CITATION: *Inquest into the death of Sunjay Chandra [2003] NTMC* [066]

TITLE OF COURT:	Coroner's Court
JURISDICTION:	Darwin
FILE NO:	D0235/2002
DELIVERED ON:	19 December 2003
HEARING DATE(S):	15, 16, 17, 18 and 19 September 2003
FINDING OF:	Mr Greg Cavanagh SM
CATCHWORDS:	CORONERS, Inquest, mental illness, medication regime, observations of carers, discharge after involuntary admission, protocols for administration of clozapine.

REPRESENTATION:

Counsel:

Assisting:	Mr Michael Grant
Representing Territory Health Services:	Mr John Reeves QC Ms Sally Sievers

Judgment category classification:	A
Judgment ID number:	NTMC 066 [2003]
Number of paragraphs:	77
Number of pages:	34

IN THE CORONER'S COURT
AT DARWIN IN THE NORTHERN
TERRITORY OF AUSTRALIA

No: D0235/2002

In the matter of an Inquest into the death of

SUNJAY CHANDRA ON 27 DECEMBER 2002 AT 5 LANTANA STREET, NIGHTCLIFF IN THE NORTHERN TERRITORY OF AUSTRALIA

FINDINGS

(Delivered 19th December 2003)

Mr Cavanagh SM:

The nature and scope of the inquest

1. Sunjay Chandra ("the deceased") died at some time between 1030 hours and 1330 hours on 27 December 2002.

2. Section 34(1) of the Act details the matters that an investigating coroner is required to find during the course of an inquest into a death. The 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*; and
> (v) any relevant circumstances concerning the death; or …"

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

> "(2) 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."

4. The duties and discretions set out in subsections 34(1) and (2) are enlarged by s35 of the Act, which provides as follows:

> "(1) A coroner may report to the Attorney-General on a death or disaster investigated by the coroner.
>
> "(2) A coroner may make recommendations to the Attorney-General on a matter, including public health or safety or the administration of justice connected with a death or disaster investigated by the coroner."

5. The public Inquest in this matter was heard at the Darwin Magistrates Court between 15 and 19 September 2003 (inclusive). Counsel assisting me was Mr Michael Grant. Mr John Reeves QC and Ms Sally Sievers sought leave to appear on behalf of Territory Health Services. I granted that leave pursuant to s40(3) of the Act.

6. I was advised at the outset of the Inquest that the circumstances of the death have caused significant distress to the deceased's family. It was further submitted that any reporting of the matter which disclosed the deceased's name, and involved the publication of sensitive information in relation to the deceased's medical condition and family circumstances, would only serve to exacerbate the family's distress and that a suppression order was appropriate.

7. In matters of this nature of the Coroner's Court generally imposes certain restrictions on the publication of reports of the proceeding. The power to do so is found in s43 of the *Coroners Act*. That section provides: --

"43. Restriction on publication of reports

"(1) A coroner shall order that a report of an inquest or of part of the proceedings, or of evidence given at an inquest, shall not be published if the coroner reasonably believes that, to publish the report, would -

(a) be likely to prejudice a person's fair trial;

(b) be contrary to the administration of justice, national security or personal security; or

(c) involve the disclosure of details of sensitive personal matters including, where the senior next of kin of the deceased have so requested, the name of the deceased.

"(2) A person shall not publish a report in contravention of an order under subsection (1).

"Penalty for an offence against this subsection: $10,000 or imprisonment for 2 years."

8. I considered that an order suppressing the publication of any information disclosing the deceased's medical condition was broader than required, and would have been unduly restrictive in terms of permissible media coverage. In the circumstances, I made an order restricting the publication of any report of the matter which disclosed the deceased's name and the names of any of his family, including his parents. That order remains in place.

Formal findings

9. One of the coroner's functions at common law is to find the cause of death. This is reflected in s34 of the Act, which requires the Coroner to find, *inter alia*, the cause of the death. This connotes a finding as to the medical cause of the death and the manner in which took place: see *R v Poplar Coroner; Ex parte Thomas* [1993] 2 WLR 547 at 552; *Alphacell v Woodward* [1972] AC 824; *Ex parte Minister of Justice; Re Malcolm; Re Inglis* [1965] NSWR 1598 at 1604. The traditional categories of finding are

unlawful homicide, lawful homicide, suicide, misadventure, accident, natural causes, and an open finding: see McCann, "The Range of Findings Open to the Coroner" in Selby (ed), *The Aftermath of Death* (Federation press, Sydney, 1992), p14.

10. It is clear from the evidence received during the course of the Inquest that the appropriate formal finding in relation to the cause of death is as set out in the autopsy report, viz:

> "The cause of death was hanging."

11. There is no doubt that the hanging was self-inflicted.

12. That being so, the mandatory findings pursuant to s34(1) of the Act are as follows:

(1) The identity of the deceased is Sunjay Chandra, who was born in Newcastle, New South Wales on 12 September 1977.
(2) The deceased died at his parents' home at 5 Lantana Street, Nightcliff on 27 December 2002.
(3) The cause of death was hanging.
(4) The particulars required to register the death are:
    (i) the deceased was male;
    (ii) the deceased was of Anglo-Indian descent;
    (iii) a post-mortem examination was carried out and the cause of death was as detailed above;
    (iv) the pathologist viewed the body after death;
    (v) the pathologist was Dr Terence Sinton, the Director of the Forensic Pathology Unit at the Royal Darwin Hospital;
    (vi) the father of the deceased is Subhash Chandra;
    (vii) the mother of the deceased is June Margaret Chandra;

(viii) at the time of his death the deceased was resident at his parents' home at 5 Lantana Street, Nightcliff; and

(ix) the deceased was not employed at the time of his death.

Relevant circumstances concerning the death

13. The deceased tragically hung himself at the home of his parents at some time between 1030 hours and 1330 hours on 27 December 2002. At the time, the deceased was subject to a Community Management Order made pursuant to the *Mental Health and Related Services Act*.

14. The deceased was born in Newcastle in New South Wales on 12 September 1977. The deceased moved with his parents to Darwin when he was three years old and resided here up to the time of his death. He was 25 years of age at the time of his death. He was the middle of three children, with an older and younger sister.

15. The deceased had a close relationship with his parents, and both were entirely supportive of him and maintained a close relationship with him until the time of his death. The parents of the deceased gave evidence during the course of the Inquest and their love of him and dedication to him was clear to see.

16. The deceased was a long-term mental health patient in the Northern Territory. He started manifesting behavioural problems at school in or about November 1990. At that time, a provisional diagnosis of specific learning disorder and developmental articulation disorder was made. He started receiving treatment with Mental Health Services after that time. He was first voluntarily admitted to the Cowdy Ward on 18 July 1993 with paranoia and auditory hallucinations.

17. The deceased was subsequently diagnosed as schizophrenic at the Princess Alexandra Hospital, Brisbane on 30 November 1993. He continued to receive treatment in Brisbane and Darwin after that time.

18. The deceased was voluntarily admitted to the Cowdy Ward on 4 March 1997 suffering from paranoid psychosis and depression.

19. The deceased was again admitted to the Cowdy Ward between 28 May and 10 July 2002. The circumstances of that admission were that he had been found by his father in an unlit flat in a disordered state, and had been drinking for several days. That admission followed a deterioration in the deceased's mental state over a number of months. That deterioration followed a change in the deceased's medication regime. During that admission, the deceased apparently assaulted a staff member and another patient on the Ward.

20. The deceased was involuntarily admitted to the Cowdy Ward once more on 7 October 2002 at the request of his case manager. The deceased had been actively hallucinating, was not sleeping, and was barely eating and drinking. During this admission he underwent various periods of seclusion and high dependency care within the Joan Ridley Unit.

21. The deceased was discharged subject to a Community Management Order on 18 December 2002. The conditions of that order included that the deceased would be compliant with medication, would attend review at the Tamarind Centre once a week, and would attend appointments with the allocated doctor once a month. Upon his discharge, the deceased was observed to have normal rate and volume of conversation, no evidence of formal thought disorder, no abnormality of perception, and to be of stable mood. There is some suggestion in the materials, however,

that the deceased continued to suffer from some psychotic symptoms and was still responsive to hallucinations.

22. The deceased was reviewed by Dr Sinorwala on 23 December 2002. He denied any symptoms or problems. He presented as withdrawn and maintained poor eye contact. The deceased claimed that he was compliant with medication. The case manager did not attend at that time.

23. The deceased hung himself at his parents' home on 27 December 2002. In the days immediately prior to his death, the deceased did not display any indication of an intention to end his life. He was withdrawn, but his behaviour was not particularly out of character. The last person to see the deceased alive was his mother, who also discovered the body. The deceased's mother left her home at approximately 1030 hours on the day of his death after telling the deceased that she would be out for several hours. She had invited him to accompany her but he declined. Upon her return at or about 1330 hours, she found the deceased hanging underneath the house. Police were called and the relevant statements and investigation reports were tendered during the course of the Inquest.

24. A review of the deceased's medication regime after death indicated that he had been prescribed Carbamazepine and Amisulpride. A toxicology report performed after the autopsy disclosed sub-therapeutic levels of Amisulpride in the deceased's blood and did not detect any Carbamazepine. The reason for this would appear to be that the deceased was not taking his medication as prescribed.

25. A number of matters of concern in relation to public health were raised prior to and during the course of the Inquest. All health care professionals who played any significant role in the treatment of the deceased were called to give evidence during the course of the Inquest. During the

course of the coronial investigation of the death by the Northern Territory Police, an independent expert review of the medical and outpatient files and relevant statements was commissioned by my office and undertaken by Dr Campbell, a Consultant Psychiatrist, and Brian O'Grady, a Clinical Psychologist. Dr Campbell is a Psychiatrist with 30 years experience who has held appointments as Director of Clinical Services at the Rozelle Hospital, as a member of the New South Wales Mental Health Review Tribunal, and various advisory and teaching appointments. Mr O'Grady is a Clinical Psychologist with extensive experience with serious mental illness who specialises in providing psychological assessment and treatment for patients with treatment-resistant positive symptoms of psychosis. Both experts gave evidence during the course of the Inquest.

26. I will deal with each issue of concern in turn.

The reduction of the deceased's dose of Clozapine in early 2002

27. From shortly after the deceased's admission to the Princess Alexandra Hospital in 1993 his condition had been effectively stabilised by use of Clozapine. Clozapine is an atypical antipsychotic medication used to treat schizophrenia. Previous attempts to treat the deceased using classical neuroleptics had met with limited success. In or about late 2001, the deceased determined to reduce his dose of Clozapine. It was his perception that the drug had an overly sedating effect and various other unwelcome side-effects. This was a matter discussed in the outpatient context with the deceased's treating psychiatrist and case manager. The deceased's treating psychiatrist at the time was Dr Robert Parker. Dr Parker had taken over the deceased's management in July 2000, and remained the deceased's treating psychiatrist until August 2002. The deceased's case manager at the time was Mr Richard Ashburner. Mr Ashburner remained in that role until in or about October 2002. The

deceased's resistance to continuing with Clozapine is summarised in Mr Ashburner's evidence:

> "At what other - well, I'll withdraw that and I'll put this question to you, what were his concerns with the side effects of the Clozapine?---He just hated it, for a start.
>
> "Right?---And in particular, he complained about sedation and not being able to do things. He complained about it interfering in personal aspects of his life.
>
> "His sexual function are you talking about?---Yes, yes. Mainly, I think, that the overwhelming thing was the sedation."

28. The management plan adopted during the course of the outpatient consultations with the deceased was that that the deceased would reduce but maintain his dose, and the situation would be monitored to determine whether any subsequent increase or decrease was warranted.

29. Following this decision and the subsequent reduction of the dose, the deceased's parents observed a dramatic decline in his condition. They drew this to the attention of the deceased's treating psychiatrist and case manager in order that some appropriate intervention could be arranged. As it transpired, the deceased's condition deteriorated to an almost catatonic state leading to his admission in May 2002.

30. The parents of the deceased registered complaint both prior to and during the course of the Inquest in relation to their perception that the treating health care professionals did not place appropriate weight on their observations, did not respond in timely fashion to their requests for assessment and intervention, and did not take appropriate steps to assess the deceased's condition and intervene before the matter became critical. During the course of the Inquest I received evidence from the deceased's

parents, Mr Ashburner, Dr Parker and Dr Campbell in relation to these transactions.

31. It is apparent from that evidence that Mr Ashburner and Dr Parker made contact with the deceased on a number of occasions between March and May 2002, when the deceased's parents were expressing concern. The deceased had his regular monthly visit with Dr Parker on 11 March 2002. The deceased's father sent an e-mail communication to Dr Parker on 18 March 2002 indicating that the deceased's condition was getting worse, that the deceased's parents were very worried about his well-being, and requesting that Dr Parker contact them has a matter of some urgency. There was a home visit by Mr Ashburner on 18 March 2002. Whether that visit was in response to the e-mail communication is unclear from the evidence.

32. There was then no contact between the deceased and his treating health care professionals until Mr Ashburner apparently made a telephone call to the deceased on 9 April 2002. The deceased was seen by Dr Parker during the course of his regular monthly visit on 10 April 2002. Thereafter, no attempt was made to contact the deceased until 30 April 2002 when an attempt at a home visit was made. The deceased was not at home. That attempt appears to have been made in response to a further communication from the deceased's father. The deceased's father sent an e-mail communication to Dr Parker on 29 April 2002 indicating that it was important they discuss the deceased as soon as possible. That was followed by an e-mail communication from the deceased's father to Mr Ashburner on 30 April 2002 again requesting contact.

33. Mr Ashburner had phone contact with the deceased at his parents' house on 2 May 2002. Mr Ashburner also saw the deceased at his residence at Shiers Street on the following day. The deceased was seen by Dr Parker

during the course of his regular monthly visit on 8 May 2002. The deceased's father sent a further e-mail communication to Dr Parker on 13 May 2002 noting that his earlier attempts to contact Dr Parker had been unsuccessful and requesting that Dr Parker made contact with him. Mr Ashburner made a home visit to the deceased at his parents' house on 16 May 2002. Again, it is unclear whether that visit was made in response to the father's communications. Mr Ashburner's evidence in relation to that attendance was as follows:

> "Yes?---But he didn't come and see me and so, I - the time that I really assessed him was on 16 May.
>
> "All right, and, what conclusions did you draw there?---My impression was that he was not as alert as he was on a higher dose but he is not plagued by worries and that he has made an informed decision to maintain his current dose. I wrote, 'No gross psychotic features evident' which wasn't quite what I really meant in reflection, he certainly had features of psychosis but they weren't gross to the extent that he was at risk, that I judged him to be at risk to himself, or others. He was holding things together I suppose and so what my plan was, was to continue to support Sunjay with his current medication regime and support return to school or other chosen activities so.
>
> "All right?---I was not of the opinion then that there needed to be demonstrated changes in his whole plan - in our plan of approach.
>
> "You'd been informed by his parents that he was giggling and shadow boxing and engaging in other sorts of inappropriate behaviour? Or was that something he told you?---I don't know that, it's possible they told me that he'd been shadow boxing, I can't recall. He told me - Sunjay told me, 'What does that matter if I giggle to myself sometimes and even just sat up shadow boxing?' So he'd volunteer that that information to me."

34. During the course of the attendance on 16 May 2002 Mr Ashburner clearly had at least some information in relation to the deceased's unusual presentations. Mr Ashburner also had opportunity to make his own mental state assessment at that time.

35. The deceased's father sent a further and lengthier e-mail communication to Dr Parker on 17 May 2002. In that communication he noted that the deceased was showing the behavioural features that had existed prior to him being stabilised on Clozapine following his admission in Brisbane. The deceased was described as being “very busy in the head, mumbling and laughing, great difficulty in concentrating enough to converse, forgetting appointments, looking in the mirror, development of bodily tics, difficulty in controlling anger, excessive drinking, etc". The communication sought some contact with Dr Parker so that the matter could be discussed. It is of some note in this context that the deceased was at that stage strongly antipathetic towards any contact between his treating health care professionals and his parents. For this reason, the e-mail communication also urged Dr Parker not to advise the deceased that his parents had been in contact.

36. The deceased was not seen again by his treating health care professionals until his admission on 28 May 2002 in the disturbing circumstances described above.

37. Dr Parker's evidence was to the effect that whilst it was necessary and desirable to take into account the observations of carers, at the end of the day it was necessary for him to make a clinical judgment as to whether the deceased required intervention. His evidence in that respect was as follows:

> "All right, was it also the case that you were prepared to accept information from other sources for the purpose of making that assessment as to the deterioration in his condition?---I suppose I was happy to accept that other information the issue is, again, always one of confidentiality with patients. I think, ideally, I mean, the Early Intervention Team as an ideal tries to work very closely with the patient and their families. Ideally, there should be a level of

> information exchanged where the team is open to information about the person, and the - their condition from family members. Ideally, there should also be a good education issue so that the family - the patient and their families should take part as part of an education program with the team members. The problem with this is that, if I was given information about a patient, in terms of say, making them an involuntary patient, I would still have to be convinced on my own clinical grounds the patient warranted involuntary admission so what I would have to do, I'll say I'll receive information. I still have to assess the patient, and decide on my own clinical grounds whether the patient can be admitted voluntarily before I'll go ahead and do it. I couldn't do it purely - I - well, I wouldn't do it purely on the basis of information I received, if it didn't concur with my clinical examination of the patient."

38. That view was endorsed by Dr Campbell. During his regular monthly attendances on the deceased in March, April and May 2002, Dr Parker did not perceive that the deceased's condition was critical. There are two matters ranged against that. First, it was accepted by both Dr Parker and Dr Campbell that a patient might present differently during the course of a short clinical assessment when compared with his presentation over an extended period as observed by carers. Secondly, Dr Parker's observations were made during the course of regular monthly attendances. No special fixture or appointment was made in response to the concerns being expressed by the parents. It would appear, however, that the deceased's symptomatology and the possibility of involuntary detention were discussed prior to 28 May 2002. Mr Ashburner's evidence in that respect was as follows:

> "MR GRANT: But just finally on that point, Mr Ashburner, you say in your statement, and you've said in evidence that the treating team debated the merit of involuntary treatment and there was some discussion as to when there should be a shift from a collaborative approach to a coercive approach. Can you, just for His Worship identify in your notes your records of those discussions so we can see when they took place?---I fear my records of those discussions are sadly lacking, let me see. I can see no notes as far as I'm looking - before that first submission where I have made a record of those discussions.

"All right, just back to paragraph 13 of your first statutory declaration then, you say, 'There the treating team debated the merit of involuntary treatment but considered more likely to achieve a satisfactory outcome by continuing to work with what Sunjay would accept'. Who was it on the treating team that you debated that particular issue with ?---Well, as I said I can't remember exactly who composed the team at that time. I can state that Doctor Robert Parker was our consultant at the time, he would have most likely have been one of the key players and that other people on the team included Anthony Forrester, who was there most of the time and Mr Samuel Herry, our family therapist who's been a stable member of the team, he would have most likely been there. Our psychologist, came and went a fair bit, so I'm not certain which psychologist would have been on the team at any of the time.

"But you can remember debating the issue in conjunction with Doctor Robert Parker? ---I cannot recall a particular occasion with Doctor Robert Parker being there, I firmly believe that it would have been the case.

"……

"All right, do you remember on how many occasions you debated it in the context of Sunjay's treatment?---No, I do not remember that.

"Was it more than once?---It would have been more than once, yes.

"All right and do you remember, just very roughly about when you had these debates?---I would have raised it to the team at times that there was increasing concern about Sunjay so the way that things were brought up - we have to review people at least every three months for people that are people that are doing less well, we can choose to review that more often, or if there's somebody who is in some degree of crisis then we can bring them up every week and discuss them and I would certainly have discussed with the team when there was substantial concerns about Sunjay.

"All right, are you able to say whether you discussed it with the team after Sunjay's parents advised you of what they were observing in terms of his rapid deterioration? ---That is the exact - type of occasion that I would bring it up, Sunjay's parents were very good at alerting me to that and after - usually after they would phone me then I'd try and see Sunjay myself, sometimes the same day and then I'd discuss observations with the team as I saw fit.

> "All right, but just putting the question again, can you recall discussing it with the team after they raised their concerns?---I cannot recall a specific occasion."

39. That account is probably less precise than one would have liked, but I do accept that the deceased's deterioration was discussed in the clinical context and that certain considered decisions were made in relation to his case management having regard to that deterioration.

40. In the final analysis, Dr Campbell was of the view that the treatment of the deceased during this period was reasonable and appropriate and I am persuaded to that view. This is not to say, however, that I accept entirely that sufficient weight or attention was given to the accounts being given and the concerns expressed by the deceased's parents. All medical experts who gave evidence in relation to the matter agreed that it was extremely important to take into account the observations of carers when making determinations in relation to the treatment of patients with a psychiatric disorder. Whilst there was some follow-up in this case, short assessments do not give as clear or complete a picture as sustained observations.

41. There was some suggestion made during the course of Dr Parker's evidence that he was not able to put to the deceased the conflicting account given by his parents in order to test those observations. This matter did not preclude an assessment over a longer or more sustained period being undertaken in order to explore the parents' concerns. I would also reject any suggestion that the conduct of the deceased's parents was unhelpful or undesirable. They were placed in the difficult position of having first-hand knowledge in relation to the deterioration of their son's condition, and having to convey that information to the deceased's treating health care professionals without compromising the deceased's relationship with those treating practitioners or their own relationship with

the deceased. The parents of the deceased were obviously perspicacious, attentive, concerned, interested and loving parents. Their response was the natural response of caring parents. I did not consider their approach to be intrusive, overreaching or inappropriate.

42. Indeed, s32 (2) of the *Mental Health and Related Services Act* provides that a person with a genuine interest in, and with a real and immediate concern for, the welfare of another person may request that the person be assessed for the purpose of determining whether the person is in need of treatment under the Act. There is no doubt that the parents of the deceased were people with a genuine interest in and a real and immediate concern for the welfare of the deceased. Their involvement was consistent with the governing legislation and the National Mental Health Strategy.

43. The question whether Dr Parker's responses to the approaches made by the deceased's parents were appropriately timely or fulsome do not bear directly on the clinical issues. For some of the period in question Dr Parker was absent from Darwin. I also have no doubt that he has a busy practice with a multiplicity of responsibilities, and considered himself in a somewhat difficult position communicating privately with the patient's parents in the context of the therapeutic relationship.

44. It was also submitted by Mr Reeves QC that these dealings were too remote from the death of the deceased to fall properly with the ambit of the Inquest. I do not accept that to be so. The Act requires the Coroner to find "any relevant circumstances concerning the death". The Act empowers the Coroner to comment on a matter, including public health, "connected with the death or disaster being investigated". It was conceded that the deceased's medication regime prior to his death was a matter relevant to and connected with the death. Certain of the evidence

heard during the course of the Inquest established that when a patient comes off Clozapine there may be a "rebound effect" from which the patient does not recover in terms of the effective stabilisation of the condition. In this case, the deceased's condition did not stabilise before the time of his death on 27 December 2002. That interaction gives rise to a sufficient nexus between the decision to reduce the dose of Clozapine in early 2002, and the attendant dealings in relation to the decision and the deceased's subsequent presentation, and the subsequent death of the deceased.

45. Having said this, I do not consider that it is necessary or helpful to make any further comment in relation to the dealings between March and May 2002 beyond what I have already said as to the importance of taking into account the observations of carers in making clinical decisions. As stated, I am of the opinion that the treatment administered during this period was reasonable and appropriate in the circumstances. Moreover, it is difficult to see that the outcome would have been materially different even had the treating clinicians acted wholly in accord with the parents' wishes. The deceased had determined to reduce his dose of Clozapine. The expert evidence was uniformly to the effect that it is generally impractical and inadvisable to administer Clozapine in the outpatient setting against a patient's will, and exceedingly difficult to do so in the inpatient setting. Mr Ashburner's evidence in that respect highlights the difficulties:

> "Finally, I just want to ask you about this question about the involuntary administration of Clozapine, you've told His Worship that you didn't think that Sunjay would have benefited from involuntary administration and you gave an example of - or in answer to the questions, you talked about the patient where you did apply to the Tribunal for the involuntary administration. I just want to clarify, whether your statement that you don't think Sunjay would have benefited from the involuntary administration applied to him as both as an inpatient and an outpatient?---I believe it does apply to both as an inpatient as an outpatient but - - -

"Could you describe why that is so?---The - because he was rejecting it so resoundingly and for so long I think he'd done his dash with it. I don't think he was going to turn the corner again, in particular with him, in linking up his unpleasant thoughts with Clozapine, I really was thinking more and more that he needed to try something different.

"Now there are practical difficulties administering Clozapine involuntarily?---There's immense - immense difficulties with administering it involuntarily. It's a tablet and unless you have somebody - the person has to swallow it, I mean you can't - it's absolutely gruesome to think about involuntarily doing that. We give injections to people involuntarily and that's the usual use for a community management order, we do that when somebody's on injection. I can go around every two weeks, give them an injection, if they don't agree with that then ultimately they have to go to the hospital and have their injection and that's where there's a limited degree of a coercive edge to it, but basically, they may have - they've got to have the injection and you know it goes in but to have a person involuntarily on oral medication it gets very hard to have any coercive edge to it.

"And with Clozapine I think you mentioned that you also have to have monthly blood tests so presumably if you're administering the drug involuntarily you've got to do the blood testing involuntarily?---That's quite correct and the thought of holding somebody down to forcibly take the blood test is gruesome and extreme and I cannot see how you'd be able to do that and then go back to working in a collaborative way to somebody with entrusting you and wanting to go ahead.

"To treat their mental illness?---That's right."

46. The only options open to the treating clinicians were to proceed as they did in the time leading up to 28 May 2002, or to force an involuntary admission. That is, of course, what eventually transpired. Dr Parker dealt with the matter in his evidence in the following terms:

"Doctor, I suppose what this boils down to is lets just assume that you had conducted a further review, and you had formed the view on your clinical assessment, that his condition was deteriorating significantly and precisely the fashion observed by Mr and Mrs

> Chandra, what would your response have been?---I certainly would have agreed that he should be admitted involuntarily.
>
> "So, we would have got to the position that we got to on 28 May, but simply sooner? ---Yeah, a couple of weeks sooner probably.
>
> "Save this, when he was found on 28 May, he was of course, in an almost catatonic state, he'd been drinking excessively, he was fearful, he was holed up in an unlit flat, would it have been beneficial to get him in earlier rather than letting him proceed to that particular state before he was admitted?---In the - I mean, I'm looking, I suppose at the - in terms of Sunjay's immediate - the admission from May to July, I don't feel in the end it would have made - like two weeks, made any real difference to the end result. I mean, I - at the end of that admission, Sunjay certainly wasn't 100%, but I don't think he - yeah I don't think coming in two weeks earlier probably would have altered that."

47. I agree that there is no basis upon which might be said that the course of subsequent events may have been altered had the involuntary admission been brought forward by two weeks.

The admission in May 2002

48. At the time of the deceased's admission in May 2002, the deceased's parents were directed by staff at Mental Health Services to take him to the Accident and Emergency Unit of the Royal Darwin Hospital to arrange admission. In the opinion of the deceased's parents, this gave rise to a potentially dangerous situation and was inappropriate given his long history as a mental health patient at the unit.

49. As it transpired, the deceased was ultimately admitted directly to the Cowdy Ward. The parents of the deceased have suggested that in circumstances where a long-term mental health patient such as the deceased attends at the Cowdy Ward in company with his carers in circumstances where the patient is quite clearly disturbed, the appropriate protocol should require direct admission rather than admission through the

Accident and Emergency Unit. I am unable to accede to that suggestion as a general proposition. Not all patients will have the same characteristics as the deceased. Not all carers will have the same depth of understanding and familiarity with the patient's condition as was the case with the parents of the deceased. The evidence heard during the course of the Inquest on this particular topic suggests that admission through the Accident and Emergency Unit will be appropriate in many circumstances given the need to conduct a physical state assessment in order to determine whether the presentation is truly attributable to a psychiatric condition, and to determine whether the prospective patient requires treatment for any underlying physical condition.

50. I make no comment or recommendation in relation to the admission protocols within Mental Health Services. Even were I minded to do so, this is a matter in which I accept Mr Reeves QC's submission that it is too remote from the circumstances of the death to allow comment or recommendation.

The admission in October 2002 and subsequent discharge in December 2002

51. The deceased was readmitted to the Cowdy Ward on 7 October 2002. That admission was facilitated by Mr Ashburner in consequence of the deceased's increasingly chaotic presentation. Mr Ashburner's involvement in that involuntary admission had a damaging impact on his relationship with the deceased. The deceased thereafter refused to acknowledge Mr Ashburner.

52. During the course of the admission medical staff were aware that the deceased was resistant to Clozapine, and the deceased was not immediately responsive to the alternative medication regime put in place.

That regime was supplemented with long-acting intramuscular injections of depo medication. As observed above, the alternative regimes were not wholly effective in stabilising the deceased's condition to the level he had enjoyed whilst on Clozapine.

53. The question posed by the parents of the deceased is whether the course of the deceased's condition would have been different had the medication taken effect and he gained some insight into his condition. Again, all the medical evidence is to the effect that Clozapine was not an available option at that stage given the deceased's resistance to taking it. Dr Sharon Crabbe was the consultant psychiatrist with ultimate responsibility for the deceased's treatment and medication regime during the period of his final involuntary admission. Dr Anne Patton was the Psychiatric Registrar with responsibility for the deceased's care from 15 November 2002 until the date of his discharge on 18 December 2002. Both gave evidence during the course of the Inquest. The alternative medication regime was described in Dr Patton's evidence in the following terms:

> "All right, now the first other drug you talk about, the Carbamazepine, that was an antiepileptic medication which also had the effect of stabilising mood?---Yes.
>
> "And that was used as an adjunct to the primary antipsychotic which was the Amesulphride?---Yes.
>
> "And the other medication you refer to the, Zuchlopenthixol I think it is or penithol? --- Zuchlopenthixol.
>
> "All right, that was a depo medication that you gave every 12 - every 14 to 28 days by intramuscular injection?---Yes.
>
> "And that was also an antipsychotic - slow release antipsychotic medication?---Yes.
>
> "Why was it necessary to try that combination of drugs, the Amesulphride and the other two?---Sunjay was tried on the

Amesulphride first and gradually increased up as is normal practice, up into a maximum dose.

"Yes?---Once he was on the maximum dose, he still wasn't as well as we would have hoped that he might get, so we tried adding in other drugs to add - to get additive effect, if you like.

"All right, and when you say he wasn't as well as he could have been, he was still responding to hallucination and still displaying some sort of psychotic symptomatology?---Yes.

"You were aware that prior to being introduced to Clozapine that he'd been unresponsive to various other antipsychotics?---I was aware that he hadn't responded well to other antipsychotic medications.

"All right, and you were aware that in fact, you observed that his response to Amesulphride by itself wasn't particularly good in terms of controlling his symptomatology?---Yes, his response to Amesulphride was slow, this was there, he did respond, he did improve. But he still had symptoms when he was on maximum doses of Amesulphride.

"Right, which is why the other two were introduced?---Yes.

"And the introduction of the other two into the regime did they have any therapeutic effect?---I believe they did, because Sunjay continued to improve, even though the improvement was slow."

54. Dr Campbell's evidence is that it was appropriate, as was done in the circumstances, to trial Amisulpride with Carbamazepine. He was also of the opinion that the new medication regime required further time to allow an assessment of its efficacy in reducing symptomatology before any alternative regime was considered. The outcome was unfortunate in the sense that the deceased's condition did not stabilise, or at least not sufficiently to avert his death, but it is not possible to criticise the trial of that particular medication regime. There is no basis on which to find that the implementation of the regime was other than an appropriate clinical determination in the circumstances.

55. There have also been concerns raised as to whether the deceased should have been discharged on 18 December 2002 upon recommendation of the treating medical practitioners. It was apparent that the deceased continued to suffer from psychotic symptoms up to the time of his discharge. Dr Patton's evidence was:

> "You introduced these other two drugs and you saw a continued improvement, but was there nonetheless, residual psychotic symptoms still?---Sunjay did have residual psychotic symptoms.
>
> "And what where they?---The main symptom that was evident to use that was that he responded to - he was responding to hallucinations.
>
> All right, and did that continue up to the time of his discharge on 18 December 2002?---Yes."

56. Dr Patton summarised the relevant considerations in relation to the deceased's discharge in the following terms:

> "All right, and you were of the view at that time that it would be more therapeutic for Sunjay to be managed in the community rather than on the ward?---Yes I was.
>
> "Were you aware at that time that there was a possibility that he'd been noncompliant with his medication upon discharge?---There was always a possibility with anybody that they might be non-compliant with medication on discharge. I find it difficult to take antibiotics myself.
>
> "Did you - but I mean, purposeful non-compliance?---There's a risk of non-compliance with any patient, it was certainly a risk with Sunjay because he didn't believe he was unwell and he didn't want to take medication and he made that perfectly clear to us on many occasions.
>
> "And he'd in fact, been, had a history, an observed history of spitting out his Amesulphride?---He had, yes.
>
> "So, what sort of plan did you have to address that particular possibility?---Well, the plan was that because there was that risk

that we would use what - how we do have under the law which is to put Sunjay on a community management order which gives us a bit more control of giving him medication in the community.

"Would that involve being seen by a case worker - a case manager once a week and a doctor once a month, what happened in between times, was really the matter for Sunjay wasn't it?---Taking medication is - as I said before, not something we could force people to do, we can put a lot of - as much safety net around it as we can and in the community the major safety net is for a case worker to keep an eye on medication in the dosed box and encourage compliance.

"But the situation with this patient is that he had an observed history of spitting out his Amesulphride?---Sunjay had, earlier on in the piece spat out his Amesulphride. Before discharge he was taking it.

"All right, he was a patient who, even on discharge though, refused to accept that he was mentally ill?---He did refuse to accept that he was mentally ill.

"Leading you to the conclusion, I presume, that he did not have insight into his condition, sufficient to having maintained his medication once his outside the ward environment?---Lots of people don't have insight into illness but take medication just the same, and Sunjay agreed to take medication and he understood that he was on a community management order. On his discharge, it was made quite clear to him by the Tribunal that under that management order, there was certain responsibilities that he had, which was to take medication and that if he didn't, the likely outcome would be that he would be back in hospital, which he clearly disliked more than taking medication, so, whilst he had no insight into his illness, Sunjay, understood enough to understand that if he didn't take medication he was likely to be back where he didn't want to be."

57. Dr Patton's evidence in relation to the appropriateness of the deceased's medication regime upon discharge was as follows:

"All right, were you satisfied by the time he was released that this particular combination of medications that he was on was sufficient to control his condition? ---What do you mean by that.

"Were you satisfied that the combination of medication he was on upon his release was sufficient to control his condition? I can't put it any more plainly?---The medication he was on upon his release was treating his condition to the best that we could treat him at the time.

"Because you didn't consider that Clozapine was open as a treatment modality of that time?---Clozapine wasn't an option at that time."

58. And further in cross-examination:

"Could you just explain to His Worship what importance - what significance the depo medication had in this community release?---The depo medication is the one bit of the plan that we can actually completely enforce. It doesn't rely on any - it doesn't rely on Sunjay putting a pill in his mouth and swallowing it and with the depo medication you can be sure that he's actually got it on board which was one of the reasons why he was given a depo medication in conjunction with the other medications.

"So, as well as the other medications that you were told my learned friend about he was also released with a depo medication?---Yes, he was.

"And that was part of your planning having him released in the way that he was? ---Yes."

59. It must also be noted that the deceased had not previously manifested any suicidal ideation or indicia that he was at risk of self-harm. During the course of his cross-examination, Dr Parker gave evidence in the following terms:

"At any stage during your treatment of Sunjay, was there any indication that he had a - that it was possible or probable that he would harm himself?---No, it's not in my review, young people with severe mental illness I routinely ask them about disturbance of mood and thoughts of self harm, and I think I've done that on a regular basis with Sunjay, I've never been given any cause for concern.

"THE CORONER: Did he have a history of attempting to self harm?---Not that I was aware of, Your Worship."

60. The decision to recommend the deceased's discharge at the time was a reasonable clinical determination. Certainly the Mental Health Tribunal, constituted by a Stipendiary Magistrate and health care professionals with extensive experience in mental health issues, did not cavil at the recommendation. Similarly, Dr Campbell did not seek to criticise the recommendation in the course of his review of the deceased's case history, subject to one minor qualification discussed further below.

61. Dr Campbell made particular mention of the fact that a step down facility in the nature of supported residential accommodation may be appropriate for certain patients moving from acute care back into the community. The Inquest heard evidence that The Manse facility operated by Mental Health Services provides supported residential accommodation, but of a lower level in terms of the numbers of supervisory staff. Mr Reeves QC made the submission on behalf of Territory Health Services that no finding, comment or recommendation was properly made in relation to this matter. The submission was put on the basis that the issue of a step down facility was too remote in both time and rationale because there was no connection between that issue and the death of the deceased. Mr Reeves submitted that the relevant connection would only be established in the event that there was some evidence that the deceased's death might have been prevented by referral to such a facility, or that such a facility was a more appropriate placement than discharge to his parent's care.

62. For the reasons given in my findings in the matter of an Inquest into the death of Sarah Rose Higgins, delivered contemporaneously with these findings, I am of the view that the Territory Coroner's function and power in relation to the making of findings, comments and recommendations is not limited to matters having a direct causal nexus with the death under

consideration. What is required is that the matter be somehow "connected" or "concerned" with the circumstances of the death in some manner relevant to the coroner's advisory function. In my opinion, the possibility that in another jurisdiction the deceased might have been discharged to a "step down" facility with a higher level of supervision in terms of compliance with medication and visual monitoring, provides a sufficient connection having regard to the matter of the deceased's death.

63. Counsel assisting submitted that I should make the recommendation that some consideration be given to the introduction of a step down facility with staffing levels somewhere between Cowdy Ward and The Manse. I have given the matter careful consideration and cannot accede to that submission. As stated above, Mental Health Services already operates The Manse facility. This Inquest did not receive sufficient evidence to determine whether The Manse facility provided the sort of service adverted to by Dr Campbell. It is also the case, picking up in part the submission made by Mr Reeves, that there was no evidence to suggest that discharge of the deceased into the care of his parents was not the most appropriate course in the circumstances, or that there have been any other cases in the Territory context where discharge to a step down facility was appropriate but not possible. The matter has been raised and is there for the Mental Health Service administrators to consider should it be appropriate to do so.

64. There is one final matter that requires some attention in the context of the discharge on 18 December 2002. The parents of the deceased gave evidence to the effect that the deceased's medication was not made available at the time of his discharge. The medication had apparently been misplaced somewhere in the Cowdy Ward and was subsequently retrieved. The matter was unfortunate but had no impact on the final outcome. I am also satisfied that the general protocols in place within the

Cowdy Ward in relation to medication on discharge are appropriate. There was an isolated breakdown in those protocols in this circumstance. No comment or recommendation is warranted.

Personnel issues

65. There were a number of personnel issues arising during the course of the Inquest which warrant some attention.

66. The first revolves around the deceased's review on 23 December 2002. Mr Rodney Collins was the caseworker who assumed responsibility for the deceased's case following his discharge. Mr Collins was due to meet with the deceased in company with the deceased's treating psychiatrist during the course of the review scheduled for 23 December 2002. He was not present at the time of that assessment. The treating psychiatrist did attend. The account given by Mr Collins during the course of the Inquest was that he was required to attend upon certain other patients in his portfolio and was unable to attend upon the deceased at the appointed time. Mr Collins accepted that this was less than ideal. There can be no suggestion, however, that Mr Collins's absence had any bearing on subsequent events.

67. Mr Collins's absence does bring another matter into focus. During the course of his evidence, Mr Ashburner indicated that his caseload as at December 2002 numbered 47 patients. Mr Ashburner indicated that load was too high. That opinion (or complaint) was supported in evidence by Dr Parker. I hasten to add that Mr Ashburner could not recall precisely what his caseload was at the time of his attendances on the deceased. There is no reason to think it would not have been something similar. Mr Ashburner also noted that in the United Kingdom the ratio is one case manager to ten patients. Turning to Mr Collins, he could not recall

precisely what his caseload was but thought it was in the vicinity of 20 patients. He considered that the United Kingdom ratio of 1:10 was ideal, but did not suggest that his own load was unmanageable. Having said that, he indicated that he would not be able to service any more patients.

68. There was also some suggestion in the evidence given by the father of the deceased that the case manager's ability to make a home visit was sometimes contingent upon the availability of a vehicle from the departmental pool.

69. Again, Mr Reeves QC made the submission that the question of caseloads and resourcing for case managers was not a matter falling within the purview of the Coroner given the lack of a causal nexus between those matters and the death of the deceased. I do not accept that submission for the reasons earlier given. It is clear from Mr Ashburner's evidence that he was not able to attend upon the deceased with the frequency he would have liked. This is clearly a matter relevant to the administration of public health.

70. I do not make any finding that case managers in the Early Intervention or Adult teams were or are overburdened or underesourced in terms of their access to transport. I do not make any recommendation to the Attorney-General in that respect. I simply make the comment that having regard to the evidence that fell during the course of the Inquest in relation to these matters, the relevant administrators within Territory Health Services may wish to review the caseloads and transport facilities of case managers in the Early Intervention and Adult teams.

71. The parents of the deceased also expressed a general concern in relation to the lack of continuity of personnel involved in the deceased's case management. The deceased's case was transferred from Mr Ashburner to

Mr Collins in or about October 2002. This is not a matter which warrants any comment or recommendation. It is a feature of the high level of professional staff turnover in Territory medical institutions. In this specific case, the transfer of the deceased's care to another case manager at what might be seen to be a critical time was reasonable in light of the fact that Dr Nagel had once again assumed responsibility as the deceased's treating psychiatrist. Dr Nagel had previously had responsibility for the deceased's treatment over many years and had a good relationship with both him and his parents. Her assumption of responsibility for the deceased's psychiatric care afforded a certain continuity notwithstanding the change in case managers.

72. In any event, after October 2002 it would have been inappropriate, or at the very least difficult, for Mr Ashburner to continue given his involvement in the deceased's involuntary admission at the time and the consequent breakdown in their relationship.

Clozapine protocols

73. It became apparent during the course of the Inquest that there was some confusion in relation to Clozapine protocols. At one stage it was thought that Clozapine could not be administered involuntarily having regard to the potential physiological effects of the drug and the consequent consent requirements. Mr Ashburner made reference to the matter in the following terms:

> "All right, and you note in your statutory declaration that also involved assisting with adherence to protocols necessary for treatment with Clozapine, could you just tell His Worship what those protocols were and why they were particularly necessary in the context of Clozapine?---Clozapine is a medication which, on top of other side effects that share some kind with many other medications of that class, has got particular, potentially fatal side

effect to do with the formation of white blood cells in the body and so there has to be regular monitoring of the white blood cell count, so that in the event of things going wrong it could be picked up early and the medication discontinued. That monitoring, initially, is weekly for the first 18 weeks of treatment and then monthly thereon."

74. During the period in which he had responsibility for the care of the deceased, Mr Ashburner was of the view that there was no power to administer Clozapine involuntarily because of the requirement for informed consent:

> "I see, and you then go in to say Clozapine can only be given with informed consent and being a tablet it's difficult to enforce compliance?---That's correct.
>
> "What made you think at that stage it could only be given with informed consent? ---The requirement in the Clozapine protocol for a client to sign in formal consent which I just happened to bring with me and if you - I presume you'd be quite familiar with this, this is the close plan CPMS protocol."

75. That position has subsequently been reassessed. Mr Ashburner gave evidence that an application has subsequently been made to the Mental Health Tribunal for an order for the involuntary administration of Clozapine to another patient. That order was apparently made by the Tribunal. It is clear from Mr Ashburner's evidence, however, that there remains some uncertainty as to the interaction between the requirement for informed consent and involuntary administration:

> "All right, see what I'm going to suggest to you is that even back then it was understood that the provisions of the Mental Health and Related Services Act allowed you to treat coercively with medication including Clozapine?---Well, certainly, I did not believe at that stage that you could force somebody to have Clozapine against their will. I believed that at all times they had to have that consent and that they could withdraw that consent at any time.

> "But you know now that's not right as a matter of law?---I know now, that there is one case in the Northern Territory where it has been agreed to allow a particular person in this particular circumstance to have it against their will, yes."

76. This is not simply a matter for the Mental Health Tribunal. The Tribunal acts in response to applications and recommendations made by treating health care professionals. There needs to be a clear and coherent policy within Mental Health Services as to the circumstances in which an order for the involuntary administration of Clozapine will be appropriate, and the legal issues arising in relation to testing and consent requirements. Again, I register Mr Reeves QC's submission that this matter falls outside the purview of the coroner. I have found that the administration of Clozapine was not appropriate or available in these circumstances. The matter was clearly given some consideration in the course of the deceased's treatment, however, and that fact, together with the apparent uncertainty as to the legal availability of such an order, operate to render the matter sufficiently connected with the death of the deceased.

77. I recommend that there be a review of the protocols within Mental Health Services in relation to the administration of Clozapine including:

(1) the broad circumstances in which it will be appropriate to make application to the Tribunal for an order for involuntary administration of Clozapine, including the characteristics of the patient's condition and the appropriateness or otherwise of an involuntary treatment order outside the acute care environment;

(2) the manner in which testing and consent requirements are to be addressed in the context of an involuntary treatment order, together with the legal and logistical issues arising therefrom;

(3) the current state of medical research in relation to the side effects of Clozapine; and

(4) the difficulties that may present in stabilising a patient following the withdrawal of Clozapine.

Dated this the 19th day of December 2003

_____

GREG CAVANAGH

Territory Coroner