REDACTED FINDING INTO DEATH WITH INQUEST

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

Court reference: 1279/02

THIS FINDING IS SUBJECT TO A SUPPRESSION ORDER PURSUANT TO SECTION 58 *CORONERS ACT 1985*

In the Coroners Court of Victoria at Melbourne

I, AUDREY JAMIESON, Coroner

having investigated the death of:

Details of deceased:

Mr X (name suppressed)

AND having held an inquest in relation to this death on the 11th to 13th September 2007 at Southbank

find that the identity of the deceased was Mr X

and death occurred on 1 May 2002 in a suburb located on the Mornington Peninsula

from:
1a. MULTIPLE LARGE INCISED DEFECTS TO THE HEAD AND SINGLE STAB WOUND TO THE CHEST

in the following circumstances:

Mr X died at the hands of his son Mr A, who was at the time on a Community Treatment Order supervised by Peninsula Health Mental Health Services. MR A was charged with his father's murder.

On 19 April 2004, in the Supreme Court of Victoria before Honourable Justice Teague and a jury, the charges against Mr A proceeded as a consent on the grounds of mental impairment. The jury returned a verdict of not guilty on the grounds of mental impairment. His Honour ordered that Mr A was liable to a custodial supervision order form a nominal term of 25 years. He ordered Mr A be remanded in custody until a bed at Thomas Embling Hospital became available.

On 7 May 2004, Mr A was transferred to Thomas Embling Hospital.

Section 17(1) *Coroners Act 1985* prescribes that a coroner must hold an inquest if she/he suspects a homicide. Section 17(3) of the Act provides a discretion to a coroner to dispense with a mandatory inquest in certain circumstances, including where a person has been charged with the offence of murder, manslaughter or defensive homicide and is subsequently found guilty, acquitted or not guilty of the offence.

Mrs B, the mother of Mr A and wife of Mr X, raised concerns about the standard of supervision provided to Mr A by his mental health team. Mrs B questioned whether her husband's death was preventable.

Section 17(3) was not utilised. Having regard to the matters raised by Mrs B, section 17(2) was also applicable – I considered it *desirable* to explore the issues further.

JURISDICTION – Section 19(1) *Coroners Act 1985*

A coroner is required to find, if possible, the identity of the deceased, how the death occurred, the cause of death and the particulars needed to register the death – the place and date of death. For the purposes of distinguishing 'how death occurred' from the 'cause of death' , the practice is to refer to the latter as the *medical cause of death* and the former as the *context* in which the death occurred or the *background circumstances* and *surrounding circumstances.*

In discharging their statutory duties, a coroner may also comment on any matter connected with the death including public heath or safety, report to the Attorney-General on the death and make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety, or the administration of justice.

On 1 November 2009, the *Coroners Act 2008* (the new Act) became operational. The provisions of the new Act effect this matter in respect of the recording and publication of the finding and provision and responses to recommendations.

BACKGROUND CIRCUMSTANCES

Mr X was born in 28 September 1949. He was 53 years of age at the time of his death. Mr X married Mrs B in 1974 and the couple had two children. They separated in June 1999 and in August 2001 Mr X moved to a suburb on the Mornington Peninsula. Mr A moved into his father's home soon after and both continued living there until Mr X's death.

Background information on Mr A

In 1993, Mr A discontinued his secondary education before completing Year 12. He also moved out of home during the same year after his father found marijuana in his bedroom. Between 1993 and 1997, Mr A lived predominantly with his grandfather. Thereafter he moved in and out of his parents' home until 1998 when a confrontation over his use of drugs again led to Mr A moving out. Mr A's use of illicit drugs escalated to heroin and intravenous amphetamines.

Mr A's use of illicit drugs over a number of years correlates with a developing history of mental ill health. His first contact with mental health services occurred in August 1997, after he demonstrated violence towards his grandfather and parents after taking an excessive amount of prescription medications. The Crisis Assessment Treatment Team (CATT) refused to attend at Mrs B's request due to the report of violence. Mr A was detained by police and later attempted to hang himself whilst in a police cell. He

was transferred to Frankston Hospital for observation and psychiatric assessment and released on the grounds that he only required drug counselling. The assessment of the drug counsellor was to the contrary.

Over the following years, Mr A was admitted as an involuntary psychiatric patient on a number occasions. He was diagnosed with schizophreniform paranoia. On 26 June 2001, he was admitted to the Peninsula Health psychiatric inpatient unit following the revocation of a Community Based Order (CBO). He was discharged on 3 July 2001 on a Community Treatment Order (CTO). He returned to the Mornington Peninsula suburb to live with Mr X. In October 2001, Mr A and Mr X had a physical altercation on a background of Mr A drinking alcohol.

Mr A remained on a CTO supervised by Peninsula Health Mental Health Services (PHMHS) up to the time of the killing of his father. Between 19 July 2001 and 18 April 2002, Ms Renae Lisle, psychologist, was Mr A's continuing care case manager. In December 2001, Mr A made sexually inappropriate remarks towards Ms Lisle during a home visit.

Mr A also had a criminal history. In 1994 he received two CBOs. One CBO related to offences of Hinder Police and Behave in a Riotous Manner Whilst Drunk, and the other for offences of Criminal Damage and Unlawful Assault. Mr A met all the requirements of these CBOs.

On 26 September 2001, Mr A received a further 12 month CBO for the offences of Wilful and Obscene Exposure in Public. During the supervision period Mr A breached the CBO when on 5 November 2005, he committed an Assault with a Weapon – Namely an Axe. He was charged with these offences and bailed to appear at the Magistrate's Court on 13 December 2001.
Community Correctional Services intended proceeding with a consolidation of the further offences and the breach of the CBO on that date, however, Mr A was granted an adjournment until 17 January 2002. Subsequent adjournments were granted on 17 January 2002 and 28 February 2002, with a return date of 17 April 2002.

On 17 March 2002, Mr A reported to the Community Correctional Services (CCS) manager, Rae Lacey, that he had been charged with further offences including criminal damage and possessing a prescribed weapon.

On 17 April 2002, at a Magistrate's Court, Ms Lacey attempted to encourage Mr A, through his legal representative and his father Mr X, to have the matters dealt with, *due to concerns in respect to Mr A's escalating offending.*
The matters were however adjourned until 9 May 2002.

IMMEDIATE SURROUNDING CIRCUMSTANCES:

On 11 April 202, Ms Lisle received a telephone call from Mr X reporting that Mr A had been up all night, talking to the television.

Later that day, Ms Lisle was present at a scheduled appointment for Mr A with Dr Ross Kirkman, Consultant Psychiatrist. Mr A was guarded but denied psychotic experiences. No changes were made to his medication. Later Ms Lisle received a

telephone call from Mrs B expressing extreme concern that Mr A was still living with Mr X when it had been previously reported by both her and Mr X about the stress that Mr A's behaviour was placing on Mr X.

Mrs B was effectively describing a crisis situation. Ms Lisle communicated this conversation to her supervisor, Ursula Paton, who subsequently met with Mrs B on 19 April 2002.

On 18 April 2002, Ms Lisle met with Mr A and Mr X at the Roesbud Clinic of Peninsula Community Mental Health Service, situated at Rosebud Hospital. The appointment had been scheduled to address accommodation issues. Ms Lisle met with Mr X alone while they waited for Mr A to arrive. They discussed Mr X's *difficulty with coping with Mr A's behaviour and explored accommodation options that be available.* Mr X indicated that although he would like Mr A to move out in the next month, urgent placement elsewhere was not necessary.

Ms Lisle then spoke to Mr A alone about alternative accommodation. *He was not angry about the decision and acknowledged that his father was under stress.* Ms Lisle then spoke to Mr A about his telephone conversation with his mother, Mrs B, on 11 April 2002 and Mrs B's concern that he was experiencing psychotic symptoms. Mr A was guarded in his response but made admissions of hearing voices telling him what to do including, at times, to self harm. He reported that he had been hearing these voices since his discharge from hospital in July 2001. He *denied suicidal ideation, thoughts of harming others, and denied being at risk of acting on (sic) the voices.*

Ms Lisle conducted a mental state examination and requested Dr Kirkman to join the interview to explore the reported symptoms. In the presence of Dr Kirkman, Mr A remained guarded about his responses. He was inconsistent in explaining what he had experienced but denied hearing voices and denied psychotic symptoms.

Ms Lisle and Dr Kirkman conferred after the interview with Mr A concluded, and planned to discuss Mr A's situation at the multidisciplinary team meeting on 22 April 2002, monitor his mental state at least weekly and discuss further whether depot medication should be reintroduced.

Ms Lisle finished her employment with PHMHS on 25 April 2002.

On 25 April 2002, Mr X attended a meeting with Mr A and his new case manager Pettie Tsoudis. Mr X advised Ms Tsoudis that he had found a bent spoon in Mr A's room and suspected that it had been used for administering drugs. He also told Ms Tsoudis that Mr A had been talking to the devil. Mr A denied this.

On 29 or 30 April 2002, Mr A purchased an axe from a hardware store on the Mornington Peninsula.

On 30 April 2002, Mr X contacted Ms Tsoudis at the Peninsula Community Health Service advising her that Mr A had been talking to the television during the night and that he had been covering the mirrors in the house so as not to see the devil. An appointment was in place for Mr A to see Ms Tsoudis and Dr Kirkman on 2 May 2002.

On 1 May 2002, between 6.30pm -6.45pm, Mr X was dropped off at his home by a friend.

At 9.44pm, Mr A purchased three cans of beer from a nearby hotel. The cans of beer were placed in a black plastic bag. Mr A was riding a bicycle when he departed the hotel. His movements at the hotel were captured in surveillance video.

At approximately 9.53pm, Mr A attended at a neighbour's house, requesting assistance stating that his father had fallen over. The neighbour attended Mr X's house and found Mr X lying immediately inside the front door of the house, covered in blood. The neighbour contacted emergency services.

Attending paramedics found Mr X to be deceased.

Attending police commenced an investigation. Mr A was conveyed to the Victoria Police Homicide Squad and interviewed. He was later released from custody. His CTO was revoked and he was admitted as an involuntary patient, initially to Frankston Hospital and subsequently transferred to Thomas Embling Hospital.

A search of the area between Mr X's house and the hotel where Mr A had purchased his beer by police and SES personnel, located a blood stained axe in a vacant lot, approximately 800 meters from Mr X's home.

Members of the Homicide Squad spoke to Mrs B, who advised them of Mr A's history of mental ill health including periods of hospitalisation and management under Community Treatment Orders. She communicated her concerns about his irrational behaviour including hearing voices and arguing with imaginary people on the television.

On 9 May 2002, Mr A was arrested and charged with Mr X's murder.

INVESTIGATION:

The identity of Mr X and the date and place of his death were without dispute and required no additional formal coronial investigation.

The medical investigation:

On 2 May 2002, at 3pm, Dr Malcolm Dodd, Forensic Pathologist, at the Victorian Institute of Forensic Medicine, performed an autopsy. Dr Dodd found no significant naturally occurring disease or evidence or defensive type injuries. The cause of death was attributed to a multiple large incised injuries to the head *(in keeping with a blow from a tomahawk, machete or small axe)* and a single stab would to the chest.

Toxicological analysis of body fluids detected alcohol in the blood and vitreous humour at a concentration of 0.07 and 0.08 gram/100ml respectively. The benzodiazpines Diazepam and its metabolite Nordiazepam were also detected.

The police investigation:

The inquest brief was prepared by Detective Senior Constable Keven Gale.

THE INQUEST:

Suppression Order:

An application for a suppression was made by Mr Best on behalf of Mr A. Mrs B supported the application.

The application was accepted. Pursuant to section 58 *Coroners Act 1985* the following orders were made:

Until further order of the Court, no corporation body or person shall publish or cause to be published or broadcast by any means of radio, television, electronically or other means, any matters that might directly or indirectly enable:

1. *Identification of Mr A in these proceedings*
2. *Identification of the current or former place of residence of Mr A*
3. *Identification of the current place of work or study of Mr A*

The purpose of this public hearing was to explore the management of the supervision of Mr A by his mental health team in the period leading up to the killing of his father.

The issues identified as requiring further exploration related to the adequacy of the supervision of Mr A's CTO by PHMHS, including whether the mental health service failed to respond to and/or act upon Mr X and Mrs B's notifications of concerns and instances of non-compliance, and failed to revoke Mr A's CTO in the face of their knowledge of instances of non-compliance. Logically arising from these issues is whether anything could have been done differently by PHMHS in its mental health management of Mr A that may have prevented Mr X's death.

CONCLUDING COMMENTS:

The death of Mr X is indeed a tragedy – killed at the hands of his son who suffered from complex mental ill health and who also exhibited anti-social behaviours. His treatment and supervision were complicated by his illicit substance abuse.

The combination of mental ill health, anti-social behaviours and substance abuse is not uncommon, yet there are few facilities that are equipped to accommodate and adequately treat the complex needs of these people. Substance abuse problems are often attributed to "psychotic-like symptoms" rather than symptoms being classified as "true psychotic symptoms".
The former would not of itself justify the invoking of coercive implications for the patient such as the reintroduction of depot (medication) and/or the revocation of a CTO. The history of Mr A's illness over the nine months leading up to the killing of his father has some identifiable features.

The mental health clinicians can only accommodate the needs of their patients/clients within the system. The lack of multi-complex mental ill health facilities is not within their control. The call for additional mental health services *per se* comes from families whose loved ones are affected by mental ill health and clinicians practicing in the field.

The Coroners Prevention Unit (CPU) has identified a series of recommendations made by coroners over the past five years calling for a coordinated and systemic approach to the treatment of persons with a range of complex mental and other related health problems. These recommendations have been directed to a number of organisations, which include the Office of Chief Psychiatrist, public hospitals and adult mental health services.

I find that **Mr X** died from multiple incised wounds to the head and a single stab wound to the chest, which were inflicted by his son Mr A. This is a two-fold tragedy for this family.

I further find that the management of Mr A on a Community Treatment Order by Peninsula Health Mental Health Service was reasonable and appropriate and did not contribute to the circumstances of Mr X's death, however, Mr A's clinical course may have been managed differently if there had been an option open to the clinicians to accommodate him where his substance abuse "psychotic-like symptoms" and "true psychotic symptoms" could have been holistically managed.

RECOMMENDATION:

I acknowledge and refer to recommendations previously made by other coroners however, **I recommend** that a working group be established and chaired by the Department of Health, to prepare a report to the Coroners Court of Victoria within one calendar year. The purpose of this report is to identify any barriers to a coordinated and systemic approach to treatment of persons with complex mental and other related health problems and any areas of system reform to overcome these barriers in Victoria.

And pursuant to section 73(1) Coroners Act 2008, I order that this redacted Finding be published on the Internet consistent with the intention of the Notice of Suppression Order dated 11 September 2007.

DISTRIBUTION OF FINDINGS:

- Mrs B
- Dr Ruth Vine, Chief Psychiatrist Department of Health
- Peninsula Health Mental Health Services
- Victoria Legal Aid
- Corrections Victoria
- The Hon. Lisa Neville, MP Minister for Mental Health, Minister for Senior Victorians, Minister for Community Services

Signature:

AUDREY JAMIESON
CORONER
Date: 13 August 2010