CITATION: *Inquest into the death of Linden Alan Kunoth* [2019] NTLC 028

TITLE OF COURT:	Coroners Court
JURISDICTION:	Alice Springs
FILE NO:	A0066/2017
DELIVERED ON:	27 September 2019
DELIVERED AT:	Alice Springs
HEARING DATE:	10 September 2019
FINDING OF:	Judge Greg Cavanagh
CATCHWORDS:	**Mental Health, involuntary admission, remained psychotic, non-compliance with Mental Health and Related Services Act in provision of leave, took his own life**

REPRESENTATION:

Counsel Assisting:	Kelvin Currie
Counsel for Central Australian Health Service	Stephanie Williamson
Counsel for Dr Ramesh Chandran Chandrasekar	John Stirk
Counsel for Family	Shaun Rich

Judgment category classification:	A
Judgement ID number:	[2019] NTLC 028
Number of paragraphs:	52
Number of pages:	12

IN THE CORONERS COURT
AT ALICE SPRINGS IN THE NORTHERN
TERRITORY OF AUSTRALIA

No. A0066/2017

In the matter of an Inquest into the death of

LINDEN ALAN KUNOTH

ON: 17 OCTOBER 2017
AT: 2 LANDER COURT, LARAPINTA

FINDINGS

Judge Greg Cavanagh

Introduction

1. The deceased was born 29 September 1993 in Alice Springs to Patricia Kunoth and Ronald Peckham. He was the fourth of five children.
2. He grew up in Bonya, Harts Range and Delmore Downs Station. He attended Yipirinya School to year 5. He was fluent in English and could speak Alyatware language. He worked in Community Development programs and also for the Central Desert Shire for a period of 12 months looking after outstations.
3. Mr Kunoth was known to be a quiet personality. He didn't drink often, however was known to smoke cannabis on a regular basis. He did not suffer from mental health issues or suicidal ideation until about June 2017 when he attempted to hang himself. He was stopped by a family member.
4. On 26 August 2017, his father called Police. Mr Kunoth appeared to be suffering visual and auditory hallucinations. His behaviour was bizarre and aggressive. He was taken by Police to the Alice Springs Hospital and involuntarily admitted to the Mental Health Ward. It was the first time he had come to attention of the Mental Health Service.
5. He was combative and floridly psychotic. It was thought that he was likely suffering drug induced psychosis in the context of heavy cannabis use. He said he was a god with the ability to read minds and heal people with his hands. He was initially placed in the high dependency unit (HDU) and heavily sedated.

6. He said his powers had come to him in the last few months. He said that sometimes the voices told him to hurt himself but that he took no notice of them because he needed to stay alive to do his godly work for his people. While there, his parents arranged for him to be visited by the Ngangkarri, the spiritual healer.
7. He was transferred to the open ward on 29 August 2017 and commenced on the injectable anti-psychotic Aripiprazole 400mg monthly. He was discharged on 5 September 2017 with an additional oral anti-psychotic to be taken daily. He was noted to still have delusions. He was referred for community follow up and was seen on 7, 14 and 19 September 2017.
8. During the course of the investigation my Office obtained expert opinions. One of the experts, Dr Michael Giuffrida, wrote:

> "I find it incomprehensible that Linden was discharged from his first mental health admission on the 5 September 2017 when he was clearly still actively psychotic with the same delusional belief system intact and almost certainly reinforced by ongoing auditory hallucinations with little or no insight into his illness or need for treatment, with the high likelihood that Linden would stop taking his oral antipsychotic medication and would resume the use of cannabis and/or other drugs. It is almost certainly the case that Linden did resume his use of substances which re-ignited the more malignant symptoms of his psychosis such that by the 27 September his psychotic symptoms had returned in full force together with his suicidal thoughts and active intent by attempting to hang himself."[1]

9. Mr Kunoth was once more admitted to hospital on 30 September 2017. His father had found him with a rope tied to the ceiling fan at his home the previous day. He said he wanted to end his life to become the devil so that he could kill sinners and sexually assault females. He said he was sorry he hadn't died as he really wanted to become the devil. He was sectioned and remained in the HDU for two days.
10. On 3 October 2017 he was still voicing the belief that he needed to hang himself to become the devil. On 5 October 2017 he fashioned a noose from a bedsheet. He was attempting to take it to the bathroom when he was stopped. On 13 October 2017 he attended a Tribunal hearing. He continued to have the same sort of delusional beliefs

[1] Report page 21

and an order was made that he be involuntarily admitted for another 14 days. It was clear he was fast becoming treatment resistant and it was decided by his psychiatrist to alter his medication from Aripiprazole to Zuclopenthixol.

11. On 16 October 2017 Mr Kunoth denied thoughts of self-harm but remained psychotic believing himself to be an Aboriginal god. He was given his first dose of Zuclopenthixol and approved for escorted leave that same day. That evening he went on leave from the ward for half an hour with his parents from 7.00pm. His parents dropped him back at the front of the hospital and he returned to the ward by himself.
12. The following day (17 October) he went on escorted leave again, at 3.30pm. He was due to return at 8.00pm. While on leave he drove his parents' vehicle to Charles Creek Camp. There he spoke to his cousin and was advised that an uncle had died in the preceding weeks. He expressed his sympathies to a number of relatives.
13. He then drove back to his parents' residence. At or about 5.30pm his mother had not sighted him for some time and went to look for him. She found him hanging from a hose with one end tied to the ceiling fan in a store room of the residence. He was unresponsive. His mother called the Ambulance at 5.36pm. The paramedics attended. However Mr Kunoth could not be revived.
14. Of the granting of leave on those days, Dr Giuffrida wrote:

> "It ought to have been entirely clear by the 16 and 17 October 2017 that Linden's schizophrenic illness was utterly treatment resistant and it was too great a risk to grant him at that point any leave and he should have been detained for close monitoring and observation over the following weeks in hospital."[2]

Leave of Absence

15. The *Mental Health and Related Services Act* (the Act) provides that a patient might leave the hospital for certain periods while still being held involuntarily. The section is in these terms:

> **166 Leave of absence**
>
> (1) This section applies to a person who:
>
> (a) is admitted to an approved treatment facility as an

[2] Report p 21

involuntary patient; and

(b) is not a prisoner.

Note for subsection (1)

Section 83 provides for the granting of leave of absence to a prisoner.

(2) An authorised psychiatric practitioner may grant the person leave of absence from the facility.

(3) Leave of absence:

(a) must not be granted except in accordance with approved procedures; and

(b) must be recorded in the approved form; and

(c) is subject to the conditions determined by the practitioner.

16. In effect, the Act provides that an involuntary patient may be granted leave from the hospital so long as three preconditions are fulfilled:

a. leave must not be granted except in accordance with **approved procedures**;

b. leave must be recorded in the **approved form**; and

c. leave is subject to the **conditions** determined by the authorised psychiatric practitioner (doctor).

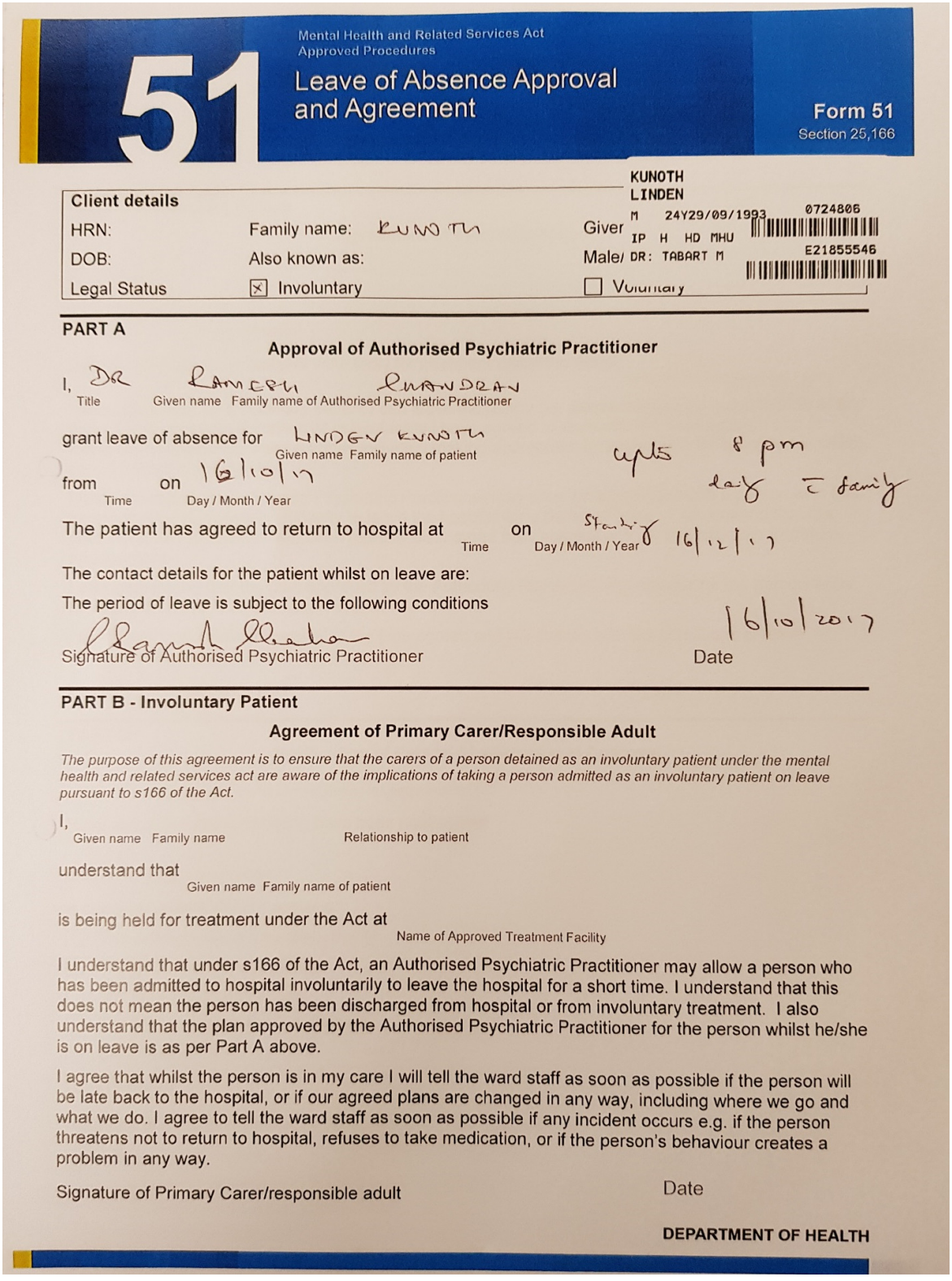
Approved Procedures

17. At the date leave was granted to Mr Kunoth, the Alice Springs Hospital had no approved procedures for granting leave. During the investigation of this matter my Office wrote to the Hospital seeking its approved procedures. The response was that they used the procedures in the Act.[3]

[3] Procedures were approved for the first time, after the death of Mr Kunoth on 13 December 2017.

Approved Form

18. The Mental Health Service had an approved form. The form for the leave granted to Mr Kunoth is reproduced below:



Mental Health and Related Services Act
Approved Procedures

51

Leave of Absence Approval and Agreement

Form 51
Section 25,166

KUNOTH
LINDEN
M 24Y29/09/1993 0724806
IP H HD MHU
DR: TABART M E21855546

Client details

HRN:
DOB:
Legal Status

Family name: KUNOTH
Also known as:
☒ Involuntary

Given name: LINDEN
Male/
☐ Voluntary

PART A

Approval of Authorised Psychiatric Practitioner

I, DR RAMESH RAVINDRAN
Title Given name Family name of Authorised Psychiatric Practitioner

grant leave of absence for LINDEN KUNOTH
Given name Family name of patient

from Time on 16/10/17 Day / Month / Year

up to 8 pm daily ± family

The patient has agreed to return to hospital at Time on Starting Day / Month / Year 16/12/17

The contact details for the patient whilst on leave are:

The period of leave is subject to the following conditions

Signature of Authorised Psychiatric Practitioner

16/10/2017
Date

PART B - Involuntary Patient

Agreement of Primary Carer/Responsible Adult

The purpose of this agreement is to ensure that the carers of a person detained as an involuntary patient under the mental health and related services act are aware of the implications of taking a person admitted as an involuntary patient on leave pursuant to s166 of the Act.

I,
Given name Family name Relationship to patient

understand that
Given name Family name of patient

is being held for treatment under the Act at
Name of Approved Treatment Facility

I understand that under s166 of the Act, an Authorised Psychiatric Practitioner may allow a person who has been admitted to hospital involuntarily to leave the hospital for a short time. I understand that this does not mean the person has been discharged from hospital or from involuntary treatment. I also understand that the plan approved by the Authorised Psychiatric Practitioner for the person whilst he/she is on leave is as per Part A above.

I agree that whilst the person is in my care I will tell the ward staff as soon as possible if the person will be late back to the hospital, or if our agreed plans are changed in any way, including where we go and what we do. I agree to tell the ward staff as soon as possible if any incident occurs e.g. if the person threatens not to return to hospital, refuses to take medication, or if the person's behaviour creates a problem in any way.

Signature of Primary Carer/responsible adult

Date

DEPARTMENT OF HEALTH

19. It can be observed that there are fields on the form for:

    a. the time the patient is to return to the hospital;
    b. the contact details for the patient while on leave; and
    c. the conditions of leave.

20. Part B is not signed. When asked about that, Dr Ramesh Chandran Chandrasekar (Dr Chandran) said he thought a doctor signing it was enough. He said that the family did not usually sign the form.[4]

Conditions

21. There is no written information responsive to the field, "the period of leave is subject to the following conditions" (and very little space to write conditions). However, in the "free space" to the right is written: "up to 8pm daily with family starting 16/12/17".
22. The Psychiatry Registrar, Dr Chandran, who signed the form, told me that other usual conditions were "no drugs or alcohol" and "supervise for his safety".[5]

The decision to approve leave

23. The approval (the form) was signed following the ward round on 16 October 2017. The ward round was led by the Consultant Dr Muir. Also there was the Registrar Dr Chandran, the RMO, the Registered Nurse and the deceased's parents.
24. Mr Kunoth said he felt better and did not have further thoughts of killing or hanging himself. The medical notes go on to say:

> "He still believes that he is an Aboriginal God, and that he has created both heaven and hell. Indeed, his thought of hanging himself was based on his delusion that this would 'release him to be spirit able to travel between heaven and hell'"

25. His father was said to be "a very well spoken, insightful man … he seemed to be very responsible".[6]
26. The Plan was:

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[4] Ibid p 20
[5] Statement of Dr Chandran dated 20 October 2017 p19
[6] Statement of Dr Muir dated 30 October 2017 p 6

1. "Continue the admission
2. For zuclo depot today prior to leave
3. Escorted leave with his parents and to return at 8.00pm tonight."

27. Dr Muir considered that the decision to grant leave was just for that day and there would be a review before further leave was granted.[7] That was not however how his Registrar, Dr Chandran interpreted the decision. As is seen from the Form 51 he noted it to be daily until 8.00pm. In his view there was no need for another Form 51 for any further leave.
28. The next day there was no review of Mr Kunoth evidenced in the medical notes. Dr Muir did not see him. On any version, he was not reviewed. Dr Chandran thought he would have spoken to him in the morning.[8]
29. Dr Chandran wasn't the only one without a clear understanding of the procedures relating to leave. That is perhaps not surprising given that there were no approved procedures. He said his knowledge of the form came from "on the job training" when the consultant asked him to complete the form and the form was provided to him by nursing staff.[9]

Issues

No approved procedures

30. The relevant parts of section 166 *Mental Health and Related Services Act* have been in the same form since the Act commenced on 1 February 2000. Over 17 years later when Mr Kunoth was given leave there were still no approved procedures. The failure to have approved procedures had a significant impact: There was no induction and training as to the procedures to be followed, the staff had differing views on what was required, the Registrar seemed to take his cue from the nurses, and the requirements for the completion of the Form 51 were seemingly not understood.
31. Prompted by the death of Mr Kunoth, the Mental Health Service developed approved procedures two months later. If those procedures had been current at the time the staff are likely to have understood that there needed to be a new Form 51 completed

[7] Statement of Dr Muir pp 7, 8
[8] Statement of Dr Chandran pp15, 16
[9] Transcript p 10

every 24 hours, that for each leave occasion there needed to be "clear documentation of client behaviour, conversation and assessed risk", and that leave on each occasion could only be approved after an assessment and in consultation with either the Team Consultant or, if after hours, the on-call Consultant.

32. It does not of course follow that if that procedure was in place, leave would not have been granted in much the same manner. Less than two months after the procedure was approved another young man, Mr Allen, was given leave in relatively similar circumstances and took his own life.[10] In relation to the granting of leave in both cases there appeared to be a lack of appreciation of the risks and appropriate mitigation.

Risk identification

33. On admission, Mr Kunoth was agitated and floridly psychotic. He was considered a high risk of harm to himself and others. Over the following two weeks his agitation settled. His psychosis however did not. The risk implications of the continuing psychosis were noted on the ward round on 16 October 2017:

> "Linden reports that since being here, he feels better and denies having further thoughts of killing/hanging himself which he initially had prior to his admission. He still believes that he is an Aboriginal God, and that he has created both heaven and hell. **Indeed, his thought of hanging himself was based on his delusion that this would 'release him to be spirit able to travel between heaven and hell'"** (my emphasis)

34. In essence it was understood that his wish to kill himself was due to his psychotic delusions and it was understood that he continued to have those delusions.
35. Dr James Goodbourn is the Acting Clinical Director of the Central Australia Mental Health Service. He provided the institutional response at the inquest. He acknowledged that there were problems with the risk assessment. In his view, one of the major issues was the failure to recognise Mr Kunoth's protracted and ongoing psychotic condition as a static risk (as opposed to a dynamic risk which might abate).
36. My office also obtained an expert report from Dr Christopher Ryan. He stated:

[10] Inquest into the death of Jordan Allen [2019] NTLC 029

> "Despite the recognised importance of leave, it is also known that patients on leave are at very elevated likelihood of completed suicide compared to patients not on leave. However it is widely believed that providing leave both for short periods initially and initially as escorted leave with family or friends might mitigate this risk somewhat."[11]

Risk Mitigation

37. It is vital that risk be mitigated. After all, the patient remains an involuntary patient in the care of the Mental Health Unit. The duty to the patient is not transferred while on leave. It is therefore incumbent on the institution to ensure there is a proper appreciation of the circumstances the patient will be in while on leave and a fulsome handover of information and strategies to those who are being tasked to escort the patient.
38. Where there is any significant risk the effectiveness of the proposed mitigation treatments would of necessity be required to be assessed prior to the decision to grant leave. That happened in part during the ward round on 16 October 2017. On that date his parents were in attendance. His father was noted to be impressive and insightful. However there appears to have been little discussion about the risks.
39. Mr Kunoth's father cannot recall discussion about diagnosis, his continuing psychosis and the unpredictability that would bring. There appears to have been no discussion about the need to observe Mr Kunoth at all times or the need to personally see him back to the ward. His father recalls that the discussion with the doctors left him feeling relieved.
40. Dr Giuffrida put it this way:

> "… there was very little discussion with Linden's parents about the nature of Linden's illness, his treatment, the risk that he posed to himself and others and any education or advice in relation to the family's ongoing monitoring, observation and supervision of Linden on leave …" [12]

41. That was evident in the fact that on Mr Kunoth's return to the Ward on 16 October 2017 he was not accompanied by any of the family. That was not through lack of

[11] Page 31
[12] Page 20

care. It had been noted throughout the course of his admission that his family and father in particular were extremely attentive and caring.

42. If at that point there was some misunderstanding about the level of supervision required, that could have been corrected in a review or a conversation with the parents the following day before further leave was taken. However, it is more likely that the issue was more a failure by Mental Health Unit staff (or at least the Registrar who approved the ongoing daily leave) to appreciate the significant risks involved.

Changes

43. Dr Goodbourn stated:

> "the process is now for carers to be interviewed regarding their understanding of their loved one's illness or condition, along with their capacity and willingness to supervise their relative on leave from the ward … we attempt to optimise this understanding by encouraging staff to employ interpreters and all staff, including doctors, nurses and PCA's spending time with family members."[13]

44. Dr Goodbourn went on to note improvements in cultural safety, staffing, documentation and further reviews in which the Mental Health Unit is engaging to ensure it continues to improve. I found Dr Goodbourn to be a very impressive witness and the many changes made by the Mental Health Unit are commendable.

Comment

45. Mr Kunoth was suffering from schizophrenia. He had two admissions at the Central Australian Mental Health Unit from the end of August 2017 until the middle of October 2017. He was provided leave prematurely and without appropriate risk mitigation while still suffering from psychosis.

46. Dr Goodbourn agreed:

> "There was little written evidence that the parents had a thorough understanding of the son's illness, medication regime or associated risks. This lack of evidence is worrying in and of itself, and Mr Kunoth's family, in their letter of 5 September 2019, confirm a lack of communication with them in respect of their son's treatment, the meaning of escorted leave and what may be required of them or other

[13] Paragraph 48

> family members. These failures are accepted by MHCAHS and I sincerely apologise to the family."[14]

47. It is a tragedy that his family were placed in that position. It is a tragedy that their son took the opportunity to act upon his long held delusions and end his life.
48. Why he was granted leave at the time was due to either a failure to properly appreciate the risks or a willingness to take those risks. It seems that safety was not the first consideration in either scenario.
49. I recently stated my views on the pre-eminence of safety in another inquest:

> "…a therapeutic environment is of no use to a dead patient. A safe environment comes before a therapeutic environment. In my view an environment that allows suicidal and psychotic patients the freedom to kill themselves cannot be considered either safe or therapeutic."[15]

50. However, the response of the Mental Health Unit to its shortcomings has been significant. I commend the service on its transparency, dedication and willingness to improve.

Formal Findings

51. Pursuant to section 34 of the *Coroner's Act*, I find as follows:

(i) The identity of the deceased is Linden Alan Kunoth, born on 29 September 1993 in Alice Springs.

(ii) The date of death was 17 October 2017. The place of death the storeroom of the residence at 2 Lander Court, Larapinta, Alice Springs.

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

(iv) The particulars required to register the death:

1. The deceased was Linden Alan Kunoth.

2. The deceased was of Aboriginal descent.

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[14] Paragraph 50
[15] Inquest into the death of *Daniel Alexander Bleaney* [2019] NTLC 025 at paragraph 69

3. The deceased was unemployed.

4. The death was reported to the Coroner by Police.

5. The cause of death was confirmed by Forensic Pathologist, Dr John Rutherford.

6. The deceased's mother is Patricia Kunoth and his father is Ronald Peckham.

Recommendation

52. The recommendation I make is identical to one of the recommendations in the inquest into the death of Jordan Allen. I **recommend** that the Central Australian Mental Health Service ensure that its approved procedure and Form support appropriate risk assessment prior to the decision to grant leave, that the Form has sufficient space for conditions to be legibly written and appropriate information for the escorting person as to what to do and who to contact if things go wrong.

Dated this 27th day of September 2019.

_____

GREG CAVANAGH
TERRITORY CORONER