



## **FINDING OF INQUEST**

*An Inquest taken on behalf of our Sovereign Lady the Queen at Adelaide in the State of South Australia, on the 28<sup>th</sup>, 29<sup>th</sup> and 30<sup>th</sup> days of June 2011, the 1<sup>st</sup> day of July 2011 and the 9<sup>th</sup> day of May 2012, by the Coroner's Court of the said State, constituted of Mark Frederick Johns, State Coroner, into the death of David Penniall.*

*The said Court finds that David Penniall aged 24 years, late of 30 Sandalwood Drive, St Agnes, South Australia died at St Agnes, South Australia on or about the 4<sup>th</sup> day of March 2009 as a result of neck compression due to hanging. The said Court finds that the circumstances of his death were as follows:*

### **1. Introduction and cause of death**

- 1.1. David Penniall died on or about 4 March 2009. He was at that time 24 years of age. He was found at his home address in St Agnes by police who were conducting a welfare check. An autopsy was performed by Dr Karen Health, forensic pathologist, who gave the cause of death as neck compression due to hanging<sup>1</sup>, and I so find.

### **2. Background**

- 2.1. I heard evidence from Dr Ione Lewis, Mr Penniall's mother. He was a sensitive young man who suffered from depression and anxiety. He made a suicide attempt in 2005 but in October 2005 he was successful in applying for a position with the Commonwealth Department of Veteran's Affairs. He performed very well in that employment and seemed to be happy. In mid 2008 he was offered a promotion to Adelaide with that Department and he accepted.

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<sup>1</sup> Exhibit C2a

- 2.2. Dr Lewis said that, understandably, the process of moving States and beginning a new position, as well as finding accommodation and settling into a new home, were extremely stressful. Matters were made worse when Mr Penniall became unwell with persistent abdominal pain. He needed to have time away from work and there was some friction with colleagues as a result of this, followed by a rapid decline in his mental state.
- 2.3. Mr Penniall sought assistance for his depression. Firstly through his general practitioner, Dr Bernard Goh<sup>2</sup>. Dr Goh saw Mr Penniall on 13 November 2008. He said that Mr Penniall came in that day because he was not feeling well:
- 'He had been to work with the Department of Veteran's Affairs and had been advised to see a psychologist from work and, in short, he had what I felt was depression and anxiety and he came to see me for help.'<sup>3</sup>
- 2.4. Dr Goh conducted a mental health assessment and diagnosed anxiety and depression. He prescribed the antidepressant cipramil and referred Mr Penniall to a psychologist. Mr Penniall found that the cipramil caused side effects as a result of which he discontinued its use. Mr Penniall attended two appointments with the psychologist, Pierre Allauch, and was also referred by his manager at the Department for Veterans' Affairs<sup>4</sup> to a psychiatrist, Dr Jules Begg. Mr Begg saw Mr Penniall in a medico-legal capacity to determine if he was fit for work. He diagnosed Mr Penniall with a recurrence of a depressive disorder which he deemed to be severe in nature. Dr Begg considered he was unfit for work for the month of December 2008. Dr Begg gave evidence that he did not discuss with Mr Penniall the possibility that he had a borderline personality disorder<sup>5</sup>. Dr Begg encouraged Mr Penniall to continue with the antidepressant cipramil and to continue seeing the psychologist.
- 2.5. Mr Penniall was to return to work on 14 January 2009 and saw Dr Begg again on that day to be assessed. On that occasion Dr Begg thought that Mr Penniall's depressive symptoms had improved. He considered that he was still suffering from the depression, but that the condition was now mild in severity. Dr Begg said that he was concerned that Mr Penniall was no longer seeing a psychologist and was no longer taking the antidepressant cipramil. However, he considered Mr Penniall to be fit for work in a part-time capacity initially, working up to full-time. Dr Begg noted certain

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<sup>2</sup> Exhibit C11

<sup>3</sup> Transcript, page 28

<sup>4</sup> Ms De Bono

<sup>5</sup> Transcript, pages 115-117 and 129

personality traits in Mr Penniall that could possibly cause difficulties in his interaction with work colleagues. However, Dr Begg made it quite clear that he would not, from the two appointments that he had with Mr Penniall, have reached a diagnosis of borderline personality disorder.

- 2.6. Surprisingly, Mr Penniall appears to have started entertaining the idea that he suffered from a borderline personality disorder at about this time. This is evident from the accounts of Dr Goh, Ms Williamson the counsellor, and the casenotes of the Norwood Medical Centre and the Modbury Hospital.
- 2.7. Mr Penniall returned to see his general practitioner on 30 January 2009 but was unable to see Dr Goh. He was seen instead by Dr Ian Chamberlain. He reported a situational crisis and was prescribed effexor. Dr Goh saw Mr Penniall a week later on 5 February 2009 and was aware of Dr Chamberlain's intervention.
- 2.8. On 17 February 2009 Mr Penniall visited a counsellor to whom he was referred by the Department of Veterans' Affairs employee assistance program. The counsellor was Ms Elizabeth Williamson. She gave evidence of seeing Mr Penniall for the first time on that day and that he had been referred by his manager, Ms De Bono. Ms Williamson said that Mr Penniall appeared to be anxious and was concerned about his role as an assistant manager within the Department. She assessed him as frank and honest and developed a good rapport with him. At the conclusion of the appointment she did not consider that he was at high risk of self-harm and believed that he was keen to address his problems.
- 2.9. Mr Penniall saw Ms Williamson on two further occasions and she also spoke with him over the telephone. Ms Williamson said that on her last meeting with Mr Penniall his mood had improved and he was calm and engaged.

### **3. Mr Penniall's admission to Modbury Hospital**

- 3.1. On 23 February 2009 Mr Penniall was admitted to the Modbury Hospital. He had taken a deliberate overdose of effexor, alcohol and possibly sedatives. He had called Lifeline as a result of which the police attended with the South Australian Ambulance Service. Upon arrival at Modbury Hospital Mr Penniall was detained by the admitting doctor pursuant to the Mental Health Act. I heard evidence from Drs Naso

(psychiatrist), Takhar (resident medical officer) and Molga (who was at that time an intern at Modbury Hospital).

- 3.2. Mr Penniall was at first treated for his overdose by appropriate observation. After the effects of the overdose were diminishing, Mr Penniall was psychiatrically assessed by Dr Maria Naso. She saw Mr Penniall at approximately 11am on 24 February 2009. Her purpose was to review the detention order. She could find no evidence of an Axis I disorder and she knew that Mr Penniall had been on the antidepressant effexor for approximately one month and that it had been prescribed to him by his general practitioner. Her evidence was that she thought either that the depression may have existed and was improving due to the effexor such that she could find no evidence of it when she assessed him, or that the condition that she ultimately diagnosed, namely borderline personality disorder, had manifested in such a way as to present symptoms of depression which the general practitioner had then treated. She did not interfere with the general practitioner's treatment of Mr Penniall with regard to the antidepressant medication, but ultimately she found that Mr Penniall had borderline personality disorder after undertaking an assessment including a mental state examination. She asked Mr Penniall about patterns of mood fluctuation, difficulties with anger and impulsive behaviour and the nature of his interpersonal relationships. As a result of that she reached the diagnosis of borderline personality disorder.
- 3.3. Counsel assisting me obtained an expert report from Dr Andrew Champion, Clinical Director of Mental Health Services at Noarlunga Health Services. Dr Champion provided an overview which was admitted in evidence<sup>6</sup>. He also gave evidence at the Inquest. In his evidence Dr Champion qualified some of the opinions he had expressed in his report after having had the benefit of reading the transcript of the evidence given by Dr Naso and other witnesses. Although Dr Champion had initially been of the view that Dr Naso could not properly have come to a diagnosis of borderline personality disorder on his understanding of the information he believed she had available to her at the time, at the Inquest Dr Champion gave evidence that he had changed his opinion. He noted that there was a great deal more information available as a result of a later statement made by Dr Naso<sup>7</sup> and the transcript of her evidence at Inquest. As a result of a consideration of that material Dr Champion expressed the opinion that Dr Naso conducted an appropriate assessment and did have

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<sup>6</sup> Exhibit C21

<sup>7</sup> Exhibit C14a

sufficient information to reach the diagnosis of borderline personality disorder. In particular, Dr Champion was significantly reassured when he understood that Dr Naso had explored the beneficial and side effects of the effexor, and that Dr Naso had attempted to call Mr Penniall's fiancé, albeit without success<sup>8</sup>.

- 3.4. Dr Champion remained critical of the fact that no phone call was made by Dr Naso to Mr Penniall's general practitioner to notify the latter of the overdose and to request that the general practitioner arrange appointments post discharge. However, this criticism was somewhat muted and Dr Champion acknowledged that it would not have been his practice, up until a year or two prior to giving evidence, to have done so himself<sup>9</sup>. Dr Champion made the following very telling remark:

'In my role as clinical director ... one common element that has emerged in looking at cases particularly of young men who have presented to hospital with overdose who have subsequently gone on to die by suicide is that a common scenario is that the young man will come to hospital, say 'I feel much better now than when I took the overdose or attempted suicide. I have every intention of seeing my general practitioner and seeing my psychologist' and then none of that actually happens, and so another reason for contacting the general practitioner, in addition to obtaining further information to clarify the diagnosis ... would be to establish that connection, to establish some kind of feedback process to confirm that a patient who did have good intentions about pursuing appointments once they left hospital actually did so and consider some kind of safety net if they fail to attend those appointments. So my practice has changed as the result of reviewing those adverse events, but I would seek to contact general practitioners in the way I'm describing. That would be my practice now.'<sup>10</sup>

- 3.5. Finally, Dr Champion was of the opinion that it was reasonable for Mr Penniall to be provided with the number of the Assessment and Crisis Intervention Service to call if he needed to in the event that he became distressed<sup>11</sup>.

#### **4. The discharge summary**

- 4.1. It is a matter of considerable concern that the separation summary relating to the admission to Modbury Hospital was not sent until 18 March 2009 to the general practitioner, Dr Goh. It should have been sent within the first day or two following Mr Penniall's discharge. It contained relevant and important information for Dr Goh and his continuing treatment of Mr Penniall. Dr Goh gave evidence that had he been provided with the separation summary and, accordingly, become aware that Mr

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<sup>8</sup> Transcript, page 288

<sup>9</sup> Transcript, page 290

<sup>10</sup> Transcript, pages 290-291

<sup>11</sup> Transcript, pages 294-295

Penniall had been admitted to Modbury Hospital having taken an overdose of the effexor medication prescribed by his practice, he would have contacted Mr Penniall to arrange for him to come in and to review the medication<sup>12</sup>. In the event, the discharge summary was not received by Dr Goh until well after Mr Penniall's death. This is a matter of considerable concern and, accordingly, I intend to recommend that the Chief Executive of the Department of Health reinforce with all public hospitals the importance of discharge summaries in mental health cases, particularly where there has been a suicide attempt, and the importance of notifying primary health practitioners of such incidents in a timely fashion, and certainly within 48 hours of discharge.

## 5. **Recommendations**

5.1. Pursuant to Section 25(2) of the Coroners Act 2003 I am empowered to make recommendations that in the opinion of the Court might prevent, or reduce the likelihood of, a recurrence of an event similar to the event that was the subject of the Inquest.

5.2. I make the following recommendation:

That the Chief Executive of the Department of Health reinforce with all public hospitals the importance of discharge summaries in mental health cases, particularly where there has been a suicide attempt, and to ensure that notification of such incidents be made to primary health practitioners within 48 hours of discharge.

*Key Words: Suicide; Pyschiatric/Mental Illness; Discharge Summary*

*In witness whereof the said Coroner has hereunto set and subscribed his hand and*

*Seal the 9<sup>th</sup> day of May, 2012.*

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*State Coroner*