



FINDING OF INQUEST

An Inquest taken on behalf of our Sovereign King at Adelaide in the State of South Australia, on the 23rd day of June and the 20th day of September 2023, by the Coroner's Court of the said State, constituted of David Richard Latimer Whittle, State Coroner, into the death of David Edward Chessell.

The said Court finds that David Edward Chessell aged 43 years, late of 12 Kenilworth Street, Largs North, South Australia died at Woodleigh House, Modbury Hospital, Smart Road, Modbury, South Australia on the 10th day of December 2017 as a result of compression of the neck due to hanging. The said Court finds that the circumstances of his death were as follows:

1. Introduction and reason for inquest

- 1.1. Mr David Edward Chessell was born on 4 September 1975. He died at Woodleigh House, Modbury Hospital on 10 December 2017. He was 43 years of age.
- 1.2. An inquest into Mr Chessell's death was mandatory, pursuant to section 21(1)(a) of the Coroners Act 2003, as Mr Chessell was subject to a Level 2 Inpatient Treatment Order (ITO) pursuant to Section 21 of the Mental Health Act at the time of his death. This renders Mr Chessell's death a death in custody as defined by section 3 of the Coroners Act 2003.

2. Cause of death

- 2.1. A post-mortem examination of Mr Chessell's remains was conducted on 10 December 2017 by Dr Neil Langlois, a senior specialist forensic pathologist at Forensic Science South Australia, who is also an Associate Professor at the University of Adelaide.

- 2.2. Dr Langlois reported that the cause of death of Mr Chessell was compression of neck in keeping with hanging.¹ After considering all the evidence, I am satisfied that Mr Chessell took his own life by hanging himself from a handrail with a ligature torn from a bedsheet. Accordingly, I find the cause of death to be compression of the neck due to hanging.

3. Background

- 3.1. Mr Chessell was born and raised in Canberra as the youngest of four brothers. Upon leaving high school he became an architectural and hydraulic draftsman.
- 3.2. He met his wife Natasha in 1995 in Canberra. They married in March 1997 and had three children together.
- 3.3. Mr Chessell joined the Australian Defence Force (ADF) in 2000, working as a Supplier for the Royal Australian Air Force (RAAF). Mr Chessell was posted within Australia at various locations including Richmond (NSW), Katherine (NT), Wagga Wagga (NSW) and Edinburgh (SA). The RAAF also deployed Mr Chessell to various international locations in the Middle East and Papua New Guinea.
- 3.4. Mr Chessell was discharged from the ADF in 2015 at the rank of Sergeant. According to his wife Natasha, Mr Chessell had difficulty transitioning to civilian life.² He commenced study in conveyancing, created computer applications and board games and later settled in the position of Operations Manager with Integrated Waste Services.
- 3.5. Mrs Chessell stated that Mr Chessell's psychological health declined after his last international deployment with the ADF, and this was never reported or managed. She stated that he self-medicated with alcohol and over-the-counter medications.³

4. Mr Chessell's admission to hospital

- 4.1. Mr Chessell was arrested on 29 November 2017 by members of South Australia Police in conjunction with the Australian Federal Police. He was charged and released on bail that same day.

¹ Exhibit C2

² Exhibit C4

³ Exhibit C4, page 3

- 4.2. Two days later on 1 December 2017 Mr Chessell was brought by ambulance to the Lyell McEwin Hospital with suicidal ideation.⁴ He reported that he had consumed an overdose of 20 tablets that included Panadeine, paracetamol and codeine. Mr Chessell stated he spent one hour in his car attempting to gas himself, and when he started to feel dizzy and thought he had failed, he sought help from police. The SA Ambulance Service was contacted, and they transported Mr Chessell to hospital. It was noted that the recent stressors for Mr Chessell were being arrested the day prior and the subsequent break-up with his wife.
- 4.3. On the same afternoon Mr Chessell was voluntarily transferred to Woodleigh House, the mental health ward of Modbury Hospital.
- 4.4. On 3 December 2017 Mr Chessell was placed on a Level 1 ITO. The Level 1 ITO was confirmed by consultant psychiatrist Dr Naz Barbato on 4 December 2017.⁵
- 4.5. The ITO '*statement of reasons*' indicates that at that time Mr Chessell presented as irritable and depressed with ongoing suicidal ideation. It is noted that he had a recent high lethality suicide attempt and ongoing regret of surviving. A provisional diagnosis of acute depressive disorder was given, and Mr Chessell was noted to be a high suicide risk at that time.
- 4.6. Dr Timothy Cheng, consultant psychiatrist, provided an affidavit detailing that he first had contact with Mr Chessell on Tuesday, 5 December 2017.⁶ Dr Cheng stated that he diagnosed Mr Chessell as suffering a major depressive episode with a differential diagnosis of an adjustment disorder. Dr Cheng also queried the possibility of temporal lobe epilepsy.⁷
- 4.7. The noted plan was for Mr Chessell to remain on the ITO with a referral to the hospital social workers to arrange legal aid for the criminal charges he was facing and to discuss the possibility of a transfer to the Jamie Larcombe Centre.⁸
- 4.8. Mr Chessell was prescribed and commenced on antidepressants, being mirtazapine (30mg at night) and quetiapine (50mg at night) to help with sleep and ruminations.

⁴ Exhibit C15

⁵ Exhibit C16

⁶ Exhibit C8

⁷ Exhibit C8, paragraph 14

⁸ The Jamie Larcombe Centre is a veterans' mental health precinct located at Glenside Health Service Campus

- 4.9. Dr Cheng saw Mr Chessell for the second and final time on 8 December 2017. Dr Cheng noted that during this consultation Mr Chessell stated:

'Killing myself is not at the forefront of my mind but if the opportunity presented itself, I might take it.'⁹

- 4.10. Dr Cheng discussed with Mr Chessell the need to remain under the treatment order and Mr Chessell agreed that he still needed to be in hospital, stating '*I still don't trust myself*'.
- 4.11. Dr Cheng placed Mr Chessell under a Level 2 ITO which was due to expire on 19 January 2018. The '*statement of reasons*' noted Mr Chessell's mental illness as major depression with suicidal thoughts, the risk of harm is noted as suicidal ideation and active plans, and the treatment justification is noted to be for Mr Chessell's health and safety.¹⁰
- 4.12. Mr Chessell died on 10 December 2017, two days after the institution of the Level 2 ITO.

5. The day of Mr Chessell's death

- 5.1. Mr Peter Roughan was the nurse allocated to Mr Chessell during the shift in which he died. Mr Roughan completed a Consumer Risk Assessment at 10am on 10 December 2017.¹¹ That risk assessment details the following next to the heading '*Behaviour*':

'Slept in till 9:50am reactive on approach. Settled, sitting in day area, reading newspaper. Isolative. Dismissive at times, offering short answers when approached by staff.'

The risk assessment also records Mr Chessell's affect as flat.

- 5.2. On this risk assessment Mr Chessell's risk level for suicide or self-harm is recorded as '*medium*', a change from the previous day when his assessed risk level was recorded as '*low*'.
- 5.3. Mr Roughan made three other notes that day relating to his dealings with Mr Chessell. The first was made at 11:30am and indicated that Mr Chessell slept until 9:50am. The

⁹ Exhibit C8, paragraph 17

¹⁰ Exhibit C16

¹¹ Exhibits C16 and C14d, page 11

note recorded that Mr Chessell seemed flat in affect and that he shrugged his shoulders when he was asked about his mood. The note stated:

'Reports feeling SI (*suicidal ideation*) but feels safe on ward. Mildly dismissive of staff at times minimal responses to questions, and that he was socially isolative.'

5.4. Another note made by Mr Roughan on 10 December 2017 was a typed retrospective note made following Mr Chessell's death which elaborated on earlier details and added that:

- Mr Chessell asked for the laundry room to be opened earlier that morning as he wanted to do washing.
- When Mr Chessell was asked if he was having suicidal thoughts, he said he was but had no plan or intent and felt safe on the ward, with no intentions of leaving the ward.
- That he presented as settled in behaviour but flat in affect.

5.5. The last person to see Mr Chessell alive was nurse William Towler.¹² He stated that he last saw Mr Chessell at approximately 12:30pm as he was performing routine checks.¹³

5.6. Mr Towler stated he could not recall exactly where Mr Chessell was at that time, but it was likely he was at the dining room table, in his room or in the upstairs lounge, as these were the places he normally occupied.

5.7. Mr Towler stated that at approximately 1:30pm he was again performing observations and was unable to locate a couple of people, including Mr Chessell. He was in the process of locating them when he was informed that an incident had occurred upstairs.

5.8. At approximately 1:30pm that day Ms Julie Ann Cook, a cleaner, found Mr Chessell slumped and unresponsive on the ground in a shower cubicle.¹⁴

5.9. Ms Cook was cleaning the bathroom and saw the door to a shower was locked. She looked through the gap and saw an unconscious male slumped on the floor with his head tilted. Ms Cook did not find a nurse on that floor, so she ran downstairs to the nurses' station and called a code blue.

¹² Exhibit C6

¹³ Exhibit C14k, page 10

¹⁴ Exhibit C5

- 5.10. According to the '*Death Report to the Coroner*' which was submitted following Mr Chessell's death, a team from the Emergency Department attended and commenced CPR, however persistent asystole was observed. CPR continued for a total of approximately 22 minutes and ceased at 2:04pm. Death was certified at 2:20pm.

6. Coronial investigation

- 6.1. Crime Scene Examiner, Brevet Sergeant Shane Castle,¹⁵ attended to conduct a forensic examination. He took a number of photographs in the bathroom where Mr Chessell was found, and in Mr Chessell's room.
- 6.2. The shower cubicle door opened outwards and in it a support rail was affixed to the wall. The horizontal section of the rail was approximately 89.6cm above the tiled floor, with a 90° bend at its southern side, bending upwards vertically.¹⁶
- 6.3. A knotted piece of white material was tied to this rail. According to the crime scene examiner, this material appeared to be of a similar nature to a torn bed sheet located in Mr Chessell's accommodation.
- 6.4. Brevet Sergeant Adam Blandford, SAPOL Western Adelaide Criminal Investigation Branch, was the investigating officer in this matter. In his report he postulates that the torn bed sheet in Mr Chessell's room was used as the ligature around Mr Chessell's neck.¹⁷
- 6.5. Registered Nurse Jacqueline Villani, Associate Nurse Unit Manager at the time of Mr Chessell's death, provided an affidavit stating that on the date of Mr Chessell's death Woodleigh House was covered by 11 CCTV cameras. These cameras were monitored by the security office within Modbury Hospital.¹⁸ Two additional monitoring screens were available within Woodleigh House.
- 6.6. The CCTV footage was seized and reviewed by Brevet Sergeant Blandford. In his report he noted the cameras are situated so as to display the outside of Mr Chessell's

¹⁵ Exhibit C10

¹⁶ Exhibit C10, paragraph 31

¹⁷ Exhibit C11, page 11

¹⁸ Exhibit C7

room, this being a common area, and the hallway that leads to the bathroom area where Mr Chessell was located. The CCTV depicts the following events:

12:44:24	Mr Chessell is seen to enter his room
12:45:50	Mr Chessell leaves the bedroom
12:46:00	Mr Chessell enters the bathroom
13:17:00	Male seen to enter the bathroom
13:19:19	Same male leaves the bathroom
13:37:00	Cleaner seen to enter the bathroom and runs out
13:40:00	Medical cart arrives

- 6.7. The CCTV footage makes it clear that nursing staff did not sight Mr Chessell for at least 53 minutes. With respect to observation frequency, the Court received an affidavit¹⁹ and an addendum affidavit²⁰ from Dr Sujeeve, the Divisional Director for Mental Health Services in the Northern Adelaide Local Health Network (NALHN). In his addendum affidavit, Dr Sujeeve stated that although a risk assessment was conducted on the morning of Mr Chessell's death, and his risk was elevated from low to medium, there was no change to the frequency of his observations from the previous day. The observation chart clearly only records observations of Mr Chessell at 60-minute intervals.
- 6.8. RN Villani stated that on the day of Mr Chessell's death, Woodleigh House was adequately staffed for patient care according to the normal staffing ratios.²¹ She also stated that the male who entered the bathroom area as noted above, was a patient who is described as non-violent who suffers from a severe intellectual disability. That patient was in the bathroom for 2 minutes and 19 seconds.
- 6.9. The investigating officer postulated that this patient entered the bathroom in order to use the facilities and the presence of Mr Chessell would have been unknown to that patient.

¹⁹ Exhibit C12

²⁰ Exhibit C12a

²¹ Exhibit C7

- 6.10. Tendered to the Court was a letter written by a number of clinicians at Woodleigh House, addressed to the Chief Executive Officer of the NALHN following Mr Chessell's death.²² It is pertinent to include the following statements:

'Having individually and collectively reflected on this incident, the senior clinical staff at Woodleigh House would like to formally raise our concerns regarding the significant and enduring risks to patient safety within the Woodleigh House environment.

...

Of particular concern are the significant number of remaining ligature points within the unit, with many rated as high risk. These risks have been consistently made known to NALHN executive and clinical governance committees via written reports through pre-existing channels of reporting and have also previously been placed on the NALHN risk register.

...

Thus far there has been little feedback or consultation from senior management regarding plans or resources to address and mitigate these risks.

...

Despite requests to modify and remove some of the ligature points and risks within the unit, no authorisation or funding has been given to address these concerns.'

- 6.11. This letter also referred to the handrail to which Mr Chessell secured the bedsheet as a known high-risk ligature point.
- 6.12. A response to the clinicians from Ms Jackie Hanson, CEO of NALHN dated 19 January 2018 was tendered to the Court.²³ In that response Ms Hanson stated:

'A document search from the NALHN executive offices has not been able to locate the consistent attempts which are highlighted in your correspondence to advise NALHN of these risks, apart from 2 briefs each very briefly stating a ligature risk existed. In addition, I note the risk was never noted on the NALHN risk register.'

- 6.13. Further information was sought from NALHN to clarify the extent to which the NALHN executive and clinical governance committees were aware of the ligature risks in Woodleigh House prior to Mr Chessell's death. In particular, the two briefs briefly stating a ligature risk existed as mentioned in Ms Hanson's letter were requested. They were provided annexed to the supplementary affidavit of Dr Sujeeve. The two briefs were:

- 6.13.1. A CEO briefing dated 21 June 2017 in relation to a ministerial tour of Modbury Hospital Adult Mental Health Services. This briefing informs the

²² Exhibit C8, HAN1

²³ Exhibit C8, HAN2

Chief Executive of SA Health (CE Health) at the time, Vicki Kaminski, of a planned visit on 28 June 2017 by the Minister of Mental Health and Substance Abuse at the time, Leesa Vlahos. The CEO requested that the CE Health provide a briefing solution in the need for capital investment due to 'Woodleigh House not being a fit for purpose building' and contemporary for Mental Health Care. I am informed that NALHN cannot find any evidence of a response from the CE Health, but the briefing is acknowledged to have been received by her on 26 June 2017.

- 6.13.2. A CEO briefing 0430 dated 21 June 2017 in relation to a ministerial tour of the Lyell McEwin Hospital Mental Health Services. I am informed that this briefing was the impetus for the ligature audit undertaken in July 2017 in response to the Minister's visit and concerns raised regarding the longstanding high number of ligature points at Woodleigh House.
- 6.14. The letter from Ms Hanson also states that she requested Dr Melissa Casey to investigate why these risks were not escalated to her office, and why they were not addressed at the local level as they were identified. The Court sought more information about this investigation and, in particular, any documents relevant to Dr Casey's investigation. In his supplementary affidavit, Dr Sujeeve advised that NALHN cannot find evidence of a response from Dr Casey or any document summarising the findings of any investigations she may have undertaken. Dr Casey resigned from her position in early 2018 and NALHN is no longer in contact with her to seek her response.
- 6.15. Additional information was provided by Dr Sujeeve in relation to the governance of ligature audits and worksite safety inspections at Woodleigh House at the relevant time. I am advised that ligature audits undertaken from 2013-2017 across all NALHN Mental Health sites were managed by the NALHN Mental Health Executive with oversight from the Work Health Safety (WHS) unit. These were tabled at local Safety and Quality meetings within the Mental Health Directorate. The ligature audits were never escalated to the Senior NALHN Executive such as the Chief Operating Officer (COO), Executive Director of Nursing (EDON) or CEO, or discussed formally at the Clinical Governance Committee (CGC). This is noted in the RCA recommendation that a '*brief should be sent to NALHN CGC annually to ensure any issues picked up in the audit are addressed*'. As indicated in Dr Sujeeve's affidavit dated 28 September 2022, this recommendation has since been implemented. Dr Sujeeve has suggested that whilst the

NALHN CEO and Mental Health Executive were aware that Woodleigh House was not fit for purpose as a building to care for acute Adult Mental Health patients, including multiple ligature points in 2017, no evidence has been located that indicates the Woodleigh House staff had escalated specific concerns about patient safety, staff safety, or environmental safety issues during this time to the NALHN CEO or senior executives.

7. NALHN root cause analysis

- 7.1. Mr Chessell's death resulted in a root cause analysis (RCA) being conducted in January 2018. NALHN engaged a psychiatrist from Melbourne to lead the review process. The RCA public report and recommendations were tendered.²⁴
- 7.2. The RCA process was extensive, and a number of recommendations were made by the RCA team. Dr Sujeeve, Divisional Director for Mental Health Services in NALHN, addressed each of these recommendations in his affidavit.²⁵
- 7.3. Dr Sujeeve noted that the overwhelming majority of the RCA recommendations have been accepted and implemented by NALHN and this process involved major system-wide changes being implemented to ensure that high-risk patients can be safely managed at Woodleigh House.²⁶
- 7.4. Dr Sujeeve noted that Woodleigh House has undergone extensive modifications and works to eliminate ligature risks and has implemented extensive practice change to increase staff safety and to modify its observational charts, safety measures and assessment measures.
- 7.5. Dr Sujeeve noted that NALHN is finalising the design of the new Older Person's Mental Health ward. This ward will be located at the Modbury Hospital with works due to commence in early 2024 with an expected completion date of December 2025.²⁷
- 7.6. The existing Older Person's Mental Health ward located at the Lyell McEwin Hospital will be relocated to Modbury upon completion of building works.
- 7.7. Following the transition of the Older Person's ward, the 20 acute beds currently at Woodleigh House will be relocated to the vacant ward at the Lyell McEwin Hospital,

²⁴ Exhibit C14a

²⁵ Exhibit C12

²⁶ Exhibit C12, paragraph 65

²⁷ Exhibit C12a, paragraph 10

leading to the decommissioning of the current Woodleigh House location. This will become a non-clinical space for future NALHN use.

8. Woodleigh House inspection by the Office of the Chief Psychiatrist

- 8.1. The Office of the Chief Psychiatrist undertook an inspection of Woodleigh House on 28 October 2022 and published a report in January 2023.²⁸ The report contained a number of recommendations, along with the NALHN response to each of those recommendations. The supplementary affidavit of Dr Sujeeve provides an update on the current status of those recommendations.
- 8.2. The first recommendation was *'In consideration of the overwhelmingly positive feedback from staff and consumers around recent increased Occupational Therapy support for Woodleigh House, it is recommended that Northern Adelaide Local Health Network (NALHN) consider formalising the role as an ongoing permanent position'*. I am advised that this recommendation has now been implemented.
- 8.3. The second recommendation was *'that NALHN Adult Inpatient Mental Health Services Model of Care document be reviewed and updated'*. I am advised that the NALHN Adult Inpatient Mental Health Services Model of Care documents for Woodleigh House will be due for review at the time that Woodleigh House is decommissioned and prior to it moving to its new location at the Mental Health building at the Lyell McEwin Hospital.
- 8.4. The third recommendation was that *'Woodleigh House review documentation processes regarding the provision of Statement of Rights to consumers to ensure consumer rights information is consistently available in consumer spaces'*. I am advised that this recommendation has been implemented. The consumer statement of rights is now readily available to consumers in the consumer pamphlet area in the foyer of Woodleigh House and are also provided to consumers via the admission pack of information they receive.
- 8.5. The fourth recommendation was that *'Woodleigh House renew efforts to roll out the CES Survey with carers as soon as practicable'*. I am advised that this recommendation is in progress. The Senior Carer Consultant who is based at Woodleigh House is leading the Division of Mental Health Services in NALHN with rolling out the 2023 CES Survey. The Senior Consultant is undertaking this piece of work in consultation with

²⁸ Exhibit C14I

the OCP Senior Carer Representative. Results will be tabled via the Division of Mental Health Governance meeting.

- 8.6. The fifth recommendation was that '*NALHN consider installation of a medication room at Woodleigh House to improve medication safety and mitigate risk*'. I am advised that works for the installation of a medication room at Woodleigh House have been quoted and approved noting this requires capital works to retrofit into existing infrastructure. Initial scoping of the space to be utilised has occurred and the building plan is in the progress of being drafted.
- 8.7. The sixth recommendation was that '*any round drainage holes in bathroom handrails be reviewed for potential ligature risk, and either plugged or covered and replaced with laser-cut lines*'. I am advised that this recommendation is in process. The handrails have been ordered to replace the ones identified as a ligature risk and Ventia has been commissioned to supply and install with expected completion by 30 August 2023.

9. Expert overview

- 9.1. The Court sought an expert overview in this matter from Professor Alexander McFarlane, who is recognised as an international expert in the field of the effects of traumatic stress in a series of domains.²⁹
- 9.2. Following a review of the evidence, Professor McFarlane expressed the opinion that Mr Chessell's death was not related to his military service, either directly or indirectly and that the availability of mental health care in the ADF and post-discharge were not relevant factors in Mr Chessell's death.
- 9.3. Professor McFarlane was of the opinion that the humiliation and shame associated with the offence for which Mr Chessell was charged on 29 November 2017 was likely a critical stressor, and that further circumstances associated with this charge, such as his wife and children leaving the family home, his fears about the possibility he would lose his job, along with the significant stress about his financial debts, were also contributing factors.
- 9.4. I accept the opinions expressed by Professor McFarlane.

²⁹ Exhibit C13

10. Conclusions

- 10.1. I find that the Level 2 Inpatient Treatment Order imposed on 8 December 2017 was lawful and appropriate.
- 10.2. I find that, at the time Mr Chessell ended his life in Woodleigh House, Woodleigh House was not fit for purpose as a building to care for acute Adult Mental Health patients.
- 10.3. I note the comment made by Brevet Sergeant Blandford that Mr Chessell's death could have been avoided if the existence of the support rail ligature risk had been appropriately addressed at an earlier time. The fact that Woodleigh House was seemingly not fit for purpose as a building to care for acute Adult Mental Health patients and was rife with ligature points in 2017 - including at the time of Mr Chessell's death - is entirely unsatisfactory. I conclude however that removal of the relevant ligature point may not have prevented Mr Chessell's death, as its absence may have led Mr Chessell to identify an alternative ligature point, or indeed a different means of ending his life. I cannot find that Mr Chessell's death would necessarily have been prevented had this particular ligature point been removed at an earlier time.

11. Recommendations

- 11.1. In light of the implementation of a number of the RCA and OCP recommendations, and the future plans for Woodleigh House to be decommissioned, I make no recommendations.

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

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

Seal the 20th day of September, 2023.

State Coroner