CITATION:	*Inquest into the death of Dale Vincent* [2005] NTMC no 052
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Darwin
FILE NO(s):	D0179/2004
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FINDING OF:	Greg Cavanagh
CATCHWORDS:	Inquest – Death In Care – security of mental health facility

REPRESENTATION:

Counsel:	
Assisting:	Helen Roberts
Mr Michael Grant	Police Fire and Emergency Services and Health and Community Services

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

No. D0179/2004

In the matter of an Inquest into the death of

DALE VINCENT
ON 11 OCTOBER 2004
AT PARAP ROAD, DARWIN

FINDINGS

(Delivered 26th August 2005)

Mr Greg Cavanagh, Coroner

Introduction

1. Dale Vincent ("the deceased") died on the 11 October 2004 in Parap Road, Darwin. He was found dead lying at the bottom of a power pole. Circumstances at the scene, and the results of the post mortem examination, lead me to the conclusion that he fell while attempting to climb the pole. The facts as set out below bring his death within the definition of a "death in care" as defined in Section 12 of the *Coroners Act* and therefore the holding of this public inquest is mandatory. His sister, Tina Vincent and his father, Bruce Vincent attended the inquest, liaised with counsel assisting me and asked some questions themselves.

2. Section 34(1) of the *Coroners Act* sets out the matters that the Coroner is required to find during the course of an investigation 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) 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;"

Coroner's Formal Findings

3. The evidence enables me to make the following formal findings:

(a) The identity of the deceased was Dale Vincent, a Caucasian male, born on the 4 April 1977 at Kilcoy Hospital in Queensland.

(b) The time and place of death was between 10 and 11 October 2004 at Parap Road, Parap, Northern Territory.

(c) The cause of death was multiple injuries after a fall from a height.

(d) The particulars required to register the death are:

(i) The deceased was male.

(ii) The deceased was Caucasian, Australian.

(iii) The death was reported to the Coroner.

(iv) The cause of death was confirmed by post mortem examination.

(v) The cause of death was multiple injuries.

(vi) The pathologist who viewed the body after death was Dr Terence John Sinton of Royal Darwin Hospital.

(vii) The father of the deceased is Bruce Alwyn Vincent born in Blackall, Queensland.

(viii) The mother of the deceased is Margaret Vincent born in Blackall, Queensland.

(ix) The usual address of the deceased was no fixed place of abode, Roper Bar, Northern Territory.

Circumstances

4. The deceased lived most of his life in Queensland with his family, and unfortunately suffered mental health problems from the age of about sixteen. He came to the Northern Territory and started living in the Roper Bar area from about 2002 onwards. His medical history reveals periods of involuntary detention under the mental health legislation. In 2004 he had two periods of detention, one in May and one in August. He was diagnosed as suffering schizophrenia. Dr Rob Parker, the Acting Director of Psychiatry with the Top End Mental Health Service, was the consultant psychiatrist caring for the deceased during those 2004 admissions. He gave evidence in these proceedings and in general terms, described the deceased's condition in this way (Transcript p42):

> "…I mean, our view was that Dale unfortunately was disabled with - very severely disabled with what we would probably describe as a simple form of schizophrenia.
>
> MS VINCENT: Yes
>
> THE WITNESS: Schizophrenia has a number of variants - paranoid, disorganised and simple. And Dale's condition was probably more typical of the simple schizophrenia, where people have significant self neglect and have an inability to care for themselves.
>
> MS VINCENT: Yes. He didn't look after himself.
>
> THE WITNESS: And they have some injunctive hallucinations or delusions. But he was very much someone who was very disabled by his inability to care for himself.
>
> MS VINCENT: That's right.

> MR VINCENT: That's right.
>
> THE WITNESS: And when he presented to us in August he'd come from, I think, a remote bush community, where he'd obviously been living but in a fairly difficult way where he'd been neglecting himself. He was obviously very disturbed by some of the ideas he was having at that time, which caused him to become agitated and (inaudible). We know that he had actually responded very well to medication when he was living in Darwin, and we actually placed him on that medication."

5. The deceased's medical records from Royal Darwin Hospital, Katherine Hospital, and the Mental Health Ward ("Cowdy Ward") at Royal Darwin Hospital have been tendered and are before me in these proceedings (Exhibit 4). Those records reveal that the deceased was resistant to taking regular medication and it was likely that he was non compliant with his prescribed medical regime when he was not in hospital. When he was not in hospital, the deceased lived in and around the remote area of Roper Bar and his style of living, combined with his mental illness, resulted in physical deterioration resulted from a lack of care.

6. In August 2004, he was admitted to Cowdy Ward for a period of four weeks as an involuntary patient. On discharge, it was noted by Dr Parker that the drug therapy had had a positive effect and that the deceased was showing some insight into his illness. It appears that he returned to living in the Roper Bar area.

7. On 4 October 2004, Detective Senior Constable Watkinson was travelling to Ngukurr in a police car when the deceased appeared on the road in front of him. He stopped. The deceased appeared dehydrated and distressed. He told the Detective that he needed to see a doctor because he was "stressing out", he also told the detective he had previously been to Cowdy Ward. Detective Watkinson gave him some water and a lift to Roper Bar store. The detective left him there with arrangements that after he had travelled to Ngukurr, to carry out a separate sexual assault investigation, he would return and give him a lift to Katherine Hospital. When he returned several

hours later the deceased was not there, although the deceased had told the store owner he was waiting for a lift from a police officer. Detective Watkinson could not find him despite asking around. It appears that the deceased had somehow made his way to Mataranka, at which place he purchased a bus ticket to Darwin.

8. On the 5 October 2004 at Mataranka, the deceased attempted to board the bus, however, there was an incident in which he assaulted the bus driver and the bus driver contacted the police. Constable Philip Hand, then Brevet Sergeant at Mataranka Police Station, attended. Constable Hand gave evidence that the bus driver told him that he, the bus driver, had told the deceased that he needed to clean himself up before he could get on the bus. A discussion ensued and he was assaulted by the deceased. When Constable Hand arrived, the deceased was still waiting at the scene sitting about 50 metres away under a tree in a park. Constable Hand described him as being very cooperative (transcript p23):

> "And did you - you asked him - I assume you asked him about the assault?---Yes, I asked him and he said he was just upset and angry for not being let on the bus.
>
> So he told - did he agree that he'd done it?---Yes, he knew why he was under arrest and as I said, he was quite co-operative, I didn't have to use any force and actually he and I walked across the road, across the Stuart Highway to the police car, but I did put him in the caged section of the police car is, as per our general orders states us to.
>
> And I think you then - you interviewed him back at the police station in regards to the assault?---Yes, I had to call out my offsider, Constable Fernandes, from his day off just to assist me in processing of the prisoner and he assisted me in interviewing Mr Vincent as we do with a formal record of interview that's taped.
>
> And he told you some things during the interview about how he was feeling, that concerned you about his mental health?---He said he was very stressed, he wasn't really concentrating on my questions and he just seemed to be somewhere else and I asked him and he just said he was stressed and he had some problems with his - he called

> them his guts, and I tried to ask him about that but he sort of said he thought he had twisted bowel or something and he did answer all of questions in the interview from what I can recall and gave an account and knew that he had assaulted the bus driver and was - he freely admitted that."

9. Constable Hand made some further inquires with police at Ngukurr and was given a history that involved mental health problems on the part of the deceased which were consistent with his own observations. He then charged the deceased with assault and drove him to Katherine Hospital. He was seen at the Accident and Emergency ward, with subsequent attention by Mental Health Services staff at the hospital.

10. When arrested by Constable Hand the deceased was complaining of "twisted guts". His family have raised a concern about that complaint and their perception that the deceased was treated as a person suffering solely from a mental illness. They had concerns that his physical problems may have been over looked or dismissed by the psychiatric staff leading to an increased level of distress on behalf of the deceased. I asked Dr Parker about this when he gave evidence (transcript p40):

> "…Well, in the August admission, which was quite a lengthy admission - at the time Mr Vincent first presented at the hospital he was actually preoccupied about this issue. He had a careful physical examination done by the registrar who admitted him to hospital and there was no cause found for any physical complaint, as to what he was actually complaining about. I understand, also, that at that time the doctor in Katherine who admitted him also noted Mr Vincent's - the things he was complaining about, and did a physical examination.
>
> But again, there was nothing to suggest he had any abdominal problems at that time. With the admission in October, I understand Mr Vincent was complaining of these issues when he examined by Dr Scott in Katherine. I understand that Dr Scott, again, examined Mr Vincent carefully and found no cause for abdominal pain of a physical nature. Mr Vincent arrived at Darwin hospital, I think, at about 1 o'clock in the morning. He was seen, at that stage, by Dr Tara Swart. She did not do a physical examination. He was then seen later that morning by Dr Fritz Swart, who was aware of Mr Vincent's - the issues he'd made about his physical problem during

> his admission in August. Dr Swart actually noted those issues. I feel that Dr Swart, given that he'd known Mr Vincent very well, if he was significantly - I think he thought about it in the context of Mr Vincent's overall sort of appearance on the morning, and considered they were probably part of a psychiatric illness rather than a physical illness, per se. Dr Swart, who's a very competent medical, and I feel that he felt there was a distinct physical cause for Mr Vincent's complaints at that time, he would have certainly done a physical examination after interviewing Mr Vincent. Another factor that I noted in the notice was that Mr Vincent had one set of observations done during his brief time on Cowdy Ward before he absconded. During those observations he had a very - his pulse, I think, was 70; his blood pressure was 100 on 60; and he was afebrile - his temperature, I think, was 36.4 degrees. Anyone who'd been in significant physical pain as a result of significant bodily complaint or an infection, for example, would most likely have had quite different observations for those. They would have had a raised blood pressure and a raised pulse, being he would have been febrile. So those physical - that brief physical examination or those observations appear to indicate that Mr Vincent wasn't in physical distress at the time even though he was complaining of these issues."

11. The deceased was transferred to Cowdy Ward at Royal Darwin Hospital by air ambulance and was admitted at about 1:00am on the 6th October when he was seen by Dr Tara Swart. He was then kept in Cowdy Ward pursuant to, initially, a twenty four hour order followed by a seven day order under the Mental Health Act, ie he was an "involuntary patient". The evidence at this inquest clearly establishes there is no physical or other barrier to prevent involuntary patients from leaving the Cowdy Ward.

12. The evidence shows that the deceased was seen again at about 11:00am by a second psychiatric registrar and the seven day order made. He was then noticed missing from the ward at about 2:30pm on 6 October, the same day that he had been admitted. At 3:59pm the police were contacted. I have before me the Top End Mental Health Services Procedure for what is to occur when a patient leaves the ward without notice (part of Exhibit 2). It provides that the responsibilities of staff when a patient leaves without notice include checking potential hiding places, searching the surrounds,

notifying the senior nurse on duty and/or case managers, and carers; noting details in case notes and with respect to involuntary patients one is to on to call for assistance from security and to then to inform the police. There is no evidence in this inquest as to whether security was or was not contacted. However the police were contacted by means of initially a telephone call to police communications. The transcript of the phone conservation is part of Exhibit 1. It is clear that the communications operator asked all the required questions and obtained as many details as could be obtained and then went on to issue a "be on the look out for". Such an alert, known as a BOLOF, is a means to disseminate information across all sectors of police radio in Darwin including the general duties units, the watch commander and any other police, CIB, traffic, or domestic violence unit who is out. The investigating officer in this matter, Detective Senior Constable Laute, gave evidence that on this occasion there would have been no utility in the police attending the hospital as the deceased had been missing for at least one and a half hours. Therefore, that appropriate response was a BOLOF and that would work in this way (transcript p13):

> "So everyone who's driving around doing their other police duties and responding to jobs and callouts is aware that this is a person to look for?---That's correct.
>
> And they hear that on the radio and essentially the police response to that is to be on the lookout for this person while they're performing other tasks?---That's correct. Your Worship, if they in between dispatch jobs where they're directly dispatched by communications. From when I've worked the road the way it was was that any people to be on the look out you write down and if you're not responding to a co-job you try and head back to the direction of your last sighting, whether it be a stolen motor vehicle or whether it be a person that's absconded from the sobering-up shelter or the hospital or whatever. Unless police communications actually dispatch a unit to the location like and - it's a job, it's a dispatch job - 'be on the lookout for' is purely to be mindful that there is a person that needs to be taken into custody.
>
> Now Dale Vincent didn't have any address or relatives in Darwin did he?---That's what the information given over the radio."

13. Locating the deceased was also made difficult by the fact that he was not a local Darwin resident and therefore there was no address or relatives that the police could attend in an attempt to find him. The job was then assigned to Senior Constable Pemberton who is the Hospital based police officer. She also made certain enquiries, particularly with Ngukurr and Mataranka Police, but they were unsuccessful in locating the deceased. I have no criticism of the police response on this occasion and it is my view that they made all appropriate enquiries consistent with their general orders and the Memorandum of Understanding in existence between the police and health in relation to patients missing from the hospital.

14. The bank records (that were obtained after the death) show that the deceased remained in the Darwin area and managed to get himself around; he obviously purchased some other clothes because he was wearing hospital pyjamas when he left the hospital. Sadly, he was not located until he was found deceased on 11 October 2004.

15. The issue, which has been at the forefront of these proceedings, is the fact that the deceased was an involuntary patient, clearly easily able to leave the ward and take himself into an unfamiliar environment where he was unsafe. I have heard evidence that between March 2003 and August 2004 the police have recorded 117 jobs relating to patients absconding from Cowdy Ward, 97 of whom were involuntary patients. Senior Constable Kay Pemberton has been based at the Royal Darwin Hospital since October 2001. She raised before me her concerns, which she has raised previously in other forums, about the amount of patients leaving Cowdy Ward without leave and the resulting policing and public and personal safety issues.

16. Senior Constable Pemberton is part of a committee known as the Mental Health and Police Liaison Committee. There is a Territory wide such committee and a more recently commenced regional committee, Darwin based. Two regional committees meetings have taken place, one in

November 2003 and one in November 2004. They fall under the umbrella of a Memorandum of Understanding between police and Health. In the November 2003 minutes it is recorded that Constable Pemberton noted "that this is an ongoing problem". Peter Mals (a mental health doctor at Forensic Mental Health) advised that the general manager had recently implanted a number of changes in the in-patient facility with a view to improving security. "Re-opening JRU on a permanent basis, decreasing the number of exit points from Cowdy and introducing a uniform system of risk assessment". As I understand the situation, the JRU, or the Joan Ridley Unit, is a secure facility. It is primarily used to house prisoners and or violent patients. It would not have been appropriate to place the deceased in the Joan Ridley Unit on this occasion. Senior Constable Pemberton described her concerns this way (transcript p30):

> "Is it your opinion, - and correct me if I'm not stating it - it's your opinion that the Cowdy Ward should be locked up, is that your view?---Yes. My opinion as a police officer, is that the Cowdy Ward should be locked up.
>
> What do you base - what's the basis for that?---Duty of care to, not only members of the public, but to the patient, you know, you've got someone that has - you know, you have people that have been sectioned sometimes because they are suicidal, or you know, and are at risk of harming themselves, and we've taken that liberty away from them by sectioning them, saying, look we are so concerned about this person, but at the same time, we have an open doors policy where they can just walk out, and I just don't see that the duty of care to that person is there."

17. I have received a statement (part of Exhibit 2) of Steven Gelding dated 29 July 2005. Mr Gelding is the general manager of Top End Mental Health Services and as such has responsibilities for Cowdy Ward. He deposes to the fact that building works are currently being undertaken at Cowdy Ward "with a view to finding an appropriate compromise between the least restrictive environment philosophy and effective risk assessment to avoid absconding". It has been put to me in submissions by Mr Grant, on behalf

of Health, that the least restrictive environment philosophy was the basis for the configuration of the Cowdy Ward in 1993 and that it was based on the most advanced professional thought at the time. The built environment of the Cowdy Ward includes breezeways and open areas and exit points, based upon that philosophy. Dr Parker also gave evidence before me about the emphasis on treating people in a less restrictive environment which has developed since the 1960's. I accept that there is a balance to be reached between what has been described by some people as "locking up" patients within a mental health facility, and securing that facility for the safety of those patients and for the public. It must be remembered that involuntary patients are, by definition, being treated without necessarily wishing to be there. In my view the absconding of approximately one involuntary patient per week reflects an appropriate balancing of those two competing interests.

18. Having said that, this inquest has been told and I accept, that a proactive approach has been taken to the changes in this area. An application for the building works was made to the Department of Infrastructure Planning and Environment in January of 2004, approximately 18 months ago. The money was made available at the start of this financial year and the construction, I am told, is almost complete. The changes which will be made will result in there being one point of entry and exit from the Cowdy Ward facility. The entry is at the far end of the hall way that stretches from the Cowdy unit end of the facility up past the Joan Ridley Unit. I am told, in Mr Gelding's statement, that it is therefore the furthermost point in the facility from the area in which the open ward patients would generally be circulating. The new reception area will be staffed by two administrative staff during working hours and those staff will have a list of the patients and their status. Dr Parker said, in evidence that "nurses and administrative staff will be able to challenge patients who they believe may be involuntary and who are leaving without permission". The doors will be locked between 4.00pm and 8.00am but unlocked during the day. This does not go as far as Senior

Constable Pemberton would like. In reference to these changes she said (transcript, p30):

> "So, as I understand it, it not proposed that the door be locked but that it would have a remote facility for being locked if necessary, do you have any comment on that?---The reception area that they're talking about, I don't think would be able to monitor that door successfully enough. Often, as it stands now, it's actually a newly built reception area, which was part of the construction, that was actually built first. You often will have one staff member in that office - you have actually two rooms that lead off, have computer systems, fax machines, photocopiers, you know, they're doing an administrative job as well as you know, a reception job. So sometimes they're not at the front desk, watching that door, they're actually in the photocopy room at the back, so monitoring who's leaving and going, isn't a possible mandate that they have. If they could guarantee that someone was going to sit there constantly and watch the door, it's a different - but I don't see that happening at the moment."

19. Dr Parker agreed with me when I asked him whether he thought that one absconder per week is too much, however he was insistent that a fully locked facility was not appropriate (transcript p51):

> "So that period of locking will be extended to 4 in the afternoon. Doctor, what do you say of the proposition that one easy way of averting any possibility that people might get passed the administration staff would be to lock the area down altogether 24 hours a day?---Well again, that would be contrary to national mental health guidelines about less restrictive environment. Again, I think people - again, we always get to the issue of the person with the mental illness, as well as the mental illness. I think people are very sensitive to - people with mental illness have often been subject to trauma; they've often been subject to hospitalisation, forced hospitalisation; sometimes injections against their will. They're often very sensitive to the issue of their right under the law, and I think we've got to be very careful that we balance the need for safety, caring for individuals also, against the need for individual rights. So people feel that they're being cared for rather than being locked up, because that could actually be counter-therapeutic and lead to people not wanting to come to Cowdy because they feel they don't have any rights or freedoms."

20. That there is a balance to be struck between the therapeutic aims of treatment on the one hand and the maintenance of a secure facility in the interests of community and patient safety on the other hand is clear. The safety of patients and the public is a very important consideration and I have already commented that the high rate of involuntary patients leaving the Cowdy Ward is too high. Certainly, it sadly resulted in the death of this young man. The evidence establishes that on the balance of probabilities, he was climbing the power pole when he fell to the ground. There are some notations in the medical records of him speaking of suicide by electrocution. However, Ms Roberts has submitted that there is insufficient evidence for me to make any finding about suicidal intent, and I agree.

21. I find that the police acted appropriately and did all that they could in these circumstances. In addition, I commend the work done by Detective Senior Constable Laute. His investigation addressed very thoroughly the issues that I needed to consider and he gave thoughtful evidence before me. I also find that the deceased was appropriately examined and properly detained under a mental health order for the purposes of treatment.

22. I move then to the issue of recommendations. Due to the fact that some major changes have and are being made in relation to the built environment of the Cowdy Ward, I do not propose to make a specific recommendation in this area. However, I would recommend that Mental Health Services and the Department of Health to closely monitor the effect of the changes that have been made. If they are not having a positive effect on reducing significantly the number of absconding involuntary patients from the ward, then further changes should be considered and should be made expeditiously.

Dated this twenty sixth day of August 2005.

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GREG CAVANAGH
TERRITORY CORONER