



FINDING OF INQUEST

An Inquest taken on behalf of our Sovereign Lady the Queen at Adelaide in the State of South Australia, on the 29th and 30th days of November 2011, the 1st day of December 2011 and the 14th day of November 2012, by the Coroner's Court of the said State, constituted of Mark Frederick Johns, State Coroner, into the deaths of Sonia Lidia Aufiero and Michael Terence Fell.

The said Court finds that Sonia Lidia Aufiero aged 28 years, late of 16 Ballater Avenue, Campbelltown, South Australia died at Majestic Grove, Highbury, South Australia on or about the 31st day of December 2008 as a result of carbon monoxide poisoning.

The said Court finds that Michael Terence Fell aged 60 years, late of 5 Scotcher Court, Delacombe, Victoria died at Majestic Grove, Highbury, South Australia on or about the 31st day of December 2008 as a result of carbon monoxide poisoning.

The said Court finds that the circumstances of their deaths were as follows:

1. Introduction and cause of death

- 1.1. Sonia Lidia Aufiero died on or about 31 December 2008. She was 28 years of age. Michael Terence Fell died on or about 31 December 2008. He was 60 years of age. The cause of death at autopsy for both Ms Aufiero and Mr Fell was carbon monoxide poisoning¹, and I so find. Their bodies were located together in a white Mitsubishi

¹ Exhibits C4a and C4b

van on 1 January 2009. It was parked on a vacant block behind the entrance wall of an estate in Highbury called Wicks Estate.

2. Reason for Inquest

- 2.1. At the time of her death Ms Aufiero was subject to a 28 day mental health detention order and was required to be detained at the Royal Adelaide Hospital². Ms Aufiero was supposed to be a patient in Ward C3 which is an acute psychiatric ward of 20 beds at that hospital. Ms Aufiero's death was therefore a death in custody within the meaning of the Coroner's Act 2003 and this Inquest was held as required by section 21(1)(a) of that Act.
- 2.2. Mr Fell was not a detained patient at the time of his death. However, during the preceding three months he had been in and out of hospital, including the Royal Adelaide Hospital, as a result of attempts he had made to commit suicide. Indeed, Mr Fell and Ms Aufiero met each other on Ward C3 and formed a friendship.

3. The evidence at Inquest

- 3.1. I heard evidence from a number of staff members from Ward C3. In particular I heard from Mr Mark Cunningham who is a mental health nurse and registered nurse, Ms Kay Bertoli, an enrolled mental health nurse, Rebecca Elton, a clinical mental health nurse and Leah Hibberd, the associate clinical services coordinator who is also a registered mental health nurse.
- 3.2. At least some of those witnesses were aware of the relationship between Ms Aufiero and Mr Fell and they did not consider it to be an appropriate one. However, certainly once Mr Fell had left Ward C3 there was little or nothing that any of the staff members could do to discourage contact between Mr Fell and Ms Aufiero.
- 3.3. It is clear from the evidence and casenotes that Ms Aufiero was in contact with Mr Fell while she was in Ward C3 after her admission on 22 December 2008. Mr Fell was not on the ward at that time but on 22 December 2008 he had been in another part of the hospital for an acute admission overnight. Text messages obtained from both Mr Fell's phone and Ms Aufiero's phone show that they were in contact over this period. Furthermore, letters that had been exchanged between the two were found in Ms Aufiero's room.

² Exhibit C46

- 3.4. Staff had assessed Ms Aufiero as a fragile and vulnerable person. For his part Mr Fell was described as a man who was sometimes quite angry and lived an itinerant lifestyle.
- 3.5. It is obviously a matter of great concern that a detained patient might abscond and a matter of tragic concern that such a person might then go on to take their own life. However, Ward C3 is not a locked ward and patients on that ward are permitted access to the whole of the premises of the Royal Adelaide Hospital, including the grounds. Accordingly, it was only in circumstances where a patient was missing for more than half an hour that there was a requirement for a search to be made and for action to be taken to locate the patient.
- 3.6. It is not suggested that on a proper assessment the regime of detention for Ms Aufiero required any greater security than that which was available on Ward C3. In other words, it was perfectly acceptable as far as the relevant clinicians were concerned that she not be on a locked ward.
- 3.7. A careful consideration of the whole of the evidence shows that the staff of Ward C3 ascertained that Ms Aufiero had absconded in a timely fashion after she had done so. At the 2pm round on 30 December 2008 Ms Aufiero was not seen. Steps were immediately put into place to ascertain her whereabouts. At that stage it had not finally been determined that she was absent from the hospital grounds themselves. The staff had a half an hour from that time in which to file a missing person's report. That requirement was complied with.
- 3.8. It was suggested that the missing person's report that was filed should have contained a reference to the possibility that Ms Aufiero had an association with Mr Fell. It was also suggested that it would have been appropriate for a contact number for Mr Fell to be included in the missing person's report, or for staff to have made some attempt to contact Mr Fell.
- 3.9. The fact of the matter is that the staff concerned did not consider it necessary to take either of those steps. They had no reason to think that Ms Aufiero was planning to abscond with Mr Fell, nor to think that there was a plan for them to harm themselves. At that stage the staff simply regarded the relationship between Mr Fell and Ms Aufiero as inappropriate. They had no reason to believe that a plan was in place of the kind that subsequently emerged.

3.10. Furthermore, the Mental Health Act at the time contained secrecy provisions which prohibited the divulgence of information concerning one detained patient to any other person. These provisions inhibited and possibly prohibited staff from disclosing the relevant information in the manner suggested. In the result, I do not think the staff should be criticised for not having attempted to contact Mr Fell, nor having disclosed his details to police in the missing person's report, even if one did not consider the prohibition contained in the Mental Health Act at the time. It is notable that the new Mental Health Act contains no such inhibition and that is a matter of some comfort. Nevertheless, as I have said, it still does not seem to me that the staff ought to have been expected to foresee the need to contact Mr Fell, nor to alert police as to his details.

4. Conclusion

4.1. This matter was investigated by Detective Brevet Sergeant Fitzgerald who in my opinion has done an excellent and thorough job in that regard. Having considered all of the material gathered by him and the oral evidence, I have no recommendations to make in this matter. The evidence disclosed that very shortly after Ms Aufiero absconded from Ward C3 she must have met Mr Fell. They arrived at a pawnbroker's shop at approximately 1:15pm that day. At approximately 3:20pm Mr Fell was recorded as having purchased some pipe or hose from a Mitre 10 at Glynde. This was subsequently used for the purposes of the carbon monoxide poisoning which was ultimately the cause of their death.

4.2. In my opinion, there has been no system failure in this case. As I have already said, I have no recommendations to make in this matter.

Key Words: Death in Custody; Suicide; Psychiatric/Mental Illness

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

Seal the 14th day of November, 2012.

State Coroner