CITATION: *Inquest into the death of Luke Peter Littlewood* [2002] NTMC 007

TITLE OF COURT:	Coroner's Court
JURISDICTION:	Darwin
FILE NO(s):	D0120/2001
DELIVERED ON:	12 March 2002
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HEARING DATE(s):	5 February 2002
FINDING OF:	Mr Greg Cavanagh SM
CATCHWORDS:	CORONERS – INQUEST Mental Health, Involuntary Patient Suicide PAWA Facilities Security

REPRESENTATION:

Counsel:

Assisting:	Mr Mark Johnson
Department of Health & Community Services:	Mr David Farquhar
Power and Water Authority:	Mr Tom Anderson

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IN THE CORONERS COURT
AT DARWIN IN THE NORTHERN
TERRITORY OF AUSTRALIA

No. D0120/2001

In the matter of an Inquest into the death of

LUKE PETER LITTLEWOOD
ON 11 AUGUST 2001
AT PARAP CEMETERY – GOYDER ROAD,
PARAP IN THE NORTHERN TERRITORY

FINDINGS

(Delivered 12th March 2002)

Mr Greg Cavanagh:

1. Luke Peter LITTLEWOOD died at the Old Palmerston Cemetery, Parap at about 4.30 on the afternoon of Saturday, 11 August 2001. The cause of death was multiple injuries, which resulted from a fall from a water tower owned by the Power & Water Authority ("PAWA") on Goyder Road, Parap.

2. The death is clearly a "reportable death" pursuant to section 12 of the *Coroners Act*. Furthermore, at the time of his death, the Deceased was a patient pursuant to the *Mental Health and Related Services Act* who was in custody, even though he was temporarily removed (or absent) from the hospital. As a result, he was a 'person in care' under section 12 of the *Coroners Act*.

3. Under section 15(1) of the *Coroners Act*, the Coroner **must** hold an inquest if the Deceased was, immediately before the death, "a person held in care". This inquest is therefore held consequential to that requirement.

4. Section 34(1) of the Act details the matters that a Coroner is required to find during the course of an inquest into a death. That section provides:

> (1) A coroner investigating –

(a) a death shall, if possible, find –

(i) the identity of the deceased person;

(ii) the time and place of death;

(iii) the cause of death;

(iv) the particulars needed to register the death under the *Births, Deaths and Marriages Registration Act;*

(v) any relevant circumstances concerning the death."

5. Section 34(2) of the Act operates to extend my function as follows:

> "A coroner may comment on a matter, including public health or safety or the administration of justice, connected with the death or disaster being investigated."

6. A public inquest in this matter was held at the Darwin Magistrates Court commencing on 5 February 2002. Counsel assisting me was the Deputy Coroner, Mr Mark JOHNSON. Mr David FARQUHAR sought leave to appear on behalf of the Department of Health and Community Services. Mr Tom ANDERSON sought leave to appear on behalf of PAWA. I granted leave to both of them pursuant to section 40(3) of the Act.

7. The senior next of kin of the Deceased was both his father, Mr Peter Graham LITTLEWOOD, and his mother, Mrs Deborah Joy LITTLEWOOD. Both of them were in attendance throughout the inquest. The Deceased's father lives at Humpty Doo and he was a witness in the inquest. The Deceased's mother lives at Toowoomba in Queensland and travelled to Darwin for the inquest.

8. The court heard from eight witnesses who gave evidence in the inquest. They were:

- Detective Senior Constable Wayne BRAYSHAW – the Police Officer in charge of the investigation of the circumstances surrounding the death of the Deceased;

- Peter Graham LITTLEWOOD, the father of the Deceased;
- Dr Patricia NAGEL, the psychiatrist in charge of the Cowdy Ward at Royal Darwin Hospital;
- Dr Sharon CRABBE, a consultant psychiatrist at the Cowdy Ward;
- Michelle PRESS, a psychiatric nurse at the Cowdy Ward;
- Cecil CHAMBERS, who was at the time of the Deceased's death, a systems co-ordinator for PAWA;
- Norman CRAMP, the manager, Water Operations for PAWA; and
- Dr Bruce WESTMORE, a consultant forensic psychiatrist who gave evidence by video conference from Sydney.

9. In addition to this evidence, a full brief of evidence was tendered by Detective Brayshaw. This evidence included 27 statements from various witnesses. There was also tendered into evidence, numerous other documentary records of the Police, the Department of Health and Related Services, and PAWA.

RELEVANT CIRCUMSTANCES SURROUNDING THE DEATH

Background of the Deceased

10. The Deceased was born in Queensland. He moved with his family to the Northern Territory and settled in Darwin in 1985. His schooling was completed in Darwin.

11. When he left school, he started working as a Trainee Manager for *Hungry Jacks*, a fast-food restaurant chain. Shortly after he turned 18, he commenced working as a Trainee Dealer (ie. Croupier) at the *MGM Casino* in Darwin. After 3 months probation, he became a full-time Dealer. After a further year, he received a further promotion, on a part-time basis, as a Games Inspector. This latter role involved considerable supervisorial duties.

12. In September 2000, the Deceased commenced to live with his sister, Celina LITTLEWOOD, and others in the granny-flat of a house in Nakara. He stayed there until January 2001 when he moved, with his sister, to live in a house at

44 Mistletoe Street, Karama. Also living in the house at Karama were Celina's de-facto partner, Sean VEYRET, and Celina's son, Beau.

13. On Monday 23 July, the Deceased didn't show up for work at the *MGM Casino*. When his employer made enquries about this, the Deceased informed them that he was resigning.

14. Over the few weeks leading up to the start of August 2001, Celina LITTLEWOOD and Sean VEYRET noticed that the Deceased's behaviour started to become more and more strange. They noted specifically that he was smoking more cannabis and he was becoming more withdrawn, ie. so that they were having trouble talking with the Deceased. They also noted that he was coming out with quotes from the Bible and making references to such things as "*purgatory"*.

Beginning of Period Spent 'in Care'

15. At 12.15pm on Friday, 3 August 2001, Police received a call informing them that a male person was observed climbing to the top of a power pole on Vanderlin Drive, near Hibiscus Shopping Centre.

16. A senior Police negotiator, Acting Sergeant Martin BRIGGS, was despatched to the scene where he commenced negotiating with the Deceased. Sergeant BRIGGS was able to convince the Deceased to come down without any harm to him, or any other person. Sergeant BRIGGS was then able to convince the Deceased that he should accompany him to the *Tamarind Centre*, the major facility for the top End Mental Health Service, so that he could receive some help. Sergeant BRIGGS then took the Deceased to the *Tamarind Centre*. I consider that Sergeant BRIGGS should be commended for the manner that he dealt with the situation.

17. At the *Tamarind Centre*, the Deceased was seen by a psychiatric nurse, Verena TINNING. She conducted a triage assessment of the Deceased and concluded that he should be involuntarily detained under section 34 of the *Mental Health*

and Related Services Act. As a consequence of this, the Deceased was taken to the Cowdy Ward at Royal Darwin Hospital. The Cowdy Ward is an approved mental health treatment facility under the *Mental Health and Related Services Act*.

18. At 4.40pm, the Deceased was assessed by Dr Sam ROBSON, a staff psychiatric registrar. While Dr ROBSON had not entered the formal psychiatry training program, he was an authorised psychiatric practitioner under the *Mental Health and Related Services Act*. Dr ROBSON concluded that the Deceased should be admitted, under section 38 of the Act, as an involuntary patient, on the grounds of his mental illness. This decision provided that the Deceased could be detained for up to 24 hours. After the Deceased was admitted, Dr ROBSON prescribed *Olanzapine*, an anti-psychotic medication, of 10 milligrams daily. He also arranged for him to be placed on observations every 15-minutes. Dr ROBSON noted that:

> "….he was happy to come into the hospital and accept the medications. However, he wouldn't, or was every reluctant, to accept that he might have any illness and that he necessarily needed to come into hospital….He lacked any insight into his condition, but was superficially quite happy to carry out our instructions."

19. At 4.15pm on Saturday 4 August, the Deceased was further assessed by Dr Patricia NAGEL, the Director of Psychiatry of the Top End Mental Health Services. In effect, she was the psychiatrist in charge of the Cowdy Ward. Dr NAGEL decided that the Deceased was still suffering from a mental illness and that he should continue to be held as an involuntary patient – under section 39 of the Act. She also completed the appropriate documentation for the Deceased to go before a Mental Health Review Tribunal at its next meeting. Dr NAGEL did not have any further dealings with the treatment of the Deceased after this.

20. The Deceased continued on medication, and under 15-minute observations, until the night of Sunday 5 August. At this stage, observations were reduced to once every 30 minutes.

21. On Tuesday, 7 August, Dr ROBSON further assessed the Deceased. In his *'Clinical Details supporting Application for Involuntary Detention on the Grounds of Mental Illness'* form, Dr ROBSON noted:

> "On admission Luke displayed a fatuous affect, he reported occasional auditory hallucinations, mild loosening of associations, bizarre and religious delusions, magical thinking. He had some insight but extremely poor judgement. Ambivalence re suicidal intent."

22. On this same date, a consultant psychiatrist, Dr Sharon CRABBE, also became involved in the treatment of the Deceased. She saw him in the company of Dr ROBSON. She described her role as that of:

> "….supervising the management and care of Luke with respect to supervising Dr Robson."

In her interview with Police, she stated that:

> "….he (the Deceased) was quite happy to carry on with the medication and stay in hospital because he felt safe here."

23. Dr CRABBE made a provisional diagnosis that the Deceased was suffering from a *schizophrenic illness*. She then arranged for the *Olanzapine* medication to be increased to double the previous dosage, ie. up to 20 milligrams daily.

24. On Wednesday 8 August 2001, the Deceased attended at the Mental Health Review Tribunal hearing. The Deceased was accompanied by his father, Peter LITTLEWOOD, and he was represented by Ms Jennifer DEVLIN, a lawyer from the Northern Territory Legal Aid Commission. The Psychiatric staff that the Cowdy Ward sought an order that the Deceased be detained as an involuntary patient for up to 2 weeks – under section 123 of the *Mental Health and Related Services Act*. The Tribunal ruled that the application by the

hospital should be granted. This then provided that the Deceased should be detained for up to 2 weeks as an involuntary patient.

25. On Thursday 9 August, Dr ROBSON further assessed the Deceased and included that following in the hospital's clinical notes:

> "Upset at having to stay in hospital because only wants to go home and doesn't believe that anything is wrong.
>
> Strong religious beliefs out of context.
>
> Poor insight and judgement."

26. On this same date, a medical student, referred only as 'Zac', spoke at length with the Deceased. He also made notes in the hospital's clinical notes. His notes of this discussion included the following:

> "Now unsure if people from mosque are out to get him: 'may or may not be'....Does not believe climbing a pole and intending to jump off is out of keeping with normal behaviour."

27. By this time, the Deceased was making further requests to the medical staff that he wanted to go home.

28. Dr CRABBE only briefly saw the Deceased on this date and, only then, because she was approached by the Deceased when she was seeing another patient. The Deceased asked Dr CRABBE about the issue of his going home to:

> "...pat his horse".

She informed him that this would be discussed by the psychiatric staff the following day, Friday. Dr CRABBE did not see the Deceased again and her only further dealings with him were in the form of team discussions about him.

29. On Friday 10 August, Dr ROBSON reduced the observations on the Deceased to 'normal' observations as he noted that the Deceased's condition had improved. He commented about the Deceased in the clinical progress notes:

> "Risk to self, moderate."

Later on the same day, Dr ROBSON recorded the following comment about him:

> "Improving mental state. Gained some insight and judgement. Still needs section."

30. Dr Robson proposed that the Deceased be allowed leave the hospital. The provisions of this leave were that the Deceased would be permitted to temporarily leave the Cowdy Ward on Saturday and stay overnight with his father. This decision was made in a joint meeting of the psychiatric team on the Friday. Dr ROBSON further noted that the Deceased would need supervision at all times. He then completed the *'Leave of Absence for Involuntary Patient'* form which provided for leave of absence from 8.00am on Saturday until 6.00pm on Sunday. He noted on this form:

> (subject to the following conditions): "Supervised by father at all times. No illicit drug use. Not to attend building sites / climb tall objects."

31. Dr ROBSON did not speak with the Deceased's father, nor any other member of his family, to explain any of this to them. While he had an opportunity to discuss this with the Deceased's sister and brother-in-law, it seems that he was content to leave this to the nursing staff. In his interview with Police, Dr ROBSON stated:

> "Normally with the leave, sometimes I'll discuss it with the family, but other times, the nursing staff will discuss the leave with their family when they arrive, to pick up the patient. It's not always possible to contact people during the day and during working hours."

32. On Saturday 11 August 2001, the Deceased's father went to the Cowdy Ward to collect the Deceased, as arranged. He arrived at some time after 9.00am. Peter LITTLEWOOD, in his interview with Police, recalled the conversation he then had with the Deceased:

> "He said, 'I've joined the Police Special Forces' and I didn't need to be. You know, twigged things aren't right here. And he said, 'Well, are we going?' And I said, 'No, I might hang on a while. I might just bloody sort this out a bit first, mate.' I said, 'What about these Police Special Forces?' And he said, 'Oh, an Indo I think or something like that with a Filipino bloke up there, patients. Where you join the Police Special Forces?' I said, 'Oh, I think I might think about it. You stay here for the day and we'll see what happens tomorrow.'"

33. It is important to note that there is no mention in the Inpatient Clinical Progress Notes of this visit, although the nurse on duty, Michelle PRESS, conceded that the visit did take place. Nurse PRESS, in the course of her evidence, was unable to specifically recall how busy she was on this day, how many staff were on duty and how many patients there were in the Cowdy Ward. But, she was unequivocal in recalling that she definitely did NOT speak with the Deceased's father at this time.

34. In his interview with Police, Peter LITTLEWOOD stated:

> "I said to, as I was leaving, I said to one of the nurses, I will be leaving and I'll be back tomorrow…."

35. However, in the course of his evidence in this inquest, Peter LITTLEWOOD stated that he was not sure as to whether or not he told the nurse about why he was leaving. He went on to state that he then left the Cowdy Ward with the intention of calling back later in the day to see how the Deceased was.

36. Approximately 45 minutes later, as Peter LITTLEWOOD was heading toward his home, he received a telephone call from the Deceased, who requested that his father return to collect him. Peter LITTLEWOOD recalled that this seemed rather strange. He asked the Deceased whether this was all right with the

nurses, to which the Deceased replied that it was. Peter LITTLEWOOD then returned to the hospital. When he arrived this second time, the first person he spoke with was the Deceased. He recalled this conversation in his interview with Police:

> "I said, 'Have you seen the nurses or anything?' And he said, 'Yeah, it's alright to go'."

37. Peter LITTLEWOOD then approached Nurse PRESS. She informed him that he would need to sign the release form. In her interview with Police, she noted that Peter LITTLEWOOD did not have his spectacles. She then went through the forms with him and got him to sign the *Leave of Absence Agreement Form*. She stated in her interview:

> "I went through both forms and in detail. Just basicly read both forms and said do you understand that Luke's under a section 123 of the Mental Health Act and you're taking responsibility for him. The special conditions of the leave is that you are to supervise him at all times, that he is not to use drugs, illicit drugs on leave an he's not to go near any buildings, building sites or high objects."

38. Peter LITTLEWOOD recalled this situation in his interview:

> "I went back to the head nurse, female one, and I said you know, 'Is it alright for him to go out like, have the doctors cleared it and all that?' She said, 'Oh yes, as long as you, you know, sign that you gotta keep him under 24 hour surveillance' and that sort of thing and that was me job to keep an eye on him."

39. In her evidence in this inquest, Nurse PRESS recalled that the Deceased's father definitely did NOT mention anything to her regarding his concerns as to whether or not the Deceased should be allowed out on leave. Nor about the bizarre comments made to him on his earlier visit that morning. As a result, Nurse PRESS did not think that there was any reason to either cancel the leave, or to consult with the 'on-call' psychiatrist. She did concede that she would only have made such a consultation if it were really necessary.

40. The Deceased and his father then left the ward and proceeded toward his father's home at Humpty Doo. On the way, they called in at Karama at the house of the Deceased's sister, Celina LITTLEWOOD. They only stayed there a short time. The main reason for this visit was so that the Deceased could collect his cricket bat, which he, understandably, was not permitted to have while in the Cowdy Ward.

41. While they were there, at 12.21pm, the Deceased made a telephone call to the Casuarina Police Station. He spoke with a Police Auxiliary, Jeanette CALLAGHAN. The Deceased asked to speak with Acting Sergeant BRIGGS, the officer who had negotiated the Deceased down from the pole eight days earlier. The Deceased informed her that he wanted to speak with BRIGGS about joining the Police Force. He further informed her:

> "….he (BRIGGS) helped me out of some trouble."

42. CALLAGHAN checked the Police *Promis* system for entries concerning the Deceased. She ascertained that there was an alert recorded on this system for an *'attempt suicide'*. She further ascertained that BRIGGS was listed as being *on duty*, but was also shown as *off sick* on that day. Her further enquiries of the Deceased revealed that the enquiry was apparently not urgent, but merely related to his interest in joining the Police Force. She then terminated the phone call. But, to be sure of her position, she then phoned the watch commander who instructed her to send an e-mail to BRIGGS. This she did.

43. The Deceased and his father then left to continue heading to Humpty Doo, stopping without any incident at the Humpty Doo shops. They arrived home at Lot 3587 Havlik Road, Humpty Doo, the home of the Deceased's father. Peter LITTLEWOOD then organised for the Deceased to make a sandwich. As the Deceased was making the sandwich, his father went to the toilet. In his evidence, Peter LITTLEWOOD described that he was only away from the Deceased for about one minute. In the time that he was in the toilet, the Deceased obtained a set of car keys to an old Mazda 323 sedan motor vehicle,

the same vehicle which his father used to collect him. This was at about 3.50pm. His father returned from the toilet and found that the Deceased had gone. His father did not have any other vehicles at the residence and sought assistance of his brother, Raymond LITTLEWOOD, to look for the Deceased.

44. The Deceased got into the Mazda and drove to the PAWA *Salonika Tank* water tower in Goyder Road, Parap. This water tower is approximately 38 kilometres from the property at Humpty Doo. The Officer in Charge of the investigation has described that this journey takes approximately 30 minutes when travelling at designated speed limits. The Deceased parked the car in the Motor Vehicle Registry car park and locked it. The Motor Vehicle Registry adjoins the Old Palmerston Cemetery.

45. The height of this water tower is 29 meters and it is fenced by a 1.8-meter high chain wire fence with 3 strands of barbed wire around the top. Access to the tower compound is gained through a double gate, which is meant to be locked by way of a chain and padlock. Once in the compound, access to the top of the tower is gained via several sets of metal ladders. To get to the first level, there is a ladder which ascends from the ground. At the first level, access is blocked by a padlocked metal plate. This padlock was secured (ie. locked) on this date. To continue climbing to the top of the tower, a person would require a key to unlock the plate, or alternatively, to climb on the outside of the metal ladder to get around the plate.

46. The Deceased gained access to the compound either by climbing the fence or gate, OR by pulling open the padlock and gate and walking through the gate, pulling it shut behind him. He then climbed to the top of the water tower.

47. Police located small pieces of grass on the top of the railing at the top of the water tower. This was consistent with similar pieces of grass found on the soles of the Deceased shoes. In addition, they also noticed that the railing has some silver paint, which had weathered to become powdery. They compared this with some similar powder, which was located on the Deceased. In all the

circumstances, I find that the Deceased deliberately climbed onto the railing and jumped to his death on to the ground below.

48. The Deceased was a patient in a mental health institution and under an order of the Mental Health Review Tribunal. The question remains as to whether the Deceased was sufficiently capable of forming the intent to take his own life.

49. For a death to amount to 'suicide', I must consider whether the act of the Deceased was the:

> "intentional act of a party knowing the probable consequences of what he is about" – see ROLFE B in *Clift v. Schwabe* (1846) 3 CB 437 at 464.

50. This test was emphatically confirmed by the UK Court of Appeal in *Re Davis (deceased)* [1967] 1 All ER 688. That case involved the death of a woman who jumped from the second floor of a building. The coroner determined that the death was a suicide and was caused by "multiple injuries following jump from the second floor window". Regarding the mental element, SELLARS LJ said (at 690):

> "The deceased was certainly in ill-health and under the stress of a disturbed mind. This may no doubt have accounted for what she did, but on all the medical evidence put before us….it does not appear to me that any coroner on a reconsideration of the cause of death would probably find that the deceased did not know what she was doing at the time of her fall or did not appreciate the probable consequences."

51. In the same case, RUSSELL LJ commented:

> "….insanity or disturbed balance of mind will justify a finding of suicide, unless it is of such a character as to deprive the person of the ability to appreciate the probable consequence of the act."

52. I have already referred to the involuntary detention order under which the Deceased was subject at the time of his death. This order was still effective when he was released from the Cowdy Ward on leave on the morning of his

death. The fact that he was released on leave did not cancel out the order made on Wednesday, 8 August 2001.

53. The medical staff at the Cowdy Ward consistently referred to the need for the Deceased's continued involuntary detention on the basis of the acute psychosis that he was suffering. These diagnoses were consistent from the time that he was admitted, although his condition was seen to be improving when he was assessed as suitable for home leave. The issue for me to consider is whether the Deceased was sufficiently capable of being able to know the probable consequences of his act, ie. of jumping from the top of the water tower.

54. I earlier referred to the amount of time that it takes to travel from the Deceased's father's property at Humpty Doo to the water tower at Parap, ie. approximately 30 minutes when travelling at designated speed limits. When considering this amount of time, some additional allowance should be made for each of the following:

- the Deceased got out of his car and locked it,
- he walked to the water tower compound,
- he entered the compound, whether by climbing over the fence or by opening the gate and closing it behind him,
- he scaled the ladder to the first level,
- he had to climb around the locked plate at the top of the first level, and
- he then had to climb the next ladders to the top of the tower.

55. The approximate time for the journey into Parap and allowing for each of the above was 40 minutes. This estimate is based on the time that the Deceased's father went to the toilet until the Deceased's body was located in the Old Palmerston Cemetery. I therefore find that the Deceased knew where he was going to after he drove off from his father's house. I further find that he intended to jump from the top of the water tower.

56. In the course of her evidence, Dr NAGEL was asked, by counsel for PAWA, about her opinion on the intentions of the Deceased. This is referred to at page 75 of the transcript:

> Q: "I want to ask you, with the benefit of hindsight today, whether in your professional opinion, having reviewed all the relevant material, that you would agree with the proposition that when Luke went to the tower and climbed it, it's extremely likely that he did so with the intention of taking his life. Do you agree with that proposition with the benefit of hindsight having reviewed the circumstances fully?
>
> A: Yes."

57. When the Deceased was admitted to the Cowdy Ward on Friday, 3 August 2001, he was assessed as having been a clear suicide risk. He admitted to the treating psychiatrists that he intended to kill himself. This was only a matter of days before his death.

58. On the basis of all the evidence available to me, I find that the Deceased intentionally jumped from the top of the water tower and that he knew that that by so jumping his death would result. I therefore find that this was a 'suicide'.

59. His body was found at 4.33pm in the Old Palmerston Cemetery by a passing pedestrian, Bradley GLYDE, who then phoned the '000' emergency number. Police attended within minutes. It was clear to them that the Deceased was already dead when they arrived.

60. During an examination of the scene, Police noticed that the gates of the compound were closed with the chain looped through the gate. The padlock was not locked, but was hanging open on one end of the chain. Four of the Police officers were able to enter the compound and then to climb to the top of the tower. To do so, each of them had to climb around the locked plate at the top of the lower ladder, as no key was yet available.

61. The body of the Deceased was taken to RDH, where life was pronounced extinct by Dr Joanna COLDRON at 6.30pm. It was only at this stage that it was ascertained that the Deceased was being held as an involuntary patient.

62. The body of the Deceased was identified by a friend, John PRICE, on Sunday, 12 August.

The Deceased's Medical History

63. The Deceased had no previously treated medical problems of any note.

64. The admission by the Deceased to the Cowdy Ward at RDH on 3 August was the first involvement either the Deceased or his father had with any mental health treatment facility.

CORONER'S FORMAL FINDINGS

65. Pursuant to section 34 of the Coroners Act, and upon the evidence adduced at the inquest, I find as follows:

I. The identity of the Deceased is Luke Peter LITTLEWOOD, a male Caucasian, who was born on 3 June 1980 at Toowoomba in Queensland.

II. The Deceased died at the Royal Darwin Hospital on 11 August 2001.

III. The cause of death was multiple injuries. These injuries were sustained as a result of a fall from the PAWA *Salonika* water tower in Parap, Darwin.

IV. The particulars required to register the death are:

a) The Deceased was a male;

b) The Deceased was a Causasian;

c) A post mortem examination was carried out and the cause of death was multiple injuries;

d) The pathologist viewed the body after death;

e) The pathologist was Dr Derek POCOCK, a locum at the Royal Darwin Hospital;

f) The father of the Deceased is Peter Graham LITTLEWOOD;

g) The mother of the Deceased is Deborah Joy LITTLEWOOD;

h) The Deceased resided at 44 Mistletoe Street, Karama at the time of his death; and

i) The Deceased was not employed in any occupation at the time of his death.

OTHER ISSUES & RECOMMENDATIONS

The Psychiatric Treatment at the Cowdy Ward

66. All the evidence before me points to a conclusion that the diagnosis and treatment of the Deceased while he was at the Cowdy Ward was appropriate and proper. All the Cowdy Ward staff, including those who did not give evidence but merely provided statements, were of this view. In addition, Dr WESTMORE provided an independent opinion which confirmed such views. The following interchange between counsel for the hospital and the Dr WESTMORE was recorded at page 159 of the transcript:

> Q: "As I understand it, you haven't expressed concerns about he initial assessment of the patient – that is, taking account of why he was in hospital, what his symptoms were, the family history, his own personal medical history, and coming to a provisional diagnosis?"
>
> A: "I have no concerns about that."

67. I therefore find that no criticism should be levelled at the staff of the Cowdy Ward in relation to the diagnosis and treatment of the Deceased while he was at the Cowdy Ward.

68. I now turn to consider the question of the decision by the psychiatric staff to grant leave of absence to the Deceased and of the procedure that under which this leave was implemented.

69. I consider that it is important to look back on the chronology of events –

Friday 3 August: The Deceased had no history of mental health treatment (or diagnosed mental illness/condition). He was then found climbing a power pole and had to be talked down from this suicidal situation. It was consequential upon this that he was then admitted as an involuntary patient.

Saturday 4 August: The original diagnosis of mental illness was confirmed by a senior psychiatrist and arrangements were put into effect for the involuntary detention to be considered by a Mental Health Review Tribunal.

Tuesday 7 August: Yet another psychiatrist, a consultant, confirmed the earlier diagnoses.

Wednesday 8 August: The Deceased appeared before the Mental Health Review Tribunal. Cowdy Ward psychiatrists submitted that the Deceased required further treatment as an involuntary patient – for up to 2 weeks. The Tribunal agreed and granted the order.

Thursday 9 August: Hospital records note that the Deceased was still displaying poor insight and judgement of his illness.

Friday 10 August: The Cowdy Ward treatment team decided that the Deceased could be allowed to go home - with stringent supervisory conditions. No psychiatrist personally sought to discuss this with the Deceased's father, nor with any other family member.

Saturday 11 August: Deceased's father attended at the hospital to collect the Deceased. Despite the fact that father did not really think the Deceased should have been in the psychiatric hospital at all, he found the Deceased at that time so delusional that he decided to leave him there until later in the weekend. It was only after receiving a subsequent telephone call (from the Deceased) that he returned to the hospital to collect the Deceased. At virtually the first opportunity, the Deceased managed to *escape*, taking a car and driving to the place from which he very soon jumped to his death.

70. No psychiatrist discussed with the Deceased's father the situation with the leave and, in particular, the father's obligations. This was apparently left to the nurse when father turned up to collect the Deceased? Furthermore, the agreement form, which the Deceased's father was required to sign, does not include any mention of the specific conditions of the leave. It is clear that the Deceased's father was not provided with a copy of the written conditions/obligations, which were set out in the leave form which had been completed by the psychiatric registrar. The Deceased's father therefore had no record or reminder of these conditions. All he had was the explanation provided to him by the nurse.

71. I find that the manner in which the conditions of the leave were explained to the Deceased's father was unsatisfactory. To have expected the Deceased's father to have fully appreciated the full extent of the obligations imposed by Dr ROBSON was, at the very least, highly unrealistic. I am not sure that the father (who, after all, loved his son and would not have been completely objective about him), would have appreciated just how dangerous his son's condition was.

72. In the course of her evidence in this inquest, Dr NAGEL conceded that the form of explanation was deficient and unsatisfactory. At page 70 of the transcript, she stated:

> "I think that it would have been appropriate for a doctor to have spoken to him (the Deceased's father) and I think that's what we've taken into account in our review to ensure that counselling around leave takes place, you know, particularly face to face."

73. As a result of a number of concerns over the Cowdy Ward treatment of the Deceased, the Coroner's Office commissioned a report by a consultant forensic psychiatrist, Dr Bruce WESTMORE, from Sydney. Dr WESTMORE provided a report dated 9 February 2002. Dr WESTMORE's report included the following:

> "….I am moderately to highly critical of the psychiatric management provided to Mr Littlewood. He was of at least moderate and probably high risk of attempting or completing suicide. There were sufficient indicators to enable a psychiatrist to come to this conclusion and the decision to provide him with leave, in his father's care, after an attempted suicide, and following what was only a relatively short admission in a patient with an acute psychosis, demonstrated what I believe was poor clinical judgement.
>
> "The consultant psychiatrist who made the decision to release him on leave had only recently started treating him and he was discharged into the care of his father whom I understand my not have had himself full or complete insight into the nature and seriousness of Mr Littlewood's condition.
>
> "In addition, his medication was doubled shortly before he was released on leave, the treating psychiatrist had identified his as being of moderate risk of self harm and he had only been in hospital for nine days, to be treated for an illness which in probability would have taken weeks, perhaps months, to resolve. That is assuming that the illness was not treatment resistant.
>
> "To balance these early comments, I would also indicate however that predicting suicide can be a difficult and problematic task. There are however identifiable factors in a patient's history which ought to make the clinician wary and

cautious and take the necessary clinical precautions to try and minimise risk."

74. Dr WESTMORE's subsequent opinions and conclusions included the following:

> "He was correctly diagnosed as suffering from an acute mental illness on admission and correctly identified initially as being at high risk of self harm.
>
> "It was, in my opinion, unrealistic to expect the father to be able to provide Mr Littlewood with the necessary support and supervision an acutely mentally ill person like Mr Littlewood, would require at this stage of his illness and medical management. Likewise, the expectation that he would remain away from heights was unrealistic.
>
> "Complicating this case further is the problematic communications between medical staff and the patient's father, particularly in regard to the issue of Mr Littlewood's leave and his father's obligations. I would note again that father's possible lack of understanding and insight about the seriousness of his son's condition.
>
> "….the decision to release him into the care of a medically unqualified person, considering the acute nature of his illness and its severity, was the incorrect decision. This decision is not based on the tragic outcome, but on the fact that risk factors were present. They should have been correctly identified and, in my opinion, acted upon in a different way than occurred in this case."

75. In the course of his evidence, Dr WESTMORE's opinions did not diverge from his report in any notable way. Counsel assisting me submitted that Dr WESTMORE came across to the court as a very competent and credible witness. I agree with this submission. I commented in the course of the inquest (refer page 181 of the transcript) that:

> "I found Dr Westmore to be impressive."

76. Dr NAGEL (the consultant Psychiatrist employed by RDH) also carried out a review of the treatment and of the decision to grant leave of absence. This

review was encompassed in a report, which was tendered to the court during NAGEL's evidence at the inquest. She noted:

> "These key features of psychiatric assessment were clearly met in this case. The diagnosis was appropriate (Early Psychosis or Drug Induced Psychosis). The original risk of self-harm was identified as 'high' and the…. risk factors were noted.
>
> "The review found that the patient's progress was thoroughly monitored through regular clinical interviews, that there was regular ward review of the observation level required, and that there was discussion of the case at the Early Intervention Team Ward Round on 10/8/01. There is evidence of a number of contacts with his father during the admission. The first was soon after his admission to the ward, the next day he was given written information and a video and over the next week the father was engaged in two interview with Treating Psychiatric Registrar, Dr Robson. One interview held between father and nursing staff is also documented. The required standards of treatment outlined above were clearly met throughout the admission."

77. Dr NAGEL referred to a number of key points, which needed to be noted in the decision to grant leave of absence. She went on to state that:

> "The….detailed list was thoroughly taken into account by the treating professionals. There had been a significant improvement in the presentation of the patient and consequent decrease in the level of identified risk. This was revealed in the gradual change in the level of observation deemed to be required.
>
> "Dr Westmore highlights the difficulty of suicidal risk assessment in the individual patient and identifies a number of important risk factors in his report. There are, however, many other factors to take into account as a treating clinician. These other factors will change more quickly, unlike those he mentions, such as gender, and age. The symptoms of psychosis, too, will be expect(ed) to change with treatment. It is these factors the clinician will be monitoring day to day. Factors such as the detail of the psychotic symptoms, the level of insight into illness, and the individuals overall reaction to the treatment environment were clearly carefully monitored for change during the admission, and which the Treating Team took into account as they came to their decision. The Treating Team also

considered another key point in their deliberations: that the relationship between the Service and the patient and his father was pivotal to the ongoing management, and that both father and son were requesting leave. There was clear evidence if improvement in the patient's mental state, and a consequent documented decease in the level of observation during the admission."

78. Dr NAGEL's summary and conclusions included the following:

> "The treatment process was at all times thorough, appropriate and consistent. The tragic outcome of the granting of leave could not be predicted – as is so often the case. Clinicians must always weigh the uncertainty of the risk of leaving hospital with the benefit to that individual of touching base with home again, and of being surrounded by family and friends. In my review of this case, I have formed the opinion that all relevant suicide risk factors had been taken into account, and careful and appropriate consideration by appropriately qualified health professionals had led to the decision to grant leave."

79. Counsel assisting me submitted that Dr NAGEL came across to the court as a psychiatrist of some experience and a witness who was sincere, genuine and honest. I agree. I commented in the course of the inquest (refer page 181 of the transcript) that:

> "I found Dr Nagel to be impressive."

80. The tragic events on the afternoon of Saturday, 11 August 2001 have very clearly indicated that the decision to allow the Deceased to go out on leave was an incorrect decision. But, this comment is very much made with the benefit of hindsight. Dr CRABBE conceded this in the course of her evidence. At page 106, I put this to her:

> Q: "Without the benefit of hindsight, you say you did the right thing, it was a value judgement, it was an opinion of yours that you stand by; I accept that, no problems with that. I just want to know whether you're prepared to accept for the benefit of hindsight, that it was wrong?
>
> A: "I think the outcome of the case has proved that."

81. Earlier, I quoted from Dr WESTMORE's report:

> "….the decision to release him into the care of a medically unqualified person, considering the acute nature of his illness and its severity, was the incorrect decision. This decision is not based on the tragic outcome, but on the fact that risk factors were present."

82. With due respect to Dr WESTMORE, it is abundantly clear that he was making his comments with the benefit of hindsight, ie. with a full awareness of the tragic outcome. However, even with the benefits of hindsight, Dr WESTMORE pointed out the various risk factors, which he considered would have been apparent to the treating psychiatrists and psychiatric registrars. In his report, he indicated that the combination of these risk factors:

> "….makes the decision to release him nine days after his admission, a matter of grave concern from a medical management perspective."

83. I accept that it will always be a difficult decision for psychiatrists, patients, families and those who sit on Mental Health Review Tribunals to weigh up the arguments for and against whether the patient should be detained involuntarily in a mental health institution. The safety and welfare of the patient must always be paramount in such considerations.

84. In the case of the Deceased, the staff at the Cowdy Ward noticed an improvement in the condition of the Deceased between the Wednesday when he went before the tribunal and the Friday when the decision was made to release him on leave. Dr NAGEL referred to the general philosophy of treatment of psychiatric patients in her evidence. At page 77 of the transcript, she stated:

> "The philosophy is that we may not detain someone in a ward if they can be managed in the community….the focus is on the least restrictive means of treatment and the onus is upon us to transfer someone to voluntary status as soon as we identify that they're able to be managed in that way."

85. When the decision to allow leave was made, I note that the Deceased was still assessed as being at moderate risk of self-harm. I have already referred to the chronology of the matter. Despite the factors outlined by Dr NAGEL in favour of releasing the Deceased on leave, I agree with Dr WESTMORE that the decision to release him some nine days after his admission was an incorrect decision.

86. I earlier quoted from Dr WESTMORE about the unrealistic expectations involved in the decision to release the Deceased into the care of his father. I note that the psychiatric staff at the Cowdy Ward relied heavily upon the close relationship between the Deceased and his father. I nevertheless agree with the comments of Dr WESTMORE in that the conditions of the release, as set by Dr ROBSON, were highly unrealistic and were therefore a recipe for disaster.

87. I have had some concerns about the perceived objectivity of the internal review carried out by Dr NAGEL (especially given Dr Westmore's opinions). In the course of final submissions to me, I put these concerns to counsel for the hospital. It is pleasing to note that counsel for the hospital responded that an independent report would be sought! He stated, at pages 185 and 186 of the transcript:

> "I can tell you that the Health Commissioner will commission a report from an independent psychiatrist from a public hospital….to look at everything in relation to the decision…."
>
> Since the evidence at the inquest was completed, I have been informed by counsel for the hospital that arrangements have now been put into effect for "an independent review of the actions, procedures and documentation of the hospital and its staff regarding the management and treatment of Mr Luke Littlewood."

88. I accept and fully endorse the undertaking by counsel for the hospital.

Access to the PAWA Water Tower

89. The PAWA have a continuing duty to the public to ensure that unauthorised people are not able to gain access to areas maintained by them and which have the potential to enable people to harm themselves. This is the same general duty of care that exists with all public utilities. In the case of facilities where particular dangers do exist, the duty on the particular authority is even greater.

90. This is the position with the water tower at Parap, known as the *Salonika* Tower, operated by the PAWA. This structure is some 29 metres in height and situated in a largely residential area with very few hills or other tall structures. I have earlier described the tower and the fence enclosure in which the tower stands.

91. There is a continuing duty on the PAWA to ensure that this tower is safely secured at all times. It is of even greater importance that all reasonable steps are taken to ensure that members of the public are not reasonably able to climb the tower and so to put themselves, or other members of the public in the area, in danger. This duty particularly exists to protect children.

92. I am satisfied that the fence and gate set-up on the compound to the water tower is sufficiently secure for a structure of this kind. This is dependant upon the gate actually being properly secured at all times when a member of the PAWA staff is not on those premises.

93. In this inquest, I heard and read evidence concerning the question of whether the gate was actually locked at the time that the Deceased arrived there on the date of his death. There are approximately 100 keys on issue to the locks to the water tower. The persons/bodies issued with keys include not only staff of PAWA, but also a number of others who need to use the tower, eg. radio and telecommunications firms. There is no effective and efficient log kept for those keys. But, this does not, of itself cause me any real concern. What does concern me is what procedures and protocols are put in place to ensure that the

lock is properly secured after each of the authorised users leaves the enclosure. In this regard, Norman CRAMP, the Manager Water Operations for PAWA, stated in his evidence, at page 147 of the transcript:

> "We've now engaged Chubb Security to carry out three inspections of all of our water facilities in Darwin. They attend those facilities three times a night, they do a full locking inspection and perimeter inspections at irregular time."

94. From the evidence presented in this inquest, it is clear that, once inside the enclosure, there was nothing to stop any person, including a relatively small child from climbing the steps to the tower, at least to the base of the first level. While Mr CRAMP referred to the danger in climbing past the locked plate at this point, it is clear that four Police officers, one of whom is in his middle-age years and another who was carrying a camera at the time. Clearly, the locked plate was not a sufficient deterrent to any person of moderate agility and some determination.

95. Once again, I will refer to the evidence of Mr CRAMP in this inquest. He informed me that the PAWA have called for quotes for alterations to be carried out on the structure. These alterations are intended to effectively prevent any person from being able to climb around the ladder and hence for such persons to defeat the security of the locked metal plate. He informed me that the authority proposes to start the alterations by the end of February this year. As I understand such alterations, they will, when completed, effectively stop access of the kind which the Deceased was able to avail himself of on the date of his death.

96. As a general comment, I find it pleasing that a utility such as the PAWA have taken such a responsible and pro-active approach to the problems, which came to the fore with the relative ease of access by the Deceased to the water tower. The authority is to be commended for such an approach, rather than waiting for

me to make recommendations for such alterations in the course of Coronial Findings.

97. Finally, I note that the Deceased's mental condition was exacerbated apparently by the heavy use of cannabis in the weeks proceeding his death. I have commented in the past of the evident link between cannabis use and psychosis, especially in young persons. I refer to the Inquest into the deaths by suicide of young people on the Tiwi Islands (handed down 24 November 1999). I recommend that Health Authorities publicise this link and educate young people about the danger.

Dated this 12th day of March 2002.

_____

Greg Cavanagh
TERRITORY CORONER