately 5pm on 18 November 2009. He was noted to have slurred speech and altered gate and smelt strongly of alcohol. He was seen by Dr Busutill who detained him under the Mental Health Act. Dr Busutill had been told by Mr Hollonds' father that he had threatened to hang himself in the backyard of his home and also that he had recently been dismissed from his job as a plasterer. His threat to hang himself and his suicide attempt were noted by Dr Busutill in the detention documentation as the reason for detention.

5.4. During the night Mr Hollonds was permitted to leave the Emergency Department to go outside for a cigarette. When this occurred he was in the company of a security guard.

5.5. From approximately 8am the following morning Mr Hollonds was observed by a nurse's assistant who was responsible for observing him and one other patient. When she took a short break at approximately 9am, Mr Hollonds left the department. When the staff member returned after her break she overheard other staff saying that Mr Hollonds had gone outside for a cigarette. Shortly after this Mr Hollonds returned and got back into his bed. During his period outside the building Mr Hollonds was not escorted by any staff member.

5.6. Shortly thereafter Mr Hollonds was seen by consultant psychiatrist Dr Ng. She assessed Mr Hollonds to determine whether his detention order should continue or be revoked. After her assessment she was of the view that the detention order should continue for a further three days and she completed the necessary documentation. Although she did not believe Mr Hollonds had a depressive or psychotic illness, she did believe that he was a significant risk to himself due to his state of mind. She wrote that he had experienced a situational crisis and was angry, impulsive and suicidal.

5.7. While Dr Ng was completing the paperwork for Mr Hollonds' detention she was informed by mental health nurse, Mr Craig, that Mr Hollonds was apparently leaving the hospital. Dr Ng confirmed with Mr Craig that Mr Hollonds was still a detained patient and Mr Craig then followed Mr Hollonds to the exit doors of the Emergency Department. Just prior to Mr Hollonds exiting the Emergency Department, Mr Craig attempted to persuade him to stay and reminded him that he was under a detention order. Mr Craig's attempts to persuade Mr Hollonds to remain were unsuccessful and he left the hospital. Thereafter Mr Hollonds travelled by taxi to his place of residence

and taxi company records show that he was dropped off at his home at approximately 11:10am on 19 November 2009.

5.8. Upon his arrival at home Mr Hollonds spoke to his flatmate and informed him that the police were on their way and that he should leave the house. He went into the kitchen and took a large knife from the kitchen bench. His flatmate did as he was asked and walked to a friend's house up the road. In the meantime Mr Craig, the mental health nurse who had attempted to stop Mr Hollonds from leaving the Emergency Department, had completed a missing person's report and contacted the police. Police records indicate that a telephone report was made at 11:06am by Mr Craig. In response to that call the police dispatched a patrol to Mr Hollonds' house and that patrol arrived at 11:28am. When officers approached the front door they could see that the door was open but the screen door was closed and locked. Attempts to attract attention from the occupants were unsuccessful and another patrol was dispatched to conduct a mobile search of the area. At 11:43am the officers who had remained in the area to search for Mr Hollonds observed a male hanging from a tree in the rear garden of the house. It was difficult for police to enter the backyard as there were dogs that appeared to be aggressive in the yard. However the police succeeded in cutting Mr Hollonds down from the tree. Unfortunately at 11:53am Mr Hollonds was declared deceased by ambulance officers who had arrived at the scene.

5.9. At the time of Mr Hollonds' absconding from the Emergency Department the security office at the Lyell McEwin Hospital was not informed. Furthermore, no 'Code Black' was called. The Inquest examined the policies relating to the calling of a Code Black and Mr Craig's reasons for not having taken that course. The Court had the benefit of an experts report from Dr Craig Raeside, Forensic Psychiatrist[3]. Dr Raeside also gave oral evidence.

5.10. Dr Raeside noted that Mr Hollonds' history suggested significant personality disturbance and he thought that Mr Hollonds likely had an underlying mixed personality disorder with borderline and antisocial traits that would lead him to behave impulsively, have poor relationships, unstable moods and be prone to self-harm and suicidal behaviour[4]. Dr Raeside commented on the fact that Mr Hollonds had been permitted to go outside for a cigarette without a staff member accompanying him. Dr Raeside referred to the difficulties presented with no smoking policies in

[3] Exhibit C35
[4] Transcript, page 220

hospitals requiring that patients who wish to smoke have to stand a considerable distance from the front doors of the facility. He said that if a person is detained then there is clearly a requirement that the staff know where they are. He said that in practice it may be alright for a patient to go outside for a cigarette without being accompanied by a staff member. He commented that if the patient is cooperative that may be appropriate[5]. Dr Raeside was not prepared to go so far as to suggest that it was never appropriate for a detained patient to be allowed outside to have a cigarette without being supervised. He said that he considered that it was a matter for clinical judgment and that staff should make an assessment as to whether the patient had settled sufficiently to permit this to occur, the immediate crisis that brought them into the hospital having passed[6].

5.11. Dr Raeside expressed the opinion that the security office should have been notified when Mr Hollonds absconded. He said that he was not critical of Mr Craig refraining from physically restraining Mr Hollonds as he left. He said that may have escalated the situation and led to violence. However, he did believe that security should have been notified of the situation and that could have been done by calling a 'Code Black' or in some other way[7]. Dr Raeside acknowledged that the Code Black policy that was in existence at the time of Mr Hollonds' admission[8] did not deal with the circumstance that confronted Mr Craig, namely that of a detained patient calmly leaving the Emergency Department. Instead, the Code Black policy was framed to deal with aggressive, disruptive, violent or otherwise disturbed behaviour.

5.12. Mr Craig's understanding of the policy was that Mr Hollonds' behaviour did not require the calling of a Code Black. On the other hand, the clinical practice manual policy that was in place at the time of Mr Hollonds' admission[9] did deal with the subject of patients who had absconded or were otherwise missing. One of the requirements of that policy document was that nursing staff would notify the security control room as part of the procedure if a patient absconded. That did not occur on this occasion. There is some element of tension between the Code Black policy and the clinical practice manual policy and that may account for Mr Craig not having alerted security when Mr Hollonds absconded.

[5] Transcript, page 235
[6] Transcript, page 248
[7] Transcript, page 239
[8] Exhibit C21t
[9] Exhibit C21r

5.13. The evidence from the various staff members in this case was that some of them would have called a Code Black if they had been in Mr Craig's position whilst others would not have. The senior member of the security staff who gave evidence expressed the opinion that it would have been appropriate to have called a Code Black when Mr Hollonds left the Emergency Department. Overall, it is clear that there was an element of confusion amongst staff as to the appropriate course to take. I make it clear therefore that I am in no way critical of Mr Craig for not having taken that step. He certainly acted very promptly in notifying police of Mr Hollonds having absconded. The police responded very quickly to that situation and Mr Hollonds was seen in the backyard of his home by police within less than an hour of his departure from the Emergency Department. Indeed, Mr Craig contacted the police within 5 minutes of Mr Hollonds' departure and he spoke to his superiors on the ward.

6. Conclusion

6.1. I was informed by Ms Cliff, counsel for the Adelaide Metropolitan Mental Health Directorate, that the Code Black policy is being reviewed. It is also clear that other steps have now been taken, for example all staff now have duress pendants to wear[10].

6.2. Having regard to the affidavit of Ms Pollard I am satisfied that appropriate steps have been taken or are in train to refine the policy with regard to Code Blacks and absconding patients. I therefore refrain from making any recommendations in that respect. However, this case has raised a difficulty in my opinion in relation to the vexed question of how to deal with patients who wish to have a cigarette. Unfortunately, it is the fact that many patients who need to be detained are smokers. To deprive them of access to cigarettes while they are subjected to the stresses of mental health detention may be counterproductive. As a result, it is considered necessary by staff to allow the patients to leave the buildings in order to have a cigarette. The policies in relation to cigarette smoking require that smokers be some considerable distance from the building entrances. Dr Raeside said it was a matter of clinical judgment whether a patient should be required to be accompanied by a staff member when going outside for a cigarette.

6.3. In Mr Hollonds' case staff were aware that he had been permitted outside unaccompanied to have a cigarette. While that may not have led Mr Craig to refrain

[10] Exhibit C32, Affidavit of Ms Pollard

from restraining Mr Hollonds when he left the Emergency Department, it may have made the situation seem less urgent simply because Mr Hollonds had been known to leave the building before and return unharmed. In my view there is an ambiguity that is undesirable. I think clearer guidance needs to be provided for staff about dealing with detained patients who need to have a cigarette. One option might be to consider the provision of nicotine patches. Of course, these may not be appropriate for a variety of reasons and I heard no evidence one way or the other on that topic. I merely raise the option as something that may be worthy of consideration. Another option could be that of an enclosed recreational outdoor courtyard area that could be connected to one of the ward exits similar to that currently attached to Ward 5H of the Margaret Tobin Centre. This would be a secure area that would allow patients, both detained or otherwise, access to an enclosed area where they could attend unaccompanied for the purposes of a cigarette or meeting with visitors.

7. Recommendations

7.1. Pursuant to Section 25(2) of the Coroners Act 2003 I am empowered to make recommendations that in the opinion of the Court might prevent, or reduce the likelihood of, a recurrence of an event similar to the event that was the subject of the Inquest.

7.2. I recommend that the Minister for Mental Health and Substance Abuse review existing practices and policies relating to smoking and detained mental health patients in order to provide the clearest possible guidance to staff about when patients are to be accompanied and when they are not when absent from secure premises for a cigarette break.

Key Words: Death in Custody; Suicide

In witness whereof the said Coroner has hereunto set and subscribed his hand and Seal the 24th day of April, 2013.

State Coroner