CHELMSFORD AND THE ROLE OF THE CORONER[1]

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INTRODUCTION

During the course of the Royal Commission into the treatment of patients with the so-called deep sleep therapy at Chelmsford Private Hospital in the 1960s and 1970s, it became apparent that incidents of death either during or shortly after this treatment had not attracted the attention of the relevant regulatory and professional bodies so as to cause earlier action to be taken in relation to the administration of this treatment. One of these regulatory systems was the availability of coronial inquests in New South Wales. But the history of Chelmsford indicates that few inquests were held and that a number of those actually conducted were unable to obtain sufficient information to make proper findings.

Inquests into deaths of patients who died at Chelmsford Private Hospital while being administered narcosis therapy or within days of being transferred from Chelmsford to another hospital after undergoing such treatment.

6th September 1967: Inquest into the death of RONALD GRAEME CARTER, died 3rd May, 1967 at Chelmsford Private Hospital. Finding: virulent and rapid pneumonia following the use of barbiturates for the purpose of continuous narcosis therapy.

3rd September 1976: Inquest into the death of AUDREY FLORENCE FRANCIS, died 14th March, 1976 at Chelmsford Private Hospital. Finding: natural causes, namely pulmonary oedema due to heart failure. (Later quashed by Supreme Court of New South Wales.)

28th December 1977: First inquest into the death of JOHN VALDEN ADAMS, died 30th September, 1977 at Hornsby District Hospital, transferred from Chelmsford Private Hospital 23rd September, 1977. Finding: acute narcotism.

13th February 1980: Second inquest into the death of JOHN VALDEN ADAMS. Finding: cerebral softening from prolonged cerebral anoxia due to cardiac-respiratory attack while undergoing deep sedation therapy at Chelmsford Private Hospital.

25th September 1981: Inquest into the death of MIRIAM VICTORIA PODIO, died 12th August, 1977 at Chelmsford Private Hospital. Coroner's opinion forwarded to the Attorney General on 4 March, 1982, stating, *inter alia*: "I have formed the opinion ... that a prima facie case of Manslaughter (Criminal Negligence) has been established against Dr Harry Richard Bailey, Dr John Herron and Dr Ian Donald

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	Gardiner. (On 28 March 1983 the Attorney General informed the Minister for Health that an *ex officio* indictment had been filed against Dr Bailey and on 23 March 1984 that no proceedings would be taken against Drs Herron and Gardiner. On 9 May 1985 a Magistrate hearing committal proceedings against Dr Bailey ruled that he should not be committed for trial on a charge of manslaughter.)
30th June 1988:	Second Inquest into the death of AUDREY FLORENCE FRANCIS. Finding: Pulmonary oedema following cardio-respiratory failure due to barbiturate intoxication administered in the course of deep sleep treatment at Chelmsford Private Hospital.

Inquests into deaths by suicide of persons administered narcotics therapy on one or several occasions at Chelmsford Private Hospital some time prior to their deaths.

18th June 1975:	Inquest into the death of ROBYN NELLIE BARWICK, died 16th December 1974. Finding: death by barbiturates self-ingested.
7th July 1978:	First Inquest into the death of SHARON MARGARET HAMILTON, died 15th February 1978. Finding: death by barbiturates selfingested.
3rd April 1979:	Second Inquest into the death of SHARON MARGARET HAMILTON. Finding: death by barbiturates self-ingested.
3rd November 1978:	Inquest into the death of BARBARA BEAUMONT SMITH, died 2nd July 1978. Finding: death by barbiturates self-ingested.
20th July 1979:	Inquest at Glebe Coroner's Court into the death of BARBARA MARY CAHILL, died 15th January 1979. Finding: cause of death not ascertainable due to decomposition of body.

Inquest into the death of Ronald Graeme Carter

Given that sedation therapy was employed at Chelmsford Private Hospital between 1963 and late 1978, it will be evident from the dates set out above that all of the inquests referred to, except the Carter Inquest, took place either towards the end of this period or after the cessation of the treatment at Chelmsford. The one inquest, therefore, that might have triggered a wider inquiry into the administration of sedation therapy at a relatively early date deserves closer examination.

The inquest commenced on 6th September 1967 and continued on 7th September and 6th and 8th November of that year. Dr Bailey described sedation treatment to the Coroner in the following terms:

> This is a form of treatment whereby the patient is artificially placed in a state of deep sleep, this state being achieved by administering to the plaintiff a combination of drugs which are then repeated at intervals so that the patient spends approximately 23 and a half out of 24 hours in a state of deep sleep.

During this period he is fed through a nasal tube and his dietary and other intakes are carefully monitored and where necessary other specific medication is prescribed and given during that period and again where clinically indicated electro therapy or electro stimulation of the brain is carried out while the patient is asleep.[2]

Dr Bailey stated that he had administered this treatment at Chelmsford Private Hospital and also at Crown Street Women's Hospital, Canterbury District Hospital and Eastern Suburbs Hospital.

The drug chart for the deceased patient indicated that on 29th April 1967 he had received 1600 mgm of Tuinal; on 30 April 1967, 2000 mgm of Tuinal; on 1st May 1967, 2000 mgm of Tuinal; and on 2 May 1967, 2400 mgm of Tuinal. Dr Bailey agreed that between 2,000 and 4,000 mgm of Tuinal could be a lethal dose if taken in a single quantity but insisted that these dosages were safe ones [3]

Dr Bailey went on to explain the procedure of drug administration:

Q. Would this be accurate, that having satisfied yourself on other occasions that the nursing staff at the Chelmsford Hospital knew the meaning of deep sedation you left it to the nursing sister's discretion firstly to administer the drugs Tuinal, Neulactil and Sparene.

A. Under my supervision on a daily basis. Yes.

Q. Secondly, the quantity of the drugs Sparene, Tuinal and Neulactil to be administered.

A. Yes.

Q. Thirdly would this be accurate, that having satisfied yourself on other occasions that the nursing staff at the Hospital knew the meaning of deep sedation you left it to the nursing sister's discretion as to the frequency that these three drugs were to be administered.

A. Subject to my general instructions given to the nurses from time to time orally.[4]

The Government Medical Officer who carried out the post-mortem, Dr James Passmore, gave the following evidence:

Q. You have heard some evidence that has been given earlier today about this treatment, Deep Sedation Therapy, which is a form of treatment given by psychiatrists to people given to depression.

A. Yes.

Q. Would you agree that it is a well-tried, well-proven way of treating such patients.

A. Yes I would.

Q. Agree that Dr Bailey has a reputation as one of the most eminent and distinguished psychiatrists in the country.

A. Yes I entirely agree.[5]

2 Carter Inquest Transcript at 23.
3 *Ibid* at 66-68).
4 Carter Inquest Transcript at 38.

Professor Roland Thorp, a pharmacologist expressed the following opinion to the Coroner:

> Q. You say the doses of the drugs used were potentially dangerous when used singularly, and when used in combination they potentiate each.
>
> A. Yes.
>
> Q. Are you saying that the drugs administered to this patient were dangerous.
>
> A. The combination of them was dangerous. Yes.[6]

Professor Thorp added that "this discretion is asking a very great responsibility of a trained nurse".[7]

Professor Maddison, who held the chair of psychiatry at Sydney University, also gave evidence on the question of the discretion available to the nursing staff:

> Q. Should it be left to a nurse's discretion to determine firstly the amount of the drugs to be administered to a patient?
>
> A. This would depend on the type of drug.
>
> Q. Should it be left to a nurse's discretion to determine first the amount of the drugs Tuinal, Neulactil and Sparene?
>
> A. No.
>
> Q. Secondly, as to the times when those drugs were to be administered?
>
> A. This I think would depend on what you mean by times.
>
> Q. Times between dosages.
>
> A. No.
>
> Q. Thirdly, the amount of such drugs to be administered.
>
> A. My answer again would be no.[8]

Under cross-examination Professor Maddison gave further evidence on the issue of discretion:

> Q. If a direction to the nursing staff that drugs are to be given to the patient every 6 to 8 hours, that would be a proper direction.
>
> A. A precise dosage. Yes.
>
> Q. It would be a proper direction to the nursing staff that in a period of six to eight hours a maximum dosage be given, that no more than X amount of drugs be given.
>
> A. It would be a highly unusual way to give a drug, but I think it could be justified.
>
> Q. Provided they were told not to exceed a specific dosage it would be alright.

5 Carter Inquest Transcript 82-83.
6 Carter Inquest Transcript at 104.
7 Carter Inquest Transcript at 108.
8 Carter Inquest Transcript at 149-150.

A. Yes I would agree with that.[9]

It is clear that when Professor Maddison was expressing these opinions he had before him the drug chart recording the dosages of Tuinal, Neulactil and Sparene administered to Mr. Carter.[10]

Professor Maddison told the Coroner that he had himself administered sedation therapy but not for some ten years. He stated that he was aware that Dr Bailey used sedation therapy extensively.[11] He declined to condemn the treatment:

> Q. You say in the book there are nevertheless some Western psychiatrists who still find it to be of considerable value in the treatment of certain states. This is a matter of discretion for the psychiatrist?
>
> A. Yes.

The Coroner (Mr Nash) did not recommend that any action be taken against Dr Bailey, making the following finding:

> On the evidence adduced there appears to be little doubt that the drugs given to the deceased were in excess of that recommended for a normal person but Dr Bailey's evidence is that these recommended doses only apply in the average case and were not excessive in the case of the treatment of the deceased having regard to the conditions and supervision under which they were given.
>
> The other professional evidence called and the documentary evidence produced and admitted are all such that the recommendation would be for the average person and would in my opinion support what Dr Bailey has said ...
>
> Whilst the evidence does cause me some concern in regard to the fact that dangerous drugs were administered by nursing staff, at the discretion of such nursing staff, with the supervision of a medical practitioner, such supervision being given only once in approximately every twenty-four hours, or such other times if such nursing staff should think it fit or advisable to contact the doctor, I am of the opinion that the evidence does not establish against any known person a prima facie case for an indictable offence in which the question is whether such known person caused the death of the deceased person concerned.[12]

It was open at this time for the Coroner to direct that a transcript of evidence given in proceedings before him that appeared to implicate any registered medical practitioner be forwarded to the Investigating Committee established under the *Medical Practitioners Act* 1938 (s27(1) of the *Act* as it then was).

Mr Nash gave evidence before the Royal Commission (not as to the considerations that led him to his decision, which was a subject on which it was ruled questions might not be asked of him) and was asked about this section:

9 Carter Inquest Transcript at 163.
10 Exhibit 21 at the Carter Inquest.
11 Carter Inquest Transcript at 151.
12 Carter Inquest Transcript at 190.

Q. I have referred you this morning to s27 of the *Medical Practitioners Act*, which we understand was amended in 1963, to permit the Coroner in an appropriate case to refer a matter directly to the Investigating Committee. Was that a section or a provision which was much utilised to your knowledge?

A. I had never used it in the time I performed the duties as Coroner.

Q. Are you able to say why?

A. I found no case that I dealt with where the section could be applied in my opinion.[13]

Mr Nash gave evidence that during his career as a Coroner he had conducted some 6,000 to 7,000 inquests (many conducted by the tendering of documents only) and that all of these involved some expert medical evidence. Mr Nash agreed that there was generally an absence of criticism of medical practitioners by their colleagues in this evidence.[14]

It is obvious in retrospect that the Carter Inquest was potentially extremely dangerous for Dr Bailey. Had the expert medical evidence, particularly that of Professor Maddison, been more strongly critical of sedation treatment as a concept and/or Dr Bailey's administration of that treatment, it may be that the matter would have been referred by the Coroner to the Investigating Committee and that there may have been instituted disciplinary proceedings that compelled a reaction by the Medical Board and the relevant professional bodies, including associations of psychiatrists.

It might be noted that such proceedings would not have been necessary to make the relevant sections of the profession aware of the administration of sedation therapy. During the period of its administration not only those medical practitioners and nurses carrying out the treatment at Chelmsford were aware of its existence, but also a number of psychiatrists who regularly visited Chelmsford: practitioners at Hornsby Hospital who saw a number of cases of the aftermath of sedation treatment at Chelmsford; some of the senior members of the body that later became the Royal Australian and New Zealand College of Psychiatrists; and some members of the Medical Board.

Information available to coroners concerning deaths at Chelmsford

An obvious question is why there were no inquests other than the Carter Inquest in 1967 prior to 1975 in relation to deaths that occurred at Chelmsford during the course of, or shortly after, the administration of sedation treatment. It is clear, however, that the Police assisting the Coroner and, therefore, the Coroner himself, are heavily dependent, in the absence of some extraneous material that has come to their attention, on the information provided in the death certificate made out by the relevant medical practitioner. Without looking at individual cases in detail, it can be said that there was abundant evidence before the Royal Commission that some of the death certificates made out in relation to deaths at Chelmsford did not accurately state the cause of death. In the case of Miriam Podio the Magistrate, while declining to commit Dr Bailey for trial on a charge of manslaughter, noted that the cause of death was not adequately stated on the death certificate signed by

13 Transcript 17,734.
14 Transcript 17,744.

Dr Bailey and that the death had not been reported in accordance with the provisions of the *Coroners Act.*

One solution to this problem would, of course, be to increase the investigative resources of coroners and those assisting them. Whether this is a cost-effective solution depends on an assessment of how frequently medical practitioners are prepared to deliberately falsify death certificates. It would certainly be more efficient to rely on the medical profession to provide this information and this has been the assumption on which the system is based to date. Moreover, there must be some question as to whether increased resources for police assisting coroners would be cost effective, given the evidence concerning various police investigations into the events at Chelmsford before the Royal Commission.

The question of what kind of information system would be able to overcome the deliberate concealment of material by medical practitioners was discussed in evidence before the Royal Commission by Dr William Barclay, who had been Director of State Psychiatric Services in the late 1960s and early 1970s. Dr Barclay had at that time established an information system that was later abandoned because of its cost and he describes this problem:

> Q. Can you tell his Honour what the core information was that you required and what was the outcome of your efforts?
>
> A. Well, we sought to have a 100 per cent reporting system that recorded the name, age, sex, at that stage the local government area of address, where the patient came from, diagnosis, length of stay in hospital and if a patient died, cause of death. That was a psychiatric case register. We were primarily interested in knowing what the description of patients by diagnosis, age, sex, etcetera was. We used the statistics for administrative purposes to see where our patients were coming from and where additional services might be required. Following the progress of our policies and programmes, changes in length of stay in hospital, changes in diagnostic categories.
>
> . . .
>
> Q. Given your experience with that statistical approach. What can you tell his Honour of the outcome of it in the state psychiatric area? What happened to the statistical efforts that you made?
>
> A. Well, they were eventually abandoned. My understanding is that it has been not cost effective. It has been too expensive to retain.
>
> Q. You have a view, do you not, as to the economic prospect of an absolute cover of all patients in public and private hospitals through statistical data?
>
> A. Yes.
>
> Q. I wonder if you would tell his Honour the view you have reached?
>
> A. Well, the general consensus is that such comprehensive 100 per cent cover by way of registration is not cost effective and that the cost is enormous and the benefits that you obtain are highly questionable and that it is much better to use sophisticated sampling techniques that will give you a picture of what is happening, but costs much less. I personally think that there is a place on occasions in some areas for a psychiatric case register even if you only conduct it for a limited period of time, providing you make

explicit at the beginning what you are on about. You only get out of a statistical system as much as you put into it. If you do not ask the right questions at the beginning you cannot get the right answers at the end.

Q. Has there been to your knowledge in the United States a new approach taken to the question of statistical data?

A. Yes. The National Institute of Mental Health has virtually abandoned the concept of psychiatric care registers on the basis that they are not cost effective.

Q. And the Americans have developed a sampling technique?

A. They use sampling techniques.

Q. Are they random sampling?

A. They are based on the statistics of probability and there are all sorts of different sampling techniques that are used, but they are essentially random sampling techniques of all various kinds.

Q. Given that they are random and if one assumes that this is the best approach that money and resources allows, it would mean that the random sampling taken would not necessarily uncover the statistical discrepancy that might have pointed to what was happening at Chelmsford. Is that a danger that you must run?

A. Yes. The problem always is that any sampling technique only gives you a statement of probability and not an absolute answer and where the numbers are small that probability is going to be inaccurate.[15]

The Lessons of Chelmsford

Section 30(2) of the *Medical Practitioners Act* (as amended in 1987) allows a coroner to send a transcript of evidence to the Registrar of the Medical Board, if the evidence (whether given or to be given in an inquest) indicates that a complaint could be made about the conduct of a medical practitioner under s28 of the *Act*. This, of course, does not advance the position essentially from that existing in the 1960s and 1970s when a coroner had the power to refer the evidence before him to the Investigating Committee, although there can be little doubt that such a referral now would be investigated by the Complaints Unit of the Department of Health in a way that could not be undertaken by the Investigating Committee in the 1960s and 1970s.

The problem still remains, however, of the information available to the coroner on which such a referral might be based. The question is ultimately what cost the community is prepared to pay to obtain this information if some comprehensive alternative to the system of medical practitioners providing information as to the cause and circumstances of death is to be established.

15 Transcript at 15, 16515,167.