CITATION: *Inquest into the death of Rita Anderson* NTMC 004 [2004]

TITLE OF COURT:	Coroner's Court
JURISDICTION:	Darwin
FILE NO(s):	D0133/2002
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HEARING DATE(s):	1- 5 September 2003
FINDING OF:	Ms ELIZABETH MORRIS DEPUTY CORONER

CATCHWORDS:

CORONERS: Inquest, Hospital Procedures, Adult Guardianship Board, Police Communications

REPRESENTATION:

Counsel:

Assisting:	Ms Lyn McDade
Department of Health and Community Services	Ms Judith Kelly

Solicitors:

Department of Health and Community Services	Mr Chris Rowe, NT Attorney Generals Department

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

No. D0133/2002

In the matter of an Inquest into the death of

RITA ANDERSON

ON 16 MAY 2002

AT BUSHLAND ADJACENT TO ROYAL DARWIN HOSPITAL, NORTHERN TERRITORY

FINDINGS

(Delivered 21 January 2004)

Ms Elizabeth Morris, Deputy Coroner:

THE NATURE AND SCOPE OF THE INQUEST

1. Rita Anderson ("the deceased") was an approximately 43 year old Aboriginal female whose remains were found in bushland adjacent to Royal Darwin Hospital on the 16th of August 2002.

2. The death is a "reportable death" pursuant to section 12 of the *Coroners Act ("the Act")* as her death was unexpected. A public Inquest was held pursuant to section 15(2) of the Act. The holding of the Inquest (and commencement date) was advertised in the local press on 5 May 2003.

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

> (1) A coroner investigating –
>
> (a) a death shall, if possible, find –

(i) the identity of the deceased person;

(ii) the time and place of death;

(iii) the cause of death;

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

(v) any relevant circumstances concerning the death."

4. Section 34(2) of the Act operates to extend the Coroner's 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."

5. A public inquest commenced at the Darwin Magistrates Court on 1 September 2003. Counsel assisting me was Ms Lyn McDade. Ms Judith Kelly sought leave to appear on behalf of the Northern Territory Government, specifically the Department of Health and Community Services and the Northern Territory Police. I granted leave to her pursuant to section 40(3) of the Act.

6. Oral evidence was taken, in person and via video teleconference facilities, over five days from 1 to 5 September 2003 inclusive. On the first sitting day the witnesses were Sweeny Anderson, a son of the deceased, Senior Sergeant Vincent Michael Kelly, the officer in charge of the investigation into the death of the deceased; Doctor Terence John Sinton, Forensic Pathologist who performed a post mortem examination of the deceased, and Professor Andrew Dawson, the Professor of Clinical Pharmacology at the University of Newcastle, who provided an expert report into the drug regime of the deceased.

7. On the second sitting day the witnesses comprised Sonia Lee Fagg, Aboriginal Liaison Officer at Royal Darwin Hospital (RDH), Denby Kitchener, Acting Executive Director of Nursing and the Nursing Director for the Medical Division at RDH, Steve Hugh Gelding, Senior Human Resources Officer of the Department of Health and Community Services, Susan Jane Paltridge, Manager, Legal Support Services, Department of Health and Community Services and Anne Cunningham, former Executive Officer of the Adult Guardianship Board.

8. On the third sitting day evidence was given by Doctor Robert Michaelis Parker, Acting Director of Psychiatry for the Top End Mental Health Service, Sarah Margaret McHugh, Clinical Nurse Manager of Ward 4B at RDH, Gary Keith Markell, security officer at RDH, Christine Naylor, Patient Care Assistant at RDH, Ferdinand Orion, Patient Care Assistant at RDH, and Susan Mary Rohrig, Registered Nurse at RDH.

9. On the fourth day of sitting the witnesses were Mr Paul Damien Lawton, Consultant Physician at RDH, Doctor Leonard George Notaras, Medical Superintendent at RDH, Doctor Vinothini Inpamathy Evangeline Saphianathan (Doctor Vino) Deputy Medical Superintendent at RDH, and Doctor Anna Ralph, Registrar at RDH.

10. On the fifth day of sitting the witnesses comprised Sergeant Shaun Rodney Furniss, of the police communication centre, and Judith Dikstein, Legal Officer with the Adult Guardianship Board.

11. In addition to those witnesses a number of documents were tendered including an investigation file compiled by Senior Sergeant Kelly and various other reports and statements tendered by Counsel Assisting and Ms Kelly, Counsel for the Department of Health and Community Services.

FORMAL FINDINGS

12. Pursuant to Section 34 of the Act, I find, as a result of the evidence adduced at the Inquest the following:

1. The identity of the deceased was Rita Anderson, also known as Rita Rory Anderson, who was recorded as being born at Calvert Hills, Northern Territory on 28 May 1958.

2. The time and place of death are at sometime after 16:00 hours on 16 May 2002 in bushland adjacent to Royal Darwin Hospital in the Northern Territory.

3. The cause of death is unknown.

4. Particulars required to register the death are:

(a) The deceased was a female.

(b) The deceased was Rita Anderson.

(c) The deceased was an Australian resident of Aboriginal origin.

(d) The death was reported to the Coroner.

(e) The cause of death is unknown. The cause of death was confirmed by a post-mortem examination.

(f) A pathologist viewed the body after death.

(g) The pathologist was Doctor Terence John Sinton, Forensic Pathologist of Royal Darwin Hospital

(h) The deceased's mother is Mary Aga-Jibinna.

(i) The deceased's father is Dick Gardalagi.

(j) The deceased resided in and around the Darwin region and at the Royal Darwin Hospital.

(k) The deceased was a pensioner.

(l) The deceased had been married, and had five children.

(m) The deceased was about 43 years old having been born in 1958.

RELEVANT CIRCUMSTANCES SURROUNDING THE DEATH

The deceased's background

13. The deceased was born at Calvert Hills, a small community near the Calvert River on the Gulf of Carpentaria on 28 May 1958. Her mother was Mary Aga-Jibinna and her father Dick Gardalagi. Her family were from the Robinson River area. She had five sons: Sweeny, Barry, David, Percy and Romany Anderson, Sweeny being the eldest, born 9 March 1973 when the deceased was 15. Their father is Gordon Jiminminya Anderson a station hand from Brunette Downs. Sweeny and his brothers were raised by their Aunty and Uncle when the deceased left the family whilst they were still young.

The deceased's medical history

14. Mrs Anderson had been an inpatient of the Royal Darwin Hospital on an almost continuous basis since March 2002. She had many admissions throughout her lifetime, and particularly since 1996. Her medical history

from 1970 comprises some six medical volumes. The majority of her admissions were for treatment relating to alcoholic seizures and trauma.

15. The records show that during 1986 the deceased was treated twice for injuries resulting from assaults and once for post-seizure care. On each admission she was intoxicated. By December 1986 she reported drinking a flagon of wine a day. At that time she was 28 years of age, had no fixed address, and had several miscarriages.

16. Between February 1987 and January 2002 police and ambulance brought the deceased to hospital some 47 times as a result of suffering a seizure. On each admission she was intoxicated. She was also brought in by police or ambulance 21 times for treatment for injuries sustained in accidents or assaults whilst intoxicated. She frequently left the hospital prior to treatment being completed. She required two admissions to intensive care for intubation and ventilation.

17. The deceased had organic brain damage, as well as chronic liver disease due to alcohol, cerebella ataxia and thrombocytopenia. It would appear from her medical files that from as early as 25, she had already reached the stage of organic brain syndrome from alcohol abuse.

18. These conditions resulted in Mrs Anderson suffering from poor judgment and impulsiveness. She displayed intermittent aggression, which could be diminished, but not completely controlled by, medication.

19. I quote from and adopt Ms Judith Kelly's submissions

> "Such a history as can be gained of the life of the deceased illustrates the desperate circumstances which befell her from her earliest years. She became a mother when still a child herself, yet lost the opportunity to raise her own children. She fell out of her own community and into an itinerant lifestyle in the suburbs of Darwin, where she appears to have been the victim of repeated abuse at the hands of others and herself succumbed to chronic alcohol abuse. This lifestyle caused the cognitive deterioration which resulted in the

impulsive and aggressive behaviour which came to characterise her and the total lack of insight into her own medical condition at the time of her final admission in March 2002".

Care and Treatment at Royal Darwin Hospital

20. In March 2002 one of the deceased's sons, Barry Anderson, attempted to look after his mother at his home in Bachelor. Mr Anderson is a married man with four children. He found, because of her irrational and threatening behaviour, he was unable to care for her as he wished.

21. Thus the deceased was returned to hospital and admitted to Ward 4B. The admission occurred with the intention of assessing and hopefully stabilising her condition, and to give the opportunity to health workers, social workers and medical professionals to find appropriate medications and placements for her. Ward 4B is a ward for acute care medical patients. Her condition was chronic and not acute. There was no other place for her to be placed pending treatment.

22. Her behaviour from the time of this admission (and indeed before) was impulsive, random and unpredictable. There was a general view that she was a danger to herself and others. This view is supported by the evidence produced at the Inquest. On occasion the deceased would harass, intimidate and assault other patients and staff members. She was a tall strong woman, despite her physical ailments.

23. From the evidence it is clear that the deceased was unable to care for herself without direction. She was unable to conduct ordinary daily routine matters to such an extent that she could live independently in the community or indeed, live in the community with support services that are available throughout the community to assist people in her condition.

24. There was a belief held by Hospital staff, due to the deceased's inability to look after herself, that it was the Hospital's obligation, because of where she was, to care for her, to look after her and to ensure that she was safe. By

keeping Rita Anderson in the hospital and denying her access to alcohol, they were providing her with an environment in which she could safely go about her life and avoid experiencing the seizures that had beset her. There was a real desire to keep the deceased from danger. I find that this desire was motivated by the best of intention, that is, the safety and well being of the deceased. The deceased, however, did not wish to remain at all times in the hospital. She wished to go about her business as she saw fit, and was frustrated by restraints placed upon her whilst she was in the hospital. This frustration was vented in her unpredictable and sometimes violent behaviour.

25. In order to manage her behaviour, from 21 March until her death, the deceased was provided with a full time 24 hour per day patient care assistant (PCA).

26. Two of these assistants gave evidence. They saw their role as, among other things, to persuade Rita to remain in hospital, and when she wandered, to convince her to come back. Christine Naylor spent a great deal of time with the deceased, and eventually developed a rapport with her, such that the deceased referred to Ms Naylor as “her friend”.

27. Dr Lawton, a consultant physician at RDH, who gave evidence at the Inquest, directed that the deceased be physically restrained if required, to keep her on the ward. He considered that given the deceased’s mental impairment, and that having regard to an adult guardianship order being pending, the hospital owed a duty of care to the deceased to prevent her from causing injury to herself. In Dr Lawton’s opinion a guardianship order would have been a “formality”, considering the evidence he was aware of in relation to the deceased.

28. She was also on a medical drug regime. There is no evidence that this was not an appropriate treatment course for the deceased. Indeed an independent

expert, Professor Dawson, confirmed that the prescribed drugs were appropriate for the deceased's condition.

29. Decision making regarding the management of the deceased was done by a series of team meetings, involving members of the medical, nursing, and social work hierarchies. Over time members of this team began to have concerns about the legitimacy of the care and containment of Ms Anderson. Legal advice was obtained, and an application for Adult Guardianship sought in attempts to define the legally appropriate course.

Application for Adult Guardianship

30. The *Adult Guardianship Act* (AG Act) makes provision for a scheme of guardianship for certain adults under an intellectual disability. Around the time of her death the deceased clearly fell within the ambit of this legislation, evidenced by the fact of an order granting guardianship being issued on 25 May 2002.

31. Evidence was given as to the practice and procedure of applications under the AG Act by Ms Anne Cunningham, the Executive Officer for the Adult Guardianship Board at the relevant time, and Ms Judith Dikstein, the present incumbent. Two issues arose during the Inquest, the length of time taken for such an application and whether or not a guardian would be able to consent to the deceased being restrained in the hospital in any event.

32. An application for adult guardianship was made initially in January 2002. The application originated from a social worker at RDH and was requested urgently. The application was returned, as the Officer receiving the request preferred that a family member make the application. Another application was made in February, the hospital having contacted and assisted Barry Anderson in making the application. No grant regarding guardianship was made until 23 May, a date probably after Ms Anderson had died, when a temporary guardianship order was granted. The Public Guardian was

appointed as the Guardian of the deceased. The application was not deemed to be urgent originally, however on 16 May it was deemed to be "urgent" and an order was made within a week.

33. There was some evidence presented as to what the criteria for an "urgent application" were. The criteria were not legislative, but adopted by whichever officer was dealing with the matter at the time. It appears that the deceased did not meet the criteria, as she was not scheduled to undergo a medical procedure to which her consent was required and was not seen (by the assessing officer) to be at immediate risk to herself without the appointment of a guardian, because she was a patient at the hospital. However Ms Cunningham was also of the view that a guardian would not alleviate the risk of the deceased leaving the hospital, as they would be unable to authorise her detention in hospital against her will.

> "Up until that time, you didn't consider the application on Rita's behalf to be urgent, did you?---Well, I didn't consider it to be any more urgent than the other ten or 15 that I had on my desk classified as urgent because I didn't see that appointing a guardian was going to improve her circumstances even in the short term.
>
> Can you explain to me why you were of that view, having regards to the provisions of the Adult Guardianship Act?---All right, the – ever since she appear to be – or as I was told that Rita was violent and she needed to have some sort of restraints put on whether it was difficult or otherwise, and guardianship provisions don't allow for any formal constraints or restraints so, therefore, appointing a guardian, even if I had appointed a guardian or tried to appoint within a week of receiving the application in February, what would her guardian have done when all we are supposed to do under the Act is make decisions in place of that person who had lost their decision making ability, so you know, the decision that could be made on her behalf was, was she to be sedated in any way, or was she to be released from hospital and even if a guardian had made those decisions, she can refuse and just walk away, no-one can tie her down or hold her back." (Transcript p93).

34. Dr Lawton told the court in his evidence

> "However, we had taken all possible steps to actually get a guardianship order and I would contend that the problem is the long delay to actually getting – to actually getting the guardianship order. This is my experience in other cases also in the Territory that there is an inordinate delay in actually processing applications to go before the courts for a guardianship. This case was relatively quick in the scheme of things but not quick enough for Rita it seems….and this is a big problem for the Territory – and a big problem for clinicians." (Transcript p211)

35. Counsel for the Northern Territory concedes that provisions for expedited procedures under the AG Act is an issue for consideration in a review of the law relating to substituted decision making. It is clear from this case that the practice and procedure of the Adult Guardianship office at the time of the deceased's death did not lead to expeditious dealing with applications. For someone to reach the stage of having a request for an application to be made, they must almost certainly have met the criteria for some time, then to have to wait several months or years for the application to come to fruition puts an incredibly difficult load on those tasked to care for them.

36. For the Officer to also hold that the deceased did not meet the "urgent" order criteria in that she was safe where she was, was of little assistance to the Hospital staff, who were attempting to keep her there against her expressed wishes.

37. It is also the case that there was not a clear understanding by health professionals in the position of care providers, of the powers and role of a guardian and any orders made.

38. Evidence was given that full guardianship orders are rarely if ever made. Rather, conditional orders are made under section 18 of that Act.

39. One of the conditional orders eventually made in relation to the deceased, was that the guardian may make decisions concerning the health care of the person and consent to health care in her best interests (subject to section 21 of the Act, pursuant to which major medical treatment requires an order of

the Court). Would this have encompassed the authority to consent to physical restraint of the deceased to prevent her leaving hospital? The view of the Executive Officer, who viewed these powers in the light of section 4 of the Act, was that they would not.

40. Section four of the AG Act is as follows:

> **4. Best interests of represented person to be promoted**
>
> Every function, power, authority, discretion, jurisdiction and duty conferred or imposed by this Act is to be exercised or performed so that -
>
> (a) those means which are the least restrictive of a represented person's freedom of decision and action as is possible in the circumstances are adopted;
>
> (b) the best interests of a represented person are promoted; and
>
> (c) the wishes of a represented person are, wherever possible, given effect to.

41. That view was also supported by the legal advice taken by the Department and provided by Mr Farqhuar of Cridlands.

42. The conundrum of course, is where the wishes of a person and the means which are the least restrictive of their freedom, conflict with their best interests, which include their safety, health and security.

43. Counsel for the Northern Territory submitted that

> "Whether, even if a guardianship order had then been in place, a decision to further restrain the deceased on, say, 16 May 2002, would have been in her best interests is a very difficult judgment to have been called upon to make. It would certainly not have given effect to her express wishes. The deceased was clearly unhappy and unsuited to the environment of an acute hospital ward and had clearly expressed her desire to leave. She was being medicated to modify her behaviour but was not otherwise undergoing a specific medical treatment or procedure. In those circumstances a decision by a guardian to authorise her restraint would arguably have been taken

without proper regard to the intention of the *Adult Guardianship Act*, as expressed in section 4 of that Act…"

44. In examining both these issues, any finding must be "connected with the death or disaster being investigated." Any comment or recommendation I make is not limited to matters having a direct causal nexus with the death. The expediency or otherwise of dealing with an application for adult guardianship is connected with the death of the deceased in this case. At the very least had such a guardian been appointed earlier, there should have been someone in a position to agitate for the deceased being a missing person, and for a search to be conducted at an earlier stage.

45. Whether or not that guardian could have authorised the deceased's restraint is a legal question which I do not have to determine. The fact I find is that an order was not made prior to the deceased's death. What this death does highlight is the lack of clarity in relation to the extent of powers and orders made under the Adult Guardianship Act, and the need for those powers to be clarified.

Application of the Mental Health Review Act

46. At various stages the deceased was assessed by a psychiatrist with a view to detaining her under the *Mental Health Review Act* (the MHRS Act). This is an Act that was implemented with a view to treating short term transitory illness that could be rectified and treated by therapeutic intervention. Chronic organic brain disease appears not to fall within the definition of "mental illness" in the MHRS Act.

47. The deceased was assessed by Dr San Pedro on the 23 March 2002 and again assessed by Dr Cynthia Parker on 14 May 2002. She was found not to be suffering from a "mental illness" as the defined by the MHRS Act, nor a "mental disturbance" at the time of examination.

48. However, whilst there is evidence that at times Ms Anderson suffered such a transitory illness or disturbance, including hallucinations, she was not assessed at the moment of its appearance. I agree with Counsel assisting that it would be inappropriate to have her under a form of continuous assessment merely in order to "catch" one of the symptoms of such a disorder.

49. Whilst the MHRS Act contains powers for health professionals to treat non-compliant patients, I find that from the evidence presented the deceased did not fit the criteria for her particular situation to be addressed.

Appropriateness of discharge

50. The deceased did not want to remain in hospital. She frequently expressed a desire to leave (although also at times seemed comfortable in remaining). On 14 and 16 May 2002, Ms Anderson became increasingly agitated and aggressive. She wanted to see her sons and wanted to leave in order to do so. Legal advice was again sought on 16 May as to whether the hospital could hold the deceased. The forthcoming advice resulted in the release of the deceased at around 16:00hrs on 16 May. Prior to her release on that day the deceased was physically contained in her room, with the Patient Care Assistant's (Christine Naylor and Ferdinand Orion) holding shut the door, in order to prevent her from leaving the hospital.

51. However on that day the deceased had received several doses of medication, including two doses of droperidol at 13:30 and 14:10hrs. She was also given diazepam at 08:30, 09:00 and 12:00hrs and Haloperidol at 08:30hrs.

52. Evidence was called from Professor Dawson, the Professor of Clinical Pharmacology at the University of Newcastle and senior staff specialist in the Hunter area toxicology unit.

53. He confirmed that the dosages Ms Anderson received were well within the therapeutic guidelines and were an appropriate course for her condition. In

his opinion the effect of the drugs would have at least "plateaued" by the time she left the hospital. He did opine that her judgment would have been impaired. He states that "it would be very unusual to discharge the patient without observation taking place. They would normally remain in care." (Transcript p40)

54. Ferdinand Orion and Chris Naylor escorted the deceased from the hospital building. She was seen walking into bushland adjacent to the hospital, and was not seen alive again.

55. I find that the decision to allow the deceased to act on her desire to leave, was the only one that hospital staff could have made in the circumstances they found themselves in. All other options had been explored, legal advice had been obtained, there was no power to detain the deceased. Whilst the deceased had been medicated, the effects of this medication had plateaued. It would not be expected that the deceased would become more sedated as time passed.

The police response and the search for the deceased

56. Police were notified that the deceased had left the hospital at about 16:00hrs on 16 May 2002. The hospital notes also indicate that the Northern Australian Aboriginal Legal Aid Service (NAALAS) and the deceased's family were also contacted at a later time.

57. During the initial conversation between Sarah McHugh and police communications, they were informed that she was not sectioned, and that she had self-discharged.

> She's just left. She's not under a Section, however she is a very aggressive patient and we've been through all the legal ramifications. She's been given a lot of sedation, but she'd been very physically aggressive and verbally aggressive towards staff and we've been advised that we cannot keep her against her will. So we were just contacting you just to let you know and she'll, she could be very

drow, I mean she, yep was getting very drowsy but we couldn't keep her here.

…

Mmm alright. Okay, so if we actually come across her then, where do you reckon….

Just to suggest if she gets in, if she does like you know, willingly, we would like her brought back…

Yep

Because she's at risk to herself and to others in the Community. But we can't forcibly bring her back. The thing is that I'm expecting that the sedation will settle, um set in, and like often she's very placid and she'd quite fine and she may you know, settle down, and I mean she'd absconded twice this week already. So yeah. We'll just wait and see.

58. The Communications call taker did not follow exactly the standard operating procedure reference for an absconder from the hospital, in that they did not ask whether the informant held "grave concerns for the person's welfare". An affirmative answer would have led to police officers being tasked to take some further immediate action.

59. Standard operating procedures are not necessarily a script to be followed, given that each instance has its own characteristics and good communication operators need to be able to glean sufficient information to assess the situation. However certain key questions, especially those that determine the response by police, must be asked and should have been asked in this instance.

60. As a consequence of the call a "be on the lookout for" was issued, but a vehicle was not dispatched. In hindsight, given where the deceased was eventually located, such dispatch may well have found the deceased. Hindsight however, is the benefit of a coronial proceeding. The deceased had returned of her own volition on previous occasions in the three days prior to her disappearance. Given the history of her leaving the hospital,

and subsequently returning on many occasions, to proceed in that manner was not unreasonable. However it is important that each occurrence should be looked at individually, rather than merely in the context of a 'habitual absconder' because of the nature of a patient's condition and medication.

61. On 8 August 2002 police were notified by the Public Guardian that the deceased had not been seen since 16 May. There was an assumption by the Office of the Public Guardian that the deceased had been listed as a "missing person" since she absconded from the hospital. This is evidenced by correspondence on the Public Guardian's file dated 15 July 2002. It was not until a telephone call between the Public Guardian and police on 8 August 2002, that it was realised by the Guardian that the deceased had not been reported as missing. It was only then that she was officially listed as a "missing person". Various enquiries were then undertaken by police to ascertain her whereabouts. On 16 August 2002 a search was conducted in the area where the deceased was last seen. The search commenced at 08:10hrs and the deceased was located at 13:36hrs on that day in an area some 600 metres north of the rear car park of the hospital.

62. Considering that the deceased had not been since 16 May in and around that area, and also considering her disabilities and condition, I find that it is probable that she died in the area where her remains were located, and not long after she left the hospital. It is improbable for her to have left then returned to that area, given that there was no food or water, or regular camp at that place. No access was made to her bank account or Centrelink payments after the deceased left hospital.

63. It is unfortunate that there was a misunderstanding between Health workers from various agencies as to the difference between a hospital "absconder" and a "missing person". It was this misunderstanding that meant that no concerted action was taken by any party to find the deceased. Indeed once

those experienced at finding people, ie., the police, commenced their investigation, the deceased's remains were relatively quickly found.

64. There are copies on the deceased's file of acrimonious correspondence between the Adult Guardianship Board Executive Officer and the Public Guardian as to division of responsibilities between the two offices. This appears to stem from a lack of clarity in relation to the roles and responsibilities of those tasked to administer a system of guardianship. A panel member was instructed at one stage to "stop looking" for the deceased as that was not the role of the Adult Guardianship Board. Information about the deceased was not passing freely between the two agencies.

Conclusion

65. Since the deceased's death, RDH has offered aggression management training on a monthly basis. From June 2003 the RDH aggression policy is outlined at staff orientation programs, and an absconding policy is referred to. RDH has also revised its aggression and absconding patients policies, which seek to clarify the use of restraint upon aggressive or absconding patients. The absconding patients policy sets out guidelines for notification to Police in the case of patients who leave the hospital against medical advice and for appropriate follow-up to that notification. A corresponding revision of the Police General Orders has also taken place (H4). Given that revision, there is no need for any recommendation along those lines.

66. I agree with Counsel for the Northern Territory, who submitted "the present inquest has identified a legal dilemma for medical professionals concerned for the welfare of patients who lack capacity to make informed decision concerning their own health care and are placing themselves at significant risk by refusing that care. However, any authority to restrain a person in such circumstances must be tempered by the law's respect for the rights of the individual, specifically the autonomy of persons suffering an intellectual disability."

67. This case is different from some others in that there is no evidence that the deceased had a wish or desire to die. It appears she merely wanted to live free of the restraint that was keeping her safe. Sadly the physical cause of her death can now not be known.

RECOMMENDATIONS

68. I recommend that the Adult Guardianship Board's practice and procedures be reviewed with a view to better managing and expediting application. I also recommend that relevant medical staff receive information about the operation of the Board and the extent of powers given under the *Adult Guardianship Act,* and that such powers be clarified to ensure certainty for those entrusted with them, and operating under them on a daily basis.

Dated this 21st day of January 2004

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ELIZABETH MORRIS
DEPUTY CORONER