



FINDING OF INQUEST

An Inquest taken on behalf of our Sovereign Lady the Queen at Adelaide in the State of South Australia, on the 25th day of November 2008 and the 4th day of December 2009, by the Coroner's Court of the said State, constituted of Anthony Ernest Schapel, Deputy State Coroner, into the death of Peter Ross Blunden.

The said Court finds that Peter Ross Blunden aged 54 years, late of 3/46 Annette Street, Athol Park, South Australia died at Cramond Clinic, Queen Elizabeth Hospital, Woodville Road, Woodville, South Australia on the 25th day of October 2006 as a result of hanging. The said Court finds that the circumstances of his death were as follows:

1. Introduction and reason for Inquest

- 1.1. On Wednesday 25 October 2006 Peter Ross Blunden, aged 54 years, was found hanging by way of a ligature fashioned out of a track pants cord in a shower room at the Cramond Clinic at the Queen Elizabeth Hospital (QEH). The cord was affixed to the inside locking mechanism of a shower room inside the clinic. In spite of resuscitative efforts administered at the scene, Mr Blunden was declared deceased. A post-mortem examination was conducted by Dr Allan Cala, a forensic pathologist employed at Forensic Science SA. In Dr Cala's report¹ he has expressed the cause of Mr Blunden's death as hanging. I find that to be the cause of Mr Blunden's death.
- 1.2. The Cramond Clinic is the psychiatric ward of the QEH. It provides acute mental health care for voluntary patients and patients who are detained under the Mental Health Act 1993 (MHA). It has both an open section and a closed section. The open section, in which patients have considerably more liberty, accommodates voluntary patients as well as detained patients who require limited supervision. The closed

section is for detained patients only and involves a higher level of supervision. The closed ward is sometimes referred to as the clinic's high dependency unit.

- 1.3. At the time of Mr Blunden's death he was a detained patient. He was accommodated within the open section of Cramond Clinic at the time of his death.
- 1.4. Mr Blunden had suffered from schizophrenia since his late 20s. Over a number of years Mr Blunden had periodically been a patient in mental health institutions. Mr Blunden came to be in the Cramond Clinic in 2006 by virtue of the fact that he was detained pursuant to the MHA. He remained a patient within the Cramond Clinic until the day of his death. However, from time to time there had been grants of leave for very short periods. For the most part the periods of leave turned out not to be particularly successful. At the time of his death Mr Blunden was the subject of a second 21 day detention order under the MHA and he was imminently to be the subject of an application for a continuing detention order before the Guardianship Board of South Australia.
- 1.5. During the course of Mr Blunden's admission to Cramond Clinic it became evident that Mr Blunden was depressed and had repetitive thoughts of suicide. The hanging that occurred on 25 October 2006 was probably the product of his depression and sense of hopelessness. There is no suggestion that any other person was involved in Mr Blunden's hanging. In all the circumstances I find that Mr Blunden's hanging was due to his own actions and was accompanied by an intention to take his own life.
- 1.6. The fact that Mr Blunden was detained under the MHA at the time of his death means that this was a death in custody in respect of which an Inquest was mandatory. In this Inquest I examined the cause and circumstances of Mr Blunden's death.

2. The relevant provisions of the Mental Health Act 1993

- 2.1. Before discussing the circumstances of Mr Blunden's hospitalisation and death, I should briefly explain the regime of detention that the MHA provides for. Section 12(1) of the MHA enables a medical practitioner to make an order for the immediate admission and detention of a person in an approved treatment centre where the medical practitioner is satisfied of a number of matters: firstly that a person has a mental illness that requires immediate treatment, secondly that such treatment is

¹ Exhibit C3a

available in an approved treatment centre and thirdly that the person should be admitted as a patient and detained in an approved treatment centre in the interests of his or her own health and safety or for the protection of other persons. Section 12(2) of the Act provides that such a detention order expires 3 days after the day it is made unless it is earlier revoked. A person so detained must be examined by a psychiatrist within 24 hours of the patient's admission to the approved treatment centre or, where that is not practicable, as soon as is practicable after that admission. The examining psychiatrist must consider whether the continued detention of the patient is justified or not. If the psychiatrist is not satisfied that the continued detention of the patient is justified, the psychiatrist must revoke the order. Otherwise, the psychiatrist will confirm the order. If the psychiatrist confirms the order, this has the effect of continuing the 3 day period that had been activated by the original detention order. Before the expiry of that 3 day period, a further order for detention for another period of up to 21 days may be imposed. A second 21 day order may be imposed upon the expiry of the first such order. Mr Blunden had been subjected to the regime of detention that I have just described and was detained under a second 21 day order at the time of his death.

- 2.2. Notwithstanding a detained patient's detention under the MHA, the Director of the approved treatment centre that houses the detained patient is authorised to grant a patient leave for such purposes and for such period and under such conditions as the Director thinks fit. Mr Blunden was granted leave on more than one occasion and in fact had experienced some leave over the course of the weekend immediately prior to his death.
- 2.3. The regime of detention that I have described only permits the imposition of two 21 day orders. These orders may be imposed by psychiatrists. Any further detention under the MHA beyond the total of the 45 days that I have described requires an order of the Guardianship Board of South Australia. The Guardianship Board may impose a continuing detention order under the MHA in the interests of the patient's own health and safety or for the protection of other persons. The Guardianship Board may only order a person to be so detained for a further period not exceeding 12 months. In this case an application to the Guardianship Board for a continuing detention order had been made and was due to be heard by the Board at a hearing that was to take place at Cramond Clinic on 26 October 2006, the day after Mr Blunden's death. The

grounds for the application, as made by Dr Gordon Ding of the QEH, included the fact that Mr Blunden required further inpatient assessment and that he was unable to function independently having regard to his chronic schizophrenia. At the time of Mr Blunden's death there were no certain means in existence by which it could be determined how long Mr Blunden would have to remain under detention.

3. Background

- 3.1. As indicated earlier, Mr Blunden had a lengthy history of chronic schizophrenia. This was complicated by the fact that Mr Blunden experienced somatic symptoms such as bodily shaking. He also had an aversion to some anti-psychotic medication. He believed that the medication contributed to his symptoms. On the other hand, Mr Blunden actively sought out other medication that he believed alleviated his symptoms and his acute anxiety. Mr Blunden's aversion to anti-psychotic medication led to a history of non-compliance as a result of which, prior to his detention, he had been placed under a community treatment order by the Guardianship Board of South Australia.
- 3.2. Prior to Mr Blunden's final admission of September and October 2006, there had been a number of previous admissions to Cramond Clinic. The clinical staff at Cramond Clinic knew Mr Blunden quite well. In fact a psychiatrist, Dr Douglas Wilson, had been treating Mr Blunden at the Cramond Clinic for several years. Dr Wilson had been working at Cramond Clinic since its opening in 1997 and had either worked within the clinic itself or in the Community Outpatient Centre attached to the clinic.
- 3.3. Unfortunately Mr Blunden had only limited insight into his condition.
- 3.4. Members of Mr Blunden's family could not relate any previous attempts on Mr Blunden's part to take his own life. Nor could Dr Wilson.
- 3.5. Mr Blunden's detention took place on 11 September 2006 in respect of an incident that had occurred that day and which was believed to be as a result of an acute exacerbation of his schizophrenia possibly due to non-compliance with medication. Although he was not at that time suicidal or behaving in a threatening manner towards other persons, Mr Blunden was assessed as being at risk to himself due to severe disorganisation and poor decision making. I need not go into the details of the reasons for his initial detention or for the confirmation and extension of his detention.

In my opinion there were proper grounds for Mr Blunden's continuing detention under the MHA for the whole of the period between 11 September 2006 and the day of his death being 25 October 2006. Nobody has suggested otherwise. The application to the Guardianship Board for a continuing detention order that was to be heard the day after Mr Blunden's death was, also in my view, based on proper grounds.

4. Issues arising at the Inquest

4.1. In this Inquest I examined a number of issues surrounding the death of Mr Blunden. These issues included the following:

- 1) Was Mr Blunden's taking his own life foreseeable within Cramond Clinic?
- 2) Were sufficient precautions taken against the possibility of Mr Blunden attempting to self-harm?
- 3) Had Mr Blunden been medicated in accordance with the regime of medication that had been prescribed for him?
- 4) Could Mr Blunden's death have been prevented?

5. The course of Mr Blunden's admission to Cramond Clinic in September and October 2006

5.1. Mr Blunden's initial period of admission appears to have been unremarkable. He had specifically denied feeling depressed on a number of occasions as was clearly documented on 19, 22, 26 and 28 September and 3 October 2006. He first reported feeling depressed on 8 October 2006 and this was over his frustration at his extended stay in hospital and out of concern that his partner might leave him. Themes of frustration about the extended hospital admission continued from this time. Indeed, by the week of his death, when it was apparent that his admission would be extended pursuant to the Guardianship Board application, he had become quite despondent. It is recorded that he was very disappointed at the attempts to prolong his admission. It will be remembered, however, that Mr Blunden was accommodated in the open ward of the Cramond Clinic and as such was allowed some freedom of movement. For instance, he was able to spend time in the hospital grounds without supervision. In addition, in an attempt to ameliorate his continued frustration engendered by the prospect of what may have appeared to him to be an open ended detention, he was

granted a number of authorised periods of leave from the clinic. I add here that although Mr Blunden may have gained an understanding that his continued detention by virtue of a Guardianship Board order was almost inevitable, his psychiatrist Dr Wilson had discussed with Mr Blunden as late as Monday 23 October 2006 the possibility of him staying at the clinic for only a couple more weeks. Although distressed by the prospect of continuing detention, he seemed to accept Dr Wilson's views about the matter and became somewhat resigned, and perhaps less distressed, by the end of their discussion. Nevertheless, it is very possible that part of what motivated Mr Blunden in the end to take his own life was the prospect of further detention.

- 5.2. There were occasions during the course of his admission where Mr Blunden expressed suicidal ideation but without suicidal plans. He made utterances from time to time to the effect that life was not worth living if he was not going to get any better.
- 5.3. At times during his admission, Mr Blunden asked for PRN (as required) medication. The medication was generally anti-anxiety medication. By the time of Mr Blunden's death, he was receiving regular anti-psychotic medication as well as PRN anti-anxiety medication. Notwithstanding Mr Blunden's propensity to ask for anti-anxiety medication from time to time, there appears to have been, as I have already reported, aversions to medication. Indeed, his post mortem toxicological results give rise to the suspicion that Mr Blunden failed to take his PRN medication notwithstanding the fact that it was prescribed for and supplied to him and that all of this was recorded in his clinical notes. I return to that particular aspect of Mr Blunden's management later in these findings.
- 5.4. Mr Blunden's last period of leave occurred on Sunday 22 October 2006 between 10am and 6pm. Sometime during the course of that afternoon staff at Cramond Clinic received a phone call from one of Mr Blunden's friends who said that Mr Blunden was at his house and voicing suicidal ideation. Mr Blunden returned to the clinic later that afternoon. That evening he was examined by Dr Boyd-O'Reilly. He told Dr Boyd-O'Reilly that at home that day he had felt worse with increasing suicidal thoughts with a plan to shoot himself, although he denied having access to a firearm. He reported an increasing sense of hopelessness in respect of his '*shakes*'. He is recorded as having experienced tremors during the course of this examination and was writhing on the bed holding his head in his hands. He expressed frustration at a

perceived lack of improvement during the course of his admission. He said things like *'I need an injection. I can't stand it (the tremor) any more'* and *'please just knock me out'*. It is recorded by Dr Boyd-O'Reilly that Mr Blunden reported *'ongoing suicidal ideation'*. Dr Boyd-O'Reilly formulated a plan whereby Mr Blunden would have no ground privileges or further leave until he was reviewed by his regular treating team of clinicians.

- 5.5. The notes record that Mr Blunden continued to be medicated.
- 5.6. The following day, Monday 23 October 2006, he was noted still to complain of mild suicidal ideation with no actual plan. He was noted by the nursing staff to have a flat, blunted affect and to be depressed looking. He was complaining of the shakes and not being able to cope. On that day Mr Blunden received a letter from the Guardianship Board concerning the hearing that was to take place later in the week. He continued to seek medication. This was the day that Dr Wilson spoke to Mr Blunden and gave him some hope of release into the community possibly within the next fortnight.
- 5.7. On 24 October 2006, Mr Blunden's 54th birthday, it was noted by Dr Ding, a resident medical officer working on rotation within the clinic, that his mental state was unchanged. A decision was made to alter Mr Blunden's depot medication from monthly to fortnightly, starting the following day. Mr Blunden's half-brother, Mr Barry O'Shea, and his wife visited Mr Blunden that day. Mr Blunden appears to have exhibited mixed emotions on this day. A small party was held in honour of Mr Blunden's birthday within the clinic. At that stage he appeared to have a degree of animation and appeared to be very appreciative of the attention given to him by other clients and staff. On the other hand, when visited by Mr O'Shea and his wife, Mr O'Shea noted that Mr Blunden was the most depressed he had ever seen him. Mr Blunden told Mr O'Shea that he was *'really down about growing old on his own in a flat and not having anything or anyone in his life'*. He said that he felt *'quite suicidal'*². When Mr O'Shea and his wife left the clinic Mr Blunden thanked them for visiting him and said that he would visit them when he was well enough to leave the clinic. That was the last time Mr O'Shea saw his brother.
- 5.8. Mr Blunden was also seen on 24 October 2006 by his brother, David Blunden. During their conversation Mr Blunden spoke of suicide saying *'I feel so down I want*

² Statement of Barry Daniel O'Shea, Exhibit C5j

to kill myself. David Blunden was very surprised by this. It was the first time that he had ever heard his brother say that he had wanted to kill himself. Prior to that, David Blunden had been aware of his brother's aversion to his medication and the severe tremors that he attributed to that medication. On the occasion that he saw Mr Blunden on 24 October 2006 his brother's hands were shaking significantly. To David Blunden, Mr Blunden was severely depressed and was more so than at any time of his life. David Blunden and Mr Blunden made plans for Mr Blunden to retrieve his Visa card from David Blunden so that he could access his own finances and be more independent. Mr Blunden was content with this and appeared to be looking forward to his brother's next visit. David Blunden had no inkling that Mr Blunden would act out on any suicidal ideation.

- 5.9. On the evening of 24 October 2006 Mr Blunden is recorded as not having sought any PRN medication and had only one small episode of what is noted to be '*pseudo shakes*'. He was asleep by 10pm.
- 5.10. Throughout Mr Blunden's admission in Cramond Clinic he had regularly been seen by Dr Ding. There appears to have been a positive rapport established between them. There are occasions recorded in the clinical history of Dr Ding playing table tennis with Mr Blunden and seeing and examining Mr Blunden on a regular basis. 24 October 2006 was Dr Ding's last day in Cramond Clinic and he was replaced by another resident medical officer, a Dr Yang. On 25 October 2006 Dr Yang examined Mr Blunden with a mental health nurse. Dr Yang recorded that Mr Blunden continued to have suicidal ideation but with no concrete plan of action. He had a depressed effect with a theme of hopelessness and said words to the effect '*I'm never getting out of here*'. His suicidality was expressed in terms of statements such as '*I just want to die*'. Dr Yang recorded that Mr Blunden lacked insight and judgment. Mr Blunden's expressions of suicidal ideation to Dr Yang do not appear to have been mentioned to any more senior medical practitioner that day.
- 5.11. 25 October 2006 was the day of Mr Blunden's death. As at the time of these events there was a system in place within the Cramond Clinic open wing whereby all patients had to be physically sighted every hour and marked off on a check sheet. At the time of these events there were 35 patients within that part of Cramond Clinic. The

statement of a mental health nurse Patricia Colleen Reeves³ reveals that at about 1:30pm Mr Blunden asked her for some spare clothes. Just before 2pm Ms Reeves obtained the check sheet and began to mark off patients she could see in the vicinity of the nurses' station. She recalled that Mr Blunden was not in his bed at that time and could not recall exactly where Mr Blunden was when she sighted him. Suffice it to say she marked him off as having been sighted at 2pm. This appears to have been the last time any person saw Mr Blunden alive.

- 5.12. Mr Blunden's roommate, Mr Steven Kopcheff, provided a statement to the Inquest⁴. Following a haircut, Mr Kopcheff went to take a shower in the cubicle in which Mr Blunden was later to be found deceased that afternoon. Mr Kopcheff said that at about 1:30pm he knocked on the shower room door and, in spite of turning the lock, could not get in because the door was jammed shut. Mr Kopcheff said that he had checked his watch to ascertain the time of this incident. There is no explanation as to why Mr Kopcheff could not open the door. There is an inference available that Mr Blunden was in the shower cubicle at that time and remained there until his death, but this would be difficult to reconcile with Ms Reeves' sighting of him at 2pm, unless it so happens that Ms Reeves' sighting had consisted of her having established his presence in the shower room at that time without actually having seen him. She says that she cannot recall where he was when she recorded his presence. In any event, at about 2:30pm Mr Kopcheff returned to the cubicle and knocked on the door. There was no answer. The door was still jammed shut and would not open. He alerted the nursing staff. A psychiatric nurse by the name of Kevin Davies eventually managed to open the door. Mr Blunden was deceased and all resuscitative efforts proved fruitless. Mr Blunden had tied a ligature around his neck. The ligature appears to have taken the form of his tracksuit pants cord. The ligature was tied to the privacy door knob on the inside of the door to the cubicle. I need not re-state the details of the efforts to resuscitate Mr Blunden. It is clear that resuscitative methods were rapid and thorough but that, by the time Mr Blunden was located, he was beyond any meaningful assistance.

- 5.13. Following the discovery of Mr Blunden the police were called and they conducted an investigation.

³ Exhibit C5b

⁴ Exhibit C5i

6. Discussion of the issues

6.1. Was Mr Blunden's taking his own life foreseeable within Cramond Clinic?

As seen earlier, Mr Blunden did not have any history of self-harm. There is no suggestion that his original detention, its confirmation or extension, occurred out of any perceived need to protect Mr Blunden from self-harm, although it was felt that he was at risk in terms of his lack of a proper ability to care for himself. Dr Douglas Wilson, who gave evidence before me, told me that Mr Blunden's statements about using a gun to self-harm was an indicator of how distressed Mr Blunden was at the time and not necessarily indicative of a positive and imminent intention to kill himself. Owing to the fact that Mr Blunden did not have access to a firearm, to Dr Wilson his statement could be interpreted as an expression of his current level of distress and feelings of frustration. Dr Wilson told me that, certainly by the day after these statements were made, the impression was that Mr Blunden did not have a plan to kill himself⁵. Dr Wilson also told me in this context that, in his discussion with Mr Blunden on 23 October 2006, Mr Blunden appeared to be reassured and calmed by Dr Wilson's and Dr Ding's assertions that Mr Blunden would not be in hospital forever⁶. Mr Blunden's last statement as recorded by Dr Yang on the day of his death, namely that he just wanted to die and that he was resigned never to emerge from Cramond Clinic, were interpreted by Dr Wilson as '*clearly an expression of frustration at being in hospital*'⁷. Dr Wilson believed that Mr Blunden was a man who appeared to be quite open and honest and would tend to provide honest answers to direct questions and that when he said on that day that he had no plans to act upon any suicidal ideation, this could be taken into account as tending to negate the risk of self-harm⁸. Dr Wilson, however, did agree that he had not been made aware of those utterances on 25 October 2006⁹. Indeed, it appears that this information was not necessarily passed on to anyone else. When asked as to what, if anything, Dr Wilson himself may have done if Mr Blunden's utterances to Dr Yang had been conveyed to him, Dr Wilson said that he would have asked for more information about his suicidal ideation and aligned those utterances with previous statements along the same lines. If he was concerned about Mr Blunden's presentation, he would have suggested that nursing staff keep a close eye on him. Dr Wilson said that he would be on the lookout for

⁵ Transcript, page 49

⁶ Transcript, page 52

⁷ Transcript, page 58

⁸ Transcript, page 58

anything that was different from Mr Blunden's past history and anything else that made him concerned. He went on to say:

'... and probably suggest to increase supervision on him, and not to be afraid of giving PRN. So I guess that would have been the strongest thing I would have said, don't - if he's looking distressed, don't be afraid to give him PRN because sometimes there can be some hesitation because they're obviously drugs that develop tolerance, and people can abuse the Benzodiazepines. But my view is if someone's very distressed, you need to deal with that problem and then, especially in a hospital setting, you can withdraw the Benzos when someone's better.'¹⁰

I note that Mr Blunden was not administered any PRN medication on the day of his death. Dr Wilson himself was influenced by the fact that on the Monday of that week Mr Blunden appeared to have been reassured by the possibility of release and that on the Tuesday he had enjoyed visitors and looked bright, reactive and inter-reactive. He pointed to the fact that his family had said the same sort of thing and that there appeared to be forward planning on the part of Mr Blunden. That is a significantly different impression from that derived by Mr Blunden's brothers. As seen earlier, both of them suggested that this was the most despondent that they had ever seen Mr Blunden. If that was the case, it is highly unlikely that they had said anything to Dr Wilson by way of any positive reassurance about the state of mind of their brother.

6.2. In the event, when asked where he would have placed Mr Blunden on a scale of risk of self-harm, Dr Wilson said:

'I guess I would have hoped within the hospital environment that I'd put his scale of self-harm as moderate, at sort of medium in that I would have thought there was a good chance that him feeling distressed would have led him to seek help rather than injure himself.'¹¹

6.3. In many ways Dr Wilson was examining the matter with a large measure of hindsight and, moreover, in deprivation of any knowledge of Mr Blunden's presentation on the actual day of his death. I say this given the fact that Mr Blunden's objectively worrying statements to Dr Yang were not passed on to Dr Wilson. Dr Wilson seemed to have a more positive spin on Mr Blunden's presentation than that as viewed by his family members the day before. While it is difficult to say that Mr Blunden's attempt at self-harm and attempt to kill himself was absolutely foreseeable, there were

⁹ Transcript, page 59

¹⁰ Transcript, pages 60-61

¹¹ Transcript, page 79

indications available within the clinic to suggest that by 25 October 2006 Mr Blunden had reached an extremely low ebb.

6.4. In my view a conclusion can be reached that on the day of his death Mr Blunden was at a higher risk of suicide than at any other point in time during his admission. Given the persistence with which Mr Blunden had signified suicidal ideation, the risk of him harming himself, either within the clinic or if not there then some place outside the clinic, was not insignificant.

6.5. Were sufficient precautions taken against the possibility of Mr Blunden attempting to self-harm?

There is no evidence that Mr Blunden was subjected to any greater level of scrutiny after he returned from his most recent leave on 22 October 2006 during which he had indicated that he wanted to shoot himself. On the day of his death he had indicated to the new resident medical officer, Dr Yang, that he wanted to die. There does not appear to have been any effective action taken that day that would have ameliorated the risk of Mr Blunden harming himself. Dr Wilson told me that he was unaware of whether *'anything formally had been done to change the level of scrutiny'*¹².

6.6. The level of scrutiny that was accorded to Mr Blunden in the light of his asserted suicidal ideation seems for the most part to have been dictated by the fact that Mr Blunden consistently denied that he had any plan as such to take his own life. Dr Wilson said in a number of written statements, as well as in his evidence, that as there appeared not to be a sustained, focussed suicidal ideation with plans as a significant part of Mr Blunden's presentation, clinical staff had elected not to transfer him to the closed, high dependency unit where there is a higher staff to patient ratio. In addition, although self-harm would be more difficult because of that heavier regime of supervision, Dr Wilson also felt that placing Mr Blunden in a closed ward may well have made things worse for him. Dr Wilson believed that the focus of Mr Blunden's frustration was the fact that he was still in hospital despite having been treated there for a prolonged period of time. There is no doubt that Mr Blunden's state of mind in this regard was a fundamental element of his presentation. Dr Wilson believed that given that was Mr Blunden's state of mind, placing him into a closed ward would have made him believe that he *'was actually going backwards'*¹³. Dr Wilson added

¹² Transcript, page 81

¹³ Transcript, page 50

that he did not think that the intensity of Mr Blunden's suicidal ideation, when he had seen him, warranted a closed ward admission¹⁴. One can well understand clinical staff's reluctance to place Mr Blunden within a regime that was even more conducive to increasing his frustrations and less conducive to proper clinical treatment. In my view there is no evidence to suggest that the decision not to place Mr Blunden within a closed environment was unreasonable.

6.7. All that said, it would have been appropriate for Mr Blunden to have received a much higher level of supervision and scrutiny within the open section of Cramond Clinic in the light of his suicidal ideation generally and particularly having regard to his presentation on the day of his death.

6.8. Had Mr Blunden been medicated in accordance with the regime of medication that had been prescribed for him?

Some of the medication that Mr Blunden was taking was anti-psychotic medication that also produced an anti-anxiety benefit at the same time. Some of this latter type of medication was given on an as needs (PRN) basis and Mr Blunden from time to time actively sought out that medication in order to reduce his somatic symptoms and levels of anxiety. It is understood that medication that has a tendency to quickly reduce anxiety is helpful in suppressing suicidal ideation or impulses.

6.9. The medication charts record that a number of drugs that might have reduced Mr Blunden's level of anxiety had recently been administered. According to those charts at any rate, the drug Oxazepam was administered to Mr Blunden at 8am on the day of his death. As well, Fluvoxamine was administered at the same time as was Benzhexol, which is a drug designed to reduce the side effects of antipsychotic medication. Lorazepam is recorded as having last been administered PRN at 1:40pm on 24 October 2006, the day before Mr Blunden's death. Olanzapine and a dose of Oxazepam were said to have been administered PRN on 22 October 2006. There is no record of any PRN medication given on the day of Mr Blunden's death, but it is recorded that he had his usual mane dose of Oxazepam at 8am.

6.10. Post-mortem toxicology, as documented in the report of Ms Heather Felgate BSc¹⁵, reveals that a post-mortem sample was analysed for the presence of Oxazepam,

¹⁴ Transcript, page 50

¹⁵ Exhibits C4a and C4b

Olanzapine and benzodiazepines including Lorazepam. The presence of Fluvoxamine was also investigated.

- 6.11. The toxicology report reveals that the presence of Oxazepam in the blood at a sub-therapeutic concentration could not be excluded, meaning that it was not detected in a therapeutic concentration. If he was administered this on the morning of his death as recorded, it is surprising that it was not present in a therapeutic concentration. The presence of Olanzapine at a low therapeutic concentration could not be excluded. Lorazepam and Fluvoxamine were not detected in the blood in any quantity. Fluvoxamine is recorded as having been given on the morning of Mr Blunden's death. The screening did not cover the drug Benzhexol or the depot antipsychotics that Mr Blunden was regularly administered. There is in any case no reason to believe that the depot antipsychotics were not administered as recorded. They are administered by way of injection.
- 6.12. However, the lack of detection at all, or detection in what might be only sub-therapeutic or low therapeutic concentrations, of other medication that was said to have recently been administered has given rise to a question as to whether or not Mr Blunden was indeed administered those medications. There is a possibility that in spite of the level of scrutiny that is accorded to patients actually taking their oral medications when administered, Mr Blunden may not in truth have swallowed the medication. There is no reason to doubt the accuracy of the medication records that were made at a time before any possible motive could have arisen to fabricate them. Some of the toxicology results will therefore have to remain a matter that is unexplained. It is sufficient for me to record that there is no evidence that Cramond Clinic staff were neglectful in administering Mr Blunden's medication. There is no evidence that anyone knew that Mr Blunden was feigning consumption of oral medication if that was the case. That said, there is no record that he was given any anti-anxiety PRN medication on the day of his death and I note in this regard, as seen earlier from Dr Wilson's evidence, that the administration of PRN meds could have been a strategy in dealing with Mr Blunden's acute level of anxiety on that day had Dr Wilson known the extent of it.
- 6.13. Could Mr Blunden's death have been prevented?
It probably goes without saying that if Mr Blunden had been placed in a closed clinical environment, his death on 25 October 2006 probably would have been

prevented, if for no other reason than that there would have been a considerably lesser opportunity for him to harm himself given the higher level of scrutiny. It is difficult to say, however, whether or not the taking of his own life at a later point in time would have occurred in any event.

- 6.14. Mr Blunden's death may also have been prevented if he had been accorded a higher level of scrutiny within the open section of Cramond Clinic or had not been allowed to place himself in a confined, private and locked area such as the shower room without an appropriate measure of supervision. As it was, he seems to have had unrestricted access to any part of the clinic. It is unfortunate that his last routine sighting was not the subject of a proper record in terms of the location where the sighting had taken place. One would have thought that patients who had exhibited any level of risk of self-harm would, in an open environment where apart from anything else they might simply walk out the door, have their movements carefully scrutinised and recorded.
- 6.15. It is also cannot be known what positive benefit if any Mr Blunden may have derived from the administration of PRN anti-anxiety medication if given to him on the day of his death.
- 6.16. During the course of the Inquest it was postulated that Mr Blunden might have been assigned a nurse 'special' to undertake the responsibility of monitoring Mr Blunden within the open ward on a virtual one-on-one basis. As to this Dr Wilson said the following:
- A. Well, definitely there is the potential to have a nursing special and it is done infrequently. It can sometimes be problematic in terms of availability of staff at short notice which are predominantly - well, you need to get a nursing agency person in or they usually use one of the regular staff to do the special and the nursing agency - but that option I don't believe was precluded.
- Q. Was that something you considered for Mr Blunden.
- A. It wasn't, because he appeared to be able to be reassured and settled on discussion of the issue of, you know, his future treatment and how long he was going to be in hospital.'¹⁶

¹⁶ Transcript, page 72

7. **Relevant changes since these events and Recommendations**

7.1. I received in evidence the affidavit of Dr Rohan Dhillon who is a Consultant Psychiatrist at the Cramond Clinic¹⁷. In his affidavit, Dr Dhillon has outlined a number of changes that have been prompted by these events. They are relevantly set out below:

1. Subsequent to Mr BLUNDEN's death, all door handles and latches, including the latch to the cubicle where Mr BLUNDEN died have been replaced with sloping/slanting door handles so they can no longer be used as hanging points.
2. The number of beds in Cramond Clinic have been reduced. Beds in the open section of Cramond Clinic have been reduced from 35 beds to 26 beds but nurse to patient ratios have remained the same. There are six nurses and one shift team leader and clinical practice consultant on duty during the day in the open section of Cramond Clinic. Staff and patients have reported that the environment in Cramond Clinic is more therapeutic and less noisy. This has allowed for a greater level of interaction between staff and patients since the bed reduction.
3. Security cameras have also been installed with a monitor in the High Dependency Unit (HDU). While the cameras do not cover the whole layout of Cramond Clinic, it does cover the entry and exit points, corridors and patient activity areas such as the courtyard smoking area so it enables better surveillance of patient movements within the Cramond Clinic.
4. The policy for sighting detained patients in the open section of Cramond Clinic now require a sighting every 30 minutes. Non-detained patients are sighted once per hour.
5. If, however, a detained patient was assessed as being not at risk of self-harm, then the 30 minute sightings may be changed to one hourly. This is a matter of clinical discretion by the treating team in consultation with senior staff.
6. At the time of Mr BLUNDEN's death, if it was suspected that a patient was non-compliant in taking medication, strategies could be introduced to ensure that the patient was taking medication such as ensuring greater supervision, crushing tablets, administering medication by wafer or syrup or the institution of a depot medication. Serum levels would also be checked if non-compliance was suspected. This remains the policy.
- ...
8. The investigating Police Officers suggested that tracksuit belts or cords, shoelaces etc. be removed from patients in the open ward. This is the policy in HDU but not in the open ward. Cramond Clinic policy for the open section is one of treating patients in the least restrictive environment. However, if a patient is assessed as being at risk of self-harm then, in all probability they will be transferred to the HDU if a bed is available or, otherwise, be transferred to a unit where there is a

¹⁷ Exhibit C7a

closed bed available or other measures would be taken to ensure a patient's safety in the open section as outlined below.

9. Arranging "specialling", that is a one to one nursing/patient ratio was and is available in the open section of Cramond Clinic if there are concerns regarding the safety of a patient and there was no closed bed available in the system.'¹⁸

7.2. I would only add to that the Inquest has demonstrated that it is highly desirable, if not a matter of routine requirement, that any expressed suicidal ideation, with or without a plan, should be passed on by nursing staff or junior medical staff to consultant psychiatrists at the clinic for their necessary action. I recommend accordingly. I direct this recommendation to the Minister for Mental Health and Substance Abuse.

Key Words: Death in Custody; Psychiatric/Mental Illness

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

Seal the 4th day of December, 2009.

Deputy State Coroner

Inquest Number 37/2008 (1580/2006)

¹⁸ Exhibit C7a