CITATION: *Inquest into the death of Paul James Guarini* [2009] NTMC 009

TITLE OF COURT:	Coroner's Court
JURISDICTION:	Darwin
FILE NO(s):	D0146/2007
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FINDING OF:	Mr Greg Cavanagh SM

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Person in care, Mental Health Patient, Suicide, Mandatory Inquest

REPRESENTATION:

Counsel:

Assisting:	Mark Hunter

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

No. D0146/2007

In the matter of an Inquest into the death of
PAUL JAMES GUARINI

ON 14 SEPTEMBER 2007
AT ROYAL DARWIN HOSPITAL

FINDINGS

Mr Greg Cavanagh SM:

INTRODUCTION

1. Paul James Guarini was a Caucasian male born on 4 August 1968 in Melbourne, Victoria. The body of Mr Guarini was found by nursing staff in the ensuite shower alcove of his bedroom in the Cowdy ward at Royal Darwin Hospital (RDH) at approximately 3am on Friday 14 September 2007.

2. Pursuant to section 34 of the *Coroners Act*, I am required to make the following findings:

> "(1) A corner 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;

3. 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."

4. Additionally, I may make recommendations pursuant to section 35(1), (2) & (3):

"(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.

(3) A coroner shall report to the Commissioner of Police and Director of Public Prosecutions appointed under the Director of Public Prosecutions Act if the coroner believes that a crime may have been committed in connection with a death or disaster investigated by the coroner."

5. At the time of his death Mr Guarini was an involuntary patient. His medical admission was subject to an order made pursuant to s 42 of the *Mental Health and Related Services Act.* As a result Mr Guarini was a "person in care" and his death was reportable pursuant to s12 of the *Coroners Act* ("the Act"). For these reasons this inquest is mandatory, pursuant to s15 of the Act.

6. Section 26 of the Act provides:

"(1) Where a coroner holds an inquest into the death of a person held in custody or caused or contributed to by injuries sustained while being held in custody, the coroner:

(a) shall investigate and report on the care, supervision and treatment of the person while being held in custody or caused or contributed to by injuries sustained while being held in custody; and

(b) may investigate and report on a matter connected with public health or safety or the administration of justice that is relevant to the death.

(2) A coroner who holds an inquest into the death of a person held in custody or caused or contributed to by injuries sustained while being held in custody shall make such recommendations with respect to the prevention of future deaths in similar circumstances as the coroner considers to be relevant."

7. Ten witnesses were called to give evidence at the inquest. They were:

(a) Ms Kellie Laura Head, one of Mr Guarini's fellow students at Charles Darwin University ("CDU");

(b) Detective Senior Constable Christopher Otto Ruzsicska, the Officer in Charge of the coronial investigation;

(c) Ms Ingrid Herbert, who was the last person to see Mr Guarini alive;

(d) Ms Francis Adeline Pagdin, Nursing Director for Northern Territory Mental Health Services ("NTMHS");

(e) Ms Brenda Ford, Mr Guarini's consultant psychologist;

(f) Dr Anne Patton, the psychiatric registrar who on 14 September 2007 ordered Mr Guarini's medical admission as a Cowdy ward patient;

(g) Dr Peter Emils Kenne, a psychiatric registrar who on 11 September discharged Mr Guarini from Royal Darwin Hospital ("RDH");

(h) Constable Lynn Joan Frame, a police officer who escorted Mr Guarini to RDH on 10 September 2007.

(i) Dr Robert Parker, Director of Psychiatry for NTMHS; and

(j) Ms Bronwyn Hendry, Director of NTMHS.

8. A brief of evidence containing 48 civilian and police statements together with other reports, photographs and police documentation was tendered at the inquest. The deceased mother attended at the Inquest and I thank her for the respect she showed to the Coronial process.

Formal Findings

9. On the basis of the tendered material and oral evidence at this inquest I am able to make the following formal findings in relation to the death of Mr Paul Guarini, as required by the Act:

(i) The identity of the deceased was Paul James Guarini who was born on 4 August 1968 in Melbourne, Victoria.

(ii) The time and place of death was approximately 3.00am on 14 September 2007 at Royal Darwin Hospital.

(iii) The cause of death was self-inflicted hanging.

(iv) Particulars required to register the death:

a. The deceased was male.

b. The deceased's name was Paul James Guarini.

c. The deceased was of Caucasian descent.

d. The cause of death was reported to the Coroner.

e. The cause of death was confirmed by post mortem examination carried out by Dr Terry Sinton.

f. The deceased's mother was Nadija ("Natalie") Graham. The deceased's father was Egidio Antonio Vincenzo Guarini.

g. The deceased ordinarily resided at North Flinders International House, on the CDU Casuarina campus.

h. The deceased was a university student.

Circumstances surrounding the death

10. Mr Guarini was the father of two adult children. His ex-wife and his children all reside interstate.

11. In 2006 Mr Guarini worked at Charles Darwin University ("CDU"). In the same year he commenced a relationship with a woman in Darwin. In early 2007 he commenced studying behavioural science at CDU and moved into North Flinders International House ("Flinders House"), which is a residence for students located on the CDU Casuarina campus.

12. The relationship between Mr Guarini and his girlfriend was a turbulent one. By early-2007 Mr Guarini reported to his general practitioner difficulties in this relationship, and disclosed at least one attempted suicide by him in 2004. Between February and July 2007 Mr Guarini was at different times treated by two consultant psychologists in Darwin. Mr Guarini had been prescribed the anti-depressant medication Aropax (paroxetine) by his general practitioner, and he is believed to have had access to this medication up until the night of his death.

13. On 7 September 2007 in the Darwin Court of Summary Jurisdiction, a full non-contact order was made for the protection of Mr Guarini's girlfriend. That order was made without admissions by Mr Guarini.

14. At about 10.15pm on the night of Monday 10 September 2007 Mr Guarini was approached by two police officers while he sat with other students at a sheltered recreational area for residents at Flinders House. Police had attended in response to a report of a suicide threat made by the deceased. Upon seeing police, Mr Guarini leapt onto a chair, put his head into a

knotted noose which had already been tied to a supporting beam and stepped off the chair. The noose is believed to have been made using a martial arts belt, and Mr Guarini had previously spoken of his qualifications in martial arts. He hung unsupported in the air for only a few seconds, but the ligature had already become tight around Mr Guarini's neck. Both Ms Head and Constable Frame gave evidence that Mr Guarini struggled with police as they supported his body, and that Mr Guarini was attempting to tighten the ligature around his neck. By the time Mr Guarini could be cut down he had lost consciousness. Police were then able to quickly revive him.

15. Once revived, Mr Guarini became upset as he told Constable Christopher O'Connell about the breakdown of his relationship. He then declared: *"You got to me this time, but I'm gonna to do it; I'll do the job"*. The deceased was at this time intoxicated, and he returned a breath alcohol reading of 0.18%.

16. At about 10.45pm Police escorted the deceased to RDH for mental health assessment, and in conversation with nursing staff Constable Frame reported the dramatic events at CDU. But at about midnight Mr Guarini was discharged into his own care from the Emergency Department, after he was interviewed by a Community Mental Health nurse and denied being suicidal. The deceased promptly returned to the CDU campus, and boasted to fellow students about his ability to deceive medical officers. Ms Head told police that Mr Guarini declared that night: *"I know exactly what to say to those people...I can fool anyone, I can say what I want, I know exactly what those psychologists wanna hear...It's not gonna stop me"*.

17. At about 2.30am the same night Police responded to reports by CDU students that they suspected an overdose (prescribed medication) by the deceased. Mr Guarini was at about 3am escorted back to RDH by Police.

The deceased was at this time unwilling to remain at the hospital for another mental health assessment, so he was sectioned as an involuntary patient pursuant to s 34 of the *Mental Health and Related Services Act.* But at about 10.30am the same morning this determination was revoked, after Mr Guarini was interviewed by psychiatric registrar Dr Peter Kenne and denied being suicidal. The doctor did not regard the deceased as being psychotic, or ill enough to be classified as an involuntary patient. The deceased was again discharged into his own care, with "follow-up" in the community. In his evidence Dr Kenne stated that he made no attempt to contact psychologist Brenda Ford, and the expectation seems to have been that Mr Guarini himself would be responsible for initiating this "follow-up".

18. On Wednesday 12 September Police again had cause to contact the deceased, following a report by psychologist Brenda Ford that she was no longer able to contact Mr Guarini on his mobile phone.

19. On Thursday 13 September the deceased received from the manager of Flinders House formal notice of a decision to require him to vacate the residence. Mr Guarini was at that time also served with a letter containing the name and address of alternative accommodation which had been sourced for him. The eviction decision had been made in response to Mr Guarini's dramatic and disturbing behaviour at Flinders House on the night of Monday 10 September.

20. On Thursday morning the deceased presented without police escort at the RDH emergency department, but left before consulting with a doctor. The reason for Mr Guarini's first attendance at RDH on 13 September is not known.

21. At about 9pm the same day concerned residents at Flinders House contacted CDU security, in response to apparent superficial self-mutilation and blood observed that night on the left arm of the deceased.

22. At about 9.15pm on Thursday night Police again escorted Mr Guarini to RDH for a further mental health assessment. Psychologist Brenda Ford also attended the hospital on this occasion, and contributed to the assessment of the deceased by psychiatrist Dr Anne Patton. A female resident of Flinders House also attended RDH at the request of the deceased, and sat with him during Dr Patton's detailed assessment interview. While in the RDH emergency department Mr Guarini was seen to dispose a piece of paper in a waste paper bin. A short time after his death a blood spattered piece of paper with handwriting was retrieved by police from that bin. The handwriting on this piece of paper is very similar to many writings later seized by police from Mr Guarini's room at Flinders House. The note disposed of by Mr Guarini at RDH contains references to Mr Guarini's former girlfriend, but does not disclose an intention to commit suicide.

23. At about 1.50 am on the morning of Friday 14 September, Dr Patton made a provisional diagnosis of anxiety disorder and borderline personality disorder. She determined that Mr Guarini would be admitted to Cowdy ward as an involuntary patient. Cowdy ward is an acute inpatient mental health unit. The deceased at this point in time became subject to an order made pursuant to s 42 of the the *Mental Health and Related Services Act.*

24. During his assessment interview with Dr Patton Mr Guarini stated that he did not want to be admitted to hospital. But once he was informed of Dr Patton's determination Mr Guarini did not resist being escorted by security guards to Cowdy ward. The deceased arrived at Cowdy ward with Dr Patton at about 2.30am, in a composed state. What transpired over the next 30

minutes establishes that Mr Guarini was already resolute and determined to take his own life.

25. Upon arrival at Cowdy ward Mr Guarini was introduced to nursing staff, and he waited a short time while Dr Patton outlined to nursing staff some of the circumstances surrounding his involuntary admission. Mr Guarini already had some familiarity with Cowdy ward because he had been admitted for one day in 2005.

26. Nurse Ingrid Herbert approached Mr Guarini after concluding her initial conversation with Dr Patton at about 2.45am. The deceased requested a light for a cigarette, and joked with Ms Herbert during a short conversation. Mr Guarini was then escorted by Nurse Herbert to a nearby courtyard area so he could smoke a cigarette which he had requested from security guards upon arrival at Cowdy ward. A short time later Ms Herbert was in the ward office and she heard the deceased re-enter the ward proper. Nurse Herbert told interviewing police two days later that when Mr Guarini re-entered from the courtyard she observed that the clock in the ward office displayed the time as 2.50am.

27. After the deceased declined nurse Herbert's offer of hospital pyjamas she escorted him to a bedroom with an ensuite bathroom. Mr Guarini entered this bedroom and the door was closed.

28. A routine check of patients was being conducted by nursing staff at about 3am, when it was noticed that the door to Mr Guarini's room had been locked from the inside. The door was immediately unlocked, and the deceased was found slumped in the shower alcove. He was partially suspended by a ligature which was tight around his neck and tied to the towel rail. Mr Guarini's shirt and a pillow case from his bed had been used

to make the hanging apparatus. Photographs of the bedroom and bathroom were taken by police a short time later.

29. In her evidence, nurse Herbert explained that Cowdy ward houses male and female patients, and that she believes privacy considerations may be the reason why patients are able to lock their bedroom door from the inside.

30. When found by nursing staff, Mr Guarini did not display signs of life. Once the ligature had been removed from Mr Guarini's neck he was dragged out into the ward corridor. A "resuscitation team" comprising Health Department medical staff then made continuous attempts to revive Mr Guarini, for approximately 30 minutes. The evidence is that all equipment required to assist the efforts of the resuscitation team was readily available and was utilized from a dedicated trolley which was located near Mr Guarini's room. The team pronounced Mr Guarini deceased at 3.30am on 14 September 2007.

Medical Clearance

31. Neither prior to or subsequent upon Mr Guarini's mental health admission on 14 September did Health Department staff perform blood alcohol or other drug screening tests.

32. Forensic pathologist Dr Terence Sinton performed an autopsy on the body of the deceased on 14 September. A blood sample was analyzed by a forensic scientist in South Australia. At the time of his death Mr Guarini's blood contained 0.112% alcohol and a potentially lethal concentration of the anti-depressant drug paroxetine (3mg / L.).

33. In September 2007, Mental health Policy and Procedure clinical protocol 1.02.0 stipulated:

> The admission of a person to an acute inpatient unit requires a medical examination to ensure that the person being admitted is experiencing no physical illness that may be contributing to or related to their mental illness or that requires independent urgent attention. This is referred to as medical clearance.

34. Doctor Robert Parker gave evidence that paroxetine is not a drug which is identifiable at the biochemistry laboratory at RDH.

35. Although Mr Guarini smelt a "little bit" of alcohol, Dr Patton told police that during and after her hour long assessment interview from 1am on 14 September, Mr Guarini was cooperative, animated and responsive to questioning. He denied being suicidal and Dr Patton identified no symptoms of psychosis.

36. Specialist nurse Ingrid Herbert told police that Mr Guarini's speech was "rational and clear" and that he was not unsteady on his feet.

37. In these circumstances, the failure of Health Department staff to perform blood alcohol or other drug screening tests on the night of Mr Guarini's death did not render his death preventable.

Observations

38. In September 2007, Mental Health Policy and Procedure protocol 1.04.2 stipulated:

> In accordance with principles set out in the National Mental Health Standards 1996 and the Mental Health and Related Services Act

> 2007, (NTMHS) strives to provide safety for clients, visitors and staff within the least restrictive therapeutic environment. The treating team's decision to institute a Special or Regular Observation must be based on a clinical and risk assessment involving accepted tools. Cultural sensitivity must be maintained regarding the process of close observation.

39. Dr Patton determined that Mr Guarini should be made subject to the standard "night" regime of observations at intervals not exceeding one hour. This was despite the doctor's determination that Mr Guarini's risk of suicide was sufficiently high to justify him being admitted as an involuntary patient.

40. Taking into account the history provided by Mr Guarini and other evidence available to Dr Patton, an initial "Special" (continuous one-on-one) regime of observations was not required. An initial regime of observations at 15 minute intervals, being the next usual level down the scale, would have constituted part of an appropriate level of care for Mr Guarini. However because Mr Guarini took his own life within ten minutes of being shown to his bedroom, the hourly observation regime chosen by Dr Patton did not render his death preventable.

Risk Assessment

41. Mental Health Policy and Procedure clinical protocol 1.06.0 requires that a full risk assessment and a documented suicide risk management plan be prepared for all inpatients who "…have suicidal intent or who are experiencing suicidal ideation".

42. Dr Patton told police that she was still completing formal documentation relevant to Mr Guarini's risk assessment at the time of his suicide. The evidence is that before Mr Guarini was shown to his room Dr Patton briefed

nurse Herbert on circumstances surrounding Mr Guarini's involuntary admission, during a conference of about 15 minutes duration.

43. Given the fact that it was about 2.45am, and Mr Guarini had by then been waiting at the hospital for more than five hours, it was reasonable that medical staff allowed him the opportunity to sleep before Dr Patton completed all documentation.

44. In her evidence Dr Patton explained Mental Health policy of promoting the least restrictive therapeutic environment while protecting inpatients from self-harm. The highest security Mental Health facility is the Joan Ridley Unit ("JRU"), which is located nearby to Cowdy ward. JRU is more secure than Cowdy ward, but it is physically very austere. Photographs in evidence indicate that bedrooms in Cowdy ward more closely resemble regular bedrooms in RDH.

45. Dr Patton told police:

> I didn't feel I had a choice not to section him, because there was a risk that was clearly evident in this situation. But I didn't enjoy doing it because I knew that even doing that can bring a patient more undone, so putting him in JRU would have brought him even more undone, in my opinion.

46. In all the circumstances of this inquest, Dr Patton's choice of Cowdy ward over JRU was reasonable.

Hanging Points in Cowdy Ward Bedrooms

47. The coronial process is conducted with the benefit of hindsight, and it is necessary to make allowance for that fact. But it must be remembered that

Mr Guarini is not the first involuntary patient to have suicided in Cowdy ward. In *Inquest into the death of Sarah Rose Higgins* [2003] NTMC 065, I stated (at [30]):

> The primary reason the deceased was involuntarily confined in the Cowdy Ward and not in the general community was so that she could be subject to a level of treatment and observation commensurate with her condition. The purpose of that involuntary detention was to ensure her safety. There was a failure of purpose

48. This inquest concerns what has become the third suicide by hanging in a Cowdy ward bedroom in a decade. Although this is the first hanging in a shower alcove, it would be astonishing if the towel rails had not previously been identified as a hanging point which could be replaced with a safe system for hanging wet towels.

49. I referred to the issue of hanging points in Cowdy bedrooms in *Higgins* (supra):

> 74. One matter arising from the police investigation is whether steps might be taken to minimise hanging points in patient rooms. The deceased was able to turn the bed on its side so as to use it as a hanging point. Whilst it is not possible to eliminate all hanging points, the risk can be minimised. Having said this, I have reviewed the findings in the Inquest into the death of Chun Huang and note that the deceased in that case was able to hang herself from the bed head without need to turn the bed on its side. It was for that reason that I did not make any recommendation in relation to hanging points in the course of that Inquest.
>
> 75. I also note that Ms Bradley gave evidence to the effect that since the death of the deceased beds have been fixed to the floor and that furniture is otherwise selected to minimise hanging points.

50. In the wake of Mr Guarini's death, a "critical incident review" was initiated by the Department of Health and Community Services. In June 2008 Dr

Karin Myhill completed her report, which is described as an "independent external investigation". The Myhill report contains eleven recommendations. Recommendation 4.1 is: "Towel rails should be reviewed for weight bearing capacity. Further evaluation and consideration be given to the installation of 'collapable' rails if the weight bearing exceeds a reasonable 'wet towel' limit".

51. In July 2008 the Department of Health and Families (as it is now known) declared that it had accepted all eleven recommendations contained in the Myhill report. Photographs in evidence show the adhesive plastic hooks which Ms Bronwyn Hendry described in her evidence as a temporary replacement for the old towel rails.

CONCLUSION

52. The evidence establishes that Mr Guarini was resolute and determined to take his own life. It is pure speculation as to when he arrived at this decision.

53. The proactive behaviour of the Department of Health and Families, in adopting and acting upon the Myhill report, has rendered the making of recommendations otiose. In all of the circumstances, I have no criticisms to make of the Police or the staff at RDH.

Dated this 9th day of April 2009.

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GREG CAVANAGH
TERRITORY CORONER