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 3rd and 4th days of May 2016 and the 17th day of November 2016, by the Coroner's Court of the said State, constituted of Mark Frederick Johns, State Coroner, into the death of Ross Matthew Alcock.

The said Court finds that Ross Matthew Alcock aged 22 years, late of 44 Dalziel Street, Stratford, Queensland died at the Royal Adelaide Hospital, North Terrace, Adelaide, South Australia on the 23rd day of February 2014 as a result of aspiration pneumonia complicating resuscitation for cardiac arrest due to neck compression due to hanging. The said Court finds that the circumstances of his death were as follows:

1. Introduction, cause of death and reason for Inquest

1.1. Ross Matthew Alcock died on 23 February 2014. He was 22 years of age. At the time of his death he was an inpatient in Ward C3 of the Royal Adelaide Hospital. He was the subject of Level 1 inpatient treatment order which had been imposed on 19 February 2014 and was still in force at the time of his death. Mr Alcock had been found at 7:10pm on 22 February 2014 hanging from an electrical cord tied inside his wardrobe. Cardiopulmonary resuscitation was commenced as soon as he was found and he was transferred to the Intensive Care Unit but, as I have said, he died the following day.

1.2. An autopsy was carried out by Dr John Gilbert, a forensic pathologist at Forensic Science South Australia, who gave the cause of death as aspiration pneumonia resuscitation for cardiac arrest due to neck compression due to hanging[1], and I so find.

[1] Exhibit C2a

1.3. Because Mr Alcock was detained under the Mental Health Act 2009 at the time of his death, his was 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. Background

2.1. Mr Alcock usually lived in Cairns but was visiting Adelaide with his mother. Just over a year prior to his death he had contact with the Cairns' mental health services for chronic anxiety in the context of an acute psychotic episode due to heavy cannabis use. He was prescribed olanzapine but apparently only took the medication for some three days and then discontinued it. In the months leading up to his trip to Adelaide he had become very isolated and fixated with conspiracy theories.

2.2. On the day of his admission to the Royal Adelaide Hospital he had been on a bus trip in the Barossa Valley with his mother visiting wineries. His behaviour became increasingly irrational. He was saying to his mother that 'the Masons were trying to get him' or words to that effect. During the bus ride home he insisted on holding his mother's hand and at one stage while the bus was in motion he attempted to open the bus doors but was unable to do so. On completion of the journey he asked to go to hospital and this resulted in his attendance at the Royal Adelaide Hospital, his assessment in the Emergency Department and his admission and detention to Ward C3.

3. The circumstances of Mr Alcock's death

3.1. It goes without saying that it is, to say the least, unacceptable that Mr Alcock had the means and opportunity to take his own life while admitted as a detained inpatient in a tertiary hospital such as the Royal Adelaide Hospital on a ward dedicated to mental health patients.

3.2. This case examined the layout of Ward C3. There were a number of factors which contributed to Mr Alcock's death. Firstly, the room he was occupying was a shared room containing two beds. The beds were separated by a wardrobe that ran between the two beds such that when a staff member or anyone else attended at the door to the room, only one bed was clearly visible, while the other was mostly concealed behind the wardrobe dividing the room. The evidence was that only the foot of the second bed was visible from the doorway and for a staff member to have proper visibility of a person occupying the second bed it was necessary to walk fully into that part of the

room. Mr Alcock's bed was in that position and he was concealed within the wardrobe which also served as a ligature point for the electrical cord. That cord was present in his part of the room and available for him or anyone else to use as a ligature.

3.3. The senior staff of the Royal Adelaide Hospital were well aware of all of these deficiencies which are self-evident from what I have said above but, in summary, were as follows:

1) The division of the room using wardrobes thus creating blind spots;

2) The availability of a ligature point because of the wardrobe;

3) The availability of a loose electrical cord that could be used as a ligature.

These issues had all been noted and were the subject of comments in audits carried out within the hospital for safety purposes. Nevertheless, they were still present and available for use by Mr Alcock or anyone else at the time of his death. They were also clearly well-known to senior staff within the Royal Adelaide Hospital. Ultimately the responsibility for this state of affairs rests with the mental health system in this State. It is unfair to single out individual employees who must work within this mental health system. Ultimately it is the government of the State which must bear responsibility for the lamentable state of affairs described above which enabled Mr Alcock to take his own life.

4. The oral evidence

4.1. Mr D'Apice was a registered nurse with a mental health nursing qualification and he gave evidence. He nursed Mr Alcock during his admission to Ward C3. Mr D'Apice noted that Mr Alcock was grossly paranoid and was stating that the Freemasons were directing him to harm himself and his family. He also said that the Freemasons were in control of the world and commanding him to do these things[2]. Mr Alcock was the subject of half-hourly observations[3]. Mr D'Apice had a poor understanding of the system for checking patients. He acknowledged that it was his responsibility to check on Mr Alcock half hourly but that he did not conduct all of the necessary checks. He said that he was incorrectly under the assumption that all of the staff were responsible

[2] Transcript, page 14
[3] Transcript, page 14

for the round checks and did not appreciate that it was his individual responsibility[4]. He was unable to explain the reasons for his incorrect understanding[5].

4.2. On the evidence it is not possible to conclude that Mr Alcock's death was directly attributable to Mr D'Apice's incorrect understanding of his obligations to conduct the half-hourly observations. Half an hour is more than enough time in the layout of Ward C3 to do what Mr Alcock did with fatal consequences. However, it is a matter of considerable concern that a matter as important as half-hourly checks was not properly understood by the staff member primarily responsible for carrying them out. Furthermore, there was no explanation by any person in a position of responsibility for how such a state of affairs could have arisen, nor any assurance that it would never happen again.

4.3. I heard from Dr Jonathan Symon, consultant psychiatrist, who had some brief dealings with Mr Alcock during his admission. Dr Symon's evidence might best be regarded as in the nature of expert evidence in this case and it was helpful to gain an insight into Mr Alcock's psychiatric condition. Dr Symon said that he believed that the medical treatment Mr Alcock received within the ward was appropriate and he was properly assessed and diagnosed. Dr Symon noted that Mr Alcock was expressly asked if he felt suicidal, but he denied that that was so and this appeared to be quite convincing[6].

4.4. Dr Symon summarised the situation as follows. He said that Mr Alcock was a young man presenting with a psychotic illness which had apparently continued over a period of approximately 12 months. He said that the psychosis was well established by the time of his admission and that inpatient treatment was certainly appropriate for him. Dr Symon said that on the information available he would not have been concerned about Mr Alcock's safety in the ward environment[7]. It was Dr Symon's opinion that on Mr Alcock's presentation, half-hourly observations were appropriate given that Mr Alcock was apparently accepting of being at the hospital, there were no signs of agitation and he seemed to be fairly settled[8].

[4] Transcript, page 18
[5] Transcript, pages 37-38
[6] Transcript, page 60
[7] Transcript, page 61
[8] Transcript, pages 66-67

4.5. Dr Symon agreed with the proposition that the layout of the rooms meant that staff ought to fully enter the room in order to view the second bed and that merely viewing the feet of the patient on the second bed without seeing more was insufficient[9].

5. Conclusion

5.1. In my opinion Mr Alcock's death could have been prevented if he had not had such ready access to a ligature in the form of the electrical cord and a ligature point in the form of the wardrobe. Dr Symon thought that half-hourly observations were sufficient because of the need not to be too intrusive bearing in mind that Mr Alcock was accepting of being in the ward and I accept Dr Symon's opinion on that question. There is a balance to be drawn between benignly observing a patient in a manner that is not too intrusive, and ensuring their safety. However, on a ward with the physical disadvantages and shortcomings of Ward C3, it is very difficult to see how that balance can easily be drawn.

5.2. I have nothing further to add.

Key Words: Death in Custody; Psychiatric/Mental Illness; Suicide Risk

In witness whereof the said Coroner has hereunto set and subscribed his hand and Seal the 17th day of November, 2016.

State Coroner

[9] Transcript, pages 76-77