FORM 37

Rule 60(1)

FINDING INTO DEATH WITH INQUEST

Section 67 of the ***Coroners Act 2008***

Court reference: 3973/06

Inquest into the Death of BAYDEN ROY SMITH

Delivered On:	3rd March, 2010
Delivered At:	Melbourne
Hearing Dates:	29, 30 October and 2 December 2008
Findings of:	JUDGE JENNIFER ANN COATE
Representation:	Mr R. McCloskey Ms E. Porter

Place of death/Suspected death: 182 Greenvale Drive, Greenvale, Victoria 3059

SCAU:	Leading Senior Constable G. McFarlane

FORM 37

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FINDING INTO DEATH WITH INQUEST

Section 67 of the ***Coroners Act 2008***

Court reference: 3973/06

In the Coroners Court of Victoria at Melbourne

I, JUDGE JENNIFER ANN COATE, State Coroner

having investigated the death of:

Details of deceased:

Surname: SMITH
First name: BAYDEN
Address: 182 Greenvale Drive, Greenvale 3059

AND having held an inquest in relation to this death on October 29, 30 and December 2, 2008
at the Coronial Services Centre, Southbank
find that the identity of the deceased was BAYDEN ROY SMITH
and death occurred between 17th and 18th October, 2006

at 182 Greenvale Drive, Greenvale, Victoria 3059

from

1a. GUNSHOT INJURY TO HEAD

in the following circumstances:

Introduction

1. Mr Bayden Roy Smith (Mr. Smith) took his life at the age of 47 by shooting himself in the head with an unregistered handgun he had in his possession at his home. In the hours before he took his life, he rang his good friend Charlie Mazza and told him something of his state of mind and that he had a gun and was going to shoot himself. He told Mr Mazza that he had removed his jewellery and written a note to his son. Mr Mazza, not having heard his friend of 10 years speak in this way before, contacted another friend to seek assistance and that friend apparently contacted the police.

2. The police received this contact in the form of a report of a man threatening to shoot himself. Senior Constable Illingworth from Broadmeadows Police Station attended at the home of Mr Smith at 182 Greenvale Drive, Greenvale about 7.30 on the evening of October 17, 2006, in response to that report. Mr Smith appeared upset and depressed and distressed to S/C

Illingworth. Mr Smith detailed his reasons for feeling so to S/C Illingworth[1] . Upon entering Mr Smith's home, S/C Illingworth saw on the coffee table the jewellery that Mr Smith had removed and the suicide note Mr Smith had written to his son.

3. After checking with the Firearms registry, and with the co-operation of Mr Smith, S/C Illingworth removed 6 registered firearms from a steel cabinet in the garage whilst still at the house with Mr Smith. Despite Mr Smith denying he had any unregistered firearms, S/C Illingworth searched the house for any other possible firearms but found none.

4. Thereafter S/C Illingworth advised Mr Smith that, under S.10 of the *Mental Health Act 1986* he was taking Mr Smith to Broadmeadows Police Station for an assessment.

5. The Crisis Assessment and Treatment team (the CAT team) arrived at about 9pm at Broadmeadows police station. The team members were Mr Quan Nguyen and RPN Kok Lim. S/C Illingworth detailed his observations to them and gave them a copy of the suicide note. The team proceeded with their assessment of Mr Smith. They spoke to no other person about Mr Smith before concluding that he was not an immediate risk to himself. Significantly, they did not speak to either Mr Smith's son Bayden Jnr or his friend Charlie Mazza.

6. At about 9.47pm, the CAT team advised S/C Illingworth that they had no concerns for Mr Smith's immediate welfare and that he would not be certified under S.10 of the *Mental Health Act 1986.*

7. Mr Mazza, having spoken a couple of times to both Mr Smith and the police during that night of October 17, received another call from Mr Smith at about 10pm indicating that he was allowed to go home from the police station as long as a friend took him home.[2] At about midnight, Mr Smith was collected from Broadmeadows police station by Charlie Mazza. Mr Mazza had no discussions with either member of the CAT team before transporting Mr Smith home. S/C Illingworth had organized the attendance of Mr Mazza to collect Mr Smith.

8. Mr Mazza took Mr Smith home. He took him inside and had a glass of coke with him and a cigarette and talked through some of the issues that were concerning Mr Smith at that time. Mr Smith indicated that he was working at 4.30am that morning and was going to tidy up a bit before he went to bed. Mr Mazza left after telling Mr Smith he would call him the next morning. Mr Mazza started calling Mr Smith at about 7.30am the morning of Wednesday October 18, 2006. He called continuously that day but got no response.

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1. Statement of S/C Illingworth 20/12/2006 (Inquest Brief)
2. Statement of Charlie Mazza 24/10/2006 (Inquest Brief)

9. Mr Smith's son Bayden Jnr, called his father at about 7am on the morning of October 18 but also got no response. Bayden Jnr was 18 years old at the time of his father's death and had been living with him in their rented home.[3]

10. That evening at about 7pm, in company with some friends, Bayden Jnr went around to his father's home and discovered his father deceased with a handgun beside him.[4] Mr Smith had a single fatal gun shot wound to his head.

11. Bayden Smith's death constituted a reportable death pursuant to s.3 *Coroners Act 1985.*

12. An inquest into Mr Smith's death was held pursuant to s.17(2) of the *Coroners Act 1985.*

13. In the course of this investigation and inquest, a number of issues were raised about the nature and adequacy of the CAT team assessment and the timing and method of release home of Mr Smith on this night. There was no issue raised about the conduct of the police at any stage from the initial call alerting them to Mr Smith's condition, right through to their investigation of the circumstances of his death.

14. Given the issues raised about the mental health assessment of Mr Smith, I considered it appropriate to obtain an independent assessment from a psychiatrist, nominated by the Royal Australian and New Zealand College of Psychiatrists. Professor Richard Ball was the psychiatrist nominated by the College. He was provided with a copy of the Inquest Brief after which he provided a written opinion.[5] Professor Ball also attended to give oral evidence at the inquest.

15. A number of mental health professionals attended the inquest to give evidence about the circumstances of this particular coronial investigation as well as evidence about crisis assessment in mental health generally. The two members of the Crisis Assessment and Treatment team from North West Area Mental Health who attended Mr Smith that night, Mr Quan Nguyen (social worker) and Registered Psychiatric Nurse Kok Keong Lim (Division 3) both provided statements for the Inquest Brief which were tendered into evidence[6] and both members also gave oral evidence. The Acting Chief Psychiatrist at the time, Professor Kurivilla George provided a

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3. After a disagreement a few days earlier, Bayden Jnr had not been home. He had been speaking with his father between 2 to 7 times a day after he left on the 12th October up until the time of his father's death. Bayden Jnr described the contents of these conversations with his father as about "general stuff" as well as receiving his father's apology for the argument they had. (See statement of Bayden Jnr :Inquest Brief)
4. Bayden Jnr recognized the handgun Mr Smith used as belonging to his father although he had believed that his father had disposed of that gun some months earlier as it had been unregistered and Bayden Jnr had expressed concern to his father about his father keeping it.
5. The written opinion of Professor Ball became Exhibit 16 during the Inquest.
6. Exhibits 10 and 11

statement[7] and also attended to give evidence as to the operation of the system generally. Dr David Muirhead, Consultant Psychiatrist and the Director of Clinical Services for North West Area Mental Health Service provided two statements[8] and also gave oral evidence. Associate Professor Dr Peter Burnett, Director of Clinical Governance NorthWestern Mental Health provided a written response to Professor Ball's report through the legal representative for North Western Mental Health[9] and also gave oral evidence.

The nature and adequacy of the mental health assessment of Mr. Smith by the CAT team

16. According to Dr Muirhead, the CAT team's role is to provide urgent mental health assessment and to co-ordinate further treatment as appropriate in the wake of that assessment[10]. As stated above, Professor George, the Acting Chief Psychiatrist gave evidence in the inquest and prepared a statement that was tendered into evidence at that time. In his statement, he listed the CAT functions as inter alia *"crisis intervention to identify problems, alleviate risks, plan and where appropriate, implement crisis management plans."*[11]

17. There appears to be little controversy on the evidence of the experts that making an accurate assessment as to the risk of suicide to a person who has threatened suicide, is a very difficult task, and especially difficult in circumstances where that person is denying any current intent to kill himself or herself.

18. Mr Nguyen and RPN Lim, the CAT team on call that night in the region, were both qualified and experienced in their fields of social work and psychiatric nursing.[12]

19. In essence the evidence of both members of the team that night was that they attended Broadmeadows Police Station at the request of the police to perform their assessment of Mr Smith. It was not a particularly busy night. They both agreed they spent about 50 minutes with Mr Smith between about 9pm and 10pm on the night of October 17, 2006. They both agreed they knew that a couple of hours earlier that evening Mr Smith had contacted a friend to indicate that he was going to shoot himself and he re-iterated this intention to police when the police arrived at about 7.30pm.[13] They knew that when police arrived at Mr Smith's home he appeared distressed and depressed and crying[14] and he was found by police to have written a

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7. Exhibit 15
8. Exhibits 13 and 14
9. Exhibit 17
10. Transcript p 176
11. Exhibit 15 p. 3
12. Dr Muirhead, consultant psychiatrist and Director of Clinical Services employed by North West Area Mental Health described RPN Lim as a very experienced senior nurse who has been doing mental health assessments for about the last 18 to 19 years. He also stated that Mr Nguyen wasappropriately experienced noting that CAT teams are only made up of experienced clinicians because of the nature of the work.
13. Transcript p 37

suicide note to his son and removed a considerable quantity of jewelry from his person and had a considerable number of firearms in his home. The team was aware those firearms had been removed. They both knew that Mr Smith normally lived with his son but that his son had wanted a break from him and had moved out a few days earlier and that this was distressing to Mr. Smith. They both knew that Mr Smith's marriage had ended a few years earlier and that during the assessment, Mr Smith reported feeling unloved.[15]

20. Upon assessment, the team found no evidence of psychosis or depressive symptoms.[16] Mr Smith denied any drug or alcohol misuse, any family history of mental illness and denied any suicidal ideation. He also denied any past history of self harm or suicide attempts. Mr Nguyen records in his statement that when Mr Smith was asked about the suicide note he "*convincibly (sic) denied any plan or intent of killing/harming himself. He said he was angry at the time.*" In his statement, RPN Lim said as to the suicide note[17] that Mr Smith denied any intent to end his own life but indicated he was upset about his relationship problems although did not "*appear upset*" during interview.[18] According to RPN Lim, Mr Smith was pleasant and co-operative, made good eye contact and showed no signs of being drug or alcohol affected.[19] His speech was normal and he showed no formal thought disorder.

21. Both members of the team agreed that the situation they were called into was serious, given the firearms, the removal of the jewellery and the suicide note,[20] and that it was not common to see such a note.[21] However, it was their mutual view on the night that the removal of the firearms by the police and the reassurance by Mr Smith that he was going home with his friend, together with his clinical presentation, reduced the risk he would harm himself upon release.

22. Mr Nguyen confirmed that in his professional opinion he assessed Mr. Smith as "*bright and happy*"[22] during the assessment, despite what the police had detailed to the CAT team about the circumstances in which they had found Mr Smith. RPN Lim agreed with that assessment.[23]

23. Upon being cross examined about the possibility that the patient may have been telling him what he wanted to hear, Mr Nguyen seemed adamant that he was bound by the answers he

14. Evidence of S/C Illingworth (TS p.39)
15. Statement of Mr Nguyen
16. Statement of Mr Nguyen
17. The suicide note (a copy of which is contained in Exhibit 7)appears to read as follows: "To my boy Bayden love you for ever never stop loving you this is hard to do but I will see my brother, everythink will be allrite love you fuck the rest thy wanted it this way you be strong for me it is the end".
18. Statement of PRN Kok Lim
19. The toxicology results contained in the post mortem report for Mr Smith do not contain any indication of drugs or alcohol present in Mr Smith
20. See Transcript p 106
21. Transcript p 80 and P114
22. Transcript p 74
23. Transcript p 112

got, but particularly in circumstances where he had no reason to probe beyond those answers.[24] I understood this answer to mean that his clinical presentation of being "*bright and happy*" and not presenting with any other inconsistencies meant he had no reason to question Mr Smith's self reporting.

24. Both members of the team stated they reached the opinion that they had no grounds to detain Mr Smith under the *Mental Health Act 1986.*

25. Both RPN Lim and Mr. Nguyen gave evidence that after questioning the patient at interview, it would be normal to speak with family and friends to obtain further information.[25] It was Mr. Nguyen's evidence that despite Mr Smith giving them his son's contact details he asked them not to contact him and they did not. Indeed they did not contact either Mr Smith's son or Mr Mazza. RPN Lim was clear that there was no legal impediment to contacting Mr Smith's son.[26]

26. Mr. Nguyen explained his initial reasoning for not speaking with Mr Mazza was that Mr Smith presented so well with no depressive or psychotic symptoms or symptoms of any risk to himself and was taking actions for his own safety such as calling his friend and asking the police to keep his weapons for him and agreeing for follow up contact with the CAT team that they did not have any concerns for him. He was assessed as low risk.[27] Mr Nguyen agreed that normally they would verify the information they have but on this occasion they did not because Mr Smith presented so well and seemed so co-operative. The CAT team believed Mr Smith had no history of mental illness or past history of self harm. Mr Nguyen conceded that Mr Smith was minimizing his situation but did not appear distressed and thus it did not concern them.[28]

27. Mr Nguyen's evidence was that they did not speak with Mr Smith's son because Mr Smith asked them not to and they assessed him as making good decisions for himself and he was denying any thoughts of killing himself. Further, Mr Nguyen stated that he always respected a patient's wish for privacy although conceded that talking to the family was important, but he did not see the need for that in this case.

28. Mr Nguyen, later during cross examination by S/C McFarlane, agreed given the state the police found him in there was some risk, but that was balanced by the police taking the firearms away.

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24. Transcript p 75-76
25 Transcript p 58 and p 98.
26. Transcript p 98
27. Transcript p 83
28. Transcript p59-62

29. Finally on assessment, Mr Nguyen agreed that had he known of the matters which had come out in evidence from Bayden Jnr and Mr Mazza during the inquest[29] about a previous threat of self harm, Mr Smith's drinking, that he was being deceptive about his employment, that he was experiencing financial and relationship problems, that he was being closed off and described by his son as "*sad and miserable*" for months and that Mr Mazza was not going to stay the night with him, Mr Nguyen answered that had he known all of that in these circumstances "*without hesitation I would use the Mental Health Act to detain the person*".[30] RPN Lim gave a far more qualified answer stating it would not have caused him to suddenly invoke the *Mental Health Act.*[31]

30. What the members of the CAT team heard at inquest was Bayden Jnr describe his father in the months leading up to his death as "*really sad and depressed*"[32] and "s*ad and miserable*" because he did not appear to have any steady job and was staying at home a lot.[33] He also gave evidence that his father had recently lost his driver's licence and was in some financial difficulty.[34] Bayden Jnr described his father as someone who was very private about his feelings and "*did not talk about things*"[35] and was able to put on a "*good act*" that he was happy, but when nobody was around he was '*really sad and depressed.*"[36]

31. The evidence of Bayden Jnr was that over the previous five years or so of his father's life he had mentioned taking his life 3 or 4 times.[37] On an occasion in the 12 month's prior to his death, in the wake of a breakdown in a relationship, Bayden Jnr found his father pulled over by the side of the road having apparently consumed a large amount of alcohol, saying he had had enough and was apparently speaking of ending his life.[38] Bayden Jnr persuaded his father to come home on that occasion.

32. Mr Mazza gave oral evidence that up until the last week of his life, he had always experienced Mr Smith as a "*happy-go-lucky*" sort of a bloke.[39] This appears to be why he reacted to Mr Smith's distressed call to him on the night of October 17, as it was so out of character. Mr Mazza also stated that in the last week of Mr Smith's life, he had been quite upset about his finances, his personal relationships, his lack of steady employment and some significant

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29. Both Mr Nguyen and RPN Lim were present in the Court during the evidence given by Bayden Jnr and Mr Mazza and S/C Illingworth before giving their evidence in the inquest
30. Transcript p 89
31. Transcript p 110
32. Evidence of Bayden Jnr TS P23
33. Ibid Pp 14 and 15 and 18
34. Transcript p 19
35. Ibid
36. Transcript p 23
37. Ibid p.15
38. Evidence of Bayden Jnr Transcript p. 14
39. Transcript p 25

fines that he was facing.[40] There is no dispute that neither member of the CAT team spoke to Mr Mazza on the night as part of their assessment of Mr Smith or for managing Mr Smith's release.

33. S/C Illingworth gave evidence that he passed on all of his observations of Mr Smith on the night to the CAT team. He also gave evidence that over about 6 years stationed at Broadmeadows as a general duties officer he had probably attended between 50 to 100 threatened suicides and about 20 to 30 actual suicides. He stated in his experience it was unusual to find someone who had prepared to the degree that Mr Smith had and he found that concerning.[41] S/C Illingworth also gave evidence that Mr Smith seemed quite happy and alert when he left the station.

34. Dr Muirhead, Consultant Psychiatrist and the Director of Clinical Services for North Western Area Mental Health Service stated that there had been an internal review of the assessment that had been made by the CAT team on this night. It was Dr Muirhead's evidence that the internal committee that reviewed this death concluded that the assessment had been appropriate.[42] However, Dr Muirhead conceded that he had heard evidence in the course of the inquest "*which cast a different light on things*"[43] and stated it was certainly possible that the information that came out in the course of the inquest may have resulted in a different risk assessment being made.[44]

35. Dr Muirhead drew the distinction between diagnosis and risk assessment for the purpose of explaining that although the extra information would indicate he was suffering from clinical depression, it may not have changed the assessment of self harm risk on this night. Dr Muirhead did go on to add that confronting Mr Smith with that extra information and assessing his reaction "*probably would have been the most instructive information about whether or not to hospitalise the man.*"[45]

36. The effect of Dr Muirhead's evidence was that hospitalisation and treatment for Mr Smith's depression may well have alleviated the on-going suicide risk.[46]

37. Dr Muirhead was questioned about whether or not the CAT team should have sought the opinion of the on call registrar on this night. He stated that in his opinion there was no indication evident to suggest the team should have sought the opinion of the on call registrar before

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40. Statement of Charlie Mazza
41. Transcript p 38
42. That report was not produced. I have no detail of who constituted the committee or how that opinion was reached.
43. Transcript p 134
44. Transcript p 144
45. Transcript p 146
46. Transcript p161

releasing Mr Smith and he was satisfied with what the clinicians did on the night and no changes to the system have been made as a result of this case.[47] Later in his evidence, when questioned about whether other clinicians in the same circumstances would have done things differently, he concluded "*I think some may and some may not have.*"[48] In conclusion, Dr Muirhead did concede that with the benefit of the extra information which came out during the inquest, one would have to question the accuracy of the assessment that Mr Smith was not clinically depressed.[49]

38. Associate Professor Dr Peter Burnett, Director of Clinical Governance North Western Mental Health made a statement and gave evidence in the inquest. He stated that it would be difficult to satisfy the criteria for an involuntary detention on the basis of what the CAT team had on the night. Dr Burnett also wanted to stress the issue of the difficult balance between individual patients' rights and the protection of the patient and others.

39. In his oral evidence,[50] he stated that there was a balance in making an assessment between respecting a person's privacy and making an accurate assessment. Associate Professor Dr Burnett also spoke of the need to consider that "*too zealous an assessment*" would run the risk of making the on-going treatment alliance more difficult. He agreed with all of the other experts that getting the balance right was often a difficult clinical judgment. He expressed the view that it was not clear whether the further information which came out in the course of the inquest from Bayden Jnr and Mr Mazza would have altered the tragic course of events, but he agreed that a discussion with both Mr Smith's son and his friend Mr. Mazza would have "*been helpful*".[51]

40. When the further material from Bayden Jnr and Mr Mazza was put to him and he was asked to give an opinion about whether or not his knowledge of that information may have changed his view about involuntary detention, he stated "*They would certainly sway one more towards insisting that he stay in hospital, but they wouldn't necessarily be conclusive because it would depend on one's assessment ...*".[52] He went on to say that it is always preferable to get "*collateral history*", particularly with a new patient.

41. Professor Richard Ball was the independent expert nominated by the Royal College of Psychiatrists to provide an opinion to the Coroner. Professor Ball stated that in his opinion not enough information was collected during the assessment and that it would have been helpful to have contact with both his son and the friend who came to pick him up. It was his clear view that the circumstances the CAT team were presented with on this night were quite concerning and

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47. Transcript p 146
48. Transcript p 166-7
49. Transcript p 247-248
50. Transcript p 231
51. Exhibit 17
52. Transcript p 234

more information should have been sought from the son and friend. It was his view that without that extra information, the assessment was not adequate.

42. Professor Ball also gave evidence about what he described as the "*Classic trap*" as described by *Stengel and others* which can be summarized as the paradox wherein a depressed and suicidal person can appear outwardly calm and relaxed as a result of having made a firm decision to end their life and know they have the means to complete that decision. It was Professor Ball's view that this was "*most likely*" the situation in this case.[53] Professor Ball did note also the difficulty of assessment in such a situation. I understood the effect of Professor Ball's evidence to be that the potential for a clinical presentation of outward calm in these circumstances always needs to be factored in to an assessment and the ability to corroborate information with family and friends as an extra safeguard always needs to be seriously considered.

43. Professor Ball gave his opinion that given the circumstances on this evening, that a "*transient admission*" allowing for further observation and the opportunity for a psychiatrist to assess Mr Smith may have lead to a different outcome. He expressed the view that the severity of the potential stressors for Mr Smith was the important consideration. He also noted that in his view the assessors failed to be aware of the "*intensity of his feeling*".[54]

44. Professor Ball was cross-examined about whether or not the current *Mental Health Act* criteria for involuntary detention would have provided any capacity to detain Mr Smith given his presentation. Professor Ball's answer was that he would "*try hard, given that it was only an hour or so before that he had been quite severely depressed and showed every sign of it.*"[55] Professor Ball went on to say that he believed that involuntary detention sometimes saved lives, implicitly suggesting that a more liberal use of it should not be shied away from in these sorts of circumstances, but that the current statutory criteria presented problems for this sort of situation.

45. Professor George, Acting Chief Psychiatrist gave evidence that this case was reported to his office and no further action was taken. He did note however that given over 300 deaths a year are reported the Office of Chief Psychiatrist, it would not be possible to investigate them all and thus it is the in-patient deaths which will be investigated rather than the deaths in the community. His evidence was that in cases such as this one, his Office awaits the Coroner's Finding.[56]

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53. Transcript p 205
54. Exhibit 16 p 2
55. Transcript p 219
56. Transcript p 186-7

Conclusion as to the nature and adequacy of the assessment

46. I accept the evidence that the task of making an assessment as to an individual's level of risk of suicide is a complex one indeed and especially in circumstances where that individual has no other recorded history in the public health system. However, the evidence in this case is that the circumstances surrounding how Mr Smith was found by police were agreed by all to be very serious. The evidence of the mental health experts who have assessed the circumstances and provided opinions as to the nature and adequacy of this assessment are varied. Each of the professional mental health practitioners apparently connected to North Western Area Mental Health Service, that is RPN Lim and Mr Nguyen and Dr Muirhead and Associate Professor Burnett all conclude that, on the basis of the material available to the team on that night, the assessment was a reasonable one.

47. The independently appointed expert, Professor Ball reached a different view after assessing all of the material provided to him. In his view, even on the material that the team had available to them on the night, they should have kept Mr Smith overnight to enable a more complete assessment.

48. Upon reconsidering the decision to release Mr Smith after learning of the extra information that would have been available had Bayden Jnr and Mr Mazza been spoken to as part of the risk assessment on that night, the picture was somewhat different. Mr Nguyen stated categorically that had he known that information he would have detained Mr Smith under the *Mental Health Act*. RPN Lim was far more qualified in his response indicating by it that he did not agree with Mr Nguyen's conclusion. Dr Muirhead stated that the new information "*cast a different light on the assessment*" and that it was certainly possible that that information may have resulted in a different risk assessment being made. Associate Professor Burnett stated that the new information would certainly sway one more towards placing Mr Smith in hospital.

49. In my view, that three of the four mental health professionals who accepted that the assessment was a reasonable one based on the material available at the time, accepted in varying ways during the inquest that the **extra** information available from Bayden Jnr and Mr Mazza would have made a real difference to the assessment, highlights an issue about the collection of information from friends and family during the crisis assessment conducted on this night. It may be reflective of a larger problem across the CAT team system but the lack of systematic review of the operation of CAT teams makes such a conclusion not possible. However, it highlights a public health and safety issue in this case.

Fostering The "therapeutic alliance"

50. The issue of making a judgment call about when to contact family against the will of the patient is clearly one that the mental health field has to make with some regularity, and is no doubt a difficult call to make. It was the evidence of Dr Muirhead that there is often a conflict between the desire for information from and about the patient and the desire to comply with the wishes of the patient and thereby build a "*therapeutic alliance*". In this case, the judgment call was that there was not an imminent risk of self harm and therefore there was time to work on the development of the therapeutic alliance or the degree of trust and co-operation necessary for the treatment of the patient which is so important for successful future treatment of the patient and therefore protection from future harm to that patient. The difficulty is that one is caught in a circular argument. If the risk assessment is compromised by inaccurate or inadequate information, the preservation of the "*therapeutic alliance*" is rendered meaningless, as in this case.

51. Professor Ball was questioned about the competing pressures of patient confidentiality and the building of the trust or "*therapeutic alliance*" when deciding whether to contact family or friends. It was Professor Ball's view that a therapist can **obtain** information from other sources without **giving** information and that this is a sensible way to address those concerns in potentially life threatening situations when balancing the competing tensions.

52. Dr Muirhead, when questioned about this, stated that whilst a mental health practitioner can override privacy considerations, one has to make a judgment about when to do that and in this case, Mr Smith had said he did not want his son contacted and his son was only 18 years old. Dr Muirhead drew a distinction between this situation and that of an 18 year old patient saying he did not want his parent contacted. I accept that this is a valid distinction, but there is no evidence from the CAT team on this night that this formed part of their reasoning. Further, it does not contemplate approaching the obtaining of information in the way suggested by Professor Ball, that is that one **obtains** information from the family member **but does not** give information.

53. Professor Ball's view about this issue was that when a CAT team is seeing someone in crisis for the first time, in the middle of the night, in circumstances such as these, the "*therapeutic alliance*" is not the critical feature but rather ensuring the assessment that is being made is the correct one. It was his view that incursions on that person's freedom may be necessary in order to make the necessary assessment as to risk. Professor Ball made clear that he would have wanted to speak with both the son and the friend. He said:

> "I'm more worried about getting people treated and keeping them alive than initially worrying about the therapeutic alliance."

It was the opinion of Professor Ball that had Mr Smith been detained overnight, he might still be alive.[57]

Conclusion

54. The evidence as to the tension between making the best risk assessment possible in the circumstances and respecting the rights and dignity of the patient and endeavoring to establish a therapeutic alliance for future treatment highlights the complexity of this task.

55. The current state of the law allows for family and friends to be contacted where concerns about the safety and health of the patient are concerned.

56. The evidence of Professor Ball that a thorough risk assessment must take precedence over the establishment of a therapeutic alliance rings sadly true in this case. Indeed, Professor Ball's evidence was that the two aims are not as contradictory as one may initially conclude in that it is possible to have a patient accept that one will speak to family and friends to obtain information but not give information.

57. In this case, some considerable weight appears to have been put on Mr Smith saying he did not want his son to be contacted and yet he had written a very moving suicide note to his son, he had given the team his son's mobile phone number and listed him as his next of kin. The evidence suggests at the very least a considerable ambivalence on the part of Mr Smith about contact with his son. I conclude this because Mr Smith, by providing his son's name and number has thereby provided the only method the CAT team would have had of contacting Bayden Jnr. There is no evidence that the CAT team sought Mr Smith's permission to talk to Mr Mazza. In fact the evidence leads me to conclude that much reliance was placed on Mr Smith's clinical presentation and thus it was not considered necessary to pursue any further collateral or corroborative material.

The release

58. Mr Smith's release on this night, and the method adopted for his release from custody and return home, emerged as an issue in this investigation as another opportunity for keeping Mr Smith safe during a time of crisis.

59. There is no dispute that neither Bayden Jnr nor Mr Mazza were spoken to by the CAT team or given any advice or confirmation of the circumstances of the release of Mr Smith.

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57. TS p226

60. Mr Mazza had been reluctant to pick up Mr Smith that night. He advised Mr Smith in a phone call from Broadmeadows Police Station at about 8.30pm that night that he should stay there and cool off[58] but was persuaded by Mr Smith to take him home because he seemed to be talking sense and had reassured Mr Mazza that he was OK.[59] Mr. Mazza had felt satisfied it was safe to take Mr Smith on the basis that he had been talking to "*a professional counsellor*". When Mr Mazza arrived at the police station, the police confirmed that Mr Smith was right to go. Mr Mazza recalled there was some conversation with the police about him staying the night with Mr Smith but his evidence was that he did not indicate he was going to stay the night. S/C Illingworth believed that Mr Mazza was going to stay with Mr Smith that night as a result of a discussion at the police station.[60] S/C Illingworth gave evidence that the CAT team had knowledge that Mr Smith was being collected by a friend that was going to stay the night with him.

61. Mr Nguyen stated that he overheard Mr Smith talking to his friend who was going to come and pick him up. It is agreed that neither member of the CAT team spoke with Mr Mazza or knew anything about him and that the basis of the team's belief that Mr Mazza was going to stay the night with Mr Smith was that he (Mr Smith) told them so.[61] In evidence RPN Lim accepted that they had been deceived about Mr Smith going home to be alone and agreed that would increase his vulnerability.[62]

62. Professor Ball was expressly asked to give an opinion about the release of Mr Smith in the circumstances in which this release was done and he stated that he would **ensure** that someone was with Mr Smith overnight if he was going to be released.[63]

Conclusion on the release home of Mr Smith

63. The evidence leads me to conclude that the CAT team formed a view about Mr Smith's low level of risk of suicide and thereafter did not take the precaution of satisfying themselves that Mr Smith was at least going to be with some form of supervision or company provided by a friend who could stay the night with him, consistent with the opinion of what was needed according to Professor Ball.

64. Mr Mazza understood correctly that Mr Smith had been assessed and released home. He was not given any warnings or instructions about what he should do by the "*counsellors*" (as Mr

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58. Statement of Charlie Mazza
59. Transcript p 26
60. Transcript p 40
61. Transcript p 70-1
62. Transcript p 120
63. Transcript p 225

Mazza referred to the CAT team) and thus was entitled to conclude that Mr Smith was safe to go home.

CONCLUSION:

65. I find that Mr Bayden Smith, within hours of his release from detention pursuant to s.10 *Mental Health Act*, and in the wake of a Crisis and Assessment Team assessment that he was a low suicide risk, in his home alone and in the early hours of the morning, intentionally took his own life by gunshot to the head.

COMMENTS:

66. The fact finding role of the coronial investigation has often been stated as one focused on establishing the truth of what happened as best the evidence allows, to achieve a range of purposes. A recognised significant purpose of the coronial investigation is to identify any opportunities for improvement in systems of public health and safety which may contribute to a reduction in preventable deaths. It is not an exercise in apportioning blame against individuals, even though it is acknowledged that the process of the investigation and inquest may well be perceived by those individuals involved in the death as such an exercise. However, to achieve improvements to our systems of public health and public safety, it may be necessary to put under scrutiny the actions of individuals trained and working inside those systems to highlight the need for improvement.

67. Thus, findings of fact about the nature and adequacy of the assessment and release made in this case are not to be perceived as attacks of the individual CAT team members. The comments and recommendations arising out of this investigation are directed at improving the maintenance of adequate systems of public mental health, including the provision of manuals, training, supervision, risk assessment tools and protocols or guidelines about issues such as when and how to engage in family contact for risk assessment purposes or how to manage a safe and well communicated plan for release from custody and return home.

The nature and adequacy of the assessment

68. It is well understood that the principles of intervention into a person's life must always be kept to the minimum necessary to ensure that person's safety and that wherever possible, people should be treated in the community and treated with respect and dignity, maintaining as much privacy as possible consistent with the person's safety. It is also understood that the future protection of a person way well be enhanced by establishing a trust which will both assist that person to feel comfortable in continuing on going contact with a therapist or calling for assistance when necessary in the future.

69. However, in my view, this case highlights some aspects of the current public mental health system of crisis assessment that warrant review.

70. It seems trite to observe that the quality of any expert assessment as to a person's risk of suicide is only as good as the information available to the assessor at the time of the assessment. In this way, it is not helpful to affirm the reasonableness of an assessment based on the information available at the time, if the quality of that information is limited by a failure to pursue reasonable and sensible avenues open to the assessors to obtain further information. That issue is highlighted in this case. The weight of the evidence was that it is generally always useful to get collateral or corroborating information from family and friends before making a final assessment, and had that information been obtained in this case, it most likely would have changed at least the assessment of the level of risk posed to Mr Smith and according to at least one member of the CAT team that night, would have resulted in recommending Mr Smith's hospitalization.

71. The evidence from the members of the CAT team was that Mr Smith had asked them not to contact his son. However, Mr Smith provided his son's mobile number enabling that contact which would otherwise not have been possible. Mr Smith had written a very intense and loving note to his son. The evidence raises the real possibility that Mr Smith's protest about contact with his son was at least ambivalent given he gave the team the only method of contact they would have had to find someone named Smith. Mr Smith did not make any protest about contact with Mr Mazza. Contact was not pursued because of the clinical assessment made that it was not necessary.

72. The decision not to pursue any information from family and friends on this night, given the evidence about the seriousness of the circumstances in which Mr Smith was taken into custody by the police, seems on balance to be contrary to common sense if not good professional practice. It is not possible to conclude that had Mr Smith been hospitalised on that night he may still be alive, but his hospitalization on that night would have provided the opportunity for a more thorough risk assessment which, on the evidence would most likely have lead to a significantly increased level of concern for Mr Smiths's safety and thus a more comprehensive treatment and release home plan.

Contact with family and friends

73. The evidence revealed at least a sense that there was a lack of clarity and guidance to mental health professionals about when and how such further information should be sought. It may be that adequate guidelines exist but were not well understood by this particular team, or it may be that there is a gap which needs to be filled by the provision of a clear set of principles and guidelines for mental health workers about how and when to contact family and friends for

information about the person and how and when to provide information to family and friends about how best to try and keep a person safe.

Release from a crisis assessment

74. Given the circumstances of Mr Smith's release home, this investigation also highlights the need to consider the necessary precautions that should be made for a person, consistent with all of the circumstances of the presentation as to the way in which that person's release should be managed by the professionals. Family and friends, satisfied that their loved one or friend has been assessed by the professional expert assessors are entitled to assume that they will only be released if it is safe to do so and that they would be given certain advice if it were not safe, or at least given advice as to how to keep the person safe if released home into their care. In this case, there was no communication by the mental health experts to the friend who was taking Mr Smith home, either to inform him of their general assessment of safety as to his release, or to enhance Mr Smith's safety by giving advice to his friend Mr Mazza about the best way to assist in keeping Mr Smith safe. Whilst it is clear on the evidence that this particular team did not consider that necessary in this case, given the seriousness of the circumstances it would seem reasonable at the least that once a decision was made to release Mr Smith, that a conservative and careful approach to Mr Smith's release should have been adopted.

The statutory criteria for involuntary detention

75. The evidence of Professor Ball raises an apparent difficulty with the application of the current statutory criteria for involuntary detention under the Mental Health Act. The evidence in this inquest suggests that when a patient is not apparently suffering a psychiatric illness within the meaning of the Act, not thought disordered or psychotic but may be acutely suicidal, the criteria for detention under the Mental Health Act may fall short of providing a mechanism to keep that person safe in hospital.

Limited detention provision for assessment and safety planning

76. The evidence in this investigation also raises the issue of risk assessments of this nature that are done late at night, with a reduced ability to obtain extra information from family, friends, GP's and others that would otherwise enhance the depth and quality of the risk assessment. It may be appropriate to consider whether or not some form of limited or temporary custody or detention order should be available to enable a 24 hour crisis mental health assessment with a modified entry criteria. Such a form of temporary or limited custody or detention would also give a far better ability to the mental health team conducting the assessment to develop a well thought through and well communicated safety plan for the release of the patient if that was the decision reached after a full assessment had been completed.

RECOMMENDATIONS:

Pursuant to section 19 of the **Coroners Act 1985**, I make the following recommendation(s) connected with the death:

1. That the Minister for Health and/or the Secretary to the Department of Health consider a review of the Crisis and Assessment Team risk assessment methods and tools to achieve a set of guidelines/protocols/procedures/ for recommended methods of acquiring the best quality information available to enhance the risk assessment processes.

2. That the Minister for Health and/or the Secretary to the Department of Health consider overseeing the development of agreed guidelines, protocols and procedures for appropriate safe release of apprehended persons which take into account that person's family and/or friends and community.

3. That the Minister for Health and/or the Secretary to the Department of Health consider providing a statutory capacity in the *Mental Health Act* to enable a limited 24 hour assessment and safety order to enable a more thorough assessment of a person's level of risk of suicide, and safe release if considered appropriate.

Judge Jennifer Coate
State Coroner

Coroners Court of Victoria

Dated: 3 March 2010

I Direct that this Finding be distributed to the following:

Attorney General
Minister for Health
Secretary, Department of Health
Bayden Smith Jnr
Mr Charlie Mazza
S/c Illingworth
Solicitors for Northwest Area Mental Health Service
Office of Chief Psychiatrist

Dr David Muirhead, Consultant Psychiatrist and the Director of Clinical Services for North West Area Mental Health Service
Associate Professor Dr Peter Burnett, Director of Clinical Governance North Western Mental Health
Professor Richard Ball, FRANCP

I further direct that this Finding, together with the comments, recommendations and distribution list be published on the Court's web-site.

FORM 37

Rule 60(1)

FINDING INTO DEATH WITH INQUEST

Section 67 of the ***Coroners Act 2008***

Court reference: 4068/05

Inquest into the Death of RITA MARY BYRNE

Delivered On:	25 February, 2010
Delivered At:	Coroners Court of Victoria at Melbourne
Hearing Date:	25 February 2010
Findings of:	JUDGE JENNIFER ANN COATE
Representation:	N/A

Place of death/Suspected death: 47 Camms Road, Cranbourne, Victoria 3977

SCAU: Leading Senior Constable Remo Antolini

FORM 37

Rule 60(1)

FINDING INTO DEATH WITH INQUEST

Section 67 of the ***Coroners Act 2008***

Court reference: 4068/05

In the Coroners Court of Victoria at Melbourne

I, JUDGE JENNIFER ANN COATE, State Coroner

having investigated the death of:

Details of deceased:

Surname: BYRNE
First name: RITA
Address: 47 Camms Road, Cranbourne 3977

AND having held an inquest in relation to this death on 25th February, 2010
at the Coroners Court of Victoria at Melbourne
find that the identity of the deceased was RITA MARY BYRNE
and death occurred between 7th and 8th November, 2005

at 47 Camms Road, Cranbourne, Victoria 3977

from

1a. NECK COMPRESSION

in the following circumstances:

1. Rita Mary Byrne (Mrs Byrne) was born in Ireland on February 13, 1928. She was 77 at the time of her death.

2. She married Anthony Matthew Byrne and had four children Deidre, Paul, Stephen and John.

3. In 1963 the family migrated to Australia and settled in the Dandenong area.

4. Upon retirement Mrs Byrne and her husband moved to 47 Camms Road, Cranbourne.

5. Mrs Byrne remained an active community member upon her retirement, involved in charity work, the local church and the church choir.

6. She was deeply affected by the loss of her husband to cancer in 2004.

7. She remained well supported by her friends and children after her husband's death.

8. Dean Westbrook lived next door at 49 Camms Road, Cranbourne. On the 1st March 2005, a search warrant was executed at his premises by police. A hydroponic cannabis crop was located together with a bypass to the electricity supply to his home. He was charged with criminal offences as a result.

9. Dean Westbrook cited this event as a turning point in his life. In discussions with his girlfriend at the time, he blamed a neighbour for reporting him to the police but did not make it clear which neighbour. During the hearing of this inquest, the homicide investigator who gave evidence as to the circumstances surrounding the death of Mrs Byrne, confirmed that the information provided to police about the cannabis crop was not provided by Mrs Byrne.

10. Dean Westbrook moved into his girlfriend's home about March 1, 2005 until about October 2005 when that relationship ended. He did not get the electricity supply reconnected to his property after the disconnection on the 1st March, 2005.

11. It would appear that around October 2005 Dean Westbrook also lost his employment and was under some financial strain.

12. On the morning of Monday, November 7, 2005 a friend of Mrs Byrne took her shopping. He drove her home at about midday, assisted her inside with her shopping and left.

13. This turned out to be the last known time Mrs Byrne was seen alive.

14. At about 6:35 am on 8th November 2005, Darren Allen was passing by 47 Camms Road when he noticed smoke coming from the premises. Mr Allen unsuccessfully tried to open the front double gates of the property. Instead, he climbed over the gates and knocked on the door but could raise nobody.

15. He then went to 49 Camms Road and knocked on that door but got no response.

16. He returned to 47 Camms Road and knocked again but still got no response. He then went to 45 Camms Road and raised Mr Bill Johnson and Ms Amy Rogers. Ms Rogers telephoned the fire brigade and Mr Allen and Mr Johnson attempted to break into the house and fight the fire with a garden hose.

17. Mr Johnson tried to search the house but was forced back by heavy smoke.

18. Once the fire brigade arrived, the fire was extinguished and Mrs Byrne was located dead on the floor in the kitchen, badly affected by fire.

19. Mrs Byrne was examined by forensic pathologist Dr Michael Burke. Dr Burke found that Mrs Byrne had injuries to her face and neck consistent with neck compression. Dr Burke did not find evidence of soot in her airways or carbon monoxide in her lungs.

20. It was Dr Burke's opinion that these findings suggested Mrs Byrne was deceased prior to the fire and that her cause of death was compression of the neck.

21. Dean Westbrook's former girlfriend Nicole Keating stated she received a call from him in the early morning of 8 November 2005. During this call Westbrook falsely informed Ms Keating he was at work.

22. He also informed Ms Keating that "something" had happened next door without elaborating.

23. The investigation into the fire at Mrs Byrne's home revealed that it had been started by petrol as an accelerant and probably ignited directly by a match or cigarette lighter.

24. A few cans were found at the fence between Dean Westbrook's property and Mrs Byrne's property and part of the fence was removed creating what was described as easy access from the Dean Westbrook's property to Mrs Byrne's property. A spray bottle containing remnants of petrol was found in Mr Westbrook's property.

25. When spoken to by police about his movements on the morning of November 8, 2005 Mr Westbrook gave a series of false accounts to police.

26. Mr Westbrook visited his former girlfriend's home on the afternoon of November 8 and she observed him to be nervous and shaking such as she had not ever observed before.

27. Mr Westbrook attended his Community Corrections Officer on Thursday 10th November 2005 unannounced. He gave a false account of various aspects of his movements and whereabouts over the previous couple of days.

28. Ms Keating stated she had intermittent contact with Dean Westbrook over the next few days.

29. Ms Keating stated to police on 12 November 2005 that Mr Westbrook had been at her home the night before and admitted that what he had told police in his statement was all lies.

30. On November 15, 2005 at about 7:30 am investigators attended 49 Camms Road with the purpose of formally interviewing Dean Westbrook for the murder of Mrs Byrne.

31. The investigators found Dean Westbrook deceased in the passenger side of his vehicle. His vehicle was parked in his garage with a hose from the exhaust pipe of his car into the cabin of his car through the driver's side window. The window was sealed with duct tape.

Conclusion

32. The false claims made by Dean Westbrook as to his whereabouts and movements at the relevant times and the explanation of the presence of the spray bottle containing the petrol cannot ever be tested now.

33. The investigators formed the belief that Dean Westbrook killed his neighbour Mrs Byrne, motivated by his belief she informed police about his cannabis crop. The evidence is clear that she did not.

34. The investigators found no other evidence linking any other person to the death of Mrs Byrne or the fire at her property.

35. I am satisfied that the above represents a summary of the circumstances surrounding the death of Rita Mary Byrne.

36. I wish to record my deepest sympathy to the family of Mrs Byrne for their loss in such traumatic and tragic circumstances.

Signature:

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Judge Jennifer Coate
State Coroner

Date: 25th February, 2010