



OFFICE OF THE STATE CORONER

FINDINGS OF INVESTIGATION

CITATION: **Non-inquest findings into the death of Paul James Cooper**

TITLE OF COURT: Coroner's Court

JURISDICTION: Brisbane

DATE: 5 February 2016

FILE NO(s): 2012/3370

FINDINGS OF: Christine Clements, Brisbane Coroner

CATCHWORDS: CORONERS: Investigation, mental health, HEAPS Review, adequacy of care and treatment

Paul James Cooper lived at Helles Street, Moorooka in Queensland. He died between 25 and 26 August 2015 at Bellbird Grove in the Enoggera Reservoir area. He was 41 years of age at the time of his death. He died due to hanging and his death was reported to the coroner.

Background

Anthony Carter was walking with his child along the creek line at Bellbird Grove, Enoggera on the afternoon of 26 August 2015. He looked up and observed the body of a male person hanging from a branch over the creek bed. The person was obviously deceased. He contacted police to report the matter.

Police attended and made a search of the area. They located a blue Holden Commodore. On checking the registration it was registered to Paul Cooper. A backpack was located in the vicinity of the body. There was a wallet which contained identification in the name of Paul Joseph Cooper of Helles Street, Moorooka. The car key fitted the Holden Commodore.

Police were satisfied there were no suspicious circumstances in the apparent hanging.

Investigation led them to Mr Cooper's residence where he co-resided with Xiao Zhang. They inspected Mr Cooper's bedroom and noted medication for bi-polar disorder, namely Risperidone 3mg and acne medication Isotretinoin 20mg capsules. There was also cholesterol-lowering medication Rosuvastatin 10mg. No suicide note was located in the vicinity of the deceased, in his vehicle or at his place of residence.

A search of his medical history indicated he had been subject to a Justice Examination Order pursuant to the Mental Health Act in July 2015 due to exhibiting paranoid behaviour. He was admitted to the Princess Alexandra Hospital.

Medical records were obtained and reviewed.

Following Mr Cooper's death, the Metro South Hospital and Health Service conducted a Human Error and Patient Safety (HEAPS) review process regarding treatment provided to Paul Cooper and interaction with him. That document noted that he was being treated by the Burke Street Psychosis Team at the time of his death. He was a full-time taxi driver prior to his most recent admission to hospital and lived in a share house with two other males. He had no family in Queensland.

There was no history of illicit substance abuse over the previous 15 years. He had not used alcohol for three to four years.

Of significance however, was that he had recently been treated with Isotretinoin 20mg. This was prescribed for treatment of severe acne.

In July 2015, his flat mate applied for a Justice Examination Order because he was concerned about Paul's mental state, including increasing paranoia and talks of suicide. Paul Cooper was assessed by the Acute Care Team at home and subsequently placed on request and recommendation for assessment. An involuntary treatment order followed and he was admitted to hospital due to worsening paranoid delusions. This behaviour pattern started when he commenced use of the Isotretinoin.

He had been taking the medication for 10 months. This coincided with the development of persecutory ideation, irritability and agitation, depressed mood and poor sleep, poor appetite, weight loss and general decline.

On admission to hospital he acknowledged increased thoughts of suicide over the past few months.

Treatment by way of medication commenced with the administration of Risperidone 1mg.

CT imaging reviewed his brain and there were some abnormalities evident including possible right cerebral hemiatrophy generally associated with seizures and hemiplegia.

He was then referred on to the Burke Street Psychosis Team for case management.

On 7 August 2015, he had a follow-up home visit with his allocated case manager. No risks were identified at the time and it was documented that he presented as 'warm, reactive, settled, interacting at a good level, spontaneous in conversation'. He presented well and was pleased to be out of hospital. He was much improved since ceasing the acne medication. He denied any auditory hallucinations or delusional ideas. The next contact with the treatment team was reviewed by the psychiatric registrar on 14 August 2015.

This occurred on 14 August and a first year psychiatric registrar reviewed him. No issues were identified at the time. It was recorded that Mr Cooper was co-operative, pleasant and did not demonstrate any formal thought disorder. He denied paranoid delusions, thoughts of harm to himself or others. He was identified as being at a low risk of harm to himself or others. He exhibited good insight and judgment at the time and there was no sign of psychosis.

The involuntary treatment was ceased as he was compliant with the treatment and happy to continue interacting with the treating team.

Between 21 and 24 August, the case manager tried unsuccessfully to contact Paul Cooper by phone and left messages but there was no follow-up. On 26 August the treatment team were informed by police that Paul Cooper had died due to hanging.

The HEAPS review identified some issues which indicated sub-optimal interaction with Paul Cooper. This included the lack of communication with his general practitioner during the period of care. A discharge summary was not completed or sent to his general practitioner. Nor was there any contact with his family, although they lived interstate and overseas. He had voiced a wish not to disturb his mother by contacting her.

The HEAPS review noted the recent use of Isotretinoin was known and that this was a possible trigger for Mr Cooper's decline and development of psychotic symptoms and suicidal ideations. As a precaution this was made known to the Therapeutic Goods Administration as a possible adverse reaction to the drug.

Finally, it was noted that there was no record to indicate what had occurred following the review by the psychiatric registrar on 14 August 2015 and in the period leading up to his death between 25 and 26 August 2015. During that period there had been unsuccessful attempts to contact him by telephone but when this was unsuccessful, no further follow-up had occurred.

In summary, the HEAPS review focused on the importance of discharge summaries being forwarded to the treating general practitioner and the importance of contact with family members where possible.

Autopsy examination was conducted on 31 August 2015 by the forensic pathologist, Dr Ong. He concluded Paul Cooper died due to hanging.

Significantly, it was noted that toxicology testing did not reveal the presence of any alcohol or drugs. This indicates that Paul Cooper was not taking prescribed medication (Risperidone) and this was unknown to the treating team who last had contact with him on 14 August 2015.

Findings required by s. 45

Identity of the deceased –	Paul James Cooper
How he died –	Mr Cooper died due to hanging.
Place of death –	Bellbird Grove, Enoggera Reservoir
Date of death–	Between the 25 and 26 August 2015
Cause of death –	Hanging.

Christine Clements
Brisbane Coroner
Brisbane
5 February 2016