FORM 37

Rule 60(1)

FINDING INTO DEATH WITH INQUEST

(Amended pursuant to Section 76 *Coroners Act 2008* on 8th July 2010)

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

Court reference: 4824/07

Inquest into the Death of DAVID MATHEW SMITH

Delivered On:	27 April 2010
Delivered At:	Melbourne
Hearing Dates:	1, 2, &15 April 2009
Findings of:	JANE HENDTLASS
Representation:	A/Sen.Sgt Dimsey assisting the Coroner
	Dr McCloskey for Northern Area Mental Health Region.
Place of death:	240 Gordons Road, South Morang, Victoria 3752

FORM 37

Rule 60(1)

FINDING INTO DEATH WITH INQUEST

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

Court reference: 4824/07

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

having investigated the death of:

Details of deceased:

Surname: SMITH
First name: DAVID
Address: 240 Gordons Road, South Morang 3752

AND having held an inquest in relation to this death on 1, 2 and 15 April 2009 at Melbourne find that the identity of the deceased was DAVID MATHEW SMITH
and death occurred on or about 25 November, 2007

at 240 Gordons Road, South Morang, Victoria 3752

from

1a. PLASTIC BAG ASPHYXIA

in the following circumstances:

David Mathew Smith was 32 years old when he died. He lived independently in a caravan at the rear of his parents' house at 240 Gordons Road in South Morang. Mr Smith suffered from a number of behavioural tics, was socially withdrawn and did not complete school. He told his treating medical officers that he had been diagnosed with Tourette's Syndrome when he was three or four years old and he continued to believe that he suffered from this disorder. He also said he had been diagnosed with Aspergers Syndrome and he had a past history of cannabis and amphetamine use.

However, Mr Smith did not suffer from the vocal tics that are an integral component of Tourette's Syndrome and his treating professionals and his mother doubted the accuracy of these early diagnoses. In 2007, he was professionally diagnosed with schizophrenia and chronic motor tic disorder. Mr Smith never accepted this diagnosis and he did not accept the concept of relapse. He always believed he was 'just different' from other people and he was entitled to be different. He attributed his 'different' thought processes and interests to his Tourette's syndrome.

Consistent with this history, Mr Smith seems to have always lived in a fantasy world; he was paranoid about intrusion into his private life and he was pre-occupied with philosophical and religious themes and alchemy. He was also a compulsive buyer and hoarder who spent his time on the computer and tinkering with or thinking about new things. He felt that people were

controlling him. However, Mr Smith felt strongly that he did not need to be controlled and that medication was unnecessary because he was not unwell and was not unhealthy.

Mr Smith also had a 13 year history of exposing himself and masturbating in front of children. He reported targeting children in parks and primary schools on about 50 occasions. Mr Smith's mother, Anne Smith, told the Court that he never accepted that there was anything wrong with this offensive behaviour. Mrs Smith and the rest of their family found this realisation shocking but she said:

"It's very hard to ... say something rational about something that's not rational."

When he died, Mr Smith was subject to involuntary psychiatric treatment in the community under a Community Treatment Order administered through the Whittlesea Community Mental Health Clinic. He was also subject to bail conditions which required him to report to Mill Park Police Station between 6am and 9pm every Monday, live at his current address, act on all directions made as part of his Community Treatment Order including attending at the Problem Behaviour Clinic, Forensicare, and notify the informant if the Community Treatment Order was revoked.

At about 10am on 24 November 2007, Mr Smith told his mother he was not going to Whittlesea Community Mental Health Clinic for his next injection. He said he would rather be in jail than feel like he did. Mrs Smith did not see him again.

At about 6.00pm on 26 November 2007, Mrs Smith found Mr Smith unresponsive on a bed in his caravan. There was a plastic bag over Mr Smith's head and an aerosol can labelled Lectra Clean near him. He was unable to be revived.

David Smith was identified by DNA matching as the child of Anne Smith.

The forensic pathologist who performed the autopsy formed the opinion that the cause of death was plastic bag asphyxia caused by occlusion of the upper airway by the plastic bag or the effects of irrespirable atmosphere caused by replacing the air inside the bag with carbon monoxide or the effects of volatile inhalation that is bromopropane within the gas causing cardiac rhythm disturbance. Toxicological analysis detected a blood alcohol concentration of 0.06g/100mL. Specifically, no risperidone or olanzapine was detected in Mr Smith's blood.

This Finding will review Mr Smith's medical and forensic history during late 2005, 2006 and 2007, summarise the issues raised by this history and make recommendations which are intended to improve the management of clients who are subject to concurrent involuntary mental health orders imposed under the *Mental Health Act* 1986 and criminal justice orders imposed under the *Bail Act* 1977.

Involvement of the Criminal Justice System

On 21 March 2003, Mr Smith was first charged with wilful and obscene exposure in public. On 26 July 2005, this charge was adjourned for a year without conviction on condition that he continued to see a psychologist. On 26 July 2006, the charge was struck out because he complied with these conditions.

However, overlapping with this criminal process, Mr Smith had been charged again with behaving in an offensive manner and wilful and obscene exposure in public on 17 April 2004 and

23 June 2005. He had refused to comply with community-based sentences imposed by the Heidelberg Magistrates' Court and, in the course of pre-sentence detention for these and other offences, he was also noted to exhibit psychotic symptoms.

Mr Smith did not accept that his behaviour was wrong. He refused to accept Legal Aid to assist the Magistrates' Court in dealing with his offences and usually appeared unrepresented. His mother was also unwelcome but she sat with him on many occasions.

On 25 August 2005, the Heidelberg Magistrates' Court directed Mr Smith to undergo pre-sentence assessment in relation to further charges of wilful and obscene exposure and offensive behaviour in a public place. A Forensicare report was prepared by psychologist, David Willshire. Mr Willshire considered he was at low risk of re-offending but he was unsuitable for a Community Based Order because he was unwilling to comply with the requirements of the order.

Despite this assessment, on 4 November 2005, the Heidelberg Magistrates' Court placed Mr Smith on a one year Community Based Order administered through Greensborough Community Correctional Services. On 7 November, Mr Smith kept his induction appointment with his Supervising Community Corrections Officer who told him he would be referred to the Sex Offender Program for an assessment. Mr Smith failed to attend any further supervision appointments or comply with any other conditions of his Community Based Order.

On 12 December 2005, Mr Smith was served with a summons alleging his breach of his Community Based Order but he failed to attend court as required on 20 February 2006. A Warrant was issued for his arrest. On 27 February, he was arrested and bailed under section 4 of the *Bail Act* 1977 to appear in Court on 24 April 2006. On 29 May 2006, the Heidelberg Magistrates' Court determined that Mr Smith had breached his Community Based Order and it was revoked. The Court sought a psychiatric assessment and adjourned sentencing of all matters to 2 October. However, Mr Smith was assessed as unfit to plead.

On 20 February 2007, Mr Smith was arrested and transferred to the Melbourne Remand Centre. On 23 February, the Melbourne Magistrates' Court remanded him to Thomas Embling Hospital. On 27 February, police executed the warrant and he was also charged with further similar sex offences committed between 27 February and 17 May 2006. On 11 April, he returned to Melbourne Assessment Prison until 18 June 2007 when he returned to Thomas Embling Hospital.

On 26 June 2007, he returned to court and a second pre-sentence report was ordered. Again, Mr Smith was assessed as unsuitable for a Community Based Order because he had been in custody and had been receiving treatment at Thomas Embling Hospital and was due for discharge on a Community Treatment Order. Accordingly, on 29 June 2007, Mr Smith was discharged from Thomas Embling Hospital on bail with conditions which included compliance with a Community Treatment Order and counselling from Forensicare.

Further, on 29 June 2007, a search warrant was executed on Mr Smith in his caravan. Police found the components for making explosives and he was charged with three offences relating to making and storing of explosives. Magistrates' Court records indicate that Mr Smith was further bailed under the same conditions on 13 September and 22 October 2007. His unresolved criminal matters and breach of his Community Based Order were adjourned to 5 December 2007. They remained outstanding when he died.

Involvement of Mental Health Services

During most of his life, Mr Smith had undergone frequent assessment by mental health professionals in relation to his so-called Tourette's Syndrome and associated tics but there is no record that he was diagnosed with any psychiatric condition until Dr Lester Walton assessed him in 26 September 2006.

On 20 February 2007, Mr Smith was remanded to the Melbourne Assessment Prison. On 25 February, he exhibited psychotic symptoms while he was in custody in the Melbourne Remand Centre when he attempted to hang himself in response to voices. He was transferred as an involuntary patient to Thomas Embling Hospital. His treating psychiatrists diagnosed schizophrenia, treated him with oral risperidone and placed him in isolation for fear of reprisals from other patients when they learned about his criminal history.

Mr Smith remained at Thomas Embling Hospital until 11 April 2007 when he was discharged back to the Melbourne Assessment Prison. However, he refused to take his oral risperidone and was thought to be non-compliant with the ariprazole and then olanzapine that were offered as substitute oral anti-psychotic medications. Mr Smith developed persistent psychopathology including grandiose, religious and spiritual ideas, and threats to harm his mother. There were also concerns about his propensity for future sexual offending.

On 18 June 2007, Mr Smith was assessed by Dr Viswanathan and re-admitted to Thomas Embling Hospital. There, he was also assessed by Dr Joseph Lee and managed in the Problem Behaviour Program. He was prescribed oral olanzapine. However, on 28 June, blood analysis detected 11ug/L olanzapine which is well below the steady state concentration of 42ug/L expected after once daily administration for one week. There was also no evidence of depression during his admission to Thomas Embling.

On 29 June 2007, Mr Smith was discharged from Thomas Embling Hospital on a Community Treatment Order administered by Northern Area Mental Health Service

Community Treatment Order

On 29 June 2007, Mr Smith was placed on a Community Treatment Order under section 14 of the *Mental Health Act* 1986. His consultant psychiatrist was Dr Gudivada Venkata Lakshama Raju. His treating psychiatrist was Dr Udo Kalul who was later replaced by Dr Anand Lingeswaran. His case manager was Beverley Moss. The order was administered by the Whittlesea Community Mental Health Clinic. His primary provisional diagnosis was schizophrenia and his order required compliance with the prescribed oral olanzapine regime established at Thomas Embling Hospital.

On 5 July 2007, Dr Lakshama assessed Mr Smith for the first time with his mother. Dr Lakshama was very worried about Mr Smith's poor compliance with his medication regime and associated this non-compliance with risk of relapse and re-offending. Mrs Smith also expressed concern that she could not supervise or monitor Mr Smith's compliance.

On 10 July 2007, Mr Smith was assessed by Dr Gunvant Patel as part of his pre-sentence assessment for court. Dr Patel formed the opinion that his recent offences occurred because he became increasingly disorganised and disinhibited by the acute deterioration in his mental state. Therefore, it was unlikely that a custodial disposition would have any additional deterrent effect on his risk of reoffending. These offences related to his making and storing explosives.

On 11 July 2007, Ms Moss visited Mr Smith at home. During this visit, Ms Moss asked Mrs Smith if she would take over supervision of Mr Smith's oral olanzapine medication but this plan quickly became untenable when Mr Smith admitted he had thrown his medication in the rubbish bin as soon as he was discharged from Thomas Embling Hospital. Mr Smith did not demonstrate any overt psychotic symptoms but Mrs Smith remained concerned that Mr Smith appeared unwell and was not always taking his medication. She said she reminded Mr.Smith that failure to take his medication constituted breach of his criminal justice system orders and could lead to his further imprisonment. In evidence, Mrs Smith said she based her assessment on Mr Smith's reports rather than her own observations.

Dr Lakshama responded to Mr Smith's non-compliance with taking his oral olanzapine by asking the Northern Crisis Assessment and Treatment team to visit him at home each night to supervise his medication and monitor his risk. The Crisis Assessment and Treatment team reported that Mr Smith agreed to their supervision, understood the consequences of non-compliance and complied with his medication.

Over the next four weeks, the Crisis Assessment and Treatment team reported that Mr Smith was not presenting as unwell and he denied he was at risk of re-offending but he did not agree to take his oral medication unsupervised. Ms Moss also said Mr Smith consistently presented a little more agitated or a little less agitated but overall it shifted very little throughout her work with him.

On the other hand, Dr Lakshama told the court he was concerned about Mr Smith's non-compliance and that was the reason he introduced fortnightly increasing doses of intramuscular risperidone as well as continuing oral olanzapine. In that context, Dr Lakshama continued to consider the relevance of Mr Smith's bail conditions before deciding on future action. He also considered the opportunity to form a therapeutic alliance with the clinical team when Mr Smith attended Whittlesea Community Mental Health Clinic for his injections. Dr Lakshama also said that depot risperidone was the only long acting depot antipsychotic formulation available in the market. When a patient is stabilised on depot medication, the levels in their blood stream tend to remain stable after even two weeks but by three weeks without an injection its clinical effectiveness would be starting to wear off.

After his intramuscular risperidone injections started on 16 July 2007, Dr Kalul or Dr Lingeswaran reviewed Mr Smith each week. They noted that Mr Smith expressed loss of control over his medications and wanted to revert to oral medication. However, Mr Smith refused to keep appointments at Whittlesea Community Mental Health Clinic for his injections and requests to provide serum for olanzapine analysis. There is also no record that Mr Smith's risperidone levels were assessed.

Therefore, after 6 August 2007, Ms Moss and a psychiatric nurse went to his home every fortnight to administer the injections. In a letter written after she gave oral evidence to the Inquest, Ms Moss says she felt very distressed and uncomfortable about inflicting this pressure on Mr Smith given that he was not showing any psychotic symptoms.

Further, on 4 August 2007, Ms Moss referred Mr Smith for weekly appointments with a clinical and forensic psychologist, Dr Sophie Reeves, based at the Victorian Institute of Forensic Mental Health. In Court, Dr Reeves was clear that Mr Smith's referral was from Whittlesea Community Mental Health Clinic and all her communications were with Ms Moss. She had no knowledge that he was under a legal obligation to accept counselling from Forensicare.

On 1 September 2007, Mr Smith attempted to commit suicide by placing a plastic bag over his head and securing it with a rubber band. He subsequently reported that his suicidal thoughts continued, he was worried about his future, deterioration in his tics which had become more pronounced when walking, his word finding difficulties and his odd ideas. He was also concerned about Court because he thought that the Magistrate might not believe he was making progress and feared a prison sentence might result.

On 2 September 2007, Mr Smith told his mother he had been feeling suicidal and making plans to kill himself using carbon monoxide. Mrs Smith told Ms Moss of this conversation and, although she did not notice any difference or hear him express suicidal tendencies, on 3 September Dr Lingeswaran assessed Mr Smith in the company of his mother. Mr and Mrs Smith told Dr Lingeswaran that they believed that the risperidone was causing his depression and *"pleaded with them to re-instate him on olanzapine."*

Then, on 4 September 2007, Mr Smith kept his first appointment with Dr Reeves. Dr Reeves said he talked about feeling quite hopeless about his future and was making plans to commit suicide. She interpreted these symptoms as depression and formed the view that he was still acutely distressed and vulnerable to suicide. With Mr Smith's permission, Dr Reeves informed his mother of his current level of distress and notified Ms Moss that he was a suicide risk.

In response to this information, Ms Moss referred Mr Smith for immediate psychiatric assessment and Dr Lakshama revoked Mr Smith's Community Treatment Order for the following reasons:

- Poor insight into mental illness
- Suicide risk
- Refusing to take treatment in the community
- No options to treat him in the community.

He was admitted for six days as an involuntary patient to Broadmeadows Adult Acute Inpatient Unit and his court hearing listed for 7 September 2007 was adjourned. Mr Smith felt that his admission of suicidal intentions was the reason for his involuntary admission and continuing injections. On the other hand, he blamed the risperidone for "cloudy thinking", lethargy and lowered mood. He was offered antidepressant medication but he refused and none was ordered.

By 10 September 2007, Mr Smith denied current suicidal thoughts and acknowledged that he no longer experienced delusions and hallucinations since taking his medication. He was discharged to Northern Area Mental Health on a further Community Treatment Order with continuing depot injections and a review appointment on 19 September. Further, after 4 September, Dr Reeves did not observe any significant suicide risk. However, Mr Smith continued to express his displeasure at being on medication because of the way it made him feel.

After discharge, Mr Smith's medical record indicates that the Crisis Assessment and Treatment team administered 37.5mg depot risperidone injections at between 10 and 18 day intervals until 2 November 2007 according to the Treatment Plan dated 10 September 2007. However, Mr Smith continued to refuse to attend the Clinic and Ms Moss still went with a nurse to administer the injections at home.

By 1 October 2007, Dr Reeves had become sufficiently concerned about Mr Smith's lack of insight and increasing preoccupation with pedophiliac thoughts to seek peer review of his symptoms and management. Dr Reeves was concerned not to breach Mr Smith's confidentiality

or, by implication, section 120A of the *Mental Health Act* 1986. Although she had understood that Mr Smith was a voluntary client referred by Ms Moss, she acted on their advice to obtain his consent to contact his Community Corrections Officer and his mother. However, she did not think that Mr Smith's antipsychotic medication was part of managing his risk of re-offending.

Accordingly, on 23 October 2007, Dr Reeves spoke to Ms Moss about Mr Smith's increasing risk of sexual re-offending and Ms Moss alerted her to the school which was close to Mr Smith's house. With Mr Smith's consent, Dr Reeves also attempted to contact his Community Corrections Officer because she understood that he remained subject to a Community Based Order and she was concerned about his risk of re-offending. However, her call had not been returned when Mr Smith died.

At his next appointment with Dr Reeves on 29 October 2007, Mr Smith continued to report deviant sexual fantasies but he had difficulty in identifying high risk triggers and Dr Reeves assessed his risk of re-offending as high. She also told the Court, it was not an imminent risk to a point where she would contact police in terms of a specific victim.

On 12 November 2007, Dr Reeves wrote to Ms Moss confirming Mr Smith's psychological difficulties including long-term sexual deviance (paedophilia and exhibitionism), schizotypal personality traits and Tourette's Syndrome. She also reported that he had limited insight into his difficulties and believed he did not need anti-psychotic medication. In Dr Reeve's opinion, his risk of sexual re-offending was increasing and would be likely to further increase with unsupervised contact with children, specific high risk situations, a deterioration of his mental state and disengagement with treatment services. However, this report was not sent because Dr Reeves was waiting for Mr Smith to provide written consent for its release.

Despite her specific concerns on 23 and 29 October and 12 November 2007, Dr Reeves observed in oral evidence that Mr Smith's mental state improved in the course of her nine sessions with him in terms of him not reporting suicidal ideation or suicidal thoughts or wanting to die or a suicidal plan. His mood was stable and had lifted slightly. He seemed to be talking a bit more about the future. There was no evidence of perceptual disturbance and no further evidence of depression or significant suicide risk. To her, it seemed a bit more hopeful but she was unable to say whether this change was due to his medication or his circumstances.

Serious non-compliance with depot medication

On 12 November 2007, Ms Moss and a nurse from the Crisis Assessment and Treatment team visited Mr Smith to administer his risperidone injection because he had not kept his appointment at Whittlesea Community Mental Health Clinic for over a week. Mr Smith was not home and Mrs Smith told them he would be home every other day except Wednesday. Ms Moss left a card asking him to attend at the Clinic on 13 November.

Mr Smith continued to express annoyance at having to take his medication to Dr Reeves. They also addressed issues relating to his sexual paraphilia. However, he did not keep his appointment with Ms Moss that day. She discussed his non-compliance at a Clinical Review Meeting and they agreed that she should try again on 14 November which was a Wednesday and Thursday and then contact the Crisis Assessment and Treatment team and write to the 'appropriate prison' because he was in breach of his bail. There is no evidence that Mr Smith's treatment team considered the legal implications of providing this information without his consent.

On 14 November 2007, Mr Smith was at work with his father when Ms Moss and the mental health nurse visited his home in a further attempt to administer his injection. When he was not

home, they decided they would report him to police for breach of a bail condition. Accordingly, Ms Moss unsuccessfully attempted to contact his Community Corrections Officer but there is no record that the police took active steps to respond to this report.

On 15 November 2007, Mr Smith also failed to keep his appointment with Dr Lakshmana. His mother said he would have known he would also be administered his injection and she thought he had just taken off in his car. His clinical team began to seriously consider revoking his Community Treatment Order because of his apparently deliberate non-compliance with his intramuscular injection regime. After Mr Smith refused to take his medication, Dr Lakshama also introduced an increasing dose of intramuscular (depot) risperidone to 50mg every two weeks together with continuing his oral medication. This dose was never administered and it is unclear whether Mr Smith was aware of the change.

On 15 November 2007, Dr Lakshama also imposed a Treatment Plan which required Mr Smith to attend the Whittlesea Community Mental Health Clinic fortnightly for depot injections, attend Forensicare as required for counselling and report to Mill Park Police Station as required by the Court. In cases of non-compliance, the Community Treatment Order was to be revoked and the Crisis Assessment and Treatment team were to administer the injection involuntarily.

On 16 November 2007, Ms Moss recorded in her notes:

> *"David's depot was due last week and in spite of two visits to his home, he had not been available and nor did he attend here yesterday as he indicated to his mother. David is on a CTO as part of his bail order. Epping Police are to be informed of his non-compliance. Dr Royce has requested that CAT attend to give David his depot. Inform Epping Police"*

Accordingly, Ms Moss contacted the police to try and identify the person responsible for supervising Mr Smith's bail conditions. The informant was unavailable and did not ring back.

On 19 November 2007, Mr Smith also failed to keep his appointment with the Mental Health Review Board. His involuntary status was confirmed in his absence. Ms Moss also spoke to Dr Reeves about Mr Smith's non-compliance with his Community Treatment Order, that is his failure to keep appointments for injection of his risperidone, and their consideration of its revocation. Dr Reeves had no further contact with Mr Smith.

On one hand, Mr Smith and his mother actively sought reversion to oral anti-psychotic medication because Mr Smith felt he was being victimised by the requirement for intramuscular injections. He told his mother:

> *"I'd rather be dead than on this medication"* and
> *"At least if I was in jail I wouldn't have to be on these injections."*

On the other hand, Dr Lingeswaran was not prepared to compromise on the issue and was considering revocation of his Community Treatment Order.

Ms Moss supported Mr Smith's application to return to oral medication because he was able to articulate to her his desire to have a job, a home and a partner. He also seemed to improve when he was working with his father, in hospital receiving attention and openly talking to Dr Reeves.

On 22 November 2007, Mr Smith received his last routine injection of risperidone. He and Mrs Smith also met Dr Lakshama to ask if he could change to an oral anti-psychotic medication. Mrs Smith told the Court that he was hopeful and expected that something would change that day. Dr

Lakshama recorded that Mr Smith continued to be insightless and saw no point in taking treatment and coming to the clinic. He displayed little understanding of the severity of his offences and felt his work with Dr Reeves was also unnecessary.

In that context, Dr Lakshama imposed a compromise. He said he would slowly introduce the change to oral olanzapine if Mr Smith started attending Whittlesea Mental Health Unit for his injections until his mother returned from a holiday she planned to take in January 2008. As a gesture of good will, he also gave Mr Smith a prescription for oral olanzapine wafers so that he could start taking in tandem with his risperidone injections. In the course of this meeting, Mr Smith gave no indication of clinical depression or suicidal symptoms. He was reactive, interactive and engaging during the interview.

However, Mr Smith left the meeting angry and adamant he was not continuing with the risperidone treatment and, after the meeting, Mr Smith told his mother there was no point starting the olanzapine. However, neither Ms Moss nor Mrs Smith considered he might be suicidal.

On 23 November 2007, Mr Smith told his mother that he felt awful because of his injection. Further, on 24 November, Mr Smith told his mother he was not going to Whittlesea Community Mental Health Clinic for his next injection. He said he would rather be in jail than feel like he did. Dr Lakshama explained that this was probably his own subjective reaction rather than a pharmacological response because the technology used to disperse riseridone in the preparation they used does not usually cause this reaction. However, Mrs Smith did not see Mr Smith again.

DISCUSSION AND RECOMMENDATIONS

David Smith had a long term history of chronic motor tic disorder which he believed was Tourette's syndrome. He had also been diagnosed with Asbergers Syndrome and he had a past history of cannabis and amphetamine use. As well, he had a 13 year history of sexual paraphilia. However, he was not diagnosed with schizophrenia until 2006.

In 2003, Mr Smith had been charged with wilful and obscene exposure in public. In July 2005, this charge was struck out because he complied with the counselling conditions imposed by the Court. Therefore, on its face, it seemed that Mr Smith was able to control the public aspects of his sexual paraphilia in the context of undertakings and threats imposed by the criminal justice system.

However, Mr Smith had re-offended in the interim and, as a consequence, he was placed on a Community Based Order despite his explicit refusal to comply with its conditions. As a consequence, he became aware that the criminal offences he had committed after 1 October 2004 placed him at risk of classification as a registrable sex offender under the *Sex Offenders Registration Act* 2004 with associated consequences for his living arrangements and his privacy. After this, he failed to comply with his Community Based Order and it was subsequently revoked.

Dr Sophie Reeves from Forensicare told the Court that some individuals find it incredibly distressing and confronting to be classified as a sexual offender. Mr Smith's mental health case manager also told the Court that his Community Corrections Officer told her that, in her opinion, he was not suitable for a Community Based Order.

Mr Smith never accepted his diagnosis with a mental illness and always attributed his 'different thought processes' to his Tourette's syndrome. Accordingly, Mr Smith did not accept that his

sexual paraphilia or manufacture of explosives was wrong. However, in the context of his prior refusal to comply with his Community Based Order, I am unable to say whether or to what degree Mr Smith's potential designation as a sexual offender influenced his capacity to comply with his Community Treatment Order and his bail conditions.

When Mr Smith died, he was on bail imposed by the Magistrates' Court under section 4 of the *Bail Act* 1977 for offences associated with his sexual paraphilia and manufacture of explosives as well as for breach of his Community Based Order. He was also subject to a Community Treatment Order imposed by his consultant psychiatrist under section 12 of the *Mental Health Act* 1986 and administered by the Northern Area Mental Health Service. This order had been confirmed by the Mental Health Review Board.

Mr Smith's Community Treatment Order required him to comply with his Treatment Plan which included attending Whittlesea Community Mental Health Clinic for fortnightly injections of risperidone and counselling from Dr Sophie Reeves who has specialist experience in assessing and counselling sexual offenders. Inversely, his bail conditions required compliance with the conditions of his Community Treatment Order and attendance at Forensicare.

Conflict between and confusion about the practical and legal administration of Mr Smith's bail order and his mental health involuntary treatment order by two different statutory authorities was a contributory factor in Mr Smith's death.

I Intra-muscular risperidone

Mr Smith was concrete in his belief that he did not need to take medication. In particular, he complained that the side effects of risperidone included clouded thinking, his lowered mood and his lethargy. He had also formed the view that risperidone caused his attempted suicide on 2 September 2007 and his mother had accepted his version of events. They both consistently pleaded for re-instatement of oral olanzapine.

However, there is no evidence of any direct relationship between Mr Smith's use of intramuscular risperidone and his suicidal thoughts and there are alternative explanations for all his known suicide attempts:

- Mr Smith's first known suicide attempt occurred on 23 February 2007 when he was remanded in the Melbourne Custody Centre and responded to voices urging this action. These symptoms led to his diagnosis with schizophrenia and administration of olanzapine at Thomas Embling Hospital. Therefore, from a timing perspective, the suicide attempt preceded administration of his antipsychotic medication and, in particular, his risperidone. Further, the oral anti-psychotic medication seems to have alleviated his psychoses and his suicide risk.

- Mr Smith's second suicide attempt on or about 2 September 2007 and Dr Reeves' assessment on 4 September that he was acutely distressed and vulnerable to suicide, occurred about six weeks after integration of his fortnightly intramuscular risperidone into his daily oral olanzapine anti-psychotic regime. On the other hand, Mr Smith was aware that his next Court date was 13 September 2007. He knew that the hearing fr breach of his bail associated with non-compliance with his Community Treatment Order included threat of a prison sentence. Further, the conditions imposed on his admission to Thomas Embling Hospital had alerted him to the real risks he could face in prison. Mr Smith had a mental illness but he was

not unintelligent. Therefore, these circumstances probably also have contributed to his fear of the criminal justice consequences of his pending hearings.

- Mr Smith's death on or about 25 November 2007 followed his deliberately avoiding administration of his intramuscular risperidone for three weeks until 22 November and toxicological analysis failed to detect any anti-psychotic medication after he died. Dr Lakshama told the Court that risperidone administered as a depot preparation should be detectable in serum for eight weeks although its clinical effect would begin to deteriorate after three weeks. Therefore, despite the influence of post mortem redistribution, this negative reading suggests that his risperidone injection on 22 November had not returned him to the steady state concentrations that would be expected if he had been compliant in the month prior to his death

Therefore, although the timing of Mr Smith's suicide attempt on 2 September 2007 and Dr Reeves' assessment that he was acutely distressed and vulnerable to suicide are consistent with implementation of his depot risperidone, his suicide attempt on 20 February 2007 and his death on or about 25 November 2007 cannot be attributed to the effects of risperidone.

On the contrary, Mr Smith's failure to accept his oral or intramuscular anti-psychotic medication was an underlying factor in all his known active suicidal behaviour. Other explanations of Mr Smith's suicide include environmental factors such as his fear of the consequences of his offending, his non-compliance with oral anti psychotic medication, his loss of autonomy and his inability to prevent interference in his very private domain.

II Risk assessment and management on Community Treatment Order

Mr Smith did not exhibit suicidal tendencies and he was not re-diagnosed with chronic motor tic syndrome and schizophrenia until 2006. There is no evidence that he experienced hallucinations or psychoses or that he was clinically depressed before that time. However, there is strong evidence that his first suicide attempt was associated with voices telling him how to act while he was in the Melbourne Assessment Prison. Further, failure to comply with his anti-psychotic medication was associated with his suicide attempt on 2 September 2007 and his completed suicide on or about 25 November 2007.

Mr Smith did not believe he had a mental illness and did not believe that he needed to take anti-psychotic medication. These beliefs underlay his feeling of loss of control and his non-compliance. Therefore, it was appropriate for his mental illness and his suicide risk to be managed through a Community Treatment Order.

That said, there is no evidence that Mr Smith continued to exhibit psychotic symptoms after discharge from Broadmeadows Inpatient Unit in September 2007. His mother never saw evidence of psychoses except when he was in the Melbourne Remand Centre. Dr Reeves did not see any perceptual disturbances as in hallucinations, seeing or hearing things. Ms Moss did not observe any evidence of psychotic symptoms.

Further, there is no evidence that his psychoses were associated with his paraphilic tendencies. On the contrary, Mr Smith admitted his active sexual paraphilia commenced when he was 19 years old. This was long before he was diagnosed with schizophrenia or is known to have experienced psychoses. Further, Dr Reeves was concerned about his risk of committing further sexual offences although she had no evidence of psychoses and, in her opinion, his mental state

was improving. Further, she did not think that Mr Smith's antipsychotic medication was part of managing his risk of sexual re-offending.

Similarly, Mr Smith's mother indicated that his pre-occupation with explosives pre-dated his diagnosis with schizophrenia and administration of his anti-psychotic medication. Although I am unable to say whether this tendency became more pronounced when he was psychotic and this was the reason that police searched his caravan and found explosives, there is no evidence that administration of anti-psychotic medication reduced his risk of re-offending.

Therefore, it was not necessarily appropriate to escalate administration of his medication to include involuntary administration of intramuscular anti-psychotic medication when Mr Smith refused to comply with taking oral preparations. On the contrary, Ms Moss felt very distressed and uncomfortable about inflicting pressure on Mr Smith to attend every two weeks at Whittlesea Community Mental Health Clinic and comply with depot administration of his risperidone given that he was not showing any psychotic symptoms.

Further, in my opinion, Dr Lakshama's failure to respond to Mr Smith's plea and re-trial oral anti-psychotic medication on 22 November 2007 was an important factor in determining Mr Smith's suicide.

III Influence of co-existing criminal justice and mental health orders

Mr Smith's treating team at Whittlesea Community Mental Health Clinic was acutely aware that Mr Smith was subject to criminal justice orders that related to his sexual paraphilia and pre-occupation with explosives. They were also concerned that failure to take antipsychotic medication could be associated with re-offending. For example, in her Executive Brief for the Manager of Psychiatric Services, Northern Region, the Manager of Northern Area Mental Health Service, Robyn Humphries stated this concern:

> *"The risk of Mr Smith committing further sexual offences and/or making or using explosives was considered to be very high if he ceased treatment. Hence he was on a CTO and depot medication was prescribed to assist with compliance."*

Dr Reeves also associated Mr Smith's limited insight into his difficulties and belief that he did not need anti-psychotic medication with potential for deterioration of his mental state and disengagement with treatment services with his increasing risk of sexual re-offending. However, she observed that Mr Smith's mental state improved in the course of her nine sessions with him in terms of him not reporting suicidal ideation or suicidal thoughts or wanting to die or a suicidal plan. His mood was stable and had lifted slightly. He seemed to be talking a bit more about the future. There was no evidence of perceptual disturbance. Therefore, there was no direct relationship between Dr Reeves' observations that Mr Smith was at increased risk of sexual re-offending and psychoses in 2007.

Dr Lakshama also limited his concern about Mr Smith's sexual re-offending by explaining that, although he was more likely to re-offend when he was being disorganised and more likely to act impulsively when he was ill, he knew that risk was being handled by Dr Reeves who was experienced in assessing and managing sexual offenders.

In my opinion, the mutual threat imposed on Mr Smith by the criminal justice and mental health systems created a dichotomy which also contributed to his suicide.

On one hand:

- Mr Smith did not display psychotic tendencies to any of his treating team while he was subject to a Community Treatment Order.
- There is no direct evidence that his mental state was related to his sexual offending or risk of re-offending.
- There is no evidence that risperidone was pharmacologically or positively associated with his depressive history or suicide.
- Mr Smith believed that the risperidone perpetuated his depressive symptoms. He strongly objected to being forced to submit to its administration.
- He refused to go to the Whittlesea Community Mental Health Clinic because of its association with the injections.
- He was also non-compliant with oral anti-psychotics at home.
- His refusal to take anti-depressants was respected despite expressed suicidal intention and Dr Reeves' diagnosis of depression.

On the other hand:

- On 22 November 2007, Mr Smith displayed little understanding of the severity of his offences and he felt his work with Dr Reeves was also unnecessary.
- Dr Laksama also confirmed that he was concerned about Mr Smith's risk of re-offending with explosives, given his pre-occupation with this kind of alchemy.
- Mr Smith's treating team had threatened Mr Smith with reporting his non-compliance as breach of bail to the police with the associated fear that this threat would have engendered.

Accordingly, :

- Dr Reeves obtained his consent to report her increasing concerns about Mr Smith's offending risk to his Community Corrections Officer.
- Mr Smith's treatment team considered revoking his Community Treatment Order and admitting him as an involuntary patient because he failed to comply with his medication but this only occurred in the context of his expressed suicidal plans.
- Mr Smith's case manager attempted to notify police when he failed to comply with his Community Treatment Order.

Mr Smith's bail conditions which required compliance with his Community Treatment Order imposed heavy legal obligations on the client's mental health treating team because, although Mr Smith's failure to keep appointments at Whittlesea Community Mental Health Clinic breached his bail conditions, section 120A of the *Mental Health Act* 1986 prohibits release of information by his treating team without his consent. Therefore, attempts to report his non-compliance breached their statutory obligations of client confidentiality.

Further, in the end, Mr Smith committed suicide because he did not feel able to comply with his obligations under the *Mental Health Act* 1986 and the *Bail Act* 1977. Dr Lakshama told the Court that he had experience with a few patients who are on concurrent criminal justice and mental health orders where one order implies that they have to comply with another order. He said:

"My sense is it works for some - a group of people- and it doesn't work for someone like David....
It's unfortunate. In some cases there's a kind of blurring in the role of what the treating team does and what the justice system or Corrections Officer should be doing and I'm of the strong belief that no matter what the person's background or the person's past is, when they come for treatment, I treat them and ... I just try and advocate as much as I can but also get them to follow whatever their social responsibilities are... so my sense has been not to sort of become a Corrections Officer."

In my opinion, Mr Smith's treating team was inappropriately influenced by his perceived propensity for further sexual offending if he failed to take his anti-psychotic medication and the consequential breach of his bail conditions if he failed to comply with his Community Treatment Order. Accordingly, they imposed rigorous compliance with anti-psychotic medication despite no evidence of further psychotic symptoms. Further, despite the confidentiality provisions of the *Mental Health Act* 1986, they attempted to report him to police and Community Corrections for failure to comply.

Consequently, Mr Smith felt forced to continue to comply with the intramuscular injections imposed by the Treatment Plan made pursuant to his Community Treatment Order. He believed that non-compliance was impossible without breaching his bail. He told his mother:

"I'd rather be dead than on this medication" and
"At least if I was in jail I wouldn't have to be on these injections."

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

RECOMMENDATION 1

The Attorney General and the Minister for Mental Health consider the therapeutic appropriateness and the legal implications of imposing bail conditions which require compliance with a Community Treatment Order.

Alternatively,

RECOMMENDATION 2

The Attorney General refer consideration of appropriate bail conditions for offenders subject to involuntary mental health orders to the Law Reform Commission for their consideration.

Signature:

Dr Jane Hendtlass
Coroner
8th July 2010

Coroners Court of Victoria

DISTRIBUTION LIST includes:
Attorney General
Minister for Mental Health