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 23rd, 24th, 25th, 26th and 29th days of October 2018 and the 25th day of March 2019, by the Coroner's Court of the said State, constituted of Mark Frederick Johns, State Coroner, into the death of James Nicholson.

The said Court finds that James Nicholson aged 65 years, late of 2 Hollins Street, Old Noarlunga, South Australia died at Flinders Medical Centre, Flinders Drive, Bedford Park, South Australia on the 21st day of August 2015 as a result of hypoxic ischaemic encephalopathy complicating hanging. The said Court finds that the circumstances of his death were as follows:

1. Introduction and cause of death

1.1. Mr James Nicholson died on 21 August 2015. He was 65 years of age. An autopsy was carried out by Professor Byard of Forensic Science South Australia who provided a report[1] giving the cause of death as hypoxic ischaemic encephalopathy complicating hanging, and I so find.

1.2. Mr Nicholson had been a patient at the Noarlunga Hospital from 14 August 2015 to 18 August 2015. On the latter date he was found by a nurse hanging from a cord removed from his tracksuit trousers inside a bathroom adjoining his room. Although initially asystolic, cardiac rhythm was re-established following 30 minutes of cardiopulmonary resuscitation. Mr Nicholson was transferred from Noarlunga Hospital to the Flinders Medical Centre Intensive Care Unit, however as I have said, he failed to improve and died after extubation on 21 August 2015.

[1] Exhibit C1a

2. Background

2.1. The background information was provided by Mr Nicholson's wife[2] and his son, Scott Nicholson, who also gave oral evidence[3]. From their accounts the following facts have been established.

2.2. In August 2008 Mr Nicholson had surgery after being diagnosed with adenoid cystic carcinoma (facial cancer). Unfortunately in December 2014 Mr Nicholson was informed that he would need radical surgery of his face with reconstruction because the cancer had returned. On 28 January 2015 Mr Nicholson underwent extensive surgery lasting 14 hours to remove the cancer and reconstruct his face. This was clearly major surgery involving severe disfigurement. Following his recovery from surgery it was recommended that Mr Nicholson should have radiotherapy and chemotherapy. Mrs Nicholson said that this was presented as a personal choice to Mr Nicholson, but that it was recommended and that Mr Nicholson was told that he may regret it if he did not have it. At this stage Mr Nicholson also had problems with opening his mouth due to the cancer and the surgery and needed to use tongue depressors to open his mouth sufficiently to enable him to eat. After giving the matter consideration Mr Nicholson decided that to give himself the best chance of survival he would embark on the further treatment. In March 2015 he commenced radiation treatment in combination with chemotherapy once per week during the radiation treatment. Mrs Nicholson said that he also commenced on a medication called dexamethasone.

2.3. Mr Nicholson's medical oncologist, Dr Stein, provided a statement[4] in which he explained that pathological analysis had shown the cancer to extend to edges of surgical resection and thus there was a high likelihood of cancer returning locally and this was why Mr Nicholson was referred to him to consider chemotherapy. He said that it is common practice to offer treatment to prevent or delay any recurrence and that Mr Nicholson was offered radiation and chemotherapy. Dr Stein described the treatment as a 'very toxic treatment with severe side effects which are very common'. He said he would 'describe it as one of the toughest cancer treatments available'[5]. He said that Mr Nicholson was provided with radiation treatment for 6½ weeks for 5 days

[2] Exhibit C3
[3] Exhibit C13a and Transcript, pages 17 and following
[4] Exhibit C8
[5] Exhibit C8

per week and during that time he had five doses of chemotherapy treatment in total[6]. Dr Stein also said that Mr Nicholson was taking significant amounts of pain relief medication. He was prescribed fentanyl, hydromorphone, dexamethasone and lyrica. Dr Stein said that the requirement for potent analgesia is common because of the extensive mouth and throat ulceration from the treatment.

2.4. Mrs Nicholson said that shortly after the time of commencing on dexamethasone, Mr Nicholson became 'very hyped up'. He would talk constantly, which was in marked contrast to his usual demeanour as a quiet man. He spoke about making plans of what he would do when his treatment had finished, including travel to South Africa. Mrs Nicholson was concerned about his hyped up state and expressed her concerns to his doctor.

2.5. Mrs Nicholson said that Mr Nicholson's last radiation treatment occurred on 11 May 2015 and Mr Nicholson had become extremely dehydrated and was unable to take enough food orally. As a result an appointment was made with a gastroenterologist for insertion of a 'PEG'[7] feeding tube. Before having the PEG tube inserted Mr Nicholson required hospitalisation for rehydration using intravenous fluids. Then he was admitted to Flinders Medical Centre for insertion of the PEG tube, a hospital stay that lasted 10 days. He was eventually discharged home and was able to independently manage his PEG tube feeding and cleansing of the PEG site.

2.6. Mrs Nicholson said that Mr Nicholson liked to be independent and to manage things as much as possible himself. She said he had very limited sleep due to the constant pain in his mouth and needed to attend to his mouth care for pain relief, sometimes more than once per hour.

2.7. Mrs Nicholson said that Mr Nicholson needed to take his morphine syrup twice per day and occasionally three times per day. However, over many weeks the painful mouth improved. She said that Mr Nicholson decided of his own volition and without medical advice to stop taking morphine once he thought the pain was starting to subside. Mrs Nicholson informed Mr Nicholson that he should not come straight off and should wean himself gradually. Mr Nicholson refused to believe that he could possibly be dependent on the morphine and refused to accept that advice, instead stopping

[6] Exhibit C8
[7] Percutaneous endoscopic gastrostomy

suddenly. After a couple of days he started to get stomach cramps at night and was sweating profusely. He was anorexic and felt so fatigued and tired that he could hardly get out of bed. Nevertheless, he worked through his withdrawal and when they next visited Dr Stein on 17 July 2015 Mrs Nicholson explained what had happened with the morphine and how unwell Mr Nicholson had been. On that occasion Dr Stein increased his dexamethasone from 2mg to 4mg for a couple of days to help him get out of the slump and then he returned to his normal 2mg dosage before reducing by ½mg per week. Mr Nicholson continued to suffer from extreme fatigue and was barely able to function. For example, he could barely manage to eat his breakfast before feeling totally exhausted.

2.8. Mrs Nicholson described an event on 22 July 2015 when she was away from home having left Mr Nicholson in the house. While away her handbag was stolen. The handbag contained the keys to her car and the house and also credit cards. Mrs Nicholson contacted Mr Nicholson to ask him to contact the bank to cancel the credit cards and to arrange for one of their sons to bring her the spare car key. However, in a short space of time the credit cards were used on her account by the thief, even before Mr Nicholson was able to arrange cancellation. Mrs Nicholson said that because Mr Nicholson was still very fatigued and was not functioning normally, this was a very stressful event.

2.9. For reasons which will become apparent in due course, not only was it a very stressful event, but it also appeared to be the trigger for some significant behavioural changes on Mr Nicholson's part. These behavioural changes were manifested in a series of incidents bracketed by the theft of the handbag and the eventual admission to Noarlunga Hospital some 3½ weeks later on 14 August 2015.

2.10. In early August 2015 Mr Nicholson asked his son Scott, who was an electrician, to install a power point in readiness for the installation of an NBN connection. Scott Nicholson said that his father kept climbing on the roof and intervening in what Scott was there to do. Scott thought this was uncharacteristic and irrational behaviour on his father's part. Mrs Nicholson said that the following day NBN technicians came to install the connection. She said that after they left she could not find Mr Nicholson and went outside to call him. She found him up on the roof. She was not happy and was concerned about his safety and asked him to come down because it was so dangerous. He said that he was scraping moss off the roof and remained up there for 2½ hours. She

regarded this as very odd behaviour. She also said that by then his dexamethasone dose had been reduced to 1.5mg as directed by Dr Stein.

2.11. Scott Nicholson said that the next event was on 5 August 2015 when his father attended Scott's investment property to help with some renovation work, including the removal of a carport and some external cladding. The following day Mr Nicholson helped Scott again by cutting wood that Scott was removing from the house. Scott said that at one point during the day he threw a lump of wood at his father with the intention that his father would catch it, however it hit his father on the leg and would have hurt him. This resulted in his father behaving unusually and uncharacteristically. He walked past Scott saying something like 'we are all fucked'. Later he seemed agitated and displayed unusual behaviour. When he left to go home he stared and Scott with 'deep black eyes with an angry face'. Scott knew this to be very unusual and thought that it was a reaction to the wood hitting his leg, for which Scott had already apologised.

2.12. Mrs Nicholson said that following the two days assisting Scott, Mr Nicholson was extremely fatigued and could not do anything much. He was very run-down for the next three days.

2.13. Mrs Nicholson said that on Tuesday of the following week, 11 August 2015, she reduced his dexamethasone dose to 1mg. The following day, according to Scott Nicholson, his father called him at about 4:30pm 'freaking out'. He told Scott that someone had broken into the family home and stolen tools from the shed. Mr Nicholson was scared and said they would come back and break into the house and hurt them. In fact, Scott found no evidence of any break-in having occurred whatsoever. Mrs Nicholson noted that Mr Nicholson had cuts on his hands which he could not account for. She was concerned about his erratic behaviour. Scott Nicholson had come over to the house and decided to stay for the night because he was so concerned about his father's behaviour. The following day, 13 August 2015, Mr Nicholson was behaving erratically and checking the shed and the carport. Mrs Nicholson thought his concerns stemmed from her handbag having been stolen, together with house keys and that Mr Nicholson remained concerned even though he had changed the locks on all of the doors. Mr Nicholson told Scott and their other son, Dennis, that he thought people were watching the house and following them.

2.14. Scott Nicholson described his father being highly irritated and anxious about things being stolen. Together with Scott he checked under the carport, checked fences and around the yard to ensure no-one had been on the property. Mr Nicholson was shaking and saying that 'they are watching us, they are going to break in and hurt me and your Mum'.

2.15. Later in the day Scott's brother came to his parents' house. Their father took them outside and was checking items because he was worried about people coming to the property and breaking in to the house and stealing things. Neither Scott nor his brother could see anything amiss.

2.16. The following day, 14 August 2015, Mr Nicholson woke his son Scott at 7am in a panic. He said he was missing one of his guns, but he had another gun that he knew nothing about. He said his paperwork did not match and he was extremely worried. Scott asked to see the paperwork and the gun and noted that the serial number matched the paperwork. The paperwork did have the incorrect brand on the gun, but the correct serial number was written and Scott assured Mr Nicholson that everything was okay. They put the gun away and locked it up but Mr Nicholson said he was worried that he would have to go to jail for having an extra gun and misplacing one. His father again went outside to check the property to ensure no-one was watching the house. He moved some stuff from under the carport which later he thought had been stolen because he could not remember moving it. He was generally shaking and working himself into a state. He became extremely worked up and was shaking. He wanted to burn things in the fireplace. He kept saying words to the effect 'we are going to be killed, we are all going to end up in jail'. Scott reached a point where he could not allow his father out of his sight.

2.17. Later that day Mr Nicholson had an appointment with Dr Stein. Mrs Nicholson was so concerned about Mr Nicholson's behaviour that she contacted Dr Stein's office and relayed her concerns about Mr Nicholson's peculiar behaviour. She wanted to ensure that she could pass this information on to Dr Stein to make him aware of the seriousness of her concern and because she felt it would be difficult for her to voice the concerns adequately at the appointment when Mr Nicholson was present.

2.18. Mr Nicholson himself continued to be very stressed, was shaking and sweating profusely. Mr Nicholson was crying and begging her not to say anything to the doctor.

2.19. Mrs Nicholson said their eldest son Dennis removed the guns to a secure lock-up storage unit due to Mr Nicholson's anxiety about them that morning. She said that she and Mr Nicholson went to the appointment with Dr Stein. She said that Dr Stein examined Mr Nicholson and voiced his concern to Mr Nicholson that he clearly was not well. He gave Mr Nicholson two options. First that he be admitted to hospital to increase his dexamethasone and to commence clonazepam for his anxiety or, secondly, that he increase the dexamethasone to 4mg starting when they got home and take clonazepam instead of going to hospital.

2.20. Mrs Nicholson said that Mr Nicholson chose the second option and they returned home. She gave him the increased dose of dexamethasone when they arrived. Mr Nicholson had his evening meal but then he began to load the fire with wood to an excessive degree until she commented on it. Scott Nicholson was there and told Mr Nicholson to sit down and calm down. Mrs Nicholson said that Mr Nicholson sat down with his head in his hands and remained incommunicative for a couple of hours. She said that at about 8:30pm she gave him his clonazepam. Mr Nicholson was staring at Scott. Scott described his father as having 'deep black eyes and a crazy, creepy look'. Scott thought this was very unusual and that he might be annoying his father so he decided to go to bed once his father had received the clonazepam.

2.21. Around 10 to 20 minutes later Mr Nicholson went down to Scott's bedroom in a panic saying words to the effect that they were 'coming down to get us all' and 'we were all fucked' and 'it's all going to be over soon'. Mr Nicholson then said that he was going to stab Scott before when Scott was looking at him in the lounge room. He said he was going to go to the kitchen and get a knife and come down and stab Scott. Mr Nicholson then said something about Mrs Nicholson which made Scott decide to physically detain his father. He grabbed his father by the shirt and dragged him out to the family room where Mrs Nicholson had remained.

2.22. Mr Nicholson begged Scott to let him go so that he could kill himself. Mr Nicholson grabbed a lamp and tried to put the cord around his neck to strangle himself while Scott was wrestling with him. Scott said that his father was trying to kick, bite and punch. He begged them not to take him to the hospital or tell anyone what had happened. They called Dennis to come around to assist and then with Dennis and Scott on either side of Mr Nicholson they drove him to the Noarlunga Hospital. Mr Nicholson disclosed that he wanted to hang himself or jump of the Noarlunga bridge and said that he had been

thinking of killing himself for two weeks. He said he could not live with what was going on in his head any longer and begged them to let him finish it.

2.23. On arrival at the Emergency Department Mrs Nicholson gave a medical history to the staff and expressed her concern that the reduction in the dexamethasone dose may have caused the change in behaviour. However, Mr Nicholson denied suicidal behaviour when he spoke to the staff. The Emergency Department doctor responded by saying to Mr Nicholson that he now had two different stories but that it was clear that Mr Nicholson's family was very upset. The doctor said that he thought that this was a textbook side effect of dexamethasone which was causing the behaviour. It was very reassuring to Mr Nicholson and the family that the side effect could be treated.

3. The consultation with Dr Stein on 14 August 2015

3.1. Dr Stein provided a statement[8]. He referred to the appointment on 14 August 2015 and noted that by that time Mr Nicholson was down to 1mg of dexamethasone. Mrs Nicholson stated at the appointment that Mr Nicholson had gone downhill again, was not sleeping, was anxious and was having feelings of hopelessness. Dr Stein said that it was clear that Mr Nicholson was not doing very well. Mr Nicholson himself denied that he was depressed and did not in Dr Stein's opinion present as a man with major depression. Dr Stein offered two options as described by Mrs Nicholson above. In Dr Stein's words, option one was admission to Ashford Hospital for observation and alteration of his medication. Dr Stein said that he offered this option because he took Mrs Nicholson's concerns seriously even though Mr Nicholson did not appear severely depressed. Option two was to stay at home over the weekend with follow-up by Dr Stein on the following Tuesday with a trial of clonazepam for Mr Nicholson's anxiety, but with presentation to hospital should there be further deterioration. Although he does not mention it in his statement, Dr Stein also increased Mr Nicholson's dexamethasone dose to 4mg for one day to be decreased the following day and thereafter to 2mg daily[9].

[8] Exhibit C8
[9] Exhibits C12 and C23

4. Noarlunga Hospital Emergency Department

4.1. I have already made reference above to the family's account of what transpired in the Emergency Department on that Friday night. The Emergency Department consultant, Dr Hannam, explained to the family that Mr Nicholson was experiencing a psychosis secondary to dexamethasone and reassured them that his symptoms would be reversed by the correct treatment. Dr Hannam diagnosed Mr Nicholson with a steroid induced psychosis and placed him on an Inpatient Treatment Order (ITO) for review by a psychiatrist the following day. He also organised for a junior doctor to take a more extensive history and that was done.

5. Inpatient treatment order review by Dr Osenk

5.1. Mr Nicholson was reviewed the following morning by psychiatrist Dr Osenk as required under the Mental Health Act 2009. She documented that he presented as calm and cooperative. She noted the history of hypomanic[10] symptoms when Mr Nicholson began dexamethasone and Mrs Nicholson's belief that his mood and behaviours were due to a combination of reduction of the dexamethasone dose and the abrupt cessation of opiates, combined with the extreme nature of his surgery and chemo/radiation treatment. For his part Mr Nicholson denied current or past suicidal ideation as well as low moods or being depressed. Notably, Dr Osenk documented that Mr Nicholson was unable to provide a clear account of the events of the previous day. Dr Osenk recorded the impression that Mr Nicholson had no evidence of any Axis I disorder and that his 'recent behavioural and mood changes likely induced by steroid withdrawal'. She thus revoked his ITO and suggested a medical admission to stabilise his medications, to monitor his response and to liaise with Dr Stein. She also suggested a special one-on-one nurse for 24 hours to 'monitor mental state/behaviours'. She also noted that the psychiatric team would be happy to be contacted further and that both Mr Nicholson and his wife were agreeable to the plan.

5.2. A medical admission note documented by RMO Dr Kumar contained the plan to increase the dexamethasone to 4mg per day and 'if he tries to leave then patient should be detained'.

[10] Hypomania is literally translated as meaning under mania or less than mania. It is a mood state characterised by persistent disinhibition and elevation or euphoria. It is a mood state less severe than full mania.

5.3. In summary, Dr Osenk took a different view of Mr Nicholson's problem from Dr Hannam. While Dr Hannam diagnosed drug induced psychosis, Dr Osenk diagnosed behavioural and mood changes likely induced by steroid withdrawal.

6. 15 August 2015 to 18 August 2015

6.1. The family continued to notice that Mr Nicholson voiced paranoid beliefs up until his hanging. The progress notes documented anxiety when the family were visiting, but no overt behavioural disturbances. The nursing staff recorded on a number of occasions the observation that Mr Nicholson appeared 'withdrawn'.

6.2. On 17 August 2015 the notes indicated that Mr Nicholson was feeling better and that he denied any suicidal ideation. A plan was formulated to discuss discharge planning with Mrs Nicholson and to cease the nurse one-to-one special.

6.3. That day the notes recorded that Mrs Nicholson contacted the RMO (Dr Stone) with concerns about her husband being discharged. She said that she felt nothing had changed and that her husband continued to voice paranoia. She repeated the events of the previous few weeks and also that Mr Nicholson had been experiencing suicidal ideation for two weeks prior to admission. She also told the RMO that Mr Nicholson had contacted her earlier and told her to tell staff that he was alright to be discharged home. Mrs Nicholson made it clear she did not want him home and that she believed he was withholding his suicidal thoughts.

6.4. Following receipt of this information the RMO was instructed by Dr Rowland (medical registrar) to contact the consultation liaison psychiatry registrar. Dr Stone accordingly contacted Dr Jackson and was told that Mr Nicholson would either be reviewed later that day or on the following day by another consultation liaison psychiatry registrar.

6.5. The following day, 18 August 2015, Mr Nicholson was reviewed by Dr Rowland and her medical team at approximately 10am. At that stage Mr Nicholson had not been reviewed by the consultation liaison psychiatry registrar. Dr Rowland recorded Mrs Nicholson's concerns and Mr Nicholson's ongoing denial of suicidal thoughts and persecutory beliefs. Dr Rowland recorded:

> 'Patient remains clearly guarded and careful in his responses.'

She recorded that she was unable to exclude the possibility that he was withholding suicidal plans. The plan at that point was for psychiatric input and to discuss a plan for discharge home with Mrs Nicholson when she arrived. It was also intended that Mr Nicholson would attend his scheduled appointment with Dr Stein at 4pm that afternoon.

6.6. Tragically, shortly thereafter Mr Nicholson entered the bathroom and used the cord of his tracksuit pants to hang himself.

6.7. The notes contain retrospective entries. There is a retrospective entry by intern Dr Krishna at 1413 hours. He documented that he contacted the consultation liaison psychiatry registrar (Dr Bauer) at approximately 10:20am under instruction from Dr Rowland. He documented that he was given the advice that because Mr Nicholson did not voice any suicidal or other harmful intentions he could be referred to the Community Mental Health Service for follow-up. Following this phone call the medical team attended the Emergency Department to assess patients and did not make the family aware of the plan for no psychiatric assessment to be done prior to Mr Nicholson's discharge. The Code Blue was called for Mr Nicholson some 10 to 15 minutes later. Dr Krishna also documented that although a recommendation had been made to increase Mr Nicholson's dexamethasone dose to 4mg daily, it had been left at 2mg (on instruction from Dr Rowland) and that on discussion with Dr Stein on 17 August 2015 a decision had also been made to leave the dose at 2mg per day. Thus, Mr Nicholson only had one 4mg dose of dexamethasone that being on the evening of 14 August 2015 at home following the order of Dr Stein. The decision to increase the dose made the following morning after Dr Osenk's consultation of mood disturbance following steroid withdrawal was not enacted and his dose remained at 2mg daily. There was no explanation for how the increased dose was not enacted, but in all the circumstances it was, if anything, fortunate that it was not.

6.8. Another retrospective entry was made at 1608 hours on 18 August 2015 by consultation liaison psychiatry registrar Dr Bauer. She documented that she received the call from Dr Krishna that morning and that Mr Nicholson was planned for discharge that day and was not voicing suicidal ideation. She was aware that Mr Nicholson had continued to deny suicidal ideation to Dr Osenk and the medical team, but that Mrs Nicholson was of the belief that he was minimising. She documented that there did not appear to be grounds to keep him against his will. She stated she was not directly asked to see

Mr Nicholson, but that she was retrospectively made aware of the intention for her to review him, following a discussion with another consultation liaison psychiatry registrar and another member of the medical team on the previous day. She stated that she would not have been able to review him until later in the day in any event. Thus any psychiatric review would have occurred after Mr Nicholson had already harmed himself.

6.9. Dr Rowland stated that a firm discharge time had not been arrived at and discharge would not have occurred without further discussions with both Mrs Nicholson and the ward consultant, Dr Soden. Dr Rowland had asked Dr Krishna to contact the consultation liaison psychiatry registrar and confirm the time they would be assessing Mr Nicholson. Thus clearly Dr Rowland was expecting a psychiatric assessment at some stage that day.

7. Expert opinion - Dr Naso

7.1. The Court obtained an expert overview and opinion from Dr Maria Naso, specialist psychiatrist. Dr Naso said that it is well known that corticosteroids such as dexamethasone can cause psychiatric symptoms[11]. She noted that they have many uses and that in Mr Nicholson's case it was used as a supportive treatment for his cancer treatment. In her oral evidence she said that patients who are undergoing chemotherapy or radiotherapy sometimes become anorexic, lethargic, listless and lose their appetite. She said that the corticosteroids induce euphoria and they increase energy levels and they also increase appetite[12]. Dr Naso said that corticosteroids can cause medical side effects and also neuropsychiatric side effects[13]. She said the rates of psychiatric symptoms vary, but up to 30% of patients on corticosteroids will experience mental state changes. She said that the emergence of psychiatric symptoms depends on dosage. She said symptoms usually will begin shortly after the commencement of the corticosteroid and that common symptoms are hypomania[14] or mania as well as depression, agitation, schizophreniform psychosis and delirium. Suicidal ideation and suicidal behaviour can be associated with all the above presentations.

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[11] Exhibit C23
[12] Transcript, page 216
[13] Transcript, page 217
[14] Hypomania is literally translated as meaning under mania or less than mania. It is a mood state characterised by persistent disinhibition and elevation or euphoria. It is a mood state less severe than full mania.

7.2. Dr Naso said that the most typical side effect presentation is one of hypomania in the early phase which then over a longer period develops into a depressive disorder. She said that it was her opinion that this is what occurred with Mr Nicholson. She regarded the episode of the stolen handbag as a significant turning point. That episode triggered an intense anxiety and paranoia which remained with Mr Nicholson right up to and throughout his hospital admission.

7.3. Dr Naso was of the opinion that it was only Dr Hannam in the Emergency Department who accurately diagnosed a steroid induced psychosis.

7.4. She noted that because the depressive symptoms developed over time following the initial hypomania and while the dexamethasone was being reduced, the potential existed that a side effect that was in fact being caused by the presence of dexamethasone, might be seen to be caused by the withdrawal of the drug. This was certainly the impression that Mrs Nicholson had arrived at, although I hasten to add that this is certainly no criticism of her in drawing what is after all a natural conclusion. Dr Naso, from an expert point of view, was able to say that a slow withdrawal such as was being practised in Mr Nicholson's case was unlikely to produce depression. She said she had never seen a case of severe depression from corticosteroid withdrawal, but that she had seen numerous cases of steroid induced depression, mania, psychosis and delirium. She also pointed out that on the several occasions that Mr Nicholson's dexamethasone dose was increased, there was no evidence of any improvement in his mental state. She said that it was fairly clear that his mental state continued to deteriorate over time despite temporary increases in the dexamethasone dose.

7.5. Dr Naso also acknowledged that another complication clouded the assessment of Mr Nicholson's mental state, namely the abrupt cessation of opiates. She noted that this caused him to be physically unwell and had an impact upon his mood state.

7.6. Importantly, Dr Naso said that it is rare for a general psychiatrist to see a steroid induced psychiatric syndrome. She said that she herself had only seen these cases as part of her role as a consultation liaison psychiatrist. She said that her medical colleagues would be more likely to have experienced such cases given their use of corticosteroids in the treatment of many medical conditions. She said that these syndromes are then either treated medically as outpatients (if mild) or on general medical units. She said that

corticosteroid induced psychiatric syndromes are not primary psychiatric illnesses, but are instead seen as organic syndromes to be treated medically in a medical setting.

7.7. Dr Naso said that following the development of corticosteroid induced hypomania there would be a high probability of the appearance of a corticosteroid induced depression. She said the depressive symptoms exhibited by Mr Nicholson were not secondary to, or consequent upon, the reduction in dose of dexamethasone.

7.8. Dr Naso said that by early August 2015 when Mr Nicholson began engaging in erratic and out of character behaviours he was demonstrating symptoms of psychosis and depression.

7.9. Dr Naso assumed (reasonably in my opinion) that Dr Stein's decision to increase Mr Nicholson's dexamethasone dose was due to Dr Stein's opinion that Mr Nicholson's symptoms were related to the reduction in the dexamethasone dose (by that point down to 1mg daily).

7.10. Dr Naso said that the treatment of corticosteroid induced psychosis is more straightforward if the symptoms are detected early. She said that Dr Hannam was correct in his statement to the family that the symptoms are reversible. She said that treatment involves decreasing the dexamethasone and eventually ceasing. She said that the concomitant use of atypical antipsychotics is necessary to bring about more rapid symptom reduction. Her experience with a steroid induced delirium was that the symptoms resolve within a week, but with mania and depression and psychosis it can take up to six weeks or longer. She said that throughout the treatment phase a high level of vigilance is required due to the risk of suicide and/or misadventure and that symptoms can fluctuate rapidly over the course of a day and behaviour is totally unpredictable.

7.11. To illustrate the latter point she gave the example of a personal experience of a patient that she had seen who was undergoing chemotherapy and who had been placed on dexamethasone. The patient was in one of the medical wards and the collateral information was that she was psychotic, that she was behaving erratically and that she was intrusive and causing all sorts of problems in a shopping centre. Dr Naso said that she was brought into hospital and placed on an ITO. It fell to Dr Naso to do the psychiatric review the following day. She said that when she did the review, which occupied some 40 minutes in total, she could not elicit one single psychotic or affective symptom. She said that as she was walking out of the room with her folder she was

just filling out the form to revoke the detention order and was about to put the date on it when she turned around and the same patient was standing behind her in the corridor completely naked. She said this was an illustration of how unpredictable the disorder could be[15]. She said that it is actually quite frightening if you have not experienced it[16].

7.12. Dr Naso was critical of Dr Osenk's decision to depart from Dr Hannam's diagnosis of steroid induced psychosis. It will be recalled that Dr Osenk arrived at a near opposite diagnosis of mood symptoms, likely secondary to a decrease in dexamethasone dose. Dr Naso did not agree with Dr Osenk's assessment that she did not have grounds to continue the ITO. Dr Naso particularly noted Mr Nicholson's inability to remember the events of the preceding day and stated that a 65 year old man who does not have a prior diagnosis of any cognitive impairment (such as Mr Nicholson) should clearly remember a highly emotive event of the day before. Dr Naso said that because he was saying he had no memory of what happened the day before, his examination by Dr Osenk could not be regarded as a normal mental state examination.

7.13. Dr Naso said that in her opinion Mr Nicholson was correctly diagnosed with a steroid induced psychosis by Dr Hannam and placed on an ITO. She said that it was appropriate for him to be admitted to a medical ward and that the nurse special should have stayed in place for the entirety of the order. She said that given the nature of the illness he should have been placed in a single room with stimulus lowered as much as possible. The medical team should have discussed with Dr Stein the withdrawal regime for the dexamethasone and the feasibility of eventually ceasing it. She said he should have been commenced on an antipsychotic such as risperidone at a starting dose of 0.5mg BD[17]. She said that a consultation liaison psychiatry team would have reviewed him daily because of the ITO and adjusted medications while reviewing his mental state.

7.14. It was Dr Naso's opinion that even seen with the benefit of hindsight, Mr Nicholson's case was a standard presentation of steroid induced psychosis. Her opinion was that if he had been correctly diagnosed and treated his suicide would have been prevented. However, she acknowledged that his long-term course was likely to present complex challenges.

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[15] Transcript, pages 223-224
[16] Transcript, page 221
[17] BD stands for twice daily

8. The consultation liaison psychiatry service at Noarlunga Hospital

8.1. This case demonstrated that the so-called consultation liaison psychiatry service at Noarlunga Hospital was such a service in name only. However, other evidence before the Court shows that the hospital's structures have now change and it is unnecessary for me to expand upon that subject[18].

9. Recommendations

9.1. Pursuant to section 25(2) of the Coroner's 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.

9.2. It was Dr Naso's opinion that it would be timely to alert the medical profession generally to the possible psychotic effects of corticosteroid induced psychosis[19] and that steroid induced psychosis is much more common than mood disturbance generated by steroid withdrawal, and it is as well to bear in mind the Occam's razor principle in this context[20].

9.3. I therefore recommend that the Minister for Health publish a reminder to the medical profession of the need to be aware of the risk of steroid induced psychosis in patients in receipt of corticosteroid medication and that the possibility that the symptoms are attributable to steroid withdrawal is much more remote than attributing the symptoms to the introduction of the corticosteroid.

Key Words: Death in Custody; Steroid Induced Psychosis; Suicide

In witness whereof the said Coroner has hereunto set and subscribed his hand and Seal the 25th day of March, 2019.

State Coroner

[18] See Exhibit C22
[19] Transcript, page 267
[20] Transcript, pages 228-229