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 28th, 29th, 30th and 31st days of July 2015, the 3rd day of August 2015, the 14th and 15th days of September 2015 and the 19th day of May 2016, by the Coroner's Court of the said State, constituted of Mark Frederick Johns, State Coroner, into the deaths of Robert Campbell and Jeremy Todd Williams.*

*The said Court finds that Robert Campbell aged 53 years, late of 7 Eddington Street, Parafield Gardens, South Australia died at Parafield Gardens, South Australia on the 14th day of March 2012 as a result of neck compression due to hanging.*

*The said Court finds that Jeremy Todd Williams aged 24 years, late of 196 Newton Boulevard, Munno Para, South Australia died at Munno Para, South Australia on the 26th day of August 2012 as a result of hanging.*

*The said Court finds that the circumstances of their deaths were as follows:*

## 1. Introduction and cause of death

1.1. Robert Cambpbell died on 14 March 2012. He was 53 years old at the time. An autopsy was carried out by Dr Gilbert of Forensic Science South Australia and in his written report[1] Dr Gilbert gave the cause of death as neck compression due to hanging, and I so find.

1.2. Jeremy Todd Williams died on 26 August 2012. He was 24 years old at the time. An autopsy was conducted by Professor Byard of Forensic Science South Australia who, in his written report[2] gave the cause of death as hanging, and I so find.

[1] Exhibit C2a
[2] Exhibit C13a

1.3. The deaths of Mr Campbell and Mr Williams were some 5 months apart. The Inquests into their deaths were conducted together because prior to their deaths each of them had been detained by police pursuant to section 57 of the Mental Health Act 2009 and transported to the Lyell McEwin Hospital after hours for medical treatment. Neither Mr Campbell nor Mr Williams was detained for treatment pursuant to the Mental Health Act 2009 at the Lyell McEwin Hospital. Both remained voluntarily overnight, but then left the next morning. Neither Mr Campbell nor Mr Williams was assessed by a psychiatric medical officer while at the Lyell McEwin Hospital. They were assessed by Emergency Department medical practitioners without particular psychiatric training, and also by mental health nurses. Mr Campbell's detention and attendance at the Lyell McEwin Hospital occurred on 12 March 2012, that is two days before his death. Mr Williams was taken to the Lyell McEwin Hospital by police at around midnight on 11 August 2012, which was some 15 days prior to his death.

## 2. Mr Campbell's attendance at the Lyell McEwin Hospital

2.1. Mr Campbell had a history of depression and self-harm and had been on medication for depression. In 2006 he had taken an overdose of Nurofen resulting in an admission to the Lyell McEwin Hospital where he was detained for a short period. In February 2011 Mr Campbell had been admitted to the Intensive Care Unit of the Lyell McEwin Hospital where he remained for a number of days following an overdose of citalopram resulting in seizures.

2.2. Mrs Campbell, the wife of Mr Campbell, gave evidence about the events leading up to 12 March 2012. She arrived home at approximately 3pm that day and said that Mr Campbell was very angry about the fact that the police had seized his car a few days before and about the fact that Mrs Campbell had been away overnight staying at her son's house. She noticed that wine glasses and bottles had been smashed. After she got home his anger intensified and he went out into the backyard, picked up a tin of paint thinner and poured it all over himself. He then grabbed some LPG bottles and put them around himself and he produced some live ammunition and a cigarette lighter and threatened to end his life. Some family friends came to assist, one of whom, Mr Drury, gave evidence. He said that he removed the flammable items around Mr Campbell and was aware that the police, fire service and ambulance service had been called. Police arrived shortly after 5pm and Mr Drury informed them that Mr Campbell was not likely to welcome their attendance given his anger

about the seizure of his motor vehicle. Mr Drury agreed to act as a go between, between Mr Campbell and the police until Mr Campbell agreed that the police could approach him. Senior Constable Roberts gave evidence that he approached Mr Campbell and started a conversation with him in an effort to resolve the stand-off. He smelt a strong smell of paint thinner fumes and was aware that Mr Campbell was clutching a lighter. He was able to remove the lighter from Mr Campbell and, with the assistance of other police, Mr Campbell was carried away. He was detained under section 57 of the Mental Health Act 2009 by the police and conveyed by ambulance to the Lyell McEwin Hospital.

2.3. Mr Campbell arrived at the Lyell McEwin Hospital Emergency Department at 1844 hours[3].

2.4. After his arrival at the Emergency Department Mr Campbell was examined by Dr Eng Lee Ooi who was working in the Lyell McEwin Hospital Emergency Department as a locum resident medical officer on that evening. This was only the second time he had been working in the Emergency Department there. He had only obtained his MBBS in 2008 and was clearly an inexperienced doctor at that time. He said that it was his understanding of his role that he was to assess all patients medically and that as regards any 'mental health issues' those 'will be referred onto the mental health team for further assessment'[4]. Dr Ooi had not worked previously as a resident medical officer in any other Emergency Department and his only previous experience in an Emergency Department was in his capacity as an intern in 2009. He said that at that time he had had minimal exposure to patients with suspected psychiatric conditions[5]. He recalled that Mr Campbell had been brought in by police pursuant to section 57 of the Mental Health Act 2009[6]. Dr Ooi said that this was the first time he had ever dealt with a patient who had been brought in by police pursuant to section 57 of that Act[7]. Dr Ooi completed a document entitled 'initial mental health assessment clinical record'[8] in which he recorded that Mr Campbell was having a rough time in his relationship with his wife and was very upset about the events involving the police seizing his motor car. He said that he had not done anything wrong and claimed to have been punched by the police officer on the day. He said that his car had been

[3] Ambulance Report contained within Exhibit C27
[4] Transcript, page 203
[5] Transcript, page 205
[6] Transcript, page 205
[7] Transcript, page 209
[8] Exhibit C27, page 28

confiscated and impounded and he claimed that he had been cooperative and was upset that he had been victimised. He was also upset that he would not be able to do anything about the matter until the following Tuesday. In relation to the events of that afternoon he said that he had poured flammable liquid around him and that he had threatened to kill himself by lighting the liquid, but he did not proceed.

2.5. Dr Ooi noted that Mr Campbell had a flat affect and had feelings of hopelessness. He had no perceptual disturbances, but had poor insight and Dr Ooi did not feel that rapport had been established with him. He expressed the working diagnosis as a situational crisis with suicide planned but not attempted on a background of depression and that he would remain as a voluntary patient for help and needed to be medically cleared. He assigned him a risk level of ¾ and under the heading 'Mental Health Act status', circled the word voluntary. Dr Ooi noted that Mr Campbell had a lacerated middle finger which required treatment and that he would be referred to the mental health team for input. He wrote 'not detainable as he is willing to stay' and signed the form.

2.6. Dr Ooi was asked about a police department form contained on the Lyell McEwin Hospital notes[9]. The form is entitled 'mental health assistance form' and is a form known as a PD145. Dr Ooi said that this was the first time he had seen such a form and so far as his responsibilities in relation to the form were concerned, he said that his understanding was that the form acted as an acknowledgement that 'we have accepted a patient and assessed the patient'[10]. Under the part of the form entitled 'outcome acknowledgement (authorised health professional or medical practitioner to complete)' Dr Ooi recorded that Mr Campbell was examined at 2015 hours on 12 March 2012. He circled the words 'not detained' and under 'assessment decision details' wrote 'situational crisis/background depression → planned suicide but did not proceed'. He signed this and then wrote under comments 'referred to LMHS mental health team'[11].

2.7. In summary, Dr Ooi concluded that Mr Campbell would not be detained. His decision was based on his reasoning that Mr Campbell was willing to stay at the hospital voluntarily for help and assessment and his understanding was that he had to

[9] Exhibit C27, page 20
[10] Transcript, page 209
[11] Exhibit C27

'use the least restrictive manner to keep them stable' and for that reason Mr Campbell was not detainable[12].

2.8. Dr Ooi reached that conclusion despite his knowledge of the circumstances leading to Mr Campbell's presentation, his assessment of Mr Campbell's risk level at 3/4, the fact that Mr Campbell was dishevelled, flat, expressed hopelessness, had poor insight and rapport had not been established. However, it was Dr Ooi's expectation on referring Mr Campbell to the mental health team in these circumstances that he would be appropriately assessed by that team. It was his expectation that they would do a 'very comprehensive assessment of a patient's mental health state'[13].

2.9. In the result, Mr Campbell did not undergo a full assessment by the mental health team. Ms Turner gave evidence at the Inquest. She is the clinical practice consultant for the mental health team in the Emergency Department at the Lyell McEwin Hospital. She gave evidence at the Inquest and conceded that Mr Campbell should have received a full mental health assessment and that he ought not to have been allowed to leave the hospital without that full assessment and that, if necessary, he should have been forcibly required to stay using powers under the Mental Health Act 2009[14].

2.10. The mental health nurse on duty overnight was Ms Buckton. Ms Buckton in her statement said that she did not recall the shift in question or Mr Campbell and she could not explain why he was not assessed by her overnight. She surmised that it was a busy shift and also suggested that she may not have assessed Mr Campbell during her shift because he might have been asleep overnight. However, the primary nurse woke Mr Campbell on six occasions during the night for medical observations[15] so it is difficult to see why Ms Buckton would have been reluctant to wake him for that purpose. In any event, no satisfactory explanation was provided as to why the opportunity was not taken during Ms Buckton's shift to conduct a full examination. The next mental health nurse on duty commenced the following morning and that nurse was Ms Bourne. She did have some contact with Mr Campbell and her note in his hospital records[16] records the time of her contact with him at 8am. Her evidence was that she thought she would have seen him as soon as she had finished handover at

[12] Transcript, page 216
[13] Transcript, page 238
[14] Transcript, page 189
[15] Exhibit C27, page 18
[16] Exhibit C27

7:15am[17], but the observation chart records that at 7:30am he was on his bed, lying on his left side and at 7:50am he was given breakfast and was requesting to go home.

2.11. There is a notation that the mental health nurse was aware of this fact. I agree with Ms De Palma's submission that this is consistent with the time of contact between Ms Bourne and Mr Campbell being 8am as recorded in the notes.

2.12. From Exhibit C32d it is clear that Mr Campbell left the Emergency Department to go home at 8:16am. It follows therefore that Ms Bourne's contact with Mr Campbell lasted for no more than 16 minutes.

2.13. In her evidence Ms Bourne said that when she spoke with Mr Campbell he was very focussed on what had happened regarding SAPOL impounding his car. He was demonstrating lots of anger about that and was expressing a desire to go and make a formal complaint to see his MP and to seek redress form SAPOL. She asked him about the events that brought him in the previous night but he was dismissive of those and denied any sort of suicidal thoughts[18]. She said that she spoke with him for maybe 20 minutes[19], but as I have said she could not have seen him for more than 16 minutes.

2.14. Ms Bourne said that she decided that Mr Campbell's presentation was more about anger management and that he did not need to be detained[20].

2.15. Ms Bourne was asked how she justified not giving Mr Campbell the mental health assessment that was supposed to happen according to the hospital's policies and protocols. She said she wanted to give him one, but that he did not want to stay for one and that he presented as someone she did not think could be forced to stay[21]. When she was pressed she did not say that he had specifically refused a request for her to conduct a mental health assessment[22].

2.16. It is a matter of concern that Ms Bourne reached this conclusion despite the information that was known to her about Mr Campbell's presentation. He had made it clear to her that he planned to go to the police that day and this was only likely to

[17] Transcript, page 261
[18] Transcript, page 251
[19] Transcript, page 252
[20] Transcript, page 256
[21] Transcript, page 272
[22] Transcript, page 272

exacerbate his anger given that his dispute with the police was the source of that anger. Furthermore, Ms Bourne had been unable to make contact with Mr Campbell's wife and no-one else at the hospital had managed to do so. It was therefore not possible to obtain her perspective. In essence, nothing had changed since the night before[23].

2.17. Mrs Campbell gave evidence that Mr Campbell arrived home by taxi from the hospital at approximately 8:15am on 13 March 2012. He continued to be angry that day because he had been told by the police that he would have to pay $800 to get his car returned. The next morning she left the house just before 9am and when she returned that afternoon at 3:45pm she found Mr Campbell hanging from the pergola outside the house.

## 3. Mr Williams' attendance at the Lyell McEwin Hospital

3.1. Mr Williams' partner of 8 years was Ms Bolwell and she gave evidence. She said that in the weeks leading up to his death they had separated but were on good terms and were trying to work things out. During their separation there had been some arguments and one such argument occurred on 10 August 2012. At about 7:30pm that evening Mr Williams sent a text message to her indicating that he was going to end his life. On receiving that message Ms Bolwell went to his home and found him on the bathroom floor sobbing. He had cuts on his arms and a knife was sitting on the bloodstained bathroom mat. She helped him into the shower and washed the blood off him and brought him back to her home.

3.2. After approximately two hours he became aggressive and started yelling. He went to the kitchen and grabbed a knife and returned to the bathroom. He eventually came out and said that he was a failure because he could not even kill himself and he tried to pass the knife to Ms Bolwell, asking that she stab him because he could not do it. He then left the house saying that he was going to kill himself. She could not go after him because of commitments with children and called the police. Patrol officers Shepherd and Bergen were tasked to deal with this matter. They located Mr Williams walking by the road just before 11:45pm. They noticed that he had superficial cuts on his wrists and arms. He told them that he had recently broken up with his partner, was working long hours and was suffering distress and depression. They detained

[23] Transcript, pages 274-275

him pursuant to section 57 of the Mental Health Act 2009 and transported him to the Lyell McEwin Hospital. He arrived with them at the hospital shortly after midnight and was assessed by the triage nurse at 12:12am on 11 August 2012. Mr Williams was seen and assessed by a mental health nurse, Ms Zeman, in the Lyell McEwin Hospital Emergency Department. He was also assessed by Dr Rawat who did not have a psychiatric background and cleared him medically only.

3.3. Ms Zeman's notes indicate that she commenced her interaction with Mr Williams at 12:45am and spent 120 minutes in making her assessment. The assessment is thorough and carefully recorded and appears in Mr Williams' hospital notes[24]. Ms Zeman accurately summarised the events that had brought Mr Williams to hospital and recorded also that his mood had been low for two months in the context of a breakdown in his relationship with his partner of 8 years. It also recorded that he was working long hours in his occupation as a truck driver and was exhausted. She recorded that he had been thinking about suicide for two weeks and that he had cut himself with a knife that night. He described symptoms of depression, low mood, feelings of guilt, hopelessness, initial insomnia, low energy and motivation and constant feelings of exhaustion. Ms Zeman noted that his appetite was difficult to assess because he was on the drug Duromine for weight loss. This is significant as will be seen shortly. He said he had trouble concentrating. Under current medications she recorded that he is on 30mg of Duromine and vitamin supplements. Under mental state examination she recorded that he was a tall man with normal weight and a beard, dressed casually. He made good eye contact and was crying at times during the interview. He was cooperative and compliant. He had a slowed rate and flow, soft tone and a monotonous delivery. He was very flat and teary, had obsessional thought patterns going 'round in circles' and was dissecting everything he did. She noted that rapport was established and that he had insight in that he knew that he was depressed. She assessed him as a medium risk of suicide or self-harm. She summarised his risks as follows, that he was exhibiting symptoms of depression, had thoughts of suicide with a plan to cut his wrists, was under a lot of stress, was exhausted, had social phobia and withdrawal/isolation, had limited supports and an ex-partner who was supportive but with increasing arguments, he acknowledged his children as a protective factor and wanted to go to work in the morning as he thought he would lose his job or would upset his boss if he did not attend.

[24] Exhibit C28, page 15

3.4. Under her plan Ms Zeman wrote that he currently did not appear to be detainable, but needed active follow-up treatment for his depression and support during his ongoing crisis. He said that he would see his general practitioner today rather than go to work and she would flag him to Northern Assessment & Crisis Intervention Service (ACIS) and request that they establish phone contact with him.

3.5. Ms Zeman faxed her assessment to Mr Williams' general practitioner that morning at 5am[25].

3.6. It is a matter of some concern that Ms Zeman herself signed and completed the police department PD145 form despite the fact that she was neither a medical practitioner nor an authorised health professional as required by the form. Ms Zeman was neither of those things and she should not have signed the form.

3.7. Secondly, there was an issue as to whether it was Ms Zeman who endorsed the original form 'not detained'. The copy retained on the hospital notes[26] is signed by Ms Zeman, but neither option 'detained/not detained' has been crossed out or circled. However, the original of the form was returned by Ms Zeman to Constable Shepherd in accordance with the protocols that exist between the public health system and the police department. Exhibit C36d is the original mental health assistance form held by SAPOL. It is identical to the copy contained on the hospital notes in that it bears the endorsements made and signed by Ms Zeman, but it is different in that the word 'detained' has been crossed out. Thus there is a crucial difference between the form as returned to Constable Shepherd and retained on SAPOL's records and the form as copied and filed on the Lyell McEwin Hospital notes. Constable Shepherd was adamant in his evidence that he would not have left the hospital without the form being correctly endorsed[27]. I accept Constable Shepherd's evidence and find that it was in fact Ms Zeman who endorsed the form 'not detained'.

3.8. After Mr Williams was seen by Ms Zeman he was also examined by Dr Rawat who was a resident medical officer at the Lyell McEwin Hospital that night working in the Emergency Department. He had obtained his degree in 2006 and worked as a resident medical officer in the Lyell McEwin and Modbury Hospitals between 2009 and 2013. He was a reasonably junior doctor when Mr Williams presented that night. He was

[25] His general practitioner was Dr Garg whose evidence I will come to shortly
[26] Exhibit C28, page 9
[27] Transcript, pages 330-331

asked the purpose of his role in relation to Mr Williams. He said that as a resident medical officer it was his task to 'medically clear a patient and then do assessment, mental health assessment, and refer the patient for further help'[28]. He said that the patient could not be allowed to leave the Emergency Department until they had been 'medically cleared'[29]. Dr Rawat said that when he saw Mr Williams he was very calm, relaxed and cooperative. Dr Rawat established that Mr Williams was prepared to remain on a voluntary basis at the hospital for further help and assessment. As a result Dr Rawat concluded that Mr Williams did not need to be detained. Furthermore, Dr Rawat discussed the matter with Ms Zeman. It is a matter of some concern that Dr Rawat did not carry out the task required by the initial mental health assessment clinical record that he completed[30] in that he did not make any assessment as to Mr Williams' risk level.

3.9. Dr Rawat did in fact note that Mr Williams was on the appetite suppressant Duromine for weight loss. He also did not appreciate the significance of this drug in the context of Mr Williams' presentation.

3.10. In any event, as I have said, Mr Williams was referred by Ms Zeman to see his general practitioner, Dr Garg, that day and, furthermore, Ms Zeman made a referral to Northern ACIS requesting that they contact him that day. Mr Williams was allowed to leave the hospital at 4:18am on 11 August 2012. Although he was seen by the mental health nurse, Ms Zeman, he was not seen by any doctor with psychiatric training.

3.11. <u>Mr Williams' contact with Northern ACIS</u>

Mr Davies is a registered psychiatric nurse and general nurse who was in 2012 working with the Northern ACIS team. He gave evidence that he contacted Mr Williams by telephone on 11 August 2012 to arrange a face to face meeting with him the following day, namely 12 August 2012. In fact, Mr Davies did visit Mr Williams and see him face to face at his home at approximately 2:30pm on Sunday 12 August 2012. In the meantime, Mr Williams had attended upon his general practitioner, Dr Garg, at 1pm that day. I will deal with Dr Garg's evidence later. Mr Davies made a record of this contact in the ACIS computerised notes (CBIS), a copy of which appears in Exhibit C28. After taking a history Mr Davies

[28] Transcript, page 347
[29] Transcript, page 347
[30] Exhibit C28, page 10-13

recorded that at the time of the assessment Mr Williams described features consistent with dysthymic illness. He had a depressed mood for most of the day for at least two years, insomnia, low energy, feelings of hopelessness and periods of poor concentration with possible over eating in the past. He noted that Mr Williams was on Duromine and his weight was now under control. He noted that Mr Williams had a fear of social situations including shopping centres, for fear that people were judging him. Mr Williams recognised that his fear was excessive or unreasonable and wanted to address it. The best treatment options in Mr Davies' view were to link Mr Williams to a psychologist for cognitive behavioural therapy and possible graded exposure therapy. He noted that Mr Williams was only available on alternative Saturdays and on Sundays, but that there were some psychologists that were available over weekends. He noted that Relationships Australia was an option but was not sure if they worked outside business hours. He noted they may offer evening courses which would be of benefit. He noted that Mr Williams had informed him that his general practitioner was going to do a mental health care plan. He noted that Mr Williams denied ongoing thoughts to harm himself and was aware of the negative consequences of self-harm in his relationship with his partner.

3.12. The evidence in this case, particularly that of Professor Goldney, which I will come to later in this finding, demonstrates that Mr Davies' diagnosis of dysthymic illness was wrong. The evidence also shows that it was part of Mr Davies' duties with Northern ACIS to perform a provisional diagnosis and he did so using DSM IV.

3.13. Mr Davies' wrong diagnosis and his communication of it to Mr Williams had a particular significance. Ms Bolwell, Mr Williams' partner, gave evidence that straight after Mr Williams' appointment with Mr Davies on 12 August 2012 he told her that Mr Davies had told him that he did not have depression and that Mr Davies could not help him. Ms Bolwell said that Mr Williams' demeanour when he related that information to her was that he was 'defeated'. She said that he no longer thought that he would be able to get any help. She said that this was in significant contrast to his demeanour when he had returned from hospital the previous morning when, it will be recalled, he had been told by Ms Zeman that he did have depression[31].

3.14. It is likely that the misdiagnosis by Mr Davies had a significant consequence. As a result of that assessment Mr Williams believed he did not have depression and it was

[31] Transcript, page 287

for this reason that he did not attend an appointment he had with Dr Garg for Tuesday afternoon, 14 August 2012. It is my conclusion that he cancelled that appointment because he did not believe that he would be put on antidepressants for treatment of his depression.

3.15. I also note that Mr Davies did not appreciate the significance of Mr Williams being on Duromine which would have affected not only the diagnosis, but also the care plan.

3.16. The misdiagnosis and the failure to recognise the significance of Duromine stem from the lack of Mr Davies' psychiatric training. I agree with counsel assisting's submission that he was not qualified to undertake the job that was expected of him by Northern ACIS and that that is not his fault, but rather the fault of the system within which he operates.

3.17. To complete the narrative relating to Northern ACIS it is necessary to record that that organisation conducted a review of Mr Davies' interaction with Mr Williams the day following that interaction, namely 13 August 2012. That review process was undertaken in a committee setting overseen by consultant psychiatrist, Dr Toh. Mr Davies was not an attendee at the review because he was not working that day. Dr Toh gave evidence at the Inquest. He did not have a specific recollection, but he agreed that it was likely that the assessment by Mr Davies would have been read out to him and that he would not have read the assessment from the Lyell McEwin Hospital Emergency Department. Dr Toh acknowledged that the way in which Northern ACIS were practising at that time was less than ideal[32]. Dr Toh conceded[33] that he should have given consideration to whether Mr Williams should be put on antidepressants and that he should have considered the medication Mr Williams was on, namely Duromine[34]. Dr Toh conceded that there was no evidence that the issue of Duromine was explored at all[35]. Dr Toh said that had he been aware of the Duromine there could have been a change in the recommendations[36]. Dr Toh gave evidence about changes that have been made to the review process since Mr Williams' case was reviewed and those changes are reassuring. There is no doubt that the review process has improved.

[32] Transcript, page 481
[33] Transcript, page 491
[34] Transcript, page 526
[35] Transcript, page 527
[36] Transcript, page 527

3.18. Following that review Mr Williams' case was referred back to Mr Davies by the computerised scheduling program operated by Northern ACIS at the time. It is now known that for some reason that has not been explained in the evidence, Mr Williams' case was mistakenly referred to a Dr Davis on 15 August 2012. That referral did not occur until 3:29pm on that day and it is therefore indisputable that Mr Williams' matter would in fact have been in Mr Davies diary when he arrived at midday on 15 August 2012 having been away for the previous two days. It is apparent that Mr Davies did nothing about the matter on that day, notwithstanding the fact that the review by Dr Toh had occurred two days previously and that Mr Davies knew that Mr Williams was going to see his general practitioner for a mental health care plan. Thereafter, Mr Williams' case was not scheduled back to Mr Davies until the evening of 26 August 2012 and by that time Mr Williams had died. Thereafter Mr Davies kept rolling the task over until 4 September 2012 which was some three weeks after the review.

3.19. It should also be added that Mr Davies recorded the name of Mr Williams' general practitioner incorrectly, writing it down as Dr Gillis rather than Dr Garg. Therefore the details of his assessment of Mr Williams would not have been transmitted to Dr Garg.

3.20. It is significant that the mistake in the scheduling of Mr Williams' case to the wrong person was not discovered as a result of any failsafe system process, but rather as a matter of luck by an ACIS mental health nurse, Susan Mullins. She was not someone in any position of management authority and the fact is that she took it upon herself to randomly check the scheduler because she was aware that there were times when scheduling errors occurred. Thus, it was only a matter of chance that the scheduling error was ever detected at all. This reflects extremely poorly on Northern ACIS, although taken in the context of the overall failure to properly diagnose Mr Williams' illness and to recognise the significance of the medications he was on, it is not surprising that the organisation would have poor administrative practices as well.

3.21. <u>Mr Williams' interactions with Dr Garg and Northern ACIS</u>

Mr Williams' general practice was the University Health Practice at North Haven. He had seen different general practitioners there over time, including Dr Rajnish Garg.

3.22. In her evidence Mr Williams' partner, Ms Bolwell, told the Court that when she spoke to Mr Williams in the early morning of 11 August 2012 after he had returned from the hospital, he told her that the hospital staff had told him that he needed to go on an antidepressant medication and that his notes would be forwarded through to Dr Garg and that Dr Garg would prescribe him an antidepressant medication and monitor him thereafter[37]. Mr Williams made an appointment with Dr Garg the following day, Sunday 12 August 2012. In the meantime he had been contacted by Mr Davies from Northern ACIS who had arranged to see him on the Sunday afternoon. Mr Williams saw Dr Garg before seeing Mr Davies on the Sunday afternoon. His consultation with Dr Garg was at approximately 1:30pm and lasted for 23 minutes[38]. It will be remembered that Dr Garg had been faxed the notes taken by Ms Zeman at the Lyell McEwin Hospital. When he saw Mr Williams, Dr Garg took a detailed history and although the consultation that Mr Williams had booked was a standard consultation, Dr Garg took longer than the time normally allotted for such a consultation. Dr Garg asked Mr Williams to re-attend the clinic to see him the following Tuesday for a long consultation with the aim of preparing a mental health care plan. The object of that plan was to set in motion the process for Mr Williams to be referred to the University Health in-house psychologist for a program of treatment. Dr Garg also understood that Northern ACIS had arranged for someone to see Mr Williams on the Sunday afternoon and it was Dr Garg's assumption that this would be a psychiatrist[39]. An appointment was made for Mr Williams to re-attend on Tuesday 14 August 2012 at 7pm. After seeing Dr Garg on that day it was Mr Williams' understanding that Dr Garg did not wish to prescribe any medication that day. He understood the plan was that he would re-attend on the Tuesday evening and Dr Garg would prepare a mental health plan and may prescribe antidepressant medication[40]. The text messages between Mr Williams and Ms Bolwell set out in Exhibit C19g are informative in relation to this visit to Dr Garg. They show Ms Bolwell enquiring of Mr Williams at 1:52pm on the Sunday, shortly after Mr Williams' visit with Dr Garg, about how the consultation had gone. Mr Williams informed her that he had a chat with Dr Garg for

[37] Transcript, page 302
[38] Exhibit C28b
[39] Transcript, pages 405-406
[40] Exhibit C19g, photographs 31-35 and Transcript, pages 299-303

a while and was going back on Tuesday to let him know about the ACIS visit that afternoon. He then said:

> 'And he'll put me on a mental health plan then, they have a syc (sic) at Uni health I can see up to an hour 10 times a year or something ' [41]

He also said that Dr Garg was not putting him on any medication just yet. Ms Bolwell responded that that was 'bad' because her understanding was that Dr Garg was meant to prescribe such medication. No doubt this is a reference to what Mr Williams told Ms Bolwell that had been told to him by Ms Zeman at the Lyell McEwin Hospital. In any event Mr Williams responded to Ms Bolwell that Dr Garg wanted to see how Mr Williams goes with talking to people now that 'I've opened up about it'. He also said that the ACIS person he was to see today would pass on more information to Dr Garg to enable Dr Garg to make a decision. In response to Ms Bolwell's concerns that Dr Garg had not prescribed antidepressants at the consultation, Mr Williams made the following response:

> 'It's more that he doesn't want to see me for the first time and give me some pills then that's it. He wants to see me more frequently, and Tuesday I've got a double appointment so he can write up a mental Health plan so he might give me something then.' [42]

That text message from Mr Williams is very revealing and although Dr Garg could not himself recall the precise content of the conversation he had had with Mr Williams, he said that was consistent with what his normal practice would have been. In other words, he would attempt to establish a rapport with the patient and to demonstrate that he was concerned about the patient, interested in the patient and then to proceed with the prescription of an antidepressant medication, rather than simply prescribe it and send the patient away.

3.23. After seeing Dr Garg, Mr Williams was visited by Mr Davies from Northern ACIS and I have previously recounted what occurred on that occasion. Mr Davies did not send any account of his assessment of Mr Williams to Dr Garg[43].

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[41] Exhibit C19g, photograph 31
[42] Exhibit C19g, photograph 34
[43] Transcript, page 442

3.24. It will be recalled that Ms Bolwell said that following Mr Williams' assessment by Mr Davies, Mr Williams came to her house to tell her how things went. It is worth repeating her account:

> 'He came over and was standing in my kitchen and literally threw his hands up in the air and said he can't get help, they said he doesn't (sic) have depression, he can't get help, and he - he just looked defeated. His whole body stance, persona, was just defeated, like he'd given up.' [44]

She contrasted this reaction to the way Mr Williams had been when he had come back from hospital when, to use her words, he had 'the spark back in his step'[45].

3.25. Mr Williams subsequently cancelled his appointment with Dr Garg for the Tuesday evening by a telephone call he made at 5:11pm that afternoon[46]. I find that he cancelled that Tuesday evening appointment with Dr Garg because he believed he would not be prescribed antidepressant medication and he did not believe that anything could be done for him following the interaction he had with Mr Davies[47]. Ms Bolwell gave evidence that she was not aware that he intended to cancel the Tuesday evening appointment[48].

3.26. So far as Dr Garg's contact with Mr Williams is concerned it lasted a total of 23 minutes, at least so far as Mr Williams' mental health was concerned. The mistake that Dr Garg made was that he failed to tell Mr Williams at the Sunday afternoon consultation to cease taking the appetite suppressant medication, Duromine. The medication Duromine is contraindicated for persons with an agitated state or history of psychiatric illness, including depression[49]. Dr Garg was unaware of these contraindications[50]. Dr Garg acknowledged in his evidence that given Mr Williams' presentation at the consult on 12 August 2012 he ought to have recommended that Mr Williams stop taking the Duromine[51].

3.27. I accept that Dr Garg was not the only health professional who dealt with Mr Williams and was aware that Mr Williams was taking Duromine. Dr Rawat had that information available to him when he examined Mr Williams. Ms Zeman was

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[44] Transcript, page 287
[45] Transcript, page 287
[46] Exhibit C35b
[47] Transcript, page 288
[48] Transcript, page 311
[49] Exhibit C39a, Tab E, Exhibit C50f
[50] Transcript, page 394
[51] Exhibit C39a

aware of it also, as was Mr Davies. It would appear that the information did not find its way to Dr Toh at the review on Monday 13 August 2012. Dr Toh said that had he been aware of the fact that Mr Williams was taking Duromine things may have taken a different course, including the possibility of a psychiatric assessment of Mr Williams[52].

3.28. Given the relatively brief window of opportunity that Dr Garg had to assist Mr Williams in this case I do not regard this mistake on his part to be particularly significant in the context of the case as a whole.

## 4. The evidence of Professor Goldney

4.1. Professor Goldney prepared an expert report in this matter on behalf of the Court[53] and gave oral evidence. He expressed concerns about the way in which the services in the Emergency Department at the Lyell McEwin Hospital are structured and were structured at the time of Mr Campbell's and Mr Williams' attendances. It is Professor Goldney's opinion that it should be mandatory for all suicidal persons presenting to an Emergency Department to have at least a psychiatric registrar carry out an assessment, or preferably to have an assessment by a consultant psychiatrist. He said that if that were impractical then at the very least those who have presented after detention by the police should, without exception, be so assessed[54]. Professor Goldney emphasised that when a patient has been brought in by the police under section 57 of the Mental Health Act 2009 it is wrong to let them go without having a full psychiatric assessment.

4.2. Professor Goldney noted that Ms Bourne, the nurse who briefly assessed Mr Campbell, could have seen him for 16 minutes at the most[55]. He said:

> 'Now there's no way in the world you can make a decent assessment of somebody in 16 minutes and it really is - I mean it's a nonsense to think that anyone, even the best qualified person, can make a decision in that short time.' [56]

Professor Goldney noted that both Ms Zeman and Ms Bourne respectively in these cases took the view that because neither Mr Campbell nor Mr Williams was

[52] Transcript, pages 527-528
[53] Exhibit C50e
[54] Transcript, page 579
[55] Transcript, page 583
[56] Transcript, page 584

detainable[57], they did not need to speak to a doctor before releasing them. Professor Goldney commented that there appears to be a tendency in the system to compartmentalise the issue around the question of detention. If the person does not need to be detained, then 'everyone breathes a sigh of relief and it's not taken as seriously'[58]. Professor Goldney said he believes that culture is evidenced by the fact that the consultant psychiatrist, when attending on morning ward rounds, is overwhelmingly preoccupied with people who have been detained and whose status needs to be reviewed under the Mental Health Act 2009. Professor Goldney said these sessions are more like a medico-legal morning than a clinical morning.

4.3. Professor Goldney was critical of the fact that someone in the Emergency Department was required to get permission from the Emergency Department consultant on-call before they could ring up a psychiatric registrar or a psychiatric medical officer. He said he could not understand why that was so unless it was a cost saving measure[59]. He remarked that even after 10:30pm at night this is an unreasonable policy which defies common sense[60].

4.4. Professor Goldney remarked on the experience of some of his psychiatric colleagues in the system who might typically have to do 11 to 15 detention reviews between the hours of 9am and 12pm on a weekend morning. Professor Goldney said this just does not leave time for any other consultations at all and that the exercise really amounts to a detention assessment service rather than a clinical service[61]. Professor Goldney said that ideally all persons who are admitted with a mental health issue should be seen by a psychiatric trainee or a medical officer on a psychiatric roster. He said that certainly the fall-back position must be that persons who come in under police escort should be seen by a psychiatric trainee or preferably a psychiatrist[62].

4.5. Professor Goldney said that in his opinion there should be free contact by medical officers with the psychiatric registrar or trainee for 24 hours per day and that it should be encouraged[63]. He said that the emphasis should be taken away from the question of whether a person is detainable or not, because it seems as if the degree of

[57] In their opinion
[58] Transcript, page 586
[59] Transcript, page 586
[60] Transcript, page 587
[61] Transcript, page 589
[62] Transcript, page 590
[63] Transcript, page 592

assessment after a decision that a person should not be detained becomes less. He said that people deserve to have a full assessment whether they are detained or not. Tellingly, he remarked that often people attend an Emergency Department having been referred there by conscientious general practitioners and on arrival at the Emergency Department 'they are getting a less qualified assessment at the ED than they've originally been given on their referral to the ED'[64].

4.6. As regards Mr Williams' case and the clinical review meeting on the Monday following Mr Davies' assessment of Mr Williams on the Sunday afternoon, Professor Goldney was critical of the fact that Mr Davies was not present at the review meeting. He remarked:

> '… how can there be continuity of care when the person who has assessed Mr Williams in his home is not there to present the information to the consultant psychiatrist?' [65]

He then expressed great concern that the case was referred to Mr Davies to continue to deal with Mr Williams, but that it was known or should have been known, that Mr Davies was not on duty that day. He said:

> 'Well … where is the urgency about this? You know, we've got people who are suffering, who in a sense are bleeding emotionally, where is the sense of urgency about this? Surely if decisions are made they should be acted upon, and if somebody is not there, somebody else should do it.' [66]

I wholeheartedly agree.

4.7. Professor Goldney noted that Mr Williams got the impression that Mr Davies did not think that he (Mr Williams) had depression. Professor Goldney was critical of the fact that, having been assessed by a mental health nurse in Ms Zeman at the Lyell McEwin Hospital, Mr Williams was assessed by another mental health nurse in Mr Davies less than 48 hours later on the Sunday afternoon. He said this amounted simply to going over the same old things:

> 'You're just going over and over things and patients get sick of that. They wonder who is going to be seeing them next. It is almost designed for a lack of continuity of care, rather than somebody who sees the person on that first day and who, then you can actually look them in the eyes and say 'I am going to see you in six days' time' and it is a quite powerful action, therapeutically, to be able to do that to somebody rather than saying

[64] Transcript, pages 592-593
[65] Transcript, page 594
[66] Transcript, page 595

> 'You have got a problem, you had better come back and I don't know who you're going to see'. It is sort of like personalisation of it.' [67]

4.8. Professor Goldney was asked about Mr Davies' provisional diagnosis of dysthymia. It was Professor Goldney's opinion that Mr Davies was not qualified to make that provisional diagnosis, a conclusion that could not be disputed by any reasonable person. Furthermore, Professor Goldney said that Mr Davies does not understand DSM IV regarding the overlap between symptoms of dysthymia and major depression. He commented that individuals with dysthymic disorder describe their mood as sad or down in the dumps. He said Mr Williams was not sad or down in the dumps, he was 'beside himself'[68]. He had cut himself. Professor Goldney said:

> 'We have got this man who is, you know, a strong work ethic who is distressed, feeling hopeless, who has cut himself and is seeking help. Now that's not sad or down in the dumps.' [69]

4.9. Professor Goldney also said that dysthymic disorder is also not to be diagnosed if the disturbance could be due to the direct physiological effects of a substance. In the present case Mr Williams was on Duromine which is contraindicated in people with psychiatric problems. Mr Davies clearly was not aware of that.

4.10. Mr Davies also said that Mr Williams had been depressed for 10 years. As Professor Goldney pointed out, Mr Williams is a man aged 24 and a 10 year period takes you back to his teenage years. He pointed out that DSM IV talks about early onset depression and notes that if the symptoms occur before the age of 21, such individuals are more likely to develop subsequent major depressive episodes. He asked 'is Mr Davies aware of that?'. He also noted DSM IV provides that the associated features of dysthymic disorder are similar to those for major depressive episodes:

> 'The differential diagnosis between dysthymic disorder and major depressive disorder is made particularly difficult by the fact that the two disorders share similar symptoms and that the differences between them in onset, duration, persistence and severity are not easy to evaluate retrospectively (and that) in clinical settings individuals with dysthymic disorder usually have superimposed major depressive disorder which is often the reason for seeking treatment.' [70]

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[67] Transcript, page 598
[68] Transcript, page 600
[69] Transcript, page 600
[70] Transcript, page 601

Professor Goldney remarked that people with dysthymic disorder are down in the dumps rather than severely depressed, but when they hit a road bump such as problems in marriage or work, they are more prone to get major depression and that is what needs to be treated. He said:

> 'You need to treat the major depression and particularly when you have got a man with Mr Williams' past history. I mean it is just to an experienced psychiatrist it is just so obvious, it's sad really that, you know, he wasn't treated properly.' [71]

4.11. Professor Goldney said that in dealing with Mr Williams' case it was necessary to consider the Duromine and that one could not make a diagnosis one way or the other while that was a factor. He posited that it could be major depression, or major depression superimposed on dysthymia, or a depressive disorder associated with the Duromine. He said that the plan should have been to take control of Mr Williams' situation and point out to him that he is on Duromine and that the Duromine may be the problem and it is necessary for him to go off it. Professor Goldney said he would have given Mr Williams a tranquiliser of some sort and seen him in four or five days after he had been weaned off Duromine. He said it would probably be okay to treat him in this way as an outpatient, but:

> '… as long as you're able to get across to him that you knew what was happening, even if you don't know 100% what the exact diagnosis is, you know, patients are very tolerant of uncertainty as long as the doctor is also tolerant of that uncertainty and because often we can't be sure, you know. But if you can say "Look, I can't be sure, I'm very worried, here's a plan of action. We'll stop this Duromine, let's see how you are in four or five days' time".' [72]

4.12. Professor Goldney said that he would make a decision about the need for antidepressants after the patient had been weaned from the Duromine, but said that he strongly suspected that Mr Williams would have needed them even without the Duromine[73].

## 5. Conclusions

5.1. Once again we have a case in which there has been a significant failure by this State's mental health system. The system almost seems designed to produce a lack of continuity of care, as Professor Goldney commented. I firmly believe, as Professor Goldney has said, that mental health patients need to have someone in whom they can

[71] Transcript, page 601
[72] Transcript, page 615
[73] Transcript, page 607

place trust and who they feel is prepared to take control of their situation, assist them and care about them. And yet, the disjointed mental health system operating in this State would almost appear to be designed to achieve anything but that outcome.

5.2. It is completely unacceptable that neither Mr Campbell nor Mr Williams got to see a psychiatric trainee or consultant psychiatrist when they had contact with the Lyell McEwin Hospital. Particularly in Mr Campbell's case, it should be noted that his behaviour in the hours prior to his admission had been highly dangerous. He had endangered not only himself by dousing himself with an inflammable liquid, but he had also surrounded himself with gas bottles and he had ammunition gathered close to his body. On top of all this he was brandishing a cigarette lighter which he was threatening to ignite. Had he done so, it is conceivable that he would not only have killed himself, but he might have killed or injured those persons in the immediate vicinity. How this could not be regarded as a major episode warranting the attention of a psychiatric trainee at the very least, or psychiatric consultant, is simply beyond comprehension and should be condemned in the strongest possible terms.

5.3. If that is the best the State's mental health system can do it is difficult to find words sufficient to match the severity of the problem.

5.4. It is a feature of the State's mental health system that it is disjointed and lacks continuity of care. In Mr Williams' case he saw two mental health nurses in the space of less than 48 hours from different services. The second of those persons managed to leave him with the message that he had dysthymia, and his brief period of optimism following Ms Zeman's message that he had a treatable illness was destroyed. As a result he cancelled his planned lengthy appointment with Dr Garg and the opportunity for him to obtain competent psychiatric treatment was lost forever and was instrumental in his subsequent suicide.

## 6. Recommendations

6.1. Pursuant to Section 25(2) of the Coroners Act 2003 the Court is 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.

6.2. I recommend that mental health nurses, particularly those in Emergency Departments, should have mandatory ongoing training in respect of their powers and duties under the Mental Health Act 2009.

6.3. I recommend that records relating to such training should be maintained centrally with the Chief Psychiatrist for monitoring purposes.

6.4. I note that I made the following recommendation as a result of the Inquest into the death of Damian Kay[74]:

> 'That a junior doctor or a mental health nurse should not discharge a suicidal patient, particularly one brought in by police under section 57(1)(c) of the Mental Health Act 2009, from an Emergency Department without having sought advice from a senior medical colleague - either an Emergency Department senior registrar or consultant, or else a psychiatric registrar or consultant on-call;'

Having considered the matter I now do not regard it as adequate to permit a discharge by a junior doctor or a mental health nurse unless the patient has consulted with a psychiatric registrar or a psychiatric consultant. Nothing less than this is sufficient in the case of a patient brought in by police under section 57 of the Mental Health Act 2009, and I so recommend.

6.5. I recommend that the clinical review process within Northern ACIS be amended to require that the person who carried out the assessment in the first instance should be present at the review to present the case to the consultant psychiatrist. Given that the ACIS system of treating persons in the community appears to be designed to cut costs, this is one cost cutting bridge too far. The very least that can be expected is that the person who actually saw the patient will make the presentation to the psychiatrist and I so recommend.

6.6. The Northern ACIS file was mistakenly transferred away from Mr Davies. The mistake was not discovered by some systematic process, but rather randomly by Ms Mullins[75] who is a fellow mental health nurse, not someone in any position of authority and who took it upon herself to randomly check the scheduler because she was aware of just how unreliable it was. I have no confidence that there is a

[74] Inquest 15/2012
[75] Exhibit C47

systematic process to audit the system to pick up such mistakes and I recommend that there be a review of the operation of the scheduler system to prevent a recurrence of this unforgivable mistake.

6.7. So far as the possible role played by Duromine in the case of Mr Williams, I make the recommendation that when a person presents to his or her general practitioner with mental health issues for the first time, the practitioner should make a check of any current medication to ascertain if there are any contraindications to the taking of such medication in the setting of a psychiatric condition and I direct that recommendation to the Royal Australian College of General Practitioners and the Australian Medical Association.

*Key Words: Psychiatric/Mental Illness; Hospital Treatment; Misdiagnosis;*

*In witness whereof the said Coroner has hereunto set and subscribed his hand and Seal the 19th day of May, 2016.*

*State Coroner*