FORM 37

Rule 60(1)

FINDING INTO DEATH WITH INQUEST

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

Court reference: 2626/08

Inquest into the Death of CRAIG WALTER STEVENS

Delivered On:	8 February 2010
Delivered At:	233 William Street Melbourne
Hearing Dates:	12 March 2009
Findings of:	JANE HENDTLASS
Representation:	Mr Kissane assisting the Coroner
	Mr Lawrie for the Chief Commissioner of Police
	Ms Greenham for C. Young, G. Stanley and D. Atkinson.

Place of death/Suspected death: Dandenong & District Hospital

FORM 37

Rule 60(1)

FINDING INTO DEATH WITH INQUEST

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

Court reference: 2626/08

In the Coroners Court of Victoria at Melbourne
I, JANE HENDTLASS, Coroner

having investigated the death of:

Details of deceased:

Surname:	STEVENS
First name:	CRAIG
Address:	1275 Thompsons Road, Cranbourne 3977

AND having held an inquest in relation to this death on 19th June, 2008
at Southbank
find that the identity of the deceased was CRAIG WALTER STEVENS
and death occurred on 19th June, 2008

at Dandenong & District Hospital, David Street, Dandenong 3175

from

1a. HYPOXIC-ISCHAEMIC BRAIN INJURY
1b. HANGING

in the following circumstances:

On 17 June 2008, Craig Stevens attempted to commit suicide by hanging in the presence of police officers, Senior Constable Cameron Young and Constable David Atkinson. After he had stopped breathing for about five minutes, he was resuscitated and transferred to the Dandenong and District Hospital. However, he had suffered irreversible hypoxic brain damage.

At 11.35am on 19 June 2008, Craig Stevens died.

The forensic pathologist who performed the autopsy formed the opinion that the cause of death was hypoxic ischaemic brain injury which was a complication arising from his hanging. No alcohol or other relevant drugs were found in ante mortem blood samples.

Accordingly, I find that Craig Stevens intentionally died from hypoxic ischaemic brain injury caused by hanging.

This Finding will now outline the background circumstances surrounding Mr Stevens's intention to die and the events of 17 June 2008. It will conclude with comments and recommendations which are intended to assist in preventing further deaths occurring in similar circumstances.

BACKGROUND

Craig Stevens was 34 years old when he died. He and his domestic partner, Kalissa Scholten, had three children. In February 2007, Mr Stevens and Ms Scholten had separated. He moved to live at 1275 Thompsons Road in Cranbourne with two boarders, Annette Allen and Peter Richards, but Ms Scholten and the children stayed in the family home at 27 Wallace Road in Cranbourne. Mr Stevens remained close to his sister, Carrun Squires. He was also involved in a personal relationship with Debbie Van Vliet and, after 16 April 2008, she stayed with him overnight about three times a week.

Mr Stevens' family and friends believed that he worked at Goldsmith Constructions in Dandenong. However, this organisation was not recorded in the telephone directory and none of his family or friends had ever been there or contacted him at work except on his mobile telephone. Therefore, the whereabouts and contact details for this organisation have not been established.

Mr Stevens' medical history included seizures, cannabis abuse and schizophrenia. In about 1998, Mr Stevens was also involved, as a passenger, in a fatal road accident near Dunolly. He never fully recovered from this incident. Mr Stevens had previously attempted to commit suicide. He also had a history of aggression when he was using cannabis. On 31 May 2007, Ms Scholten's father successfully applied for an Intervention Order after Mr Stevens assaulted him.

Medical Consultations

Mr Stevens' Medicare records indicate that his usual general practitioners in 2006 and 2007 were at Casey Medical Centre and Dr Magdy Massaud in Cranbourne.

On 13 June 2007, Mr Stevens consulted Dr Brett Ogilvie at Casey Medical Centre about his overwhelming anxiety and depression. On 20 June, Dr Ogilvie referred him to a psychologist, Ray Coates, for counselling and prescribed Zoloft (sertraline). Sertraline is prescribed for depression and anxiety.

On 1 and 21 December 2007, Mr Stevens continued to be stressed and depressed when he consulted Dr Massaud. Dr Massaud prescribed diazepam and continued to prescribe sertraline.

On 28 December 2007, Mr Stevens consulted Dr Alex Mogilevski at Casey Medical Centre with a lower left dental abscess. This consultation was not reported to Medicare and Dr Mogilevski

made no comment in his notes about Mr Stevens' mental state. There is no evidence that Mr Stevens consulted anyone at Casey Medical Centre after this appointment.

On 22 April 2008, Mr Stevens consulted Dr Massaud again. He had been off his medication for a month and was depressed but reported no suicidal ideation. Dr Massaud re-prescribed 50mg sertraline daily. Dr Massaud did not see Mr Stevens again.

Ms Van Vliet says that Mr Stevens continued to take his antidepressant medication in the week before his death. However, Ms Scholten was of the view that Mr Stevens was very erratic in his compliance with his medication and avoided taking it whenever possible. No sertraline was detcted in blood samples taken after Mr Stevens attempted suicide. Therefore, although I am unable to say whether he took sertraline after Dr Massaud prescribed it on 22 April 2008, it seems likely that he did not take his medication in the days leading up to 17 June 2008.

Mental Health Reports

At 10.09am on 30 April 2008, Ms Squires contacted the Southern Health Psychiatry Triage clinician because she believed that Mr Stevens was mentally ill. She told them she was concerned that Mr Stevens was confused, lonely and depressed. He had called his parents seven times already that day and abused them. He was using alcohol and possibly cannabis heavily, displaying verbal and physical aggression and threatening suicide regularly. He was abusive to his parents and became paranoid about Ms Squire's relationship with them. Ms Squires also said that Mr Stevens had resigned from work and was heavily in debt. His amenities were being cut off at home. However, he had extended his job for another week, and was planning to sell his motorcycle, which would relieve the financial burden.

At 1.18pm on 30 April 2008, Mr Stevens' other sister also contacted the Southern Health Psychiatry Triage clinician. She said that Mr Stevens had asked to see his children one last time and described Ms Scholten's fear for the children and that he would commit suicide.

The Psychiatry Triage clinicians provided advice to Mr Stevens' sisters and were sufficiently concerned about Mr Stevens to seek contact with him. However, his sisters were both of the opinion that he would become more suicidal if that occurred. Further, the consultant psychiatrist expressed the opinion that Mr Stevens' behaviour was not new and, therefore, they should be guided by the family's experience.

After some discussion, the Psychiatry Triage clinician agreed not to initiate contact with Mr Stevens on 30 April 2008. Instead, she registered him on the Client Management Interface (CMI), placed him on alert for one week and documented concerns about his history of aggression. She also notified the Crisis Assessment and Treatment team pending assessment and

referral. Therefore, by implication, the Psychiatry Triage clinician had formed the opinion that Mr Stevens may require further clinically significant mental health services in the next week.

On 7 May 2008, a Psychiatry Triage clinician contacted Ms Squires to check on Mr Stevens' situation. Ms Squires said he had sold his motorcycle, seemed less concerned about his financial situation and reasonably settled. However, she also said that the family remained on tenterhooks over his behaviour.

On 19 May 2008, a Psychiatry Triage clinician contacted Ms Squires to check on Mr Stevens' mental state. Ms Squires said she had seen Mr Stevens over the last week and the situation remained the same. He continued to ring the family and threaten suicide. However, Ms Squires had told him that she would contact police if he threatened to commit suicide again. The Psychiatry Triage clinician referred Ms Squires to personal support.

On 16 June 2008, Mr Stevens told Ms Scholten that he was feeling suicidal. Ms Scholten told Ms Squires about this increased risk and she went to his house to talk to him. Ms Squires says that he could not stop crying and said there was no life for him.

As Ms Squires was leaving Mr Stevens' house at about 9.30am on 16 June 2008, Mr Stevens contacted Debbie Van Vliet to invite her over to his house. He told her on the telephone that he had been crying most of the day and she later found out that he had smeared his windows with mud so that his co-residents would not know. However, from Ms Van Vliet's perspective, there was no suggestion that he was suicidal and she stayed with him overnight. At about 6.45am on 17 June 2008, Ms Van Vliet left at the same time as Mr Stevens left for work. Ms Van Vliet had no further contact with him.

Events of 17 June 2008

On 17 June 2008, Mr Stevens spoke to Ms Scholten on the phone. He was very distressed and yelling at her and said he was going to commit suicide to get peace. She rang the Psychiatry Triage clinician and was advised to ring Triple Zero.

At about 10.30am on 17 June 2008, Mr Stevens also rang his mother and abused her. After five minutes, Mrs Stevens ended the phone call. Then, using the times recorded in the Police Communications log, at 10.31am Mrs Scholten rang Triple Zero on her mobile phone and asked for police so that she could report that Mr Stevens was threatening to commit suicide. She told the police operator that she believed he was at work at Goldsmith Constructions in Dandenong. She also said that he had a history of cannabis use, attempted suicide and undiagnosed mental instability, he would be verbally aggressive towards police and had no respect for police, and that his residential address was 1275 Thompsons Road in Cranbourne.

At about 11.00am on 17 June 2008, Mr Stevens rang his father and abused him. At 11.30am on 17 June 2008, Mr Stevens also rang Ms Scholten again. He said, "That's it, I'm dead." Ms Scholten received two text messages at 11.43am and 11.47am from Mr Stevens indicating he was going to commit suicide in the next 15 minutes and he was looking forward to his last breath. Ms Scholten contacted Ms Squires and told her about Mr Stevens' threats and that she had contacted the Crisis Assessment and Treatment team. At 11.30am, Ms Squires also contacted Triple Zero.

Police Response

At 10.38am on 17 June 2008, the police operator recorded that he was unable to find a listing for Goldsmith Constructions in Dandenong. Accordingly, at 10.47am, the police communications liaison officer at the Emergency Services Telecommunications Authority (ESTA) tasked Senior Constable Cameron Young and Constable David Atkinson to speak with the complainant at 27 Wallace Road in Cranbourne to further investigate the complaint. The information that had been obtained from Ms Scholten was provided to Senior Constable Young and Constable Atkinson by way of the electronic screen on the mobile data terminal in the police car.

At 11.26am on 17 June 2008, Senior Constable Young and Constable Atkinson went to 27 Wallace Road but they could not find Ms Scholten. No one else was at home. Therefore, they decided to go to Mr Stevens' home at 1275 Thompsons Road to see if he was there or if there was someone else there who could provide them with his workplace address.

At 11.55am on 17 June 2008, Senior Constable Young and Constable Atkinson arrived at Mr Stevens' house and could see his silhouette in the rear shed. When they drove up the driveway further, they could see he was standing on a drum which had been placed on a metal chair. He had a length of rope which was tied to the rafters at one end and was formed into a noose around his neck. Ms Scholten is of the opinion that he was waiting for her to come.

At 11.58am on 17 June 2008, Constable Atkinson informed ESTA of the situation and an ambulance was despatched to the scene. Acting Sergeant Graeme Stanley was the Divisional Patrol Supervisor responsible for Cranbourne. He was not aware of the history of his crew's response to Mr Stevens' suicide threats but, when he heard the radio message, Acting Sergeant Stanley left his office to assist them. En route, when Acting Sergeant Stanley heard the situation and the distressed tone of Constable Atkinson's voice on the radio, he activated the lights and sirens on his police car so that he could travel more quickly through traffic to help his crew. At 12.06pm, he arrived at the scene.

In the meantime, Senior Constable Young and Constable Atkinson had less than ten seconds available to them to try and persuade Mr Stevens to accept their assistance. Although they had no training in how to approach a suicidal person, Senior Constable Young said that that he

thought that Mr Stevens would not act if they continued to talk to him in a calm and passive tone. Mr Stevens told them to go away but they refused.

When the police officers were two or three metres away from him, Mr Stevens kicked out the metal drum and fell so that he was in limbo with the rope tightened around his neck. Senior Constable Young and Constable Atkinson tried to support Mr Stevens to relieve the pressure on his neck but he lashed out at them until he lost consciousness and stopped breathing.

At 11.58am, Senior Constable Young took over the support of Mr Stevens while Constable Atkinson communicated further with ESTA to urgently request an ambulance because Mr Stevens had stopped breathing. Constable Atkinson then went to look for something to cut Mr Stevens down. He could not find anything suitable for the task.

After that, Constable Atkinson supported Mr Stevens as much as he could while Senior Constable Young continued to look for a cutting implement. He found a chisel in the shed but this failed to cut the rope. He then smashed a bottle and used the sharp glass to cut the rope that was suspending Mr Stevens.

Then, Senior Constable Young and Constable Atkinson placed Mr Stevens in a recovery position. They could not find a pulse but they were unable to attempt resuscitation while the ligature remained in place and they were unable to cut it with the broken bottle. There were no suitable cutting implements in the personal protection kit which is routinely carried in the boot of the police car. Other police officers who arrived on the scene were also unable to find any suitable implement to cut the rope from around Mr Stevens' neck.

At 12.10pm on 17 June 2008, an emergency ambulance arrived at 1275 Thompsons Road. The ambulance officers found Mr Stevens on the ground with the rope still tight around his neck. His neck was blue where the rope had compressed his circulation. The ambulance crew cut the rope with scissors from their equipment, commenced resuscitation efforts and called for the Mobile Intensive Care Ambulance and back up. After three or four minutes, they restored a spontaneous pulse. However, Mr Stevens had been unable to breath for more than five minutes when spontaneous respirations were restored.

At 1.17pm on 17 June 2008, Mr Stevens was transported by emergency ambulance to the Dandenong Hospital. Assessment indicated that he had suffered hypoxic brain injury and he was admitted to the Intensive Care Unit. However, his condition was irreversible and he died.

COMMENTS AND RECOMMENDATIONS

On 17 June 2008, Craig Stevens was depressed, aggressive and suicidal but he had not been drinking alcohol or using cannabis or other drugs and he had not taken his antidepressant

medication. He died after he intentionally hanged himself in the presence of police officers, Senior Constable Cameron Young and Constable David Atkinson, who were trying to help and save him. However, they did not have any cutting equipment in their personal equipment or in their vehicle. This delayed their attempts to cut the rope that suspended Mr Stevens' body. They were also remained unable to find anything that could cut the ligature around Mr Stevens' neck to allow blood flow to his brain until ambulance officers arrived with cutting equipment. By then, Mr Stevens had suffered irreversible brain damage.

I commend Senior Constable Cameron Young and Constable David Atkinson for their commitment and ingenuity in their attempts to prevent Mr Stevens' death in very difficult circumstances.

Police personal protection kit.

The Inquest heard that there is a standard issue personal protection kit in every police car. Its contents include bandages, an asthma pump, basic first aid equipment and face shields to allow safe delivery of mouth-to-mouth resuscitation. These kits are put together and maintained by the station sergeants to ensure they meet the requirements authorised by Victoria Police Policy. However, these personal protection kits do not include sharp implements which could be used against police if they were accessed by unauthorised people. Further, Victoria Police Manual 101-3 prohibits police carrying non-issue equipment such as pocket knives except where authorised by the Police Station Manager.

In the situation that faced Senior Constable Young and Constable Atkinson on 17 June 2008, an appropriate sharp instrument would have allowed them to cut the rope from the hanging point and the rope around Mr Stevens' neck more quickly and would probably have saved his life.

Acting Sergeant Graeme Stanley told the Court that cutting equipment would also be useful to police in a number of other circumstances including cutting seatbelts off injured people in road accidents. Further, ambulance officers continue to carry scissors to enable them to perform their duties and it seems to me a pair of scissors or a pocket knife is an essential component of any first aid kit. If this equipment was kept in the boot of the police car, any occupational health and safety issues for police officers would be minimised. Therefore, I am unable to accept that a complete prohibition on sharp equipment in the personal protection kit is appropriate Victoria Police Policy.

In his submission, Counsel for Victoria Police said that the contents of the container for the personal protection kits was currently under review by the Health Safety and Wellbeing Division - Human Resource Department, Victoria Police.

Accordingly, I recommend that:

RECOMMENDATION 1

Victoria Police continue to support the review currently being undertaken by their Health Safety and Wellbeing Division - Human Resource Department and take into account the facts surrounding Craig Stevens' death.

Further, I recommend:

RECOMMENDATION 2

Victoria Police include adequate strong scissors and/or other cutting equipment in the personal protection kits carried in police cars.

Signature:

Dr Jane Hendtlass
Coroner

8 February 2010

DISTRIBUTION LIST includes:

Senior Constable Cameron Young
Constable David Atkinson
Sergeant Graeme Stanley
Dr Magdie Massaud
Dr Alex Mogilevski
Consultant Psychiatrist, Southern Health Psychiatry Triage