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 14th day of September and the 25th day of November 2021, by the Coroner's Court of the said State, constituted of Ian Lansell White, Deputy State Coroner, into the death of Matthew Wade Ansink.

The said Court finds that Matthew Wade Ansink aged 32 years, late of 13 Rook Road, Mount Gambier, South Australia died at Glenside Hospital, 226 Fullarton Road, Glenside, South Australia on the 28th day of June 2019 as a result of subarachnoid haemorrhage due to ruptured basilar artery aneurysm. The said Court finds that the circumstances of his death were as follows:

1. Introduction and reason for inquest

1.1. Matthew Wade Ansink was a patient at the Glenside Hospital when he was found collapsed in the shower at about 1:23pm on 28 June 2019. He had last been seen alive at 11:45am earlier that day. His cause of his death was a subarachnoid haemorrhage caused by the rupture of a basilar aneurysm. He was 32 years of age at the time of his death.

1.2. When he died, Mr Ansink's death was subject to a Level 1 Inpatient Treatment Order[1] pursuant to Section 21 of the Mental Health Act. The ITO was valid and was due to expire at 2pm that very day. There are no concerns in relation to the lawfulness of Mr Ansink's detention at Glenside. That is, at the time of his death he was in legal detention pursuant to the ITO. His death is classified as a death in custody under the

[1] ITO

Coroners Act 2003, as amended.[2] A mandatory Inquest is therefore required pursuant to the Act to ascertain the cause and circumstances of his death.[3]

2. Cause of death

2.1. On 1 July 2019, a post-mortem examination was performed on Mr Ansink by Dr Cheryl Charlwood, a forensic pathologist employed by Forensic Science South Australia. Dr Charlwood's post-mortem report was tendered to the Inquest.[4] She found that the cause of death was a subarachnoid haemorrhage due to rupture of a basilar artery aneurysm. This finding was confirmed by neuropathologist, Professor Blumbergs.[5] On his examination of Mr Ansink's brain, he observed that there had been a massive recent basilar subarachnoid haemorrhage, extending over both Sylvian fissures and the base of the brain. He also located a ruptured saccular aneurysm at the apex of the basilar artery. I accept Dr Charlwood's opinion as the cause of Mr Ansink's death as supported by Professor Blumbergs and make a finding accordingly.

2.2. Mr Ansink's mother, Mrs Beverley Ansink, stated in her affidavit[6] tendered at the Inquest, that there may have been a connection between Mr Ansink's medication and substance abuse, including methamphetamine, and the intercranial haemorrhage, perhaps contributing to the rupture of the aneurysm.[7]

2.3. Psychiatrist Dr Antoinette Bearman provided an affidavit[8] outlining Mr Ansink's mental health treatment from 2016 to his death. She referred to literature suggesting '…*some association between methamphetamine use and stroke in young people*'. However she concluded from examination of his medical casenotes that '…*there were no risk factors that Matthew could or would suffer a stroke*'.[9]

2.4. Dr Charlwood advised that methamphetamine use has been associated with heart disease and hypertension and can be a factor in both ischaemic and haemorrhagic types of stroke, particularly among younger people. Hypertension can be a factor in the development and rupture of aneurysms but there are many factors that may be involved. Dr Charlwood was unaware of any major link between antidepressant medications and

[2] The Act
[3] Section 21(1)(a) of the Act
[4] Exhibit C2a
[5] Exhibit C3a
[6] Exhibit C9
[7] Exhibit C9
[8] Exhibit C5
[9] Exhibit C5, paragraph 39

stroke. Pathologically it was not possible for Dr Charlwood to say whether Mr Ansink's use of methamphetamine had contributed to the cause of his death. There is also a known association between smoking and stroke, again, particularly in the young. Mr Ansink was known to be a smoker.

3. Background

3.1. Mr Ansink was born in Mount Gambier on 4 February 1987 to Beverley and Stephen Ansink. He was the middle child of three children. Mr Ansink achieved high grades during most of his schooling. However, he left high school having partially completed year 12 and commenced an apprenticeship as an electrician at a local timber mill. He was unable to complete that apprenticeship due to issues with depression and anxiety. Nonetheless, he then completed a pre-university course in Foundation Studies and commenced a degree in Social Work. He was an artistic young man with an interest in painting and playing guitar.

3.2. Mr Ansink was first diagnosed with depression on 4 September 2002. He was prescribed the antidepressant Cipramil at that time. He also contracted glandular fever at the age of 16. His depression and anxiety became more apparent after that bout of glandular fever. This contributed to his inability to complete his studies and continue his employment.

3.3. On 21 June 2005, Mr Ansink began to receive mental health support through the Southern East Regional Community Health Service. He also continued to see his general practitioner, Dr Crisp, for mental health support and care.

3.4. Mr Ansink spent many years on various prescription medications following intervention from the mental health services. His regular medication was alprazolam. Some of the medications appeared to his mother to cause serious side effects.

3.5. In 2011 Mr Ansink bought his own home and commenced renovations. Unfortunately, due to water damage in 2011, his home was in very poor condition. There was an attempt to find him alternative housing by the mental health services but they could not find him a location that allowed him to bring his pets with him. As a result of this, Mr Ansink remained in the house. His mother noticed a deterioration in his mental health and felt that her son ought to have been detained at that time.

4. Mr Ansink's decline in mental health

4.1. In 2012 Mr Ansink was allocated to a new social worker, Mr Matthew Harfull from the Limestone Coast Local Health Network.[10] Mr Harfull assisted in arranging reviews of Mr Ansink's medication with the psychiatric registrar, monitored his mental state and explored therapeutic options for him to engage in. Mr Harfull also had contact with Mrs Ansink as necessary. His contact with Mr Ansink would usually be every two to four weeks. It took Mr Harfull some time to build a rapport with Mr Ansink. However, over time Mr Ansink came to confide in Mr Harfull, in particular about his use of cannabis and methamphetamine.

4.2. Mr Ansink was taken off alprazolam in January 2015 due to a change in government regulations. He was trialled on a number of alternative medications, including clonazepam. Mr Ansink found the withdrawal from alprazolam to be difficult and he expressed a feeling of being abandoned by the mental health system. Mrs Ansink also observed that there were times when her son had to wait for his medication, due to scripts running out. This added to his severe anxiety.

4.3. On 28 November 2016, Mrs Ansink contacted Mr Harfull in regard to concerns she held for her son's welfare, following a family wedding. In response Mr Harfull conducted a home visit with Mr Ansink that day. However, Mr Ansink refused a voluntary admission to hospital or any other psychiatric assistance.

4.4. About two hours later Mr Harfull received two concerning text messages from Mr Ansink which suggested suicidal ideation. As a result he contacted the police and the ambulance service. Mr Harfull also attended Mr Ansink's home address as did Mr Ansink's parents.

5. Mr Ansink is detained under the Mental Health Act

5.1. Mr Ansink was subsequently admitted to the Mount Gambier Community Mental Health Service as a voluntary patient. It was determined that he was suffering from a drug-induced psychosis. Due to his threats of suicide, a Level 1 ITO was put in place in case he attempted to leave overnight. His prescription for alprazolam was

[10] Exhibit C8, Affidavit of Matthew Harfull dated 28 January 2020.

recommenced. As a result of this incident, Mr Harfull felt that his rapport with Mr Ansink had been severely damaged as he had been the one to contact the authorities.

5.2. Following his overnight admission, Mr Ansink continued to use methamphetamine and cannabis. On one occasion, on 31 May 2019, Mr Harfull saw Mr Ansink smoke his alprazolam tablets with cannabis. Mr Ansink stated that this was the position he felt he had been placed in by mental health services.

6. Events prior to Mr Ansink's death

6.1. On 11 June 2019 Mr Harfull submitted a clinical review of Mr Ansink's condition, citing his longstanding poor engagement with the service. Along with the mental health team, Mr Harfull formulated a plan whereby Mr Ansink would be offered an independent psychiatric assessment before being discharged from the service. Mr Harfull discussed this with Mrs Ansink who indicated that she wanted her son to be detained for six months and forced to participate in drug rehabilitation to address his use of cannabis and methamphetamine. This detention did not occur.

6.2. On 21 June 2019 Mr Ansink became distressed and expressed suicidal ideations to his mother who then called the police. Mr Ansink was conveyed to the Mount Gambier Hospital by ambulance and detained under a Level 1 ITO. The order was confirmed by Dr Bearman. Mr Ansink was then transferred to the Royal Adelaide Hospital where he was reviewed and transferred to the Rural and Remote Ward of Glenside Campus. He tested positive to methamphetamine, cannabis and benzodiazepines on admission.

6.3. The following day Mr Ansink was seen by Dr Law, the duty doctor, a psychiatrist and a mental health nurse. A diagnosis was made of situational crisis suicidal ideation and worsening mental state, secondary to drug abuse. The records indicate differential diagnoses of schizophrenia relapse, longstanding drug abuse and a Cluster B personality.

6.4. Dr Bearman first saw Mr Ansink on 24 June 2019. She noticed that Mr Ansink was distressed and it was difficult to take a history from him. He spoke of the breakdown of two relationships, the death of his cat, the loss of his job and his poor living conditions at home. He was not able to tolerate questions from her about his history, family or personal situation.

6.5. While at Glenside, an attempt was made to get Mr Ansink to withdraw from alprazolam again. He was treated with Valium on this occasion to assist in the withdrawal. The plan was to transition him to diazepam.

6.6. On 25 June 2019 Mr Ansink was seen by the psychiatry registrar and reported that he was feeling a lot better. He was missing his animals and mentioned that he had a good rapport with his social worker, Mr Harfull.

6.7. Mr Ansink did not respond well to any attempts made by any of the psychiatrists at Glenside to engage with him. However, by 26 June 2019, Mr Ansink was noted to be socialising with other clients and playing pool. By 28 June 2019 it appeared to mental health nurse, Ms Jinhua Yang, that Mr Ansink was responding well to treatment. He appeared to be calmer, less agitated and less anxious.

6.8. He had started to engage with other clients and expressed a willingness to stay at Glenside as a voluntary patient. He reported that he had made a friend. These recent improvements in his mental health were seen as very encouraging.

7. Circumstances surround Mr Ansink's death

7.1. I turn now to the circumstances of the death of Mr Ansink. As already mentioned, Mr Ansink was found collapsed in the shower. Ms Yang had last seen Mr Ansink alive at 11:45am, walking down the corridor towards his bedroom. Ms Yang went to check on Mr Ansink because he was not in the lunch room. She went into his bedroom and noticed that the bathroom door was slightly ajar. She could see Mr Ansink on the bathroom floor through the gap and called for help.

7.2. She opened the door and turned off the shower and covered Mr Ansink's body with a towel. Resuscitation was attempted, firstly by Ms Yang and then by the ambulance service once they arrived. Further attempts were made to revive Mr Ansink by the ambulance officers, however life was pronounced extinct at 2:20pm.

8. Conclusion and recommendations

8.1. Following the death of Mr Ansink, Constable Nathan Mabikafola and Probationary Constable Melissa Holden arrived at Mr Ansink's room at about 2:50pm. Detective Sergeant Glen Shephard of Limestone Coast Criminal Investigation Branch

commenced an investigation.[11] It was the opinion of Detective Shephard that there were no suspicious circumstances surrounding his death and that the ITO was both valid and appropriate. Further in his view, there were no deficiencies in the care of Mr Ansink either at the Mount Gambier Hospital or the Glenside Hospital. I agree with his opinion concerning the treatment and care of Mr Ansink at both the Mount Gambier Hospital and the Glenside Hospital.

8.2. It is very sad that this young man died unexpectantly from natural causes at a time when his mental health was improving so well.

8.3. I make no recommendations.

Key Words: Inpatient Treatment Order; Death in Custody; Mental Health; Natural Causes

In witness whereof the said Coroner has hereunto set and subscribed his hand and Seal the 25th day of November, 2021.

Deputy State Coroner

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[11] Exhibit C16