IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: 2010 / 4337

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)
*Section 67 of the **Coroners Act 2008***

Inquest into the Death of: PEDRO ARCOS-VAZQUEZ

Delivered On:	12 September 2014
Delivered At:	Coroners Court of Victoria 65 Kavanagh Street, Southbank
Hearing Dates:	15, 16 & 17 October, 2013
Findings of:	JUDGE IAN L. GRAY, STATE CORONER
Representation:	Ms R Ellyard on behalf of the Chief Commissioner of Police Mr J Snowdon on behalf of Monash Health Mr D O'Callaghan on behalf of Mr David Otis
Counsel Assisting the Coroner	Ms N Hodgson

I, JUDGE IAN L. GRAY State Coroner, having investigated the death of PEDRO ARCOS-VAZQUEZ

AND having held an inquest in relation to this death on 15, 16 & 17 October 2013

at Melbourne

find that the identity of the deceased was Pedro Arcos-Vazquez

born on 4 April 1969

and the death occurred 9 November 2010

at 142 Bourke Road, Clarinda

from:

1 (a) INCISED INJURY TO THE NECK

in the following circumstances:

Background

1. Pedro Arcos-Vazquez (Pedro) was born in Madrid Spain on 4 April 1969. He is the second youngest of 6 children born to Angel and Carmella Arcos-Vazquez. He was raised and educated in Madrid and upon finishing school he commenced an apprenticeship as a chef. He worked in Madrid in his chosen profession, meeting his now estranged Australian wife Judy Joseph in 1991 whilst she was travelling.

2. Judy and Pedro married in Spain on 11 November 1992 and shortly after moved to Melbourne where their first child was born. Pedro continued to work in Melbourne as a chef at restaurants including the Hyatt Hotel. Their second child was born in 1995.

3. In 2004, Pedro was involved in a bicycle accident where he sustained serious injuries requiring numerous operations. These injuries prevented him from working for more than 6 months.

4. During this time of unemployment, Pedro became withdrawn and depressed resulting in the deterioration of his marriage and family life. Judy suggested counselling for his depression which he participated in, and once his injuries healed and his mental health improved, he re-commenced working as a chef.

5. Over time, Pedro found it difficult to hold down a regular job for an extended period. He often became impatient with other staff members resulting in conflict within the work place. He either left the job or was asked to leave by management. His final job was in February 2008 and he did not work again after this date.

6. Pedro's mental health deteriorated again with him withdrawing from his life, spending most of his time in his bedroom. He had minimal contact with his wife and family.

7. In September 2010, his marriage to Judy broke down, and he moved out of the family home into 142 Bourke Road, Clarinda.

8. He had little or no contact with his children, but saw Judy occasionally as she was assisting him trying to get work and his life back on track. The house he moved into was only around the corner from the family home.

9. At approximately 9.30pm on 9 November 2010, Pedro, aged 41 years, died as a result of multiple sharp force injuries to the head, neck, face and arms following a dispute between himself and Mr   within a room of a boarding house situated at 142 Bourke Road, Clarinda.

10. Mr   was charged with the murder of Pedro on 11 November 2010 (following admissions) and on 12 September 2011 he pleaded not guilty on the basis of mental impairment.

11. Justice Coghlan heard the matter in the Supreme Court and set out the facts as follows:

"a. Pedro and   were residents of the boarding house at Clarinda and the two developed a friendship.

b. On two occasions prior to the 9 November 2010, police were called to the boarding house as a result of altercations that occurred between Pedro and   . The dates attended by the police were 18 October 2010 and 7 November 2010.

c.   had a history of mental illness commencing at the age of 16 years. He had been diagnosed as suffering from   and had been treated with   medications.

d.   was on a Community Treatment Order until 27 October 2010 before he was discharged from that order.

e.   was being treated in the community by his GP, Dr Michael Kozminsky.

f. At approximately 10.30am, on 9 November 2010,   presented at the Moorabbin Police Station where he made a brief reference to killing a man as part of a broader conversation. His behaviour was bizarre and he appeared to be suffering mental health issues.   ultimately appeared to withdraw the admission that he made and following a psychiatric assessment by a psychiatric nurse from PACER (Police, Ambulance, CATT, Emergency Response) he was released.

g. On returning to the boarding house,   told another resident what he had done and then showed the resident into Pedro's room where he lay deceased on the bed. A call was made to triple zero. It was not, however, effective because there were difficulties about the address that was given and the police, in fact, attended the wrong address on that occasion.

h.   told another person on 11 November 2010 about what he had done and showed her the body. She contacted the police and on 11 November 2010,   was arrested and conveyed to the Moorabbin Police Station and later charged with murder.

i. *was interviewed by the police and although during that interview there were a number of responses which were clearly indicative of him suffering from some form of mental illness - in general he told the police what had happened.*

j. *During the day of Pedro's death, 9 November 2010, had attended his general practitioner, Dr Kozminsky, where he was prescribed medication to assist him quitting smoking. The drug was Champix.*

k *After filling the prescription at discount drug store, Bourke Road, Clarinda, he took the prescribed amount. He also took his regular medication, Seroquel, which was prescribed for his mental health issues.*

l. *After a short time, reported that he started to hear voices and saw blackened out eyes on passers-by. He became agitated and started to pace around his room.*

m. *The voices were saying to him, "You have to do this. You have to kill Pedro to make the house safe for everyone else". described the voices as being Satanic, like demon voices.*

n. *told police that at about 10.00pm, he kicked Pedro's door in, entered Pedro's room and caused the injuries that led to Pedros' death."*[1]

I adopt this summary of the circumstances proximate to the death.

12. A post-mortem examination was conducted on 12 November 2010 by Dr Michael Burke, forensic pathologist of the Victorian Institute of Forensic Medicine. It revealed that the cause of death was incised injury to the neck. A total of 14 facial head and neck injuries were observed during the post-mortem.

13. Pedro is survived by his ex wife Ms Judy Joseph and two daughters, Lana and Jenna.

Scope of the Inquest

14. The issues identified for consideration in this inquest were:-

    1. Should the fact that Mr being on a CTO have been information available to attending police via LEAP?

    2. The provision of mental health services to Mr in the months before Pedro's death including:
        a. the decision to discharge Mr from his CTO on 27 October 2010;
        b. the discharge of Mr care to his GP without a discharge plan or transition period.

    3. The provision of Champix with Seroquel, to a person with a psychiatric illness, and the possible affects on the day of Pedro's death.

    4. The attendances by police on 18 October and 7 November 2010.
        a. Should the police have adopted a different approach on either of these occasions?
        b. Can the police assist in whether there would be any advice to aid communications in similar future circumstances and including possibly recording of information in the LEAP system?

[1] Closing Submission by Counsel Assisting the Coroner, paragraph 2.2

Concessions by Monash Health.

15. Mr was under the care of Monash Health at the time of the death of Pedro.

16. Counsel for Monash Health, Mr Snowdon, made two appropriate and helpful concessions in relation to the care of the Mr . As put by Counsel Assisting, Ms Hodgson, they were:-

"Firstly that there should have been a contemporaneous note made at the time of discharge by from his Community Treatment Order (CTO) by Dr Camilleri. Secondly, there was inadequate documentation and communication of the transition from Monash Mental Health Community Care to Dr Kosminsky. The context for this concession was that had already been Dr Kosminsky's patient for some months and he had seen him on multiple occasions. Further, that Dr Kosminsky was well known to and respected by Monash Health Mental Health Staff because of his treatment of drug and alcohol and mental health patients."[2]

The Witnesses

17. The following witnesses gave evidence:- Senior Constable Peter Cantsilieris, Sergeant Kevin Bond, Dr Kamel Sanghvi, Dr George Camilleri, Dr Michael Kozminsky, Mr David Otis, Associate Professor Richard Newton.

18. After the inquest, submissions were received from Counsel Assisting, the Chief Commissioner of Police (CCP) and solicitors acting for Mr David Otis. I thank the parties for their submissions.

The Issues

Issue 1:- Should the fact of Mr being on a CTO have been information available to attending police via LEAP?

19. The evidence is that Mr was on a CTO on 18 October 2010 but had been released from it by 7 November 2010.

20. I accept that the evidence establishes that LEAP does not have the capacity through the personal warning flag system to record information about a person, which might include their mental health diagnosis or status.[3]

21. I also accept that in circumstances in which Mr had been recently removed from a CTO, but had not come to police attention during the period immediately proceeding their attendance at the house on 18 October 2010, or whilst he was on his CTO, there was no occasion for the information about either the presence of or removal of the CTO to have been recorded on LEAP.

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[2] Closing submission by Counsel Assisting, paragraph 4.1

[3] Submission on behalf of Chief Commissioner of Police ,paragraph 4

22. On the evidence I accept the CCP's following submission:-

"Victoria Police has policies and procedures in place that govern the circumstances when information should be included on LEAP and the type and extent of the information that should be so included. Those policies and procedures are sufficient to ensure that appropriate details of police interactions with the public and with alleged offenders are recorded in LEAP. Nothing arises in this inquest to suggest any change in necessary."[4]

23. As to whether there should have been any action taken in relation to the threatening remarks made by Mr to Sgt Bond, I accept the evidence given by Sgt Bond and agree with the submission:-

"There was nothing said or done by Mr during his conversation with Sergeant Bond which should have prompted any further or formal action being taken. Whilst with the benefit of hindsight it can be seen that Mr was capable of acting violently towards Mr Arcos-Vazquez, that does not mean the comments made by him on 7 November 2010 were intended as serious threats or that there was any basis on which Sergeant Bond could have concluded they were so intended."[5]

24. At the end of the inquest I raised with Counsel for the CCP the issue of general access to health information about members of the public via a broader information system which might assist police to identify persons like Mr and take preventative action. I accept that this clearly raises broad issues of cross departmental information sharing and access, as well as issues of privacy. I did not pursue the matter through expert evidence and I do not intend to make any comments or recommendations in respect of it.

25. Ultimately I accept the CCP's submission that:-

"There is no basis for any adverse comment or criticism of any police witness or police conduct arising from the evidence; and
there are no issues arising from this inquest, insofar as it relates to Victoria Police, which require that any comment or recommendation be made by the Coroner."[6]

Issue 2:- Provision of Mental Health Services to in the months before Pedro's death including:

a. the decision to discharge from his CTO on 27 October 2010;
b. the discharge of . care to his GP without a discharge plan or transition period.

26. As Counsel Assisting noted, the decision to discharge Mr from his CTO was criticised by Professor Newton on three grounds:- (1) because of its failure to take into account input of the psychiatrist who had been providing his continuous care; (2) because there had been no consequences applied when he had failed to meet the conditions of the CTO: (3) because

[4] Submission on behalf of Chief Commissioner of Police, paragraph 12

[5] Submission on behalf of Chief Commissioner of Police, paragraph 16

[6] Submission on behalf of Chief Commissioner of Police, paragraph 19

Mr was vulnerable and should not have been given autonomy in relation to the direction of his treatment. I agree with that criticism: in the light of the evidence of Dr Sanghvi and Dr Camilleri there appears to have been no compelling justification for the revocation of the CTO. However in this context I also note Mr Otis' clearly expressed opinion that the CTO itself was problematic and a barrier to Mr treatment:

"'It took me a long time to reach that conclusion but yes. I did think the CTO was a barrier to his engagement with our service."[7]

27. Mr Otis wanted Mr reviewed, and he was reviewed by Dr Kozminsky. As Mr Otis said, he (Mr Otis) can make a suggestion but *"it is up to the psychiatrist about what happens."*[8]

28. Mr Otis gave evidence and explained and contextualised the decision for the discharge from the CTO, based as it was upon the engagement with Dr Kozminsky who himself confirmed that there was a good doctor/patient engagement. Mr Otis' evidence was:

"I told Dr Kozminsky that we were reviewing ' for discharge and wanted to know - for discharge from his CTO and wanted to know his view of it. He stated that he would prefer that kept on his CTO but that he takes over treatment. So he was happy to take over treatment but would prefer to stay on the CTO. I asked Dr George Camilleri about this and he stated that administratively it would be very difficult to manage that and I would agree with that. I told Dr Kozminsky this and he told me that he was prepared to take over treatment, knowing that would be discharged from his CTO. I know that my - I can't remember specifically what comments that I made to Dr Kozminsky but I remember that my thinking at the time was that we were making this decision because we expected that it was going to work and we thought that we had reasonable evidence to think that it was going to work, that he was going to engage with Dr Kozminsky and take that last step towards managing his own mental health. I decided to not do the discharge quickly because if it didn't work, if he needed CAT team follow up or any sort of more assertive follow up it's very difficult for a GP to achieve that but much easier for me. So it would allow the option for Dr Kozminsky to call me and ask me for help. The other possibility was that with removal of the mandatory nature of the treatment, which I believe resented, he may have decided that he was quite happy to engage with us after that. My rapport with seemed quite good."[9]

29. I agree with Ms Hodgson's submission that the evidence supporting the discharge from the CTO is ultimately unconvincing. In saying that, I fully accept the degree of difficulty confronting case managers such as Mr Otis and I am entirely satisfied that Mr Otis conducted himself conscientiously and professionally.

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[7] Transcript pg 190

[8] Closing submission by Counsel Assisting, paragraph 5.44

[9] Transcript pg 224

30. Mr Otis gave his opinion as to Mr violent behaviour (the behaviour ended up in the death of Pedro):-

"My strong suspicion is that he may have taken some sort of very strong illicit drug and that in turn – it is such a flip on who he was as a person – who he is as a person, it is sort of like you have to turn someone who is extremely non violent to someone who is extremely violent and I would be thinking methamphetamine or some sort of illicit drug it would kind of have to be in that scene to know about like these synthetic drugs that often change – things that have a very volatile effect and exit your body very quickly as well. That is what I would be suspecting but I am speculating, I don't know."[10]

31. Any criticism of Mr Otis for prompting the discharge from the CTO must be tempered with a recognition that he acted with care and professionalism. The evidence is that Mr Otis supported a decision to discharge Mr from the CTO, although it was not actually his ultimate decision. As indicated earlier he was satisfied that there had been a good repore established with Dr Kozminsky and believed that the discharge would be ultimately beneficial.

32. In respect of Mr Otis, I accept the following submissions made on his behalf:-

"It is our submission that none of the practitioners involved with Mr and certainly not Mr Otis could reasonably have foreseen that that Mr behaviour or mental state was such that he was likely to act out in the way he did.

Although there is no direct evidence to support it, Mr Otis' conclusion that Mr ingested some strong psycho-active illicit substance prior to killing Mr Arcos-Vazquez is plausible and a distinct possibility.

We submit that nothing other than involuntary admission as an in-patient could have prevented that and there was nothing in the practitioners' observation of Mr Lloga prior to the death of Mr Arcos-Vazquez that would have indicated or justified the involuntary admission of Mr into psychiatric care.

It is submitted that neither Mr Otis's actions nor any omission on his part contributed to the death of Mr Arcos-Vazquez. Mr Otis, with the information he had available to him, from the Mr medical file, from his collaboration with other health professionals and from his direct dealings with Mr over 17 months, could not reasonably have been expected to predict the homicidal behaviour that eventuated on 11th November 2010."[11]

33. In relation to the transfer to Dr Kozminsky, I note the concessions made by Mr Snowdon. In my view a discharge plan should have been prepared for Mr and should be prepared in all cases were a transfer of this nature is involved. I intend to recommend

[10] Transcript pg 237

[11] Submissions on behalf of David Otis, paragraphs 27 – 30

accordingly. However, I do not find that the absence of a discharge plan or summary, or a proper transition, would have altered the outcome in respect of Mr ultimate actions.

Issue 3:- The Provision of Champix with Seroquel to a person with a psychiatric illness, and the possible effects on the day of Pedro's death.

34. I note and accept the evidence on this topic given by Professor Olaf Drummer and agree with the proposition put by Counsel Assisting that :-

> *"there is inconclusive evidence available to suggest that Champix and the prescribing of Champix played any role in the psychotic and violent state of and accordingly in Pedro's death."*[12]

Issue 4:- The attendances by police on 18 October and 7 November:-

a. Should the police have adopted a different approach on either of these occasions?

b. Can the police assist in whether there would be any advice to aid communications in similar future circumstances and including possibly recording of information in the LEAP system?

35. In dealing with those questions the Counsel Assisting submitted:-

> *"The evidence of police was credible and consistent with presentation to health professional around the same time. There is no evidence to suggest that police should have been alerted to any dangers posed by to Pedro or the community.*
>
> *The members who gave evidence said they may have acted differently if they were aware was or had been on a CTO. This was tempered, particularly by Sergeant Bond that it would also depend on how the person was presenting. It cannot be said that there is cogent evidence to suggest a personal warning flag about psychiatric condition or status as a CTO patient would have altered the police members actions or the outcome."*[13]

I agree.

36. In her assessment of the evidence as whole, Counsel Assisting proposed the following possible conclusions:-

> "*a. The decision to discharge from his CTO should have been made with the input of the psychiatrist who had been providing his continuous care.*
>
> *b. The CTO was ineffective because there had been no consequences applied when had failed to meet the conditions of the CTO when it was in place.*
>
> *c. was a vulnerable man who in the context of his presentation, should not have been given autonomy in relation to the direction of his treatment."*[14]

37. I agree the evidence supports each proposition. I do so bearing in mind the need not to be retrospectively overly critical of persons in the role of Mr treating doctors, and

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[12] Closing Submission by Counsel Assisting the Coroner, paragraph 6.5

[13] Closing submission by Counsel Assisting, paragraph 6.6-6.7

[14] Closing submission by Counsel Assisting, paragraph 7.1

taking into account the need to balance competing considerations in the difficult decision making process confronting them.

RECOMMENDATIONS

Pursuant to section 72(2) of the **Coroners Act 2008**, I make the following recommendation(s) connected with the death:

1. I recommend that the Royal Australian College of Psychiatrists, or other relevant professional body, either mandate, or at least strongly recommend, that those responsible for the provision of psychiatric treatment and care of a patient who is being transferred to a general practitioner, prepare a discharge summary, taking into account input from the psychiatrist, or psychiatrists who have been providing care to the patient.

I extend my condolences to the family of Mr Pedro Arcos-Vazquez .

I direct that a copy of this finding be provided to the following:

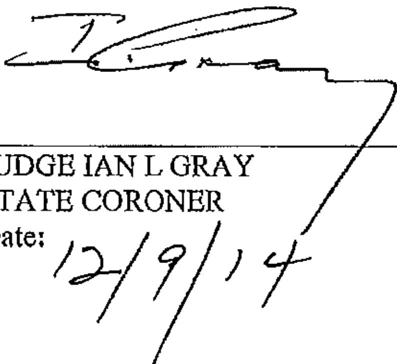
Mrs Judy Joseph

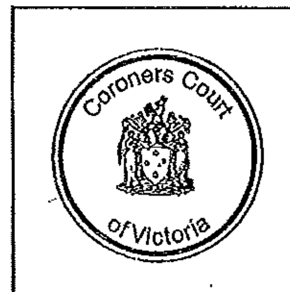
Chief Commissioner of Police

Monash Health

Mr David Otis

Signature:





JUDGE IAN L GRAY
STATE CORONER
Date: 12/9/14