MAGISTRATES COURT of TASMANIA

CORONIAL DIVISION

Record of Investigation into Death (With Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Duncan Fairley, Coroner, having investigated the death of Stephen Russell Harris

With an inquest held in Launceston on 18 November 2016 find as follows

Introduction:

1. Stephen Russell Harris died whilst a patient of the North West Regional Hospital (Spencer Clinic) on 18 December 2014. As at the date of his death Mr Harris was the subject of an involuntary treatment order made pursuant to section 55 of the *Mental Health Act* 2013. Section 24 of the *Coroners Act* 1995 provides that an inquest must be held if the deceased "*was immediately before death a person held in care*".

2. Section 3 of the *Coroners Act* 1995 defines a "*person held in care*" as including:

> *"a person detained or liable to be detained in an approved hospital within the meaning of the Mental Health Act 2013 or in a secure mental health unit or another place while in the custody of the controlling authority of a secure mental health unit, within the meaning of that Act"*

I am satisfied that Mr Harris was the subject of an order, falling within the above definition, at the time of his death.

Findings:

3. Pursuant to section 28 of the *Coroners Act* 1995 the evidence at the inquest satisfies me that the following formal findings can be made:

   a) The identity of the deceased was Stephen Russell Harris;
   b) Mr Harris died in the circumstances set out further in this finding;
   c) The cause of Mr Harris' death was undetermined but likely to be associated with a cardiac arrhythmia;
   d) Mr Harris died on or between 18 and 19 December 2014 at the North West Regional Hospital (Spencer Clinic) in Tasmania; and
   e) Mr Harris was born at Ouse, Tasmania on 26 March 1958 and was 56 years of age; he was unemployed and divorced at the date of his death.

Background:

4. Stephen Russell Harris was born at Ouse, Tasmania on 26 March 1958, the 10th of 11 children. His early years are described as being relatively uneventful, although I note that in later life Mr Harris alleged that he had been sexually assaulted as a child.

5. Upon leaving school aged 14 years Mr Harris worked in various roles, including with the Hydro Electric Commission where he was involved in the development of the Lower Pieman scheme. During 1983 Mr Harris married. There were 2 children born of the union – Derrin and Janessa. It is apparent that by this point in his life Mr Harris was already suffering from significant mental health issues, with hospital records revealing that from the age of 23 he was variously diagnosed as suffering from schizophrenia, schizoaffective disorder and bipolar disorder.

6. Subsequent to the breakdown of his first marriage in about 1987, Mr Harris met and married Kathryne Ann Harris, a woman with an intellectual disability. A single child was born to the relationship but taken into care. Mr Harris was unable to maintain contact with his third child.

7. By 2014 Mr Harris was residing alone at a unit in Orion Court, Devonport. He maintained contact with a limited number of his siblings, including his brother David Wayne Harris who gave evidence at the hearing of the inquest. David described his brother's long battle with mental illness and illicit substance abuse. During periods when his mental health was improved David stated that Mr Harris enjoyed tending to his garden, fishing and working in the bush. In the years immediately before his death David described Mr Harris as significantly overweight and sometimes short of breath. He noted that his brother had resumed smoking cigarettes during that time.

Circumstances surrounding the death:

8. On 18 December 2014 Mr Harris presented to the Mersey Community Hospital suffering from an injury to his forehead which he claimed to have sustained in a fall. The hospital notes indicate that he was disorientated, agitated and aggressive towards staff. Mr Harris was reviewed by the Mental Health Crisis Assessment Team but absconded from the Hospital prior to receiving treatment. An application for an *Urgent Circumstances Treatment (Involuntary) Order* pursuant to Section 55 of the *Mental Health Act* 2013 was pursued and granted. Tasmania Police were tasked to locate Mr Harris and take him into protective custody.

9. In the days prior to his presentation at the Mersey Community Hospital Mr Harris failed to keep an appointment with the Devonport Adult Community Mental Health Service (DACMHS) for his monthly intramuscular injection of Paliperidone Depot, a long acting antipsychotic agent. During his testimony David Harris referred to having spoken with his brother about the missed appointment. Mr Harris was aware that he needed to reschedule the procedure and stated that he would do so. Records from the DACMHS suggest that Mr Harris may have been non-compliant with his oral medication regime for a number of months prior to December 2014.

10. It was determined that Mr Harris should be taken to the North West Regional Hospital (Spencer Clinic) by police due to his agitated state and the risk of further aggression towards medical personnel. Mr Harris was admitted to the North West Regional Hospital shortly after 1.00pm on 18 December 2014. Upon initial examination Mr Harris was assessed as suffering from a manic and psychotic relapse of his illness. An ECG investigation was performed which indicated prolongation of the QT interval, however, on subsequent review I am satisfied that the auto-analyser on the ECG erred in the QT time interval and that the true interval was within the safe range. Mr Harris was prescribed Clonazepam, a psychoactive benzodiazepine medication together with Paliperidone Depot. Subsequent to the administration of these medications Mr Harris settled into the High Care Unit. By 5.00pm Mr Harris was noted to have fallen asleep.

11. Throughout the evening of 18 December 2014 nursing staff continued to regularly record Mr Harris' clinical observations. He was noted to be asleep and breathing steadily at 11.30pm by Leslie Latimer, Registered Nurse in Charge. Nurse Latimer described Mr Harris' breathing as normal and without any sign of irregularity. At 12.30am Mr Harris was again checked by nursing staff who observed that he was not breathing. A Code Blue alert was activated and Spencer Clinic staff immediately began CPR. The Code Blue team arrived promptly and took over care of Mr Harris. Unfortunately, the extensive efforts to resuscitate Mr Harris failed and he was pronounced deceased at 1.00am on 19 December 2014.

Post Mortem Examination:

12. An autopsy was undertaken by Forensic Pathologist, Dr Donald Ritchey on 22 December 2014. In his opinion the cause of Mr Harris' death was probable cardiac arrhythmia.

13. Dr Ritchey's report includes the following comment:

> *"The autopsy revealed a well-developed, obese adult Caucasian man with a contusion of the left side of the forehead but no other evidence of significant injuries. The heart was moderately enlarged (cardiomegaly) and there was thickening of the left main chamber of the heart (left ventricular hypertrophy). Although the heart was not normal the extent of anatomical disease was not obviously fatal. The ECG abnormalities identified during his brief hospitalization suggest cardiac arrhythmia as a possible mechanism of death."*

14. Dr Ritchey went on to observe that Paliperidone is considered to have a *"possible risk"* of fatal cardiac arrhythmia in susceptible individuals. During his testimony at the Inquest Dr Ritchey confirmed the opinions set out in his report and expanded upon the nature of cardiac arrhythmia and the likely causative factors. In addition to Mr Harris' mental health issues and medication regime he referred to age, obesity and long term cigarette use as possible contributors.

Report on Mr Harris' Care:

15. Section 28 (5) of the *Coroners Act* 1995 provides:

> *"If a coroner holds an inquest into the death of a person who died whilst that person was a person held in custody or a person held in care or whilst that person was escaping or attempting to escape from prison, a secure mental health unit, a detention centre or police custody, the coroner must report on the care, supervision or treatment of that person while that person was a person held in custody or a person held in care."*

The legislation requires that the death of every person who is detained in any State-run institution is carefully and independently examined.

16. I accept the opinion of Dr Ritchey concerning the cause of death. I am unable to find that Mr Harris' death would have been avoided had he received alternative treatment while a patient of the Spencer Clinic HCU. I am satisfied that the steps taken at the North West Regional Hospital were an appropriate response to Mr Harris' presenting condition. As such I am satisfied that the care afforded to Mr Harris was appropriate and in line with contemporary standards and requirements.

Comments and Recommendations:

17. The circumstances of the unfortunate death of Mr Harris are not such as to require me to make any additional comments; neither do they call for any recommendations pursuant to section 28 of the *Coroners Act* 1995.

18. I convey my thanks to Constable Rory Carmichael, the investigating officer for his thorough investigation and report. My thanks also to Senior Sergeant Paul Reynolds, counsel assisting on the inquest.

19. In conclusion I extend my sincere condolences to the family and friends of Stephen Russell Harris.

Dated: 4th May 2017 at Launceston in the State of Tasmania

Duncan Fairley
Coroner