



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 and 19th days of December 2012 and the 19th day of September 2013, by the Coroner's Court of the said State, constituted of Anthony Ernest Schapel, Deputy State Coroner, into the death of Eugeniusz Szczepaniak.

The said Court finds that Eugeniusz Szczepaniak aged 75 years, late of 127/106 Yorktown Parade, Maroubra, New South Wales died at the Lyell McEwin Health Service, Haydown Road, Elizabeth Vale, South Australia on the 19th day of April 2010 as a result of neck compression due to hanging. The said Court finds that the circumstances of his death were as follows:

1. Introduction, reason for Inquest and cause of death

- 1.1. Mr Szczepaniak was 75 years of age when he died at the Lyell McEwin Hospital (LMHS) on 19 April 2010. At the time of his death Mr Szczepaniak was detained pursuant to the Mental Health Act 1993 (MHA). At 1:30am on the day in question Mr Szczepaniak was found hanging in the bathroom of his private room within the psychogeriatric unit of the LMHS (Ward 1H). He was deceased. Mr Szczepaniak was hanging by the neck from the inside door handle of the bathroom door. The hanging was effected by way of a ligature that had been fashioned out of the cord of his pyjama pants. Mr Szczepaniak had last been seen alive by nursing staff at 12:30am during an hourly check of his room.
- 1.2. Due to Mr Szczepaniak's detention under the provisions of the MHA this was a death in custody that pursuant to the Coroners Act 2003 required a mandatory Inquest into its cause and circumstances.

- 1.3. A post-mortem examination of Mr Szczepaniak's remains was conducted by Dr Karen Heath who is a forensic pathologist at Forensic Science South Australia. In her post-mortem report¹ Dr Heath expresses the cause of death as neck compression due to hanging. The ligature that had been located around Mr Szczepaniak's neck at the scene of his death was examined by Dr Heath and it corresponded in size and pattern to a ligature mark around the deceased's neck. There were other anatomical features indicative of hanging. I find that the cause of Mr Szczepaniak's death was neck compression due to hanging.
- 1.4. Mr Szczepaniak was alone in his ensuite bathroom at the time of his death. There is no evidence of the involvement of any other person in Mr Szczepaniak's death. It is clear that Mr Szczepaniak was responsible for his own death. It is also clear that he intended to take his own life by way of hanging.

2. Issues at Inquest

- 2.1. At the Inquest the Court examined a number of issues including the following:
- Whether the level of scrutiny of Mr Szczepaniak, having regard to the risk of self-harm, was adequate;
 - The elimination of hanging points within patients' living environment and LMHS's Ward 1H;
 - Whether Mr Szczepaniak had been appropriately medicated;
 - Whether Mr Szczepaniak's death could have been prevented.

3. Background

- 3.1. Mr Szczepaniak was a 75 year old divorced man who normally resided alone in New South Wales. His son and daughter-in-law lived in Adelaide. Mr Szczepaniak had other close relatives in New South Wales. In 1987 Mr Szczepaniak was diagnosed with schizophrenia and was placed on a Disability Support Pension. Since Mr Szczepaniak's arrival from Poland he had irregular employment, said to be due to a limited ability to cope with stress and pressure as well as difficulty interacting with co-workers and management. At one stage he did sustain employment for a number of years; the employment in question having involved a measure of independence on

¹ Exhibit C2a

his part. In the 1990s there was a lengthy and stressful process that had involved Mr Szczepaniak attempting to secure the emigration to Australia of his son and his son's family. As I understood the evidence this application was rejected in the first instance but in the event was successful. As part of this episode Mr Szczepaniak had apparently threatened a Court with a bomb and this had resulted in a psychiatric admission for a fortnight. Mr Szczepaniak had a history of non compliance with treatment.

- 3.2. The only evidence of previous ideation of self-harm was contained in a report of the Transcultural Mental Health Centre in New South Wales dated 4 December 2003 in which it was said that Mr Szczepaniak had '*admitted to having had suicidal thoughts and one unsuccessful suicidal attempt*'. This document would make its way to the files of the facility in which Mr Szczepaniak was detained in South Australia prior to his death within that facility. There was no independent evidence of this suicidal ideation nor of any suicide attempt other than what Mr Szczepaniak himself had apparently told the authorities in New South Wales. In addition, there is no evidence as to when it had been that any such suicidal ideation or attempt was entertained.
- 3.3. More recently, however, Mr Szczepaniak had expressed persecutory delusions that included beliefs that the Secret Service were following him. He also expressed grandiose delusional ideas about his own inventive skills and capabilities. Various clinical assessments of Mr Szczepaniak detailed a longstanding, basically untreated psychotic illness consistent with chronic paranoid schizophrenia.
- 3.4. At Easter 2010 Mr Szczepaniak came to South Australia to visit his married son. Police apprehended him pursuant to Section 23 of the MHA after he allegedly assaulted his son's wife with a wrench in the belief that she was poisoning him and controlling his son and grandchildren. He had voiced homicidal ideation to the effect that he wanted to kill his daughter-in-law. His son evidently had to restrain Mr Szczepaniak who had suffered an injury as a result.
- 3.5. Mr Szczepaniak in the first instance was brought by police to the Modbury Hospital where he was initially admitted to a medical ward because of the injury sustained at the time of his alleged assault on his daughter-in-law, elevated blood pressure and atrial fibrillation. He improved medically and on further psychiatric assessment it was deemed appropriate for him to be transferred to the LMHS Ward 1H which is the

Older Persons Mental Health Services acute unit. He was at the Modbury Hospital from 2 April 2010 to 7 April 2010 and then at the LMHS from 7 April to 19 April 2010, the day of his death. The ward in which Mr Szczepaniak was accommodated was a closed ward, said to be a 'high dependency' unit.

- 3.6. The initial detention under the MHA, as distinct from his apprehension by police under that Act, occurred at the Modbury Hospital. The detention would be confirmed and extended under various provisions of the MHA and his transfer from one approved treatment centre, Modbury, to another, the LMHS, was also undertaken pursuant to the MHA. I do not need to recite the detail of the various detention orders made in respect of Mr Szczepaniak except to say that all orders were manifestly lawful and appropriate and that Mr Szczepaniak's state of detention at the time of his death was lawful and appropriate. Mr Szczepaniak lodged an appeal against his detention to the Guardianship Board that but for his death would have been heard on 23 April 2010. As a measure of the intractability of Mr Szczepaniak's psychosis, his lack of insight and therefore of the appropriateness of his detention, his sole ground of appeal was that his son's 'girlfriend' had tried to poison him. He also suggested that they were poisoning him in hospital.
- 3.7. The basis of Mr Szczepaniak's lawful detention was consistently documented as involving an assessment that Mr Szczepaniak was psychotic insofar as he harboured persecutory delusions and was a danger principally to others. However, there was little revealed in his presentation either at Modbury Hospital or LMHS to suggest that Mr Szczepaniak had harboured or expressed thoughts of self-harm that might have considered him to have been a suicide risk.

4. Discussion of the issues at Inquest

- 4.1. Dr Luiza Gheorghiu is the consultant psychiatrist who was principally involved in the management of Mr Szczepaniak at the LMHS. In her evidence she asserted that the monitoring for the closed unit in which Mr Szczepaniak was accommodated was similar to that of the open unit and involved hourly sightings of the patient. This frequency of monitoring could be upgraded according to a risk assessment made on a case by case basis. Throughout his admission Mr Szczepaniak remained in the closed High Dependency Unit. She emphasised that there was no evidence of suicidal ideation or intent to harm himself and that this had been established by direct inquiry.

She saw no other indication of suicidal ideation. There had not been a decline in Mr Szczepaniak's mood nor a decline in his neuro-vegetative function. Dr Gheorghiu told the Court that there was no further information gained from New South Wales regarding the assertions within the report that I have referred to, to the effect that Mr Szczepaniak had admitted to having had suicidal thoughts and having made one unsuccessful suicidal attempt. In any event there were no clinical signs observed by either herself or her intern as to suicidal ideation.

- 4.2. I record that although I accept the evidence that Mr Szczepaniak was examined for suicidal ideation, I was unimpressed by the fact that none of this was documented. Clinicians treating persons detained under the Mental Health Act should be conscious of the fact that their management of those persons will be the subject of close analysis if a person dies whilst so detained. There will come a time when a Court such as this, in the context of a mandatory Inquest into the circumstances of a death in custody, will be less willing to accept undocumented and otherwise unsupported assertions as to the extent and appropriateness of clinical examinations.
- 4.3. Dr Russell Draper is the clinical director of the Older Persons Mental Health Service, Central and Northern. In his oral evidence before the Court he explained the nature of the facility in which Mr Szczepaniak was housed. He referred to it as a 'quasi' high dependency unit. I reject the characterisation of 'quasi'. It was a high dependency unit. In describing the facility as something less than a high dependency unit, Dr Draper stated that protocols and regimes that might normally be applied to younger persons detained within a closed psychiatric unit might not necessarily apply to the elderly. He told me that although the unit was a closed unit, as of April 2010 it was not considered formally as a psychiatric intensive care unit so that the procedures that were applicable included one hourly sightings in respect of patients, which could be changed according to clinical and risk assessment. A number of written protocols were tendered in evidence through Dr Draper which all concerned nursing observation regimes within psychiatric facilities under the umbrella of the Central Northern Adelaide Health Service. He explained that in the light of the events surrounding Mr Szczepaniak's death all patients in the closed ward section of Ward 1H are now subjected to 15 minute observations, Category C. I do note that the protocol that was in operation at the time with which this Inquest is concerned, with

an effective date of July 2009², did suggest in terms that Category C observations of 15 minutes were to be assigned to all ‘consumers’ admitted or transferred to a designated acute secure unit, for example an Intensive Care or High Dependency Unit. This was a high dependency unit at that time and a strict analysis of the protocol should have dictated 15 minute observations even taking into account that it was a geriatric facility. In any event, according to Dr Draper, the response to this particular death within this facility is such that a patient in Mr Szczepaniak’s circumstances would now be observed every 15 minutes.

- 4.4. The circumstances of Mr Szczepaniak’s death were examined by an independent expert psychiatrist, Dr Craig W J Raeside. Dr Raeside provided a written report³. Dr Raeside is a specialist psychiatrist who practices as a consultant forensic psychiatrist in a private capacity. He was previously employed fulltime by the South Australian Mental Health Service based at James Nash House, the State psychiatric inpatient unit for prisoners. Dr Raeside notes in his report that Mr Szczepaniak continued to express homicidal ideas in the context of his paranoid delusional beliefs but also noted that there was no documentation about any suicidal ideation or marked depressed mood. In Dr Raeside’s opinion his presentation was consistent with his previous history of longstanding chronic paranoid schizophrenia. Dr Raeside noted that he received appropriate inpatient hospital care in the secure High Dependency Unit. He could find no evidence of any concerns in relation to his diagnosis or management. Specifically, Dr Raeside noted that Mr Szczepaniak did not indicate any intention to harm himself, either spontaneously or upon being directly questioned.
- 4.5. A significant event for Dr Raeside was Mr Szczepaniak being informed that his family no longer wanted any contact with him and that arrangements were being made for him to be transferred back to New South Wales notwithstanding. Despite that information, however, Mr Szczepaniak did not appear to have reacted adversely. The evidence suggested that throughout his admission at the LMHS Mr Szczepaniak appeared bright and reactive without features of depression, although at times irritability was noted.
- 4.6. Dr Raeside observed that on 18 April 2010 nursing entries indicated Mr Szczepaniak remained relatively settled and quiet. He did not interact with other patients but did

² Exhibit C37a

³ Exhibit C38

allow staff to take his blood pressure manually. He was noted to eat and drink well. There is no other description of any disturbance in his mental state at that time. Mr Szczepaniak was found at 1:30am hanging in his bathroom. He left no note or made any previous indication that he may have intended to take his life.

4.7. Dr Raeside regards Mr Szczepaniak as having been appropriately detained and placed in a secure ward at the LMHS. There was no indication that Mr Szczepaniak demonstrated, voiced or was expected to have been experiencing suicidal thoughts. There did not appear to be any strong suggestion that he was depressed in mood. When advised that he was being sent back to New South Wales, albeit that his family there did not wish to have any further contact with him, there was no indication made by Mr Szczepaniak that he wanted to stay in South Australia or made any threats to harm himself as a result.

4.8. Dr Raeside expresses the following general conclusion:

'In conclusion, from a psychiatric perspective it would appear that Mr Szczepaniak received appropriate treatment following his presentation to hospital. I do not think there is anything more that staff should have reasonably done that might have prevented Mr Szczepaniak's ultimate death, seemingly by suicide, although based on the history suicide would have been an unexpected outcome.'⁴

4.9. At the Inquest Dr Raeside gave oral evidence. In his oral evidence Dr Raeside was asked to comment about the absence of notations within Mr Szczepaniak's clinical record about the exploration of self-harm. As alluded to, the comprehensive notes made by clinicians do not expressly contain reference to the exploration of that issue with Mr Szczepaniak. Dr Raeside expressed the view that assessments of risk of self-harm should be the subject of note taking so that the clinical thought processes of those assessing a patient can be judged. I agree with this observation for the reasons stated earlier.

4.10. He also commented upon the regime of hourly observations that were part of Mr Szczepaniak's regime of scrutiny and suggested that one hourly observations were not inappropriate. He suggested that 15 minute observations are usually for people who are obviously quite distressed and needing to be seen almost constantly because of their fluctuation in presentation. This appears to accord with Dr Draper's assessment, but as seen a strict reading of the applicable protocol suggested otherwise.

⁴ Exhibit C38, page 9

Interestingly, Dr Raeside in his evidence stated that the community group that is at the highest risk and has the highest rate of suicide is the elderly, an observation that appears to be at tension with Dr Draper's views about the management of mental illness and suicide risk in the elderly within an acute psychiatric facility such as the one under discussion in this Inquest.

- 4.11. Dr Raeside was not in favour of the idea of CCTV monitoring within private rooms of a high dependency psychiatric facility, a measure advocated by investigating police. There are persuasive reasons as to why CCTV monitoring might be regarded as counter-productive therapeutically. I say no more on the subject.
- 4.12. Dr Raeside was in favour of prisoners being relieved of hanging implements such as pyjama cords that in this case were used by Mr Szczepaniak. This is a correct observation in my view. There appears to be no reason why patients should be allowed to possess such things regardless of risk. There are clearly other alternatives to garments that have potential ligatures.
- 4.13. There are two further matters that require discussion. Firstly, it is recorded in the clinical record that Mr Szczepaniak was administered an oral dose of risperidone at 9:00pm on 18 April 2010. He was found deceased at 1:30am the following morning. In addition, he had been administered with risperidone consta by way of IM injection on 14 April 2010. Risperidone is an antipsychotic that can be administered both orally and by way of injection. The injected medication is administered on a fortnightly or other basis. It is slow release and may remain in the muscle into which it is injected for some time before it is fully released into the bloodstream and takes therapeutic effect. The oral version is designed to enter the bloodstream more quickly and takes effect in an expedited way. Despite the administration that I have just described, risperidone was not found in the bloodstream of Mr Szczepaniak at post-mortem. However, it appears that the fact that it was not detected is not inconsistent with there having been a low therapeutic presence of the medication in his bloodstream. Although Mr Szczepaniak had a previous history of non-compliance with medication, there is no evidence that Mr Szczepaniak had been non-compliant at the time that these administrations of risperidone are documented to have occurred. The fact that the administration was documented on both occasions naturally suggests that there had been compliance. In any event the absence of evidence of medication in Mr Szczepaniak's post-mortem bloodstream does not preclude the medication

having been administered. The slow release injected version may not have entered the bloodstream at that point and there was the possibility that a low therapeutic concentration may not have been detected on sampling. In any event, there is no evidence that failure to administer the medication or consume the medication if administered would have altered the outcome in this particular case.

- 4.14. The other issue concerns the question of hanging points within singly occupied rooms in the High Dependency Unit in question. Dr Draper told me of certain modifications that have been made in respect of door handles in particular. I do note, however that a door handle would not constitute the only hanging point within an ensuite bathroom.

5. Conclusions

- 5.1. I make the following general findings.
- 5.2. I was satisfied that the level of scrutiny of Mr Szczepaniak having regard to the risk of self-harm was in accordance with the usual practice conducted within the facility in question. However, when examined against the then existing Mental Health Directorate procedure concerning nursing observation, it appears that 15 minute observations may have been more appropriate. However, I take into account the evidence of Dr Draper that such procedures might be modified in relation to a facility such as this which accommodates elderly patients. In any event there was no evidence that Mr Szczepaniak was at obvious risk of self-harm. The hourly sightings would therefore seem on balance to have been appropriate and in this regard I note that Dr Raeside comes to that conclusion.
- 5.3. There is documentation to support the conclusion that Mr Szczepaniak was appropriately medicated at the time of his death. I am unable to explain fully the absence of risperidone in Mr Szczepaniak's bloodstream. In any event, the matter is moot as there is no evidence that the presence or absence of risperidone affected the outcome.
- 5.4. Work has been undertaken to eliminate hanging points within the patients' living environments in Ward 1H. I add the rider that there appears to be other hanging points available such as rails in bathrooms.

5.5. I am not satisfied that Mr Szczepaniak's death could have been prevented having regard to the lack of perceived risk of self-harm and to his then regime of scrutiny. That said, 15 minute observations would have made it more difficult, but not impossible, for him to have carried out his intent.

6. Recommendations

6.1. I do not see the need to make any recommendations in this matter.

Key Words: Death in Custody; Suicide

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

Seal the 19th day of September, 2013.

Deputy State Coroner