



FINDING OF INQUEST

An Inquest taken on behalf of our Sovereign Lady the Queen at Adelaide in the State of South Australia, on the 11th, 12th, and 13th day of June 2019 and the 15th day of December, 2020 by the Coroner's Court of the said State, constituted of Anthony Ernest Schapel, Deputy State Coroner, into the death of Stephen John Barton.

The said Court finds that Stephen John Barton aged 43 years, late of 2/6 Chiton Avenue, Seaford Rise, South Australia died at the Noarlunga Hospital, Alexander Kelly Drive, Noarlunga Centre, South Australia on the 12th day of August 2014 as a result of blunt neck trauma. The said Court finds that the circumstances of his death are as follows:

1. Introduction, reason for inquest and cause of death

- 1.1. Stephen John Barton was aged 43 when he died in the early hours of the morning of 12 August 2014 in the Morier Ward of the Noarlunga hospital. The Morier Ward is the psychiatric facility of that hospital. I shall refer to the facility as Morier. Mr Barton was a patient in Morier. He was the victim of a homicide at the hands of another patient with whom he was sharing a room. At about 1am on 12 August 2014 during routine checks of the ward's patients, Mr Barton was found lying on the floor between his bed and a wardrobe. This was in room 7 in the open ward of Morier. When Mr Barton was found, the person with whom he shared that room, Mr Lindon Sekrst, was present. Mr Sekrst was standing between Mr Barton and the bed with one foot on Mr Barton's neck. The member of the nursing staff who discovered this scene found that Mr Barton had no carotid pulse and was not breathing. The deceased was unresponsive. Resuscitation was attempted by medical and nursing staff without success. Life was certified extinct at 1:38am.

- 1.2. Mr Barton had last been seen alive, and apparently sleeping, at about 12am. Mr Barton died as the result of violence inflicted by Mr Sekrst.
- 1.3. There is no evidence that Mr Barton and Mr Sekrst were previously known to each other. The incident that led to Mr Barton's death occurred only a matter of a few hours after Mr Sekrst's admission to Morier. Prior to that Mr Sekrst had been kept within the Noarlunga Hospital Emergency Department (the ED) for approximately three days.
- 1.4. Both Mr Barton and Mr Sekrst were patients in Morier. Both men had been detained pursuant to Inpatient Treatment Orders (ITOs) imposed under the Mental Health Act 2009. The fact that Mr Barton was the subject of an ITO at the time of his death means that his death was a death in custody in respect of which a coronial inquest was mandatory. These are the findings of that inquest.
- 1.5. Mr Barton's remains were subjected to a post-mortem examination that consisted of a full autopsy. The examination was conducted by Dr John Gilbert, a forensic pathologist at Forensic Science South Australia. Dr Gilbert's post-mortem report was tendered to the inquest.¹ Findings at autopsy included scalp and facial bruises, bruising and small abrasions over the neck with internal bruising of the strap muscles of the neck. There were fractures of the tips of the left and right superior horns of the thyroid cartilage. There were also bruises over the dorsal aspects of both hands and on the right lower forearm. Dr Gilbert expresses the opinion that the hand and arm bruises may have been defensive in nature and may have resulted from Mr Barton attempting to shield himself from blows such as punches. There were also bruises over the knuckles of his left ring finger and right middle finger. Dr Gilbert opines that it is possible that these resulted from the deceased punching his assailant, but that they could also be defensive in nature. Rib and sternal fractures were attributed to the unsuccessful cardio pulmonary resuscitation that was administered to Mr Barton.
- 1.6. Toxicological analysis was undertaken in respect of Mr Barton post-mortem. An analysis of the specimen of blood revealed it did not exhibit a blood alcohol concentration. The blood contained low therapeutic levels of paracetamol and risperidone and its metabolite. Paracetamol is an analgesic. Risperidone is an anti-psychotic drug that was prescribed for him.

¹ Exhibit 2a

- 1.7. In his report Dr Gilbert asserts that Mr Barton's death appears to have resulted from neck compression. This was indicated by external bruising and abrasions over the neck, by internal bruising of the neck structures and by fractures of the left and right superior horns of the thyroid cartilage. The history suggested that the neck compression was at least partly due to the assailant applying pressure to the deceased's neck with his foot. However, unwitnessed manual neck compression or ligature compression could not be excluded. No person had witnessed any such application of force. There is no crime scene evidence of the use of a ligature. I accept that it is possible that manual neck compression was applied. Regardless, if the force to the neck was applied either by hand or foot it is obvious that there must have been considerable pressure applied.
- 1.8. Dr Gilbert explains that factors potentially contributing to death in the context of neck compression include occlusion of the airway and interference with the blood supply to the brain due to compression of the carotid arteries and jugular veins. Death may also be the result of sudden pressure on the carotid arteries. Pressure receptors in the carotid arteries can transmit impulses to the brain stem that in turn send impulses via the vagus nerve to the heart, resulting in cardiac arrest.
- 1.9. Dr Gilbert expresses the cause of death as '*blunt neck trauma*'. I find that to have been the cause of Mr Barton's death.

2. Background relating to Mr Barton

- 2.1. The evidence suggests that Mr Barton's mental health began to deteriorate in his mid-20s. He underwent a number of admissions to psychiatric facilities including the Glenside Hospital and the Margaret Tobin Ward at Flinders Medical Centre. Dr Michael Warhurst, a senior consultant psychiatrist at the Adaire Clinic at Noarlunga, was Mr Barton's psychiatrist in the community from 2011 to the time of his death. Dr Warhurst saw Mr Barton approximately once per month. By the time Dr Warhurst commenced seeing Mr Barton, Mr Barton had been diagnosed with paranoid schizophrenia. In the community Mr Barton received antipsychotic medication injections. By January 2013 he had become socially isolated and resisted social activities. However, his mental state was stable. There were no incidents of violence or concerns for his own safety. By April 2013 he did not appear to display residual symptoms or experience delusions.

- 2.2. In October 2013 Mr Barton's Community Treatment Order expired. He began to miss appointments. In July of 2014 a family member raised a number of concerns in respect of Mr Barton's mental health. Mr Barton began voicing delusions in relation to his mother having been kidnapped and held in a cave. On 28 July 2014 Dr Warhurst and Mr Barton's mental health key worker attended at Mr Barton's home. He was assessed as being guarded and as experiencing breakthrough delusional beliefs. Mr Barton indicated that he did not wish to engage with services. Dr Warhurst therefore made the decision to impose a Level 1 ITO under the Mental Health Act 2009. As a result Mr Barton was transferred to the Noarlunga Hospital.
- 2.3. On 29 July 2014 the ITO was reviewed. It was believed that Mr Barton was experiencing an exacerbation of schizophrenia. It was considered that Mr Barton was suitable to be accommodated in the open ward of Morier.
- 2.4. The Level 1 ITO was followed by the imposition of a Level 2 ITO. There is no suggestion that the imposition of the ITOs was anything other than lawful and appropriate, and I so find.
- 2.5. During Mr Barton's period of detention at Morier he was cooperative and polite, although guarded. He continued to display some delusional behaviour including habitually speaking with an American accent and, at first, maintaining his belief that his mother was kidnapped and being held in a cave. It was anticipated that Mr Barton would remain under detention until 15 September 2014. Mr Barton did not appear to exhibit any distress or resistance in relation to that plan.
- 2.6. Mr Barton was occasionally allowed to leave the facility with an escort for the purpose of shopping. He complied with treatment. He had contact with his family who visited him.
- 2.7. By 11 August 2014, the day prior to Mr Barton's death, it was thought that Mr Barton had improved. He denied any delusions about his mother. He denied thoughts of self-harm or harm in relation to others. It was believed that he was responding well to medications. Thus a plan was formulated for Mr Barton to be released from inpatient detention and to be placed on a Community Treatment Order.

- 2.8. Mr Barton occupied room 7 in the open ward of Morier. He was originally accommodated with another roommate who was ultimately discharged. This meant that the other bed in his room became available and this would be assigned to Mr Sekrst.

3. Background relating to Mr Sekrst

- 3.1. At the time with which this inquest is concerned Mr Sekrst was 23 years of age. Mr Sekrst had been using methamphetamine. His behaviour had been deteriorating since early 2014. On 8 August 2014 Mr Sekrst's sister and grandmother visited him at his home. He did not want them in the house and acted irrationally. His home was in disarray. Mr Sekrst's sister contacted a mental health triage service. As a result, a community mental health nurse attended at the premises. Mr Sekrst refused to open the door to the nurse and to police. The mental health nurse detained Mr Sekrst under the Mental Health Act 2009 on the basis of information provided by members of his family, including information relating to alcohol and drug use. Nursing observations were also taken into consideration in the decision to detain Mr Sekrst.
- 3.2. Mr Sekrst was conveyed to the ED where he would remain on detention for the next three days until his admission to Morier.
- 3.3. As far as Mr Sekrst's mental health background is concerned, it was said that in 2008 following an ecstasy and alcohol binge, he had become delusional and angry and had started hitting his head against a wall, an incident that culminated in police attendance. In mid-2014 erratic behaviour was noticed by his family. Mr Sekrst had experienced previous referrals to the Child and Adolescent Mental Health Service and the Noarlunga Emergency Mental Health Service but had disengaged from those services.
- 3.4. While at the ED Mr Sekrst was visited by his sister. According to her statement Mr Sekrst did not want to see her as he was angry at her saying '*I'm here because of you*'.² Mr Sekrst was hostile towards his sister. Nursing intervention was required when he started raising his voice.
- 3.5. Mr Sekrst was seen by the associate clinical services coordinator, Mr Stephen Francis.³ Mr Francis, who is a registered mental health nurse, attended one of the cubicles within the ED and spoke with Mr Sekrst. Mr Sekrst was initially quiet and reserved and

² Exhibit C48

³ Exhibit C53

insisted that he did not need to be in the ED. Mr Francis explained that the ITO on which Mr Sekrst had been placed would be reviewed the following day. He explained that the outcome of the review would be that Mr Sekrst would either become a voluntary patient or that he would continue to remain under the ITO for a period of seven days. Mr Sekrst became more vigilant and mildly irritable. He declined to hand over his property and again insisted that he did not need to be there and had to leave. Mr Sekrst's lack of cooperation prompted Mr Francis to summon security. When he left to do this Mr Sekrst attempted to leave the ED. A code black was called. Mr Sekrst shook the doors in an attempt to open them. Mr Sekrst then walked towards Mr Francis which caused another registered nurse to grab Mr Sekrst's arms from behind.

- 3.6. Mr Sekrst also reportedly said to his sister, '*you're all in on it*'.
- 3.7. On Saturday 9 August 2014, the day after Mr Sekrst was taken to the ED a psychiatrist, Dr Angelos Giannakoureas, conducted a review of Mr Sekrst's detention under the Mental Health Act 2009. The review took place during the morning of that day.
- 3.8. During Dr Giannakoureas' review of Mr Sekrst he denied that he had any thoughts of harming himself or others. He said that he consumed alcohol rarely and denied using any illicit substances. He said that he felt safe. In Dr Giannakoureas' statement he indicates that Mr Sekrst made some unusual comments which made him feel that there was some significant underlying pathology.⁴ Mr Sekrst did not appear to have a grasp of the situation or why he was there in the ED. He appeared anxious but denied perceptual abnormalities such as hallucinations. Dr Giannakoureas suspected that Mr Sekrst was suffering from an underlying psychotic illness that may have been substance induced or was possibly reflective of an evolving illness such as schizophrenia. The doctor confirmed the detention order.
- 3.9. In his oral evidence, Dr Giannakoureas described the accommodation arrangements within Morier. The closed ward within Morier involved patients being accommodated in single rooms. In that environment there is a higher nurse to patient ratio with patients being under closer supervision. Patients may not leave. All patients in the closed ward are detained patients. On the other hand, the open ward within Morier involved an environment in which patients could interact with each other and, for the most part, share a bedroom. There would be a mixture of detained and voluntary patients in the

⁴ Exhibit C100

open ward. A detained patient might leave the ward and return, but would be required to seek leave with time limits imposed.

- 3.10. Based on his assessment of Mr Sekrst, Dr Giannakoureas formed the view that Mr Sekrst was not at overt risk of harming himself or others. He believed that he would be suitable for accommodation in an open ward as distinct from a closed ward within Morier. Dr Giannakoureas prescribed risperidone which is an antipsychotic and sedative.
- 3.11. In his oral evidence Dr Giannakoureas explained that he believed that any risks involved with Mr Sekrst warranted him being detained and being compelled to stay in the hospital. However, he did not consider the risk high enough to warrant him being placed in the secure and closed facility, at least in the first instance. The option of stepping a patient up to a closed ward would always be open if it was thought necessary. This was a possible option for Mr Sekrst should the circumstances have warranted it.
- 3.12. Dr Giannakoureas agreed with cross-examining counsel that Mr Sekrst's assertion to his family, '*you're all in on it*' was an indicator of paranoid ideation.⁵ However, to Dr Giannakoureas there was no indication that Mr Sekrst was likely to become aggressive. He said that although Mr Sekrst was disorganised and paranoid, he was actually quite timid.⁶
- 3.13. In cross-examination by Mr Kalali, counsel assisting, Dr Giannakoureas on a number of occasions asserted that there was no '*overt*' risk of self-harm or harm to others, *overt* meaning that there was no indication that he would attack anyone. Dr Giannakoureas said that when he assessed Mr Sekrst he could not have predicted that he would do something as violent as what he would do with respect to Mr Barton.
- 3.14. Surprisingly perhaps, the verbalised paranoid ideation reflected in the statement '*you're all in on it*' did not prompt Dr Giannakoureas to explore what Mr Sekrst had meant by it. Dr Giannakoureas believed that it was a reference to his family, but in conversation with Mr Sekrst he was evasive and guarded and generally showed no interest in participating in the process. Dr Giannakoureas did not explore the circumstances in which he had made that comment. He agreed that one interpretation of the statement

⁵ Transcript, page 52

⁶ Transcript, page 54

was that Mr Sekrst held an irrational belief that the members of his family had in some way wrongly conspired to see him detained.⁷

- 3.15. Dr Giannakoureas was questioned about the fact that Mr Sekrst and Mr Barton were ultimately placed in the one bedroom. Dr Giannakoureas made it plain that this accommodation arrangement was not of his making. However, it must have been evident that a shared room would be a distinct possibility for Mr Sekrst. Dr Giannakoureas said that many patients with paranoid ideation, if not most of them, share rooms with other patients in Morier open ward, to the lay person a troubling thought if ever there was one. When asked whether Mr Barton would have been in a position of vulnerability given Mr Sekrst's paranoid ideation, which conceivably could have involved a delusion that his roommate Mr Barton was '*in on it*', Dr Giannakoureas agreed but added that he could not have predicted who Mr Sekrst would be sharing a room with or whether he would in fact be in a room by himself. He agreed that if he had been placed in a closed ward Mr Sekrst would have been accommodated singly.
- 3.16. When Dr Giannakoureas was asked by counsel assisting, Mr Kalali, as to whether Dr Giannakoureas held any opinion as to how an event such as Mr Barton's attack and death at the hands of Mr Sekrst could be prevented in the future, Dr Giannakoureas suggested that '*...there could be an argument for closer monitoring in closed wards, single beds in the rooms, etc*'.⁸ This sentiment would be echoed by other witnesses.

4. The Morier Ward

- 4.1. Morier comprised a high dependency unit that was a closed facility. It also contained the open ward. The closed ward would only accommodate patients who were detained pursuant to an ITO. The open facility could accommodate both voluntary and detained patients. We are concerned here with the open ward. The open ward could accommodate a maximum of sixteen patients depending on whether two '*swing*' rooms were devoted to the closed or open ward. In the open ward there were five rooms that each could accommodate two persons. Room 7, the room that was occupied by Mr Barton and Mr Sekrst, had an en-suite bathroom. The five double rooms could be locked by the occupant or occupants from the inside. This would have the effect of keeping other patients and other unauthorised persons out of the room. However, ward

⁷ Transcript, page 70

⁸ Transcript, pages 66-67

staff were in possession of a key that would enable the room to be unlocked from the outside if necessary. Observations of patients on the ward were conducted on an hourly basis both during the day and during the night. Room 7 was at the opposite end of a corridor from the nurses' station, a distance of approximately 25 metres. Evidence was given that except for very loud noises such as yelling or shouting, sound emanating from room 7 would probably not be heard at the nurses' station.⁹ In any case I was satisfied that no person on the ward heard anything of a disturbance from room 7 at the time of the event involving Mr Barton and Mr Sekrst. CCTV cameras were not installed in the rooms.

- 4.2. I was told in evidence that the open facility of Morier was the only psychiatric facility in the public mental health system in which rooms were dually occupied. I was also told that Morier was generally full, which meant that at any given time there would be ten patients occupying the five double rooms.
- 4.3. The Court called four witnesses who had a connection with the Noarlunga Hospital and Morier. They were Dr Giannakoureas to whom I have already referred, Dr Claire McCarthy who is now a psychiatrist but who was then a trainee, and two members of the nursing staff, Mr MacPherson and Mr Purcell. All four clinicians were unanimous in their view that dual accommodation in the open facility of Morier was an undesirable circumstance. Various reasons for that observation were expressed. They were all compelling. I will return to the issue in due course.

5. Mr Sekrst is reviewed and placed in Mr Barton's room

- 5.1. As indicated earlier, Mr Barton was accommodated in the ED from 8 August 2014 until the evening of 11 August 2014. In the period following Dr Giannakoureas' assessment, Mr Sekrst was also seen by Dr Claire McCarthy who was then in her fifth year of psychiatry training. Although Dr McCarthy did not have the authority to alter the ITO relating to Mr Sekrst, she nevertheless reviewed him. This review took place on the afternoon of 10 August 2014 in the ED. She took the view that Mr Sekrst should remain on the ITO. Dr McCarthy gave oral evidence and told the Court that during her interview with Mr Sekrst he seemed to be grinning which was incongruent with the nature of the conversation she was having with him. She took the view that Mr Sekrst would be at risk of harm to himself secondary to his vulnerability and at risk of

⁹ Transcript, page 138

misadventure. Dr McCarthy did not disagree with the recommendation that Mr Sekrst be accommodated in an open ward once a vacancy became available. She explained as follows:

‘The closed ward is quite an intimidating place to be and, when people are first involved with mental health services, it can be quite stressful for them. We didn’t have indication of someone who was going to run away, who was going to hurt someone, who wouldn’t cope in the open ward. So it seemed to be the best option.’

If she had disagreed with Dr Giannakoureas’ assessment she would have contacted him. She did not disagree. Dr McCarthy observed that Dr Giannakoureas had identified paranoid ideation on Mr Sekrst’s part. She said in evidence regarding Mr Sekrst’s presentation, ‘Yes, he verbalised paranoid ideation “You’re all in on it”’.¹⁰

- 5.2. Dr McCarthy told the Court that she believed that she had regard to EPAS notes that indicated that for some months Mr Sekrst had become paranoid and frightened and had lost a lot of weight. She recognised that this circumstance had become worse in the last fortnight. She agreed that paranoia could have involved persecutory delusions.¹¹ Dr McCarthy also acknowledges that the major feature of Mr Sekrst’s presentation was paranoid ideation and that in this regard the expression ‘You’re all in on it’ could indicate that he entertained a delusion that people were out to get him. She agreed that the people out to get him in his mind could extend from members of his family to clinicians and potentially to patients in the ward.¹²
- 5.3. Dr McCarthy stated that one matter that she considered as part of her review was whether Mr Sekrst was still suitable to go into an open ward.¹³ Notwithstanding the tragic events that would unfold in the open ward, in her oral evidence she maintained that on the information that was available at the time of her review, Mr Sekrst was suitable for an open ward.
- 5.4. Dr McCarthy did not have any belief as to whether or not Mr Sekrst would be placed in a single bedroom or a twin bedroom. She said that she was not told this.¹⁴ Asked pointedly by Mr Kalali, counsel assisting, as to whether Mr Sekrst was a suitable candidate to share a room with another patient, Dr McCarthy said ‘I guess it’s not ideal

¹⁰ Transcript, page 90

¹¹ Transcript, page 95

¹² Transcript, page 96

¹³ Transcript, page 92

¹⁴ Transcript, page 96

that anyone has to share a room'.¹⁵ She added that people who are distressed want privacy as the ward is a difficult environment for people to be in. She agreed that it would have been preferable for Mr Sekrst to have been placed in a single room. She agreed that there had been the potential for Mr Sekrst to have formed a belief that the person sharing the room had been placed in it to spy on Mr Sekrst.¹⁶

- 5.5. Dr McCarthy agreed that people in Morier were doubled-up for resource considerations alone; that there were not enough single rooms to cater for the number of people on the ward.¹⁷ She acknowledged that other hospitals do not have shared accommodation. She said '*They have single beds*'.¹⁸ She informed the Court that at the time of the inquest Morier still had shared rooms.
- 5.6. It was common ground in the inquest that there is no therapeutic benefit to be derived from dual accommodation in a psychiatric ward. Indeed, certain pitfalls were identified including a general reluctance for patients to occupy a double room.¹⁹ It is also clear that Mr Sekrst, like all other dually accommodated patients in Morier, was placed into dual accommodation with Mr Barton due to resource considerations alone.
- 5.7. The inquest called two nurses from Morier, Mr MacPherson and Mr Purcell.
- 5.8. Mr David MacPherson is a psychiatric nurse who at the time with which this inquest is concerned had worked in Morier for several years. Mr MacPherson gave some general evidence about the operation of Morier. Mr MacPherson explained the circumstances in which Mr Sekrst was placed in to room 7 with Mr Barton. Mr Sekrst was considered to be a priority patient due to the fact that he had been in the ED for an extended period. Mr MacPherson explained that at the relevant time there were three patients who needed to be admitted including Mr Sekrst. One patient had a history of violence and aggression. This person had been admitted due to a verbal outburst and ongoing confrontational behaviour at his supported residential facility. The other patient was in an agitated state. Of the three patients requiring admission to Morier, Mr Sekrst appeared to be the most suitable to be admitted to shared accommodation in the now available room 7. He was the most settled in behaviour.²⁰

¹⁵ Transcript, page 96

¹⁶ Transcript, page 97

¹⁷ Transcript, page 97

¹⁸ Transcript, page 97

¹⁹ Transcript, page 124

²⁰ Transcript, page 132

- 5.9. Mr MacPherson told the Court that nothing about Mr Sekrst was known to suggest that he needed to be considered as high risk of violence to others. His consumer summary did not demonstrate any history of him being violent to others. Hence Mr Sekrst's placement in room 7.
- 5.10. Mr MacPherson expressed his views in relation to dual occupancy. He suggested that 50% of patients suffered from paranoia as one of a number of symptoms in a constellation of symptoms. He said it was a very common symptom in mental illness. Notwithstanding this, patients who might be exhibiting symptoms of paranoia can be placed into double rooms at Morier. However, he suggested that this was a far from ideal scenario. For a start, patients were, generally speaking, reluctant to occupy a double room. When they receive the information that they will occupy a double room they usually receive it adversely. They generally indicate that they would prefer their own space in their own room. Mr MacPherson explained that the principal consideration in assigning dual occupancy was the availability of beds and the gender of the patient.²¹ In 2014 it was standard practice that beds would be filled as soon as they became available. Since that time, as explained by Mr MacPherson, they give more consideration to the identities of persons who share rooms and that they now shuffle beds around and move people to a single room from a shared room if it is thought to be a safer option. I make the obvious point that if safety is ever a consideration at all, as it no doubt should be, a serious question mark arises as to whether dual occupancy should ever be permitted.
- 5.11. Mr MacPherson agreed that ideally single rooms for each patient should be the norm. He said '*definitely, yes*'.²²
- 5.12. Mr MacPherson identified a number of circumstances that could give rise to difficulty where patients share rooms. They included one patient wanting to lock the room and the other patient not wanting to lock the room, the possibility of disputes arising between the two occupants as well as allegations of impropriety. There are other difficulties occasioned by one patient wanting to sleep with a light on and the other

²¹ Transcript, page 150

²² Transcript, page 152

wanting to sleep with the light off. The occupancy of the toilet might possibly also give rise to a bone of contention. Mr MacPherson was asked by me:

‘Q. So there’s all sorts of situations that might trigger a moment of irrationality on the part of one of the occupants.

A. Certainly. It’s quite plausible.’²³

5.13. Mr Ward Purcell is also a psychiatric nurse who gave evidence in the inquest. Mr Purcell has worked at Morier since 2006. Mr Purcell spoke of the considerable pressure on beds in the mental health system such that Morier is generally full.

5.14. Mr Purcell dealt with Mr Sekrst on the evening of his admission to the open ward at Morier. As part of the admission process Mr Sekrst was asked to come into the treatment room with Mr Purcell. He described Mr Sekrst as being a little distant as if the latter believed Mr Purcell was wasting his time. He was also a little guarded. The conversation was not free flowing and Mr Sekrst did not offer any information that was not directly sought from him. However, there was no overt hostility or belligerency. Mr Sekrst was not overtly rude to Mr Purcell.²⁴ It was at approximately 7pm on the evening in question that Mr Purcell conducted this conversation with Mr Sekrst. Mr Purcell told the Court that it was an expectation that Mr Sekrst would be seen by a psychiatrist the following day. Mr Purcell assessed Mr Sekrst’s risk as being low. Mr Purcell was aware of Mr Sekrst having been involved in a previous incident where he had hit his head on a wall.

5.15. Mr Purcell saw Mr Sekrst from time to time throughout the evening. He did not have much interaction with him but was aware that Mr Sekrst had conducted a number of telephone conversations. He also saw him walk in the direction of the courtyard, presumably to smoke.

5.16. Mr Purcell told the Court that when he learnt the following day of the incident involving Mr Barton he was ‘...*shocked beyond belief*’.²⁵ He explained that there was nothing in Mr Sekrst’s demeanour to indicate that he was likely to commit an act such as the act he committed overnight. He had not been overly agitated, aggressive or hostile. He

²³ Transcript, page 157

²⁴ Transcript, page 174

²⁵ Transcript, page 183

had not presented as particularly psychotic. For instance, Mr Purcell did not see Mr Sekrst scanning the room for cameras or do anything that would make one think that Mr Sekrst was concerned about people spying on him.

- 5.17. Mr Purcell shared the view of all other witnesses that single rooms would be more ideal. He said '*I can think of a number of reasons why I wouldn't care to share a room with somebody*'.²⁶ Mr Purcell elaborated by giving examples including patients wanting to shower in the middle of the night, patients who want to have the lights on all night, patients who through illness or otherwise refrain from showering, bathing or washing their clothes. He also said that there were those who snored and those who would '*...entertain themselves*' in the middle of the night.²⁷ In fact he said there were '*...a million reasons*' as to why it was inappropriate for patients to share a room. He said '*that's the truth of the matter*'.²⁸ Mr Purcell also said, as did the other witnesses, that double rooms are assigned purely on a basis of bed availability.

6. The fatal attack

- 6.1. The circumstances surrounding the fatal attack have been ventilated in other jurisdictions. Mr Sekrst was charged with the murder of Mr Barton. On 29 February 2016 Mr Sekrst was found guilty of Mr Barton's murder. On 30 November 2016 the Court of Criminal Appeal quashed Mr Sekrst's conviction and ordered a retrial. However, the Director of Public Prosecution subsequently accepted a plea of guilty to manslaughter from Mr Sekrst. This meant that there was no retrial on the charge of murder. On 26 October 2017 Justice Bampton in the Supreme Court sentenced Mr Sekrst to a term of imprisonment of 7 years and 3 months with a non-parole period of 5 years 9 months and 18 days. The sentence was backdated to 12 August 2014.
- 6.2. The evidence presented to this Court, the judgment of the Court of Criminal Appeal and the sentencing remarks of Her Honour Justice Bampton, make it plain that the incident in room 7 of Morier was not witnessed or heard. As indicated earlier, the incident was discovered on a routine nursing observation made at about 1am on 12 August 2014, only a few hours after Mr Sekrst had been admitted to Morier and in

²⁶ Transcript, page 187

²⁷ Transcript, page 187

²⁸ Transcript, page 187

particular to Mr Barton's room. The last routine hourly check had occurred at about midnight and nothing untoward had been observed.

- 6.3. It is apparent from the judgment of the Court of Criminal Appeal that at the trial which had culminated in his original conviction for murder, Mr Sekrst had relied on a defence of self-defence. However, when Mr Sekrst subsequently pleaded guilty to manslaughter after his murder conviction was quashed, it was advanced on his behalf that in a disturbed and paranoid mental state he had become concerned about Mr Barton's behaviour and in particular by his repetitious talking to himself during his sleep and that as a consequence he pre-emptively assaulted Mr Barton while he lay in his bed. Mr Sekrst admitted through his counsel that he struck Mr Barton three times to the head and face and then placed him in a head lock which he maintained until Mr Barton stopped moving, thereby causing his death. Through his counsel it was acknowledged that Mr Sekrst had not acted in self-defence and that there had been no wrongdoing on Mr Barton's part.
- 6.4. I note that when the scene in room 7 was first discovered by nursing staff, Mr Sekrst said to a nurse that he had heard a bang, had gone around to the other side of the wardrobe that separated the two beds and that he saw Mr Barton lying on the floor and not breathing. Because Mr Sekrst had weak arms he had used his foot in an attempt to restart Mr Barton's breathing.
- 6.5. It is worthwhile observing that at post-mortem Mr Barton was assessed to be 178cms in height and 78kgs in weight. Police holdings indicate that at an unspecified time Mr Sekrst's statistics were 194cms in height and 70kgs in weight.
- 6.6. In my view it is not necessary for this Court to favour any particular factual scenario that to date has been proffered by Mr Sekrst either at the time of the incident or to various courts since. Suffice it to say that it is clear that Mr Sekrst's plea of guilty to manslaughter was an acknowledgment that his application of force to Mr Barton was unlawful and that it caused his death. In any event, whatever precipitated the fatal attack, it is manifest that Mr Sekrst's actions were grossly excessive, irrational and borne out of his mental disturbance.

7. **Conclusions**

- 7.1. The Court reached the following conclusions.
- 7.2. Mr Barton's detention in Morier was at all times lawful and appropriate.
- 7.3. Mr Barton's cause of death was blunt neck trauma. His death resulted from the compression of his neck. Mr Barton's death may have been the result of a number of mechanisms associated with that compression including occlusion of his airway, interference with the blood supply to the brain due to compression of the carotid arteries and jugular veins and/or to sudden pressure on the carotid arteries leading to cardiac arrest.
- 7.4. Mr Sekrst caused Mr Barton's death by applying pressure to Mr Barton's neck.
- 7.5. Mr Sekrst's actions were grossly excessive, irrational and borne out of his mental disturbance.
- 7.6. I find that the placement of Mr Sekrst into dual accommodation with Mr Barton was a contributing factor in Mr Barton's death. I acknowledge that there was no overt indication that Mr Sekrst would harm anybody. However, given the practice of dually accommodating patients in the open ward of Morier, there seems to have been a certain inevitability in an incident of this kind occurring at some point in time. It was not so much a question of whether such an incident would occur and when, but to whom. To my mind this state of affairs continues as long as dual accommodation arrangements exist at Morier.
- 7.7. The practice of requiring detained patients in an open ward to be dually accommodated is a highly undesirable practice. This is especially so when in the first instance little is known about the background of a newly admitted patient. It is also especially so when it is believed that the newly admitted patient is experiencing paranoid ideation and where routine checks on that patient are spaced as far apart as an hour. Since the events with which this inquest is concerned the mental health authorities in this State have been on notice as to these circumstances.

8. Recommendations

- 8.1. Pursuant to section 25(2) of the Coroners Act 2003 I am empowered to make recommendations that in the opinion of the Court might prevent, or reduce the likelihood of, a recurrence of an event similar to the event that was the subject of the Inquest.
- 8.2. The Court recommends that dual occupancy of rooms in psychiatric wards in public hospitals in South Australia should no longer be permitted. This recommendation is directed to the attention of the Minister for Health and Wellbeing and the Chief Executive of SA Health.

Key Words: Homicide; Death in Custody; Inpatient Treatment Order

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

Seal the 15th day of December, 2020.

Deputy State Coroner