



# MAGISTRATES COURT *of* TASMANIA

## CORONIAL DIVISION



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### **Record of Investigation into Death (Without Inquest)**

*Coroners Act 1995  
Coroners Rules 2006  
Rule 11*

**IN THE MATTER OF  
THE CORONERS ACT 1995  
AND THE DEATH OF  
SHANE DESMOND LOCKWOOD**

#### **PREAMBLE**

On 25 June 2010 I published findings upon Mr Lockwood's death following an investigation without inquest. Subsequently, members of Mr Lockwood's family made representations to the Chief Magistrate seeking a re-opening of the investigation on the basis that it had not previously been sufficiently thorough. On 28 February 2011 the Chief Magistrate, pursuant to section 58(1) of the *Coroners Act 1995*, directed that the investigation into the death of Mr Lockwood be re-opened and the findings be re-examined. He further directed that the re-opened coronial investigation be conducted by myself.

In accord with the Chief Magistrate's direction I have re-opened the investigation and caused some further enquiries to be made. I am now in a position to make the findings which follow.

#### **CIRCUMSTANCES SURROUNDING THE DEATH**

Mr Lockwood had a long history of mental illness with a diagnosis of chronic schizophrenia. From 1990 to 1994 his illness necessitated him being treated in hospital on eleven occasions. There was an incident in 1993 when he intentionally shot himself in the stomach. Following this event he was an inpatient in the psychiatric unit of the Launceston General Hospital ("the LGH") for about one month.

Clozapine is a second generation antipsychotic medication and is often highly effective in the treatment of psychotic illness including schizophrenia. A relatively common side effect is agranulocytosis (lack of white blood cells) and its use requires close monitoring including regular blood testing. In 1994 Mr Lockwood was commenced on Clozapine

when other medications had proven unhelpful. It had a beneficial effect so that he did not require inpatient care from 1994 until 2009.

From 2007 Mr Lockwood's medication was administered through the Clozapine Clinic at the LGH. His blood levels were monitored and reviewed on a monthly basis. In January 2008 his white cell count dropped markedly. The Clozapine was ceased for 3 days and Olanzapine substituted. Nevertheless, over this brief period Mr Lockwood's mental health markedly deteriorated. When the blood levels returned to normal the Clozapine was cautiously reintroduced. As is unfortunately often the case, Mr Lockwood's psychotic symptoms were not as effectively treated with Clozapine following this temporary interruption.

On 8 January 2009 an abnormal blood count was again found and Mr Lockwood's Clozapine was ceased immediately. Mental state examination at this time showed that Mr Lockwood had persecutory ideas and an increased amount of speech but there was no indication of immediate risk to himself or others. He was offered inpatient care during this change of medication phase but declined.

Over the week following the cessation of the Clozapine Mr Lockwood's blood count remained low. Concerns were raised by his family that he was not taking his alternative medication. On 19 January he was brought to the LGH by police on an Initial Order under the *Mental Health Act* 1996. Mr Lockwood was assessed as being psychotic and unable to satisfactorily provide for himself. He was detained and provided inpatient care until 26 February when he was discharged under a Community Treatment Order (CTO). At this time Mr Lockwood's medication regime required him to take daily doses of Risperidone, Olanzapine and Temazepam along with a fortnightly 50mg dose of Risperidone Consta to be administered by intra-muscular injection. It was a condition of the CTO that Mr Lockwood comply with this regime.

The LGH's Discharge Summary stipulated, inter alia, that Mr Lockwood was to be allocated a case manager who was to book an appointment for Mr Lockwood's review by his doctor within two weeks post discharge. The summary further provided that his next depot of Risperidone Consta was due on 5 March and that the case manager would ensure that this would be administered on that date. It was intended that Mr Lockwood was no longer to receive his depots of Risperidone Consta at the LGH which had been his long established practice but rather was to have them administered by his general practitioner at George Town.

At this same time a Care Plan was drawn up for Mr Lockwood. It provided that he was to be discharged to his home at George Town and that his general practitioner was to be Dr Phillip Dawson. The Plan also sets out his medication regime and stipulates some non-pharmacological interventions as part of Mr Lockwood's recommended treatment. They are stated to be:

- *“Observation of response to medications.*
- *Careful monitoring of mental state.*

- *Family meetings to collate history/gain information re his progress/discharge planning.”*

In addition, the Care Plan incorporated some recommended crisis strategies, namely:

- *"Gardening, listening to music.*
- *Discuss with sister (Sanza)/other family members.*
- *Discuss with GP.”*

Consistent with the Care Plan, Mr Lockwood returned to his George Town home on 26 February 2009. He lived alone. From this point Community Mental Health Services-North became responsible for Mr Lockwood's ongoing care as stipulated in the Care Plan.

Dr Ben Elijah is the Clinical Director for Mental Health Services-North. He has provided a report which chronicles the Services' dealings with Mr Lockwood as shown in his outpatient notes. They show:

- On 3 March 2009 Mr Lockwood's case manager recorded having received a telephone call from Mr Lockwood's sister who conveyed her concerns about Mr Lockwood being given his anti-psychotic agent on 5 March at his general practitioner's surgery. It is recorded that Mr Lockwood's sister was advised that the general practitioner was aware of the dosage, and that he would write the prescription which Mr Lockwood was then to collect and take to his chemist. Once dispensed the medication was then to be taken back to the general practitioner for its administration.
- On 4 March a note has been made by the case manager that she made telephone contact with Mr Lockwood and confirmed that arrangements were in place for him to see his general practitioner the next day for his medication. Separately, on the same day, Mr Lockwood was reminded by his case manager by telephone of his upcoming CTO hearing on 16 March.
- Dr Sketcher has recorded that on 16 March he attended a hearing of the Mental Health Review Board concerning Mr Lockwood's treatment order. Dr Sketcher noted reports made by Mr Lockwood and his sister that he was anxious about difficulties with his vision and that he may have cataracts. Dr Sketcher has further noted that Mr Lockwood's speech was thought to be indicative of a degree of (psychotic) disorganisation. Both Mr Lockwood and his sister also expressed concerns that *"travel to his general practitioner's surgery might be difficult."*
- Dr Sketcher has also noted that on 16 March Mr Lockwood's CTO was upheld and *"the plan noted was for the case manager to discuss with Community Support in*

*George Town regarding the patient's concerns, to book an onward appointment with the Registrar for review and for blood tests to be conducted."*

- On 20 March it was noted by Mr Lockwood's case manager that the necessary blood test forms had been forwarded to his general practitioner and that a regular appointment for administration of his depot medication had been negotiated with the general practice.
- On 31 March the case manager noted a telephone call made to Mr Lockwood whom she said *"sounded more coherent."* He advised her that he was getting to his appointments for his medication by himself. He was advised in turn that he was to have a new case manager from next week.
- On 3 April Mr Lockwood had his blood tests. (The results showed a normal blood count but a raised prolactin which is apparently a common finding often related to physical side effects.)
- On 16 April Mr Lockwood was advised by his new case manager of an appointment with Dr Sketcher on 21 April. It was noted that Mr Lockwood reported that he was making arrangements for transport. The note records that Mr Lockwood *"expressed some concerns about procedures surrounding his medication procurement, including travel to the pharmacy and concerns that the pharmacy may not have a consistent supply."* He was also concerned about the financial impact of travel. He also expressed concerns about difficulties keeping track of time and remembering what day it was. The case manager suggested to Mr Lockwood that he note down his concerns so that they could be discussed with Dr Sketcher at the upcoming appointment. The case manager noted that Mr Lockwood *"was appropriate in his speech, i.e. content, amount, volume and length. Reported he was okay, and was visiting with his sister at the time of the phone call."*
- On 16 April the case manager has also noted that an appointment with Mr Lockwood for the following day had been cancelled as that was the day for his next depot injection.
- At 8.10am on 21 April senior staff of Mental Health Services-North were advised of Mr Lockwood's death.
- The notes record that at 10.45am on 21 April Dr Sketcher reported a telephone conversation with Mr Lockwood on 17 April when he stated *"that he would prefer to receive his depot injection fortnightly at the LGH rather than the George Town general practitioner's office. He also asked for a community car to transport to and from the hospital every fortnight. He was advised that his concerns would be discussed with his case manager, and further at the review which was scheduled for 21 April when he would be seen by both. He was agreeable for this to occur."*
- Also on 21 April Mr Lockwood's case manager made a report of a telephone call with Mr Lockwood on 16 April when the subject of transport to his upcoming

appointment was discussed and *"Mr Lockwood was happy to arrange this with the Wattle Group as he had done in the past. He expressed concerns about transport to and from the pharmacy for his medication, and the consistency of medication being readily available."* He was advised to jot down points upon these matters and they could be explored at the upcoming meeting with Dr Sketcher. The case manager has recorded that *"there was no concerns about his mental state at that time."*

Ms Sanza Lockwood is one of Mr Lockwood's sisters. At times she acted as *"a point of contact"* between her brother and his mental health providers. She had been very supportive of her brother on the two occasions that his Clozapine was ceased because of his low white cell count. On the second occasion she regularly visited him at the LGH, sometimes twice daily. After his discharge she reports ongoing difficulties encountered by her brother surrounding his fortnightly depots of Consta Risperidone. On the first occasion she says that her brother had to make three separate visits to the surgery. She says that at about the time his next depot was due her brother telephoned her to advise that *"there was no medication at the doctor's surgery for his treatment."* She says that her brother *"was very distressed and told me the police would come and arrest him because he was under an order"*.

Ms Lockwood's last contact with her brother was just before Easter in 2009. (Easter Sunday was on 12 April) She said that at that time Mr Lockwood *"seemed fine"* but he reported that he was still not having any contact from his support worker as promised. Ms Lockwood offered to contact the support worker for him but he responded by saying that *"they were going to contact him."*

In her statement Ms Lockwood makes this observation of her brother's care following his discharge from the LGH:

*"I can't understand how Shane was supposed to organise all of this to access his medication, when he had been administered his medication for almost 15 years via the one process through the hospital system and was now left to fend for himself because the mental health team did not follow the care plan. Especially considering Shane was under a Community Treatment Order."*

On 17 April Mr Lockwood attended his general practitioner at 11.00 am to receive his Risperidone depot. However, the medication was not with the surgery because of an apparent administrative bungle related to the script and it was not until 6.03pm that it was administered. It was in the intervening period that Mr Lockwood spoke to Dr Sketcher where he obviously expressed his frustration with the arrangements in place concerning his medication.

In the early evening of 20 April police from George Town attended at Mr Lockwood's residence after a sister had raised concerns for his welfare. Mr Lockwood was located in a lounge room chair. He was clearly deceased. A kitchen knife was protruding from his chest. The premises appeared to be secure with all doors and windows shut or locked.

Enquiries made indicate that Mr Lockwood called on his sister, Ms Penni Berne after about 6.00pm on Friday 17 April. He had visited her twice earlier in the day. On the final

occasion she says that *"he seemed fine and then left."* Of his demeanour on the day she says: *"He seemed his normal self; he did not outline any erratic behaviour, or make any mention of self-harming. He was being very social and met with quite a few people that day before returning home."*

There is no evidence of Mr Lockwood being seen alive after his last visit to Ms Berne on 17 April. A calendar found in Mr Lockwood's home had the days marked off up to and including 17 April 2009.

A post-mortem examination was undertaken by forensic pathologist, Dr Donald Ritchey. Toxicological testing was also carried out. It revealed the presence in Mr Lockwood's blood of alcohol (0.12g/100mL), Temazepam within the sub-therapeutic range, and Olanzapine and Risperidone, both within the therapeutic range. Dr Ritchey makes these comments upon the toxicology:

*"The blood levels reported for risperidone are within the 'therapeutic range' meaning no specific dose-related toxicology would be expected. Both risperidone and olanzapine are reported to have potential interactions with temazepam (a benzodiazepine medication also recovered from PM blood) (low blood pressure, cardiac arrhythmias, respiratory depression) but no interactions that are pertinent to this case. Specifically there is no reported association with serotonin syndrome that could produce agitation and potentially an impulsive suicide.*

*Although it is not correct to state that these medications are "experimental" the use of these (any) drugs does represent an experiment of sorts in individual patients because of the unique way we interact with medications. I see no reported evidence that this specific combination of drugs has been reported to increase suicidal ideation or acts of suicide in others treated and have no reason to implicate such in the present case. As stated previously these drugs (Risperidone and Olanzapine) are given IM and orally and would not be given IV. There is no evidence to suggest IV administration of the drugs in Mr. Lockwood and the "therapeutic levels" strongly suggests that IV administration did not occur.*

*In summary, at the time of Mr Lockwood's suicide he had therapeutic blood concentrations of prescribed medications."*

Dr Ritchey concluded that Mr Lockwood had died from a stab wound to the chest. He further opined that *"the position of the shirt and jumper and the absence of defensive injuries suggest a self-inflicted injury."*

DNA testing of the knife recovered from Mr Lockwood revealed the following:

- A swab taken from the underside of the knife handle returned a mixed profile with Mr Lockwood returning the major profile. An inconclusive female DNA contributor was also detected.
- A further swab of the handle returned results of a mixed profile. A component of the profile matched Mr Lockwood.

Tasmania Police undertook an investigation of Mr Lockwood's death. It concluded that there were not any suspicious circumstances and that Mr Lockwood had taken his own life.

In his report Dr Elijah makes these comments upon the management of psychiatric patients who reside beyond the City of Launceston:

*“The management of individuals who live at a distance from Launceston is an ongoing matter of concern for the Mental Health Services-North. Clearly in an ideal world, a local psychiatrically trained nurse would be beneficial to patients and families of the region. Mental Health Services-North have currently applied for funding for a Rural and Remote Registrar who would be able to liaise with local general practitioners and visit the areas to provide psychiatric review. It is my understanding that there is currently no individual available in the capacity of local psychiatric nurse for the George Town Region. However Mental Health Services-North endeavours to deal with these difficulties in ways which are most beneficial to patients and their families.”*

## **FINDINGS AND COMMENTS**

My further investigation of this matter has not made it necessary for me to vary those formal findings required by section 28(1) of the *Coroners Act 1995* and made by me on 25 June 2010. I am able to repeat them here.

I formally find that Mr Lockwood was born in Longford on 8 February 1964 and was aged 45 years. He was divorced and unemployed at the time of his death.

I further find that Mr Lockwood died as a result of a stab wound to the chest. He died at 32 Widdowson Street in George Town. The evidence does not enable me to make a precise finding upon the time and date of death but only permits me to find that Mr Lockwood died in the period after 6.00 pm on 17 April and before 6.00 pm on 20 April 2009.

I am also satisfied that there are no suspicious circumstances surrounding Mr Lockwood's death and that his fatal stab wound was self-inflicted. It is, in my view highly probable, in light of Mr Lockwood's medical history, that this act of self-harm occurred when Mr Lockwood's psyche was substantially impaired by his illness.

Members of Mr Lockwood's family have expressed concerns relating to the level of care and support provided to Mr Lockwood in the period following his discharge from LGH. I share those concerns.

Mr Lockwood had a long history of severe psychiatric illness. In January 2009 his illness necessitated him being admitted to LGH as an involuntary patient under the provisions of the *Mental Health Act 1996*. He was discharged after about 6 weeks but subject to a CTO which obligated him to take his prescribed medications. These included a fortnightly intra-muscular depot of Risperidone Consta which was, contrary to previous practice, to be administered by a general practitioner in George Town and not at the

LGH. All of these circumstances necessitated Mr Lockwood being closely monitored, a need recognised by the terms of his Care Plan. Unfortunately the evidence shows that the necessary level of monitoring did not occur.

In my view, proper compliance with the Care Plan required Mr Lockwood's case manager to have regular face to face meetings with Mr Lockwood. Telephone contact was not, in my view sufficient. Such meetings would have permitted the ongoing assessment of Mr Lockwood's mental state and most particularly the reaction to his medications. Critically too such meetings would have presented the opportunity for those difficulties which arose around Mr Lockwood's ongoing illness to be dealt with promptly and in an environment where Mr Lockwood could feel supported and less isolated. Additionally it would, in my opinion, have been appropriate for the case manager to have attended with Mr Lockwood at the time of his first depot injection to ensure that he fully understood what was required of him; that the process that had been put in place proceeded smoothly, and that arrangements were firmly fixed for all future administrations. This would also have been an opportunity for Dr Dawson to be fully apprised of Mr Lockwood's recent psychiatric history and of his important role in his ongoing care. Had this step been taken it is likely that many of Mr Lockwood's anxieties which later arose relating to his depot medication would have been avoided.

The evidence does not permit a finding that Mr Lockwood would not have taken his own life if his Care Plan had been more closely and appropriately managed. Nevertheless, it is my opinion that the prospect of this outcome being avoided would have been greater had he received closer monitoring and more personal support in the weeks following his discharge from the LGH and most particularly on 17 April 2009.

The circumstances surrounding Mr Lockwood's death demonstrate, in my view, the critical need for a high level of personal and co-ordinated support to be provided to those persons suffering from mental illness who are resident away from hospital and in the community. In that context I strongly support all efforts being made to ensure that such support is available.

I conclude by conveying my sincere condolences to Mr Lockwood's family.

**Dated:** 25 January 2018 at Hobart in the State of Tasmania.

**Rod Chandler**  
**CORONER**