CORONERS ACT, 2003

SOUTH *AUSTRALIA*

FINDING OF INQUEST

An Inquest taken on behalf of our Sovereign King at Adelaide in the State of South Australia, on the 2nd day of December 2022 and the 30th day of June 2023, by the Coroner's Court of the said State, constituted of David Richard Latimer Whittle, State Coroner, into the death of Vaughan Weston Williamson.

The said Court finds that Vaughan Weston Williamson aged 41 years, late of Glenside Hospital, 226 Fullarton Road, Glenside, South Australia died at Glenside, South Australia on the 30th day of October 2017 as a result of an undetermined cause. The said Court finds that the circumstances of his death were as follows:

1. Introduction and reason for inquest

1.1. Vaughan Weston Williamson was born on 28 June 1976. He was 41 years of age at the time of his death on 30 October 2017.

1.2. This was a mandatory inquest pursuant to section 21(1)(a) of the Coroners Act 2003 as Mr Williamson died whilst subject to a Level 3 Inpatient Treatment Order (ITO), which renders Mr Williamson's death a death in custody pursuant to section 3 of the Act.[1]

2. Cause of death

2.1. Dr John Gilbert, forensic pathologist at Forensic Science SA, performed a post-mortem examination on 2 November 2017.[2] Despite specialist neuropathological examination and specialist cardiac pathological examination, a clear anatomical cause of death was not able to be determined.

[1] Order of the Tribunal Exhibit C20, page 210, see also affidavit of Amy Martin, Exhibit C10
[2] Exhibit C2a

2.2. Dr Gilbert stated in his report that the post-mortem findings suggested that death may have resulted from hyponatraemia and may possibly have been contributed to by mixed drug side effects.[3] Dr Gilbert recommended an overview of this case by a consultant psychiatrist well-versed in the treatment of schizophrenic patients. That overview was provided by consultant forensic psychiatrist Dr Daniel Sullivan, who also gave oral evidence in the inquest.[4]

3. Social background

3.1. Mr Williamson's father Gary described Vaughan as the eldest child of two boys and two girls born to Gary's then wife Barbara.[5] In his early years, Vaughan was a quiet child who was sociable and artistic, and enjoyed painting. Vaughan's parents first became concerned about his mental health when he was about 12 years old. It was around this time that Mr Williamson had his first medical appointment regarding concerns as to his mental health.

3.2. Gary Williamson recalls that when Vaughan was about 16 years of age, he was introduced to marijuana by a neighbour with whom he attended school. Around that time Vaughan first started hearing voices and his mental health began to deteriorate. Mr Williamson left school and started working in a wooden box factory.

3.3. In his early 20s Mr Williamson had a partner with whom he resided until the relationship ended, when he moved back home with his parents. Gary Williamson took on his son as an apprentice in his carpentry business. Mr Williamson had a car and was socialising a lot with his brother and other friends.

3.4. In his mid to late 20s Mr Williamson stopped taking his prescribed medication and before long Mr Williamson was first detained under the Mental Health Act. According to Gary Williamson, this was the beginning of a merry-go-round of mental health detentions followed by short releases back into the community.

[3] Exhibit C21, page 3
[4] Exhibit C16
[5] Exhibit C15b

4. Medical, guardianship and treatment order history

4.1. In 1999, at the Queen Elizabeth Hospital, Mr Williamson was diagnosed with a severe form of treatment resistant schizophrenia.[6]

4.2. His illness was typified by paranoid and persecutory delusions and distressing command auditory hallucinations, characterised by disinhibited behaviour and a forensic history.

4.3. A detailed statement of Mr Williamson's many mental health treatment orders and guardianship orders was provided by Ms Donna Attard, a Deputy Registrar at the South Australian Civil and Administrative Tribunal (SACAT).[7] It is not necessary in this document to set out each and every order which was made. There is no suggestion or reason for concern that any of the treatment orders, whether inpatient (custodial) or community based, was unlawfully or improperly imposed. I proceed on the basis that each and every order was lawful and properly imposed.

4.4. The first order, a Community Treatment Order in November 2002, was followed on 19 December 2002 by an order for electroconvulsive therapy (ECT) and continuing mental health detention at the Queen Elizabeth Hospital until 19 March 2003, and then a Community Treatment Order until 19 December 2003.

4.5. Gary Williamson recalls that his son experienced terrible side effects from ECT, and likened the experience to having his brain fried. He asked his father to make sure that he never had ECT again. Thereafter, Gary Williamson remained firm in his opposition to ECT.

4.6. From then until his death on 30 October 2017, Mr Williamson spent the majority of his life subject to either an inpatient or community-based treatment order.

4.7. In September 2010 Mr Williamson was found not guilty, on the basis of mental incompetence, of an offence of arson relating to the burning down of his Housing Trust property. He was released on a licence, with conditions of supervision, for five years. He transitioned to Wondakka, a community rehabilitation unit in Elizabeth North, in 2011.[8]

---

[6] Exhibit C9, page 2
[7] Exhibit C11
[8] Ibid

4.8. On 22 January 2014, while still subject to the conditions of his licence, Mr Williamson was admitted to James Nash House, a secure mental health facility.

4.9. By order of the Guardianship Board dated 12 February 2015, Mr Williamson was placed under the joint guardianship of his father Gary Williamson, and the Public Advocate. This order remained in force at the time of Mr Williamson's death.

4.10. Whilst still under this guardianship order, on 29 September 2015 Mr Williamson was transferred to the closed ward of the Glenside Inpatient Rehabilitation Service,[9] ('Glenside') where he remained until his death.

4.11. Consecutive year-long Level 3 inpatient treatment orders were made on 14 October 2015, 12 October 2016 and 11 October 2017. Mr Williamson was still subject to the last ITO at the time of his death on 30 October 2017. Specifically, I find that the Level 3 ITO to which Mr Williamson was subject at the time of his death was lawfully and properly imposed.

4.12. During his long final admission at the Glenside Inpatient Rehabilitation Service, Dr Darryl Watson was a senior consultant psychiatrist involved with reviewing Mr Williamson and his medication and treatment plans, as well as discussing his treatment with the resident medical officers at least weekly.

4.13. Dr Watson described Mr Williamson as displaying complicated, extreme and very difficult to manage behaviours.

4.14. Over the years Mr Williamson was prescribed a range of different medications and combinations of medications. In 2004 he commenced taking clozapine,[10] described by Dr Watson as the only antipsychotic medication with any proven benefit for treatment resistant schizophrenia.

4.15. On 14 September 2017 Mr Williamson refused to take clozapine. Dr Watson explained that not every medication is easy to enforce, and clozapine only comes in tablet form.[11] Clozapine by itself was not particularly effective for Mr Williamson, and several other

[9] Exhibit C20, page 199
[10] CBIS entry page 1360
[11] Exhibit C9, page 4

medications were trialled, as additions to clozapine, to treat Mr Williamson's underlying psychiatric condition.

4.16. Dr Sean Dennis, a psychiatric resident medical officer at Glenside, observed that Mr Williamson became increasingly unwell when he began refusing clozapine on 14 September 2017.[12] He would hear voices that he found distressing. Dr Watson also recalls that Mr Williamson's condition worsened after he ceased clozapine, and it was becoming more difficult to manage his complex behaviours.[13]

4.17. Against that background, an application was made to SACAT for ECT on 1 May 2017 by Dr Gareth O'Reilly, psychiatry registrar at Glenside. As previously noted, Mr Williamson had undergone ECT in 2002.[14]

4.18. At the SACAT hearing on 17 May 2017, the application was opposed by Mr Williamson's father Gary, in accordance with the previously expressed wishes of his son, for whom Mr Williamson senior was a long-term dedicated advocate.

4.19. Dr Watson provided an opinion to the Tribunal, stating that all reasonable treatment options had been attempted, and it was unlikely that Mr Williamson would make any further improvement without ECT.

4.20. The application for ECT was refused on 22 May 2017.[15]

4.21. A meeting was held on 21 June 2017 between Dr Watson and Mr Williamson's joint guardians to discuss his ongoing treatment. A decision was made to trial alternative antipsychotics.[16] It was noted at this time that Mr Williamson was refusing to take metformin, a medication to control his blood glucose, and that he was refusing to engage with dental referrals.

4.22. The alternative medications selected were olanzapine and chlorpromazine. Mr Williamson commenced olanzapine on 12 October 2017 by way of intramuscular injection. The dosage was 300mg.[17] Mr Williamson's last depot injection of olanzapine was at 3:15pm on 26 October 2017.[18]

---

[12] See also Exhibit C20, page 42
[13] Exhibit C9, page 5
[14] Exhibit C11, page 2
[15] Exhibit C20, page 212 (order), Statement of reasons at page 215
[16] Exhibit C20, page 42
[17] Exhibit C20, page 159 (Depot medication record)
[18] Exhibit C20, page 198

4.23. At the time of his death, Mr Williamson's regular medications were:

- Chlorpromazine 200mg twice a day (antipsychotic, oral)
- Olanzapine 300mg by depot injection (depot)
- Clonazepam (benzodiazepine, sedative)
- Olanzapine 10mg twice a day (wafer tablets)[19]

4.24. In addition to his regular medications, the nurses were also authorised to give Mr Williamson extra medication if he were displaying signs of agitation, such as disrobing. Those medications, referred to as PRN[20] medications, were:

- 5mg to 10mg of Olanzapine, up to a maximum of 20mg
- Clonazepam 1mg to 2mg, up to a maximum of 6mg
- Chlorpromazine 50mg to 200mg

5. Circumstances leading to death - the events of 30 October 2017

5.1. In the weeks leading up to his death it appears that Mr Williamson was particularly unwell. The casenotes indicate that he assaulted and threatened several people, including nurses, other patients and a security guard. For that reason, he was subject to periods of time in seclusion.

5.2. On 30 October 2017 Mr Gordon MacLeod, an enrolled nurse who has been working in the realm of mental health since 1983, was assigned one-on-one nursing of Mr Williamson.[21] Mr MacLeod had known Mr Williamson for a number of years and was familiar with his diagnosis and behaviour.

5.3. When Mr MacLeod had a tea break in the afternoon, enrolled nurse Marcus Jallah assumed nursing responsibilities for Mr Williamson. Mr Jallah was also familiar with Mr Williamson.[22]

5.4. Dr Sean Dennis reviewed Mr Williamson on the afternoon of 30 October 2017. His affidavit details his observations.[23]

---

[19] Exhibit C8, page 2
[20] 'as required'
[21] Exhibit C7
[22] Exhibit C6, page 2
[23] Exhibit C8

5.5. Handwritten entries within the medical records of Glenside Hospital form a timeline of events relating to 30 October 2017.[24]

5.6. The first note, made at 5:30am, indicates that Mr Williamson was aggressive towards nursing staff and accepted his oral medication on the third attempt by staff to persuade him to take it. He then slept for a period of time, and then spent some time awake in his room.

5.7. The next series of notes appear to have been completed retrospectively by Mr MacLeod, who signed and dated them.

5.8. Mr MacLeod notes that Mr Williamson was in bed at the commencement of his shift at 7am. He rose at about 7:50am and went to the dining room, where for breakfast he consumed a large bowl of prunes and between 500-800mls of juice and water. Mr Williamson was giggling in response to internal stimuli. He initially refused his 8am medication but then complied.

5.9. Mr Williamson then went into the lounge for half an hour before returning to his room.

5.10. At 10:15am Mr Williamson refused to allow staff to take his observations.[25]

5.11. At about 10:50am he left his room, had two cups of cordial and sat outside in the internal courtyard, returning to his room at 11am.

5.12. Between 11am and 12pm Mr MacLeod notes that Mr Williamson was seen pacing around the courtyard. He then returned to his room for a shower. Lunch was taken to Mr Williamson in his room.

5.13. Dr Dennis states that at around midday Mr MacLeod asked him if Mr Williamson needed any extra medication. Dr Dennis replied that if Mr MacLeod thought he was manageable then there was no need for extra medication. Dr Dennis suggested that if Mr MacLeod was unsure if he needed extra medication, he could discuss this with the shift coordinator Peggy Fraus.[26] Medication was not administered at that time.

[24] Exhibit C20, Volume 21
[25] Exhibit C20, page 137
[26] Exhibit C8, page 4

5.14. Between 1pm and 2pm Mr Williamson was recorded as leaving his room naked on three occasions. This was known by staff to indicate that Mr Williamson was becoming agitated, and that aggressive behaviour may be imminent.

5.15. Mr MacLeod then spoke with Ms Fraus about administering PRN medications. After checking with the pharmacy, a decision was made to administer 10mg olanzapine and 2mg of clonazepam in tablet form. Mr Williamson accepted this medication at 2pm, with about a litre of milk.[27]

5.16. Dr Watson stated that it is not unusual for these two medications to be given together to manage agitation.[28]

5.17. Mr MacLeod describes that during the afternoon Mr Williamson was increasingly sedated, was slower than usual, and was slurring his speech, which was becoming increasingly difficult to understand.[29]

5.18. Between 2pm and 3pm Mr MacLeod notes that Mr Williamson was doing circuits of the internal courtyard before returning to his room. By 3pm, he was resting on his bed.

5.19. Between 3pm and 4pm, Dr Dennis saw Mr Williamson in his room, with two security guards and Mr McLeod also present. Dr Dennis states that Mr Williamson was slightly drowsy, but not complaining of any new symptoms. Dr Dennis noticed vomit on the floor. As was quite usual, Mr Williamson was dismissive and gave only minimal answers to questions asked. He told the doctor he was not having any problems.[30]

5.20. Mr MacLeod, in the notes, described finding clear fluid which Mr Williamson told him was vomit, and which Mr MacLeod then cleaned up.[31]

5.21. By 4pm Mr Williamson was noted by Mr MacLeod to be awake and standing in the bathroom and '*very sedated*'.[32] Mr Williamson drank a cup of water and returned to bed.

5.22. Marcus Jallah took over the nursing of Mr Williamson between 4pm and 4:45pm. After receiving a handover from Mr MacLeod, he went to see Mr Williamson, finding him

[27] Exhibit C7, page 4
[28] Exhibit C9, page 5
[29] Exhibit C7, page 5
[30] Exhibit C6, page 3
[31] Exhibit C20, page 116
[32] Exhibit C10, page 116

naked outside his room. He asked Mr Williamson to go back into his room to get dressed, which he did, before asking for milk. Mr Jallah went with Mr Williamson and security to the kitchen, where Mr Williamson drank milk and a glass of water before returning to his room and resting on his bed for about 10 minutes. He was then pacing around his room. At 4:45pm Mr MacLeod returned from his break and again assumed care of Mr Williamson.[33]

5.23. The notes indicate that Mr Williamson was then sighted regularly from 5pm.

5.24. At 5pm Mr MacLeod went to check on Mr Williamson. He observed that Mr Williamson was attempting to sit up but '*due to sedation found it too difficult*'. Mr MacLeod noted that '*his level of sedation was quite marked and made the decision not to offer him tea due to the risk of choking as his swallowing reflex may have been impeded*'.[34] Additional vomit was noted on the mattress and bedside locker.

5.25. At 5:20pm Mr MacLeod stated that he went to check on Mr Williamson and noted that he appeared to be highly restless and was trying to sit up.[35] Mr Williamson appeared highly uncoordinated. He entered the room and gently guided Mr Williamson back into a lying position.

5.26. Mr Jallah checked on Mr Williamson, as he was not present for dinner, and found him sleeping. He decided not to wake him.[36]

5.27. At about 5:30pm, Mr MacLeod and Mr Jallah went to check on Mr Williamson together. Mr Jallah stated that they found Mr Williamson lying on the floor to the left side of the bed, still clothed but with his pants lowered to just below his buttocks. There were faeces on the floor, on Mr Williamson and on the bed sheets. Mr Williamson was snoring and appeared to be asleep. Mr MacLeod thought it appeared as though Mr Williamson had fallen to the floor.

5.28. Mr MacLeod went to speak with the senior nurse on duty and asked the resident medical officer to come and review Mr Williamson urgently. In the company of Ms Peggy Fraus, Mr MacLeod attempted to wake Mr Williamson with a view to cleaning him and

[33] Exhibit C6, page 3
[34] Exhibit C7, page 5
[35] Exhibit C7, page 5
[36] Exhibit C6, page 4

moving him off the floor. Mr Williamson required assistance to stand and was very drowsy and unsteady on his feet. He then sat down on the bed.

5.29. While he was trying to stand up, Mr Williamson was defecating.[37] Mr MacLeod observed that he was straining to inhale through clenched teeth. Mr Jallah left the room and came back with face washers and towels. They then cleaned Mr Williamson and laid him back down on the bed.

5.30. Then Mr Jallah noticed that Mr Williamson's breathing was irregular, and his face was turning blue. He told Mr MacLeod who pushed his duress button, activating a code blue, and checked for signs of life. At that time Mr Williamson's carotid pulse was noted to be present. CPR commenced at 5:55pm.

5.31. Dr Dennis attended Mr Williamson's room in response to the code blue and saw the shift coordinator and others performing CPR on Mr Williamson. He assisted in the attempts to resuscitate Mr Williamson.

5.32. Dr Dennis made a handwritten note relating to the events that occurred at 6pm. He has noted that an automatic defibrillator was connected, and that Mr Williamson was in pulseless electrical activity. At no time was a shockable rhythm identified and no shocks were given. Two 1mg shots of adrenaline were administered.

5.33. Sadly, attempts at resuscitation were unsuccessful. An ambulance was called at 6pm and arrived at the patient at 6:10pm. The SAAS patient clinical record indicates that the initial rhythm appeared to be a third-degree heart block.[38] There was no return of spontaneous circulation at any stage. Mr Williamson was declared life extinct at 6:37pm.

6. Discussion as to cause of death

6.1. Dr Gilbert – specialist forensic pathologist

Although Dr Gilbert considered the cause of death to be uncertain, he expressed the view that the post-mortem biochemistry suggests Mr Williamson was hyponatremic at

[37] Exhibit C7, page 6
[38] Exhibit C20, page 125a

the time of his death and that death may have resulted from hyponatraemia,[39] with a possible contribution by mixed drug side effects.[40]

6.2. Biochemical analysis of a post-mortem sample of vitreous humour showed lower than expected sodium (116mmol/L) and chloride levels (97mmol/L) when compared with the potassium level (12.3mmol/L) and a lower-than-normal osmolality level (258mosmol/kg).

6.3. Symptoms of hyponatremia with serum sodium levels in the range of 115-125mmol/L can include lethargy, confusion, anorexia, nausea and vomiting. If the serum sodium levels are below 115mmol/L symptoms can include muscle cramps, weakness convulsions and coma. The severity of symptoms may be more marked if there is a rapid rather than gradual fall in the serum sodium level. At post-mortem, Mr Williamson's sodium level was 116mmol/L.

6.4. However, while the post-mortem biochemistry was suggestive of hyponatremia, Dr Gilbert states that he cannot exclude that electrolyte loss due to vomiting may have affected the results.[41]

6.5. Dr Gilbert also expressed the view that the complete heart block noted by the ambulance officer may possibly be noteworthy. While cardiac conduction abnormalities are not a usual manifestation of hyponatremia, there are several individual case reports of heart block occurring in association with hyponatremia.[42]

6.6. I note that Mr Williamson had been hyponatraemic on 26 October 2017. This was attributed to drinking excessive water. This was treated by seclusion and limiting his water intake, and by 28 October 2017 Mr Williamson's serum sodium was at the lower limit of the normal range (137mmol/L). Impaired glucose tolerance was also noted, although a diagnosis of non-insulin dependent diabetes mellitus had not been confirmed.

6.7. I accept the opinion of Dr Gilbert that hyponatraemia was a possible cause of the death of Mr Williamson. He had been hyponatremic three days prior to his death, and on the

[39] Hyponatremia is a condition where sodium levels in the blood are lower than normal. In many cases, too much water in the body dilutes sodium levels.
[40] Exhibit C2a, page 3
[41] Exhibit C2a, page 3
[42] Ibid

day of his death he was seen to consume large amounts of liquids. He also vomited, and appeared to be lethargic, which are symptoms of hyponatremia.

6.8. I turn now to the toxicology results, and the possibility that mixed drug side effects contributed to the death of Mr Williamson.

6.9. A specimen of blood taken at autopsy was analysed by senior forensic scientist Dr Lindsay who stated in her report[43] that various drugs were detected in the blood, namely:

- olanzapine[44]
- zuclopenthixol[45]
- clonazepam[46] and its metabolite 7-aminoclonazepam
- chlorpromazine[47]
- benztropine[48]
- flupentixol

6.10. Interpreting the findings, Dr Gilbert stated that due to post-mortem distribution it is not possible to determine the likely drug concentrations present in Mr Williamson's blood at the time of his death.

6.11. Dr Gilbert stated that if the concentration of 0.39mg of olanzapine per litre present at post-mortem was present at death, this is a greater than therapeutic concentration of olanzapine and is potentially toxic.

6.12. Dr Lindsay also detected 0.12mg/L of zuclopenthixol. Dr Gilbert stated that this is just about the upper end of the therapeutic range and straddling the lower end of the toxic range (0.12mg/L).[49] However, as noted by Dr Gilbert and Dr Lindsay, post-mortem drug redistribution would be expected in this case given the 2½ day interval between death and autopsy.

---

[43] Exhibit C5
[44] An atypical antipsychotic, antimanic and mood stabiliser used for the treatment of schizophrenia, related psychoses as well as for acute mania in bipolar disorder
[45] Antipsychotic used in the treatment of acute and chronic schizophrenia, for other psychosis and the manic phase of manic depression
[46] A benzodiazepine
[47] Antipsychotic
[48] An anticholinergic agent used to counter the effects of antipsychotic medications
[49] Exhibit C2a, page 2 at [5].

6.13. Dr Gilbert stated that the effect of post-mortem redistribution would be particularly relevant to the interpretation of the levels of olanzapine, chlorpromazine and zuclopenthixol where the recorded post-mortem blood levels were likely to be higher than those actually present at the time of death.

6.14. As the magnitude of the increase in drug levels cannot be accurately determined, the likely drug concentrations present at the time of death cannot be predicted. Dr Gilbert has expressed the view that there is no clear evidence of excessive dosage of any of the prescribed medications.

6.15. However, given the presence of three antipsychotic medications, as well as clonazepam and benztropine, there was scope for additive CNS (central nervous system) depressant effects, possible effects on cardiac rhythm due to QT prolongation, and additive anticholinergic effects. Accordingly, Dr Gilbert recommended an expert overview by a psychiatrist to address the appropriateness of the medications prescribed to Mr Williamson.

6.16. <u>Dr Sullivan – consultant forensic psychiatrist</u>

That overview was provided by Dr Daniel Sullivan, the Executive Director of Clinical Services at Forensicare, the Victorian Institute of Forensic Mental Health. He qualified as a consultant forensic psychiatrist in 2004 and has extensive clinical experience treating patients residing within secure mental health facilities.

6.17. Dr Sullivan was in no way involved with the care of Mr Williamson. He provided his expert report and oral evidence at the request of the Coroners Court, based solely upon the materials provided to him.[50]

6.18. Dr Sullivan opined in his report that the medication regime for Mr Williamson, as it was on 30 October 2017, was '*generally appropriate*',[51] as was his treatment and supervision.[52]

[50] Exhibit C16, page 2. The affidavit of Mr Gary Williamson was also provided to Dr Sullivan subsequent to the provision of his report (Transcript, page 24)
[51] Exhibit C16, page 7 at [29] and [54]
[52] Exhibit C16, page 8 at [35]

6.19. Dr Sullivan postulated that Mr Williamson's sedated appearance on 30 October 2017 reflected either:

- reduced conscious state associated with metabolic disturbance;
- reduced cardiovascular output; or
- sedation induced by sedative medication.[53]

6.20. Dr Sullivan was called to give oral evidence to further explore these three possibilities in addition to other matters on 5 December 2022.

6.21. Dr Sullivan's evidence regarding Mr Williamson's medication regime

Dr Sullivan said that there is strong evidence establishing that clozapine is the most effective medication for treatment resistant schizophrenia, and that it has significant effect for patients who are violent or aggressive.[54]

6.22. However, Mr Williamson ceased taking clozapine of his own volition on 14 September 2017.

6.23. Dr Sullivan explained that there are limited means available in Australia for the involuntary administration of clozapine, and Dr Sullivan was unaware of any occasion where this had been done.[55] Accordingly, it was necessary to trial other antipsychotic medications.

6.24. Dr Sullivan observed that the main consequence of ceasing clozapine for Mr Williamson appeared to be an exacerbation of his psychotic symptoms and a deterioration in his behaviour.[56] There was no indication that Mr Williamson suffered from any significant physical manifestations of withdrawal from clozapine, referred to as 'cholinergic rebound'.

6.25. In October 2017, Mr Williamson's regular prescribed medications were olanzapine, clonazepam and chlorpromazine.[57] This medication regime was regarded by Dr Sullivan as being '*generally appropriate*',[58] given Mr Williamson's objection to continuing clozapine. When asked why he used the caveat '*generally*', and whether

[53] Exhibit C16, page 8 at [33]
[54] Transcript, page 25
[55] Transcript, page 34
[56] Transcript, page 27
[57] Exhibit C8, page 2, [4]
[58] Exhibit C16, page 7

there was any aspect of the medication regime he regarded as inappropriate, Dr Sullivan responded '*not in sum total, but the principles of prescribing antipsychotic medication can be complicated*'.[59]

6.26. In terms of alternative treatment options for Mr Williamson, Dr Sullivan noted that other antipsychotic medications could have been prescribed. However, he regarded olanzapine as the most appropriate antipsychotic medication for a person who displayed aggressive or agitated behaviour,[60] as Mr Williamson was known to do. He also expressed the view that ECT was '*probably the most likely intervention to improve Mr Williamson's mental state and potentially reduce behavioural disturbance*',[61] but acknowledged that this was strongly opposed by Mr Williamson's family.

6.27. Dr Sullivan explained that each of the regular medications prescribed to Mr Williamson was also a sedative. He described the dosage of chlorpromazine, 200mg twice daily, as '*fairly modest*'[62] and the dosage of clonazepam, 1mg twice daily, as a '*low to moderate dose*'. In relation to the dosage of olanzapine, 10mg twice daily, Dr Sullivan stated that this was a '*moderate to high dose*' but observed that *'it's a fairly normal dose to be used in a forensic or extended rehabilitation setting*'.[63]

6.28. When considering the effect that the combination of Mr Williamson's medications may have had, Dr Sullivan stated:

> 'Well firstly all three medications of themselves are sedative. The second is that medications can interact and have a synergistic effect; that is, the effect is not just the addition of three separate medications, but they interact in ways that cause them to be more sedative than you would expect just for the combination of the three.' [64]

6.29. Dr Sullivan stated that he could not predict the degree of sedation that these three medications would have had on Mr Williamson having not met him, bearing in mind that the sedative effect of a drug on a person will depend upon their degree of tolerance or habituation to the medication, and the rate of metabolism of these medications in their liver. Despite this caveat, Dr Sullivan expressed the view that the medications administered to Mr Williamson constituted a '*reasonably significant amount of*

[59] Transcript, page 33
[60] Transcript, page 34
[61] Exhibit C16, page 8
[62] Transcript, page 28
[63] Transcript, page 29
[64] Transcript, pages 29-30

sedation' and a sedative effect '*certainly wouldn't be unexpected for people prescribed this combination of medication, even if they were familiar to it*'.[65]

6.30. Mr Williamson was also prescribed PRN medications, which were administered on and proximate to the date of his death. Dr Sullivan was not critical of the PRN medications prescribed to or administered to Mr Williamson.[66]

6.31. One of the PRN medications prescribed to Mr Williamson was zuclopenthixol acetate, an antipsychotic medication. Dr Sullivan explained that zuclopenthixol acetate is a short acting medication which is '*very sedative in its effect*'.[67] The last recorded administration of zuclopenthixol acetate to Mr Williamson was at 3pm on 27 October 2017. The notes indicate that 150mg was administered to Mr Williamson, which Dr Sullivan regarded as being within the accepted range.[68] Dr Sullivan stated that the sedative effect of this drug would be at its highest within the first half hour to hour after administration, and that he would expect a sedative effect to still be present on 30 October 2017.[69]

6.32. At 2pm on the 30 October 2017, Mr Williamson was administered the prescribed doses of the PRN medications olanzapine (10mg) and clonazepam (2mg).[70] As stated earlier in these findings, the administration of these medications was deemed necessary as Mr Williamson had exited his room in a state of undress on three occasions.[71]

6.33. Dr Sullivan opined that the administration of the PRN medications was appropriate based on the clinical notes which stated that Mr Williamson was still manifesting disturbed behaviour for which those medications were an appropriate prescription.[72] However, he would expect that the nurse administering the medication would not do so if the patient appeared overly sedated.

6.34. There is no evidence to suggest that Mr Williamson was overly sedated prior to the administration of olanzapine and clonazepam on the day of his death. The observations

[65] Transcript, page 41
[66] Transcript, page 37
[67] Transcript, page 32
[68] Transcript, page 33
[69] Transcript, page 33
[70] Exhibit C7 at page 4, [11]
[71] Exhibit C6 at page 3
[72] Transcript, page 38

of increasing levels of sedation, as detailed above, were made after the administration of the PRN medications.

6.35. I accept Dr Sullivan's evidence on this topic and find that Mr Williamson's medication regime, and the administration of PRN olanzapine and clonazepam was appropriate in the circumstances.

7. The cause of Mr Williamson's presentation and decline on 30 October 2017

7.1. As previously stated, Dr Sullivan noted that it is unclear whether Mr Williamson's sedated appearance on 30 October 2017 reflected reduced conscious state associated with metabolic disturbance (such as hyponatraemia), reduced cardiovascular output, or sedation induced by sedative medication.[73] In his report, Dr Sullivan opined that the two most likely causes of death were cardiac or metabolic, and noted that neither was determined convincingly on post-mortem examination.[74]

7.2. Dr Sullivan explained that a person suffering from a metabolic disturbance, such as hyponatraemia, may present with sedation or confusion.[75] He also stated that a metabolic disturbance can cause vomiting, as Mr MacLeod observed at some stage between 3pm and 4pm.[76]

7.3. Dr Sullivan noted the possible significance of the observation that Mr Williamson's feet were blue and a little swollen. It was his view that this may have indicated impaired blood flow to the peripheries, suggesting that a cardiac cause may have led to Mr Williamson's sedation and collapse.[77] However, in his view, this was not the most likely cause of Mr Williamson's sedation.[78]

7.4. Dr Sullivan opined that Mr Williamson's presentation on the afternoon of 30 October 2017 could have been due to the medications he had been administered, or '*it could also reflect deterioration due to an underlying medical condition or a medical cause which is causing that sedation as well*'.[79]

[73] Exhibit C16, page 8 at [33]
[74] Exhibit C16, page 8
[75] Transcript, page 43
[76] Exhibit C20, page 116
[77] Transcript, page 48
[78] Transcript, page 49
[79] Transcript, page 39

7.5. In conclusion, Dr Sullivan favoured the theory that the level of sedation caused by the medications administered to Mr Williamson was increased due to some sort of medical condition which led to Mr Williamson's death, which in combination with the medications made him look more sedated than would be expected from the medications alone.[80]

7.6. I accept the evidence of Dr Sullivan and find that the death of Mr Williamson was not caused by the administration of excessive sedative medications.

7.7. However, the evidence does not enable a finding to be made as to the cause of his death.

8. Mr Gary Williamson's concerns

8.1. Mr Gary Williamson attended Court to give oral evidence and his affidavit was received in evidence.[81] In January 2019 he wrote to the Court detailing his concerns about the treatment of his son at Glenside. These concerns included: that an order for ECT was applied for despite knowing of Mr Williamson's previous reaction to it and the ongoing objection to it; that Mr Williamson's refusal to take his medication in October 2017 was precipitated by the introduction of a new medication, to which Mr Williamson reacted with paranoia; the administration of PRN olanzapine and clonazepam; and whether Mr Williamson was properly observed every 15 minutes.

8.2. Following the evidence in the inquest, Mr Williamson made a statement in which he described his son's ward as an inhumane place. He described his son as a '*gentle giant*' who loved his brothers and sisters. He perceived that Mr Williamson, and other large men in the ward, were overly medicated in order to keep them subdued.

8.3. Throughout Mr Williamson's many years of illness, his father Gary was a dedicated and passionate advocate for his son. In considering the evidence and making findings as to the cause and circumstances of Mr Williamson's death, his father's concerns have been front of mind.

[80] Transcript, page 49
[81] Exhibit C15b

9. Conclusions

9.1. The ITO upon which Mr Williamson was detained for treatment was properly and lawfully imposed.

9.2. The medication, treatment and care received by Mr Williamson proximate to his death was appropriate.

9.3. On the available evidence, Mr Williamson's cause of death remains undetermined.

10. Recommendations

10.1. I have no recommendations to make in this matter.

Key Words: Death in Custody; Inpatient Treatment Order; Undetermined Cause

In witness whereof the said Coroner has hereunto set and subscribed his hand and Seal the 30th day of June, 2023.

State Coroner