IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2017 0485

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)
Section 67 of the Coroners Act 2008

Findings of:	**CAITLIN ENGLISH, DEPUTY STATE CORONER**
Deceased:	**AISHA DEVI BECK**
Date of birth:	1 June 1977
Date of death:	29 January 2017
Cause of death:	I(a) Gunshot wound to the head
Place of death:	2 Ashkanasy Avenue, Pascoe Vale, Victoria

TABLE OF CONTENTS

HER HONOUR:

BACKGROUND

1. Mrs Aisha Devi Beck **(Mrs Beck)** was born in Myanmar on 1 June 1977. She was 39 years old at the time of the fatal incident.

2. Mrs Beck met Mr Beck around 2005 and at the time Mr Beck was living in Singapore and travelling back and forth to Myanmar.[1] Mrs Beck arrived in Australia to live with Mr Beck in April 2006 and they were married in June 2006.[2]

3. After several years of trying to conceive, Mr and Mrs Beck utilised an invitro-fertilisation program to conceive a child and Aziza was born in the Royal Children's Hospital on 27 April 2013.[3]

4. On 10 September 2015, police were contacted following reports that Mrs Beck had been approaching neighbours' houses with Aziza and asking to speak with Mr Tony Abbott.[4] Upon police attendance, Mrs Beck stated that "*she was 'the mother Mary'* and she had, "*just given birth to Jesus"* and requested that "*Tony Abbott*" and "*the Norwegian Embassy*" be called.[5] Mrs Beck was then transported by police to Northern Health for assessment and was made subject to a Temporary Treatment Order.[6]

5. Following an inpatient stay at North Western Mental Health, the Temporary Treatment Order was revoked on 14 September 2015 and Mrs Beck was released from hospital with agreement that she would undertake treatment in the community.[7]

6. Upon discharge from hospital, Mrs Beck regularly attended Centreway Medical Centre, where she continued to receive prescriptions for olanzapine (an anti-psychotic medication). During these appointments, Mrs Beck was noted to have experienced periods of distress, where she worried about her neighbours, prayed a lot and felt that god was "*ready to take her*".[8]

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[1] *Coronial Brief*, Statement of Mohamed Beck dated 20 February 2017, 1-2
[2] Ibid
[3] Maternal Child Health records provided to the Court dated 29 January 2018
[4] Mental health records provided by Northern Health, 120-122
[5] Ibid
[6] Ibid, 15
[7] Ibid, 15-16
[8] *Coronial Brief*, Centreway Medical Centre correspondence dated 14 June 2017, 83-84

7. In a statement provided by Mr Beck, he noted that at an unknown date in 2016, Mrs Beck had expressed thoughts of killing him, Aziza and herself. Mr Beck stated that during this conversation, Mrs Beck communicated that:

> *"...she was very scared for Aziza and would question why we had her. She would say that she would have to take Aziza with her as no-one would care for her...she would worry that Aziza could not take care of herself if something happened to her".*[9]

8. On 29 February 2016, following a disclosure of suicidal ideation to her general practitioner (**GP**), Mrs Beck was referred to a psychiatrist.[10] A report from this psychiatrist indicates that Mrs Beck described experiencing thought disorder, homicidal and suicidal ideation with thoughts of killing both her daughter and herself.[11]

9. In late 2016, Mrs Beck received a letter from Centrelink advising that she had defrauded them of $23,000. Mr Beck reported that this accusation caused Mrs Beck to experience significant distress and "*really got her down*".[12]

10. Mrs Leanne Devenney, a neighbour of Mrs and Mr Beck, stated that Mrs Beck had disclosed her mental health issues to Mrs Devenney sometime after her hospitalisation in 2015. On one occasion, Mrs Devenney reported that Ms Beck had expressed suicidal ideation, noting that if she killed herself, she would have to kill Aziza due to concerns for her welfare in her absence.[13]

11. Mr Beck noted that in the weeks prior to the fatal incident, Mrs Beck had been "*having those thoughts again*"[14] and the evidence suggests that Mrs Beck was experiencing a resurgence of her suicidal ideation.

12. On 23 January 2017, Mr Beck returned to work following a seven-month absence taken in an effort to provide Mrs Beck with support with her mental health issues. Mr Beck advised that his return to work caused concern for Mrs Beck, as Mrs Beck would be required to leave the house to retrieve Aziza from Kindergarten. During this period, Mrs Beck also advised Mr Beck that she had ceased taking her medication but "*felt fine*".[15] Mr Beck also reported that Mrs Beck would vary her dosage without getting advice from her doctor.[16]

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[9] *Coronial Brief*, Statement of Mohamed Beck dated 20 February 2017, 2-6
[10] *Coronial Brief*, Centreway Medical Centre Medical Records, 91
[11] *Coronial Brief*, Letter from Dr. Roger Chau, Consultant Psychiatrist to Dr Geok Ng dated 31 March 2016, 102
[12] *Coronial Brief*, Statement of Mohamed Beck dated 20 February 2017, 3-4
[13] *Coronial Brief*, Statement of Leanne Devenney dated 29 January 2017, 13
[14] *Coronial Brief*, Statement of Mohamed Beck dated 20 February 2017, 4
[15] *Coronial Brief*, Statement of Mohamed Beck dated 20 February 2017, 3-4
[16] Ibid

THE PURPOSE OF A CORONIAL INVESTIGATION

13. Mrs Beck's death constituted a '*reportable death*' under the *Coroners Act 2008* (Vic) (**the Act**), as the death occurred in Victoria and was violent, unexpected and not from natural causes.[17]

14. The jurisdiction of the Coroners Court of Victoria is inquisitorial.[18] The Act provides for a system whereby reportable deaths are independently investigated to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which the death occurred.[19]

15. It is not the role of the coroner to lay or apportion blame, but to establish the facts.[20] It is also not the coroner's role to determine criminal or civil liability arising from the death under investigation,[21] or to determine disciplinary matters.

16. The expression "*cause of death*" refers to the medical cause of death, incorporating where possible, the mode or mechanism of death.

17. For coronial purposes, the phrase "*circumstances in which death occurred*,"[22] refers to the context or background and surrounding circumstances of the death. Rather than being a consideration of all circumstances which might form part of a narrative culminating in the death, it is confined to those circumstances which are sufficiently proximate and causally relevant to the death.

18. The broader purpose of coronial investigations is to contribute to a reduction in the number of preventable deaths, both through the observations made in the investigation findings and by the making of recommendations by coroners. This is generally referred to as the Court's "*prevention*" role.

19. Coroners are also empowered:

    (a) to report to the Attorney-General on a death;[23]

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[17] Section 4 Coroners Act 2008
[18] Section 89(4) Coroners Act 2008
[19] See Preamble and s 67, *Coroners Act 2008*
[20] *Keown v Khan* (1999) 1 VR 69
[21] Section 69 (1)
[22] Section 67(1)(c)
[23] Section 72(1)

(b) to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice;[24] and

(c) to 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.[25] These powers are the vehicles by which the prevention role may be advanced.

20. All coronial findings must be made based on proof of relevant facts on the balance of probabilities.[26] In determining these matters, I am guided by the principles enunciated in *Briginshaw* v *Briginshaw*.[27] The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about individuals, unless the evidence provides a comfortable level of satisfaction that they caused or contributed to the death.

21. In conducting this investigation and completing this finding, I have taken into account the evidence in the coronial brief, as well as the additional statements made by Dr Chau, Dr Ng and Dr Mian. With respect to potential prevention opportunities and potential recommendations, I also sought a submission from the Royal Australian College of General Practitioners regarding the appropriateness of assertive follow up with patients by General Practitioners (GP's).

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Identity of the Deceased, pursuant to section 67(1)(a) of the Act

22. Upon reviewing the available evidence, Coroner Rosemary Carlin completed a Form 8 *Determination by Coroner of Identity of Deceased* dated 30 January 2017, concluding that the identity of the deceased was Aisha Devi Beck born 1 June 1977.

23. Identity is not in dispute in this matter and requires no further investigation.

Medical cause of death, pursuant to section 67(1)(b) of the Act

24. On 30 January 2017, Dr Noel Woodford, a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, conducted an autopsy upon the deceased's body. Dr Woodford provided a written report, dated 25 April 2017, which concluded that Mrs Beck died from a gunshot injury to the head.

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[24] Section 67(3)
[25] Section 72(2)
[26] Re State Coroner; ex parte Minister for Health (2009) 261 ALR 152
[27] (1938) 60 CLR 336

25. A full toxicological analysis was negative for common poisons but Olanzapine was detected in postmortem blood specimens at a concentration of 0.1 mg/L.[28]

26. Dr Woodford commented that:

(a) the entrance wound was within the mouth and the projectile passed upwards and posteriorly, with no significant lateral deviation. There was an associated exit wound over the top of the head, posteriorly in the midline;

(b) examination of the roof of the mouth and the buccal contents suggest a close-range injury with features in keeping with a single self-inflicted gunshot wound;

(c) there was no significant natural disease that may have caused or contributed to Mrs Beck's death.

27. I accept the cause of death proposed by Dr Woodford.

Circumstances in which the death occurred, pursuant to section 67(1)(c) of the Act

50. On 29 January 2017, at approximately 8.15am, Mr Beck left the family home to attend work.[29] Mrs Beck was awake prior to Mr Beck departing and made him some lunch to take to work. Aziza was awake and playing at the time Mr Beck left the residence.[30]

51. At approximately 1.30pm, Mrs Devenney heard a loud "*bang*" nearby and a second loud "*bang*" was heard soon after the first one. Mrs Devenney did not investigate the noise further as she believed that the noise could have originated from her neighbour down the street who was doing renovation work.[31]

52. At approximately 5.30pm, Mr Beck returned home from work.[32] He found the front door and flyscreen unlocked and thought this was unusual as both were usually locked. Mr Beck entered the house and noticed that it was unusually quiet and strange that Aziza did not come running to greet him as usual.[33]

53. Mr Beck observed Aziza to be lying on a mattress on the floor and Mrs Beck lying next to the mattress in the main lounge room. As Mr Beck approached the two, he noticed the serious

[28] Olanzapine is indicated for the treatment of schizophrenia and related psychoses. It can also be used for mood stabilization and as an anti-manic drug. Therapeutic post mortem concentrations range up to approximately 0.5 mg/L.
[29] *Coronial Brief*, Statement of Mohamed Beck dated 20 February 2017, 4
[30] Ibid
[31] *Coronial Brief*, Statement of Leanne Devenney dated 29 January 2017, 12
[32] *Coronial Brief*, Statement of Mohamed Beck dated 20 February 2017, 5
[33] Ibid

injuries inflicted to the head of Aziza and the firearm lying next to Mrs Beck. Mr Beck then ran outside the family home and screamed for help.[34]

54. Mrs Devenney and her husband came to Mr Beck's aid and Mrs Devenney went inside Mr Beck's home and found both Aziza and Mrs Beck lying in the lounge room seriously injured. Mrs Devenney told her husband what happened and asked him to call emergency services.[35]

55. Police members and paramedics attended at approximately 5:40pm.[36] Paramedics observed that both Aziza and Mrs Beck had sustained clear injuries that were incompatible with life and were pronounced deceased shortly after.[37]

56. The police investigation established that Mrs Beck had been suffering from a mental illness, as well as being isolated and concerned about the family finances.

57. The summary on the coronial brief stated: '*All available evidence indicates that during the day of Sunday 29 January 2017 Aisha Beck made the decision to end her life. This decision also meant, for Aisha, that she would have to take the life of her daughter as she felt that Aziza would not be able to be cared for if she wasn't there.*'

58. Mrs Beck has had access to means as, unbeknownst to her husband, she was aware of the location of keys to his gun safe.

59. The police investigation concluded '*During the investigation there has been no evidence uncovered to indicate that any other person has played a part in the death of Aisha and Aziza Beck.*' [38]

60. I accept the conclusions of the coroner's investigator that no other third party was involved in the deaths of Aziza and Aisha Beck.

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[34] Ibid
[35] *Coronial Brief*, Statement of Leanne Devenney dated 29 January 2017, 13; Statement of Brian Devenney dated 29 January 2017, 18
[36] *Coronial Brief*, Statement of Craig Hazelwood dated 2 May 2017, 25
[37] Ibid
[38] *Coronial Brief, Summary* 5-6.

COMMENTS PURSUANT TO SECTION 67(3) OF THE ACT

Family Violence risk factors

61. The unexpected, unnatural and violent death of a person is a devastating event. It is important to recognise that violence perpetrated by an intimate family member is particularly shocking, given the family unit is expected to be a place of trust, safety and protection.

62. For the purposes of the *Family Violence Protection Act 2008* (**the Act**), the relationship between Mrs Beck and Aziza clearly fell within the definition of '*family member*'[39] under that Act. Moreover, Mrs Beck's actions by shooting Aziza and causing her death constitutes '*family violence.*'[40]

63. Considering Aziza's death occurred under circumstances of family violence, I requested that the Coroners' Prevention Unit (**CPU**)[41] examine the circumstances of Aziza's death as part of the Victorian Systemic Review of Family Violence Deaths (**VSRFVD**).[42]

64. I note that filicide generally refers to the murder of a child greater than 12 months of age by a parent.[43] Whilst filicides are rare, they have significant and far reaching impacts on those involved and the broader community. Filicide statistics indicate that this phenomenon affects female and male children equally[44], whilst younger children were found to be at greater risk of fatal harm from their mothers and older children at greater fatal risk from their fathers.[45]

65. The available statistics on filicide further evidence that the majority of victims of filicide are aged below six years of age which demonstrates "*that the risk of a child being killed decreased with age*".[46] Whilst maternal infanticides have been identified as more common

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[39] Family Violence Protection Act 2008, section 8(1)(d)
[40] Family Violence Protection Act 2008, section 5(1)(a)(i)
[41] The Coroners Prevention Unit is a specialist service for Coroners established to strengthen their prevention role and provide them with professional assistance on issues pertaining to public health and safety
[42] The VSRFVD provides assistance to Victorian Coroners to examine the circumstances in which family violence deaths occur. In addition the VSRFVD collects and analyses information on family violence-related deaths. Together this information assists with the identification of systemic prevention-focused recommendations aimed at reducing the incidence of family violence in the Victorian Community
[43] Bourget, Dominique, Jennifer Grace, and Laurie Whitehurst. "A review of maternal and paternal filicide." *Journal-American Academy of Psychiatry and the Law* 35, no. 1 (2007): 74. 'Infanticide' is the offence of homicide of a child under 12 months of age by a parent.
[44] Ciani, A. S. C., & Fontanesi, L. (2012). Mothers who kill their offspring: testing evolutionary hypothesis in a 110-case Italian sample. *Child abuse & neglect*, *36*(6), 519-527
[45] Debowska, A., Boduszek, D., & Dhingra, K. (2015). Victim, perpetrator, and offense characteristics in filicide and filicide–suicide. *Aggression and violent behavior*, *21*, 113-124
[46] Debowska, A., Boduszek, D., & Dhingra, K. (2015). Victim, perpetrator, and offense characteristics in filicide and filicide–suicide. *Aggression and violent behavior*, *21*, 113-124

than paternal perpetrated infanticides, gender differences in rates of filicides have not yet been found.[47]

66. I confirm that research has identified characteristics specific to women who have committed filicide and which may place a child at greater risk of being killed.[48] Moreover, studies have reported that a sense of social isolation and lack of social support, as well as heightened levels of stress, are factors associated with a greater risk of maternal filicide.[49]

67. The available evidence suggests that Mrs Beck had no friends or family in Australia and thus had no support network available to her. On occasion Mrs Beck did make contact with her neighbour, Mrs Devenney, but this contact was limited due to Mrs Beck's concerns that she was imposing on her neighbour.[50] Mr Beck also reported that Mrs Beck did not know how to use an ATM and did not possess a driver's licence, having failed her learners permit test on four occasions.[51] As a result, Mrs Beck was reliant on Mr Beck for transport and was rarely seen to leave the house without him.[52] These factors meant that Mrs Beck faced barriers to her independence, which were likely to have contributed to Mrs Beck's sense social isolation and lack of support network in Australia.

68. Altruistic filicides are characterised by the parent's desire to protect relieve or shield a child from real or imagined suffering or harm and studies have identified this motivation as being most common among maternal perpetrated filicides.[53] Filicide research indicates that mothers are most commonly motivated to kill their child out of a misguided belief that they are preventing or ending suffering. This is also evident in regard to filicide-suicides undertaken by mothers. A study undertaken by researchers into filicide found that maternal filicide-suicide was also most often altruistically motivated, with some mothers choosing to end their child's life prior to their own in the belief that the child will suffer without them.[54]

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[47] Bourget, Dominique, Jennifer Grace, and Laurie Whitehurst. "A review of maternal and paternal filicide." *Journal-American Academy of Psychiatry and the Law* 35, no. 1 (2007): 74

[48] Ibid

[49] McKee, G. R., & Shea, S. J. (1998). Maternal filicide: a cross-national comparison. *Journal of clinical psychology*, *54*(5), 679-687

[50] *Coronial Brief*, Statement of Mohamed Beck dated 20 February 2017, 3; Statement of Leanne Devenney dated 29 January 2017, 12

[51] *Coronial Brief*, Statement of Mohamed Beck dated 20 February 2017, 3

[52] Ibid

[53] Walklate, Sandra, and Stephanie Petrie. "Witnessing the pain of suffering: Exploring the relationship between media representations, public understandings and policy responses to filicide-suicide." *Crime, media, culture* 9, no. 3 (2013): 265-279

[54] Léveillée, Suzanne, Jacques D. Marleau, and Myriam Dubé. "Filicide: A comparison by sex and presence or absence of self-destructive behavior." *Journal of Family Violence* 22, no. 5 (2007): 287-295.

69. The available evidence suggests that Mrs Beck strongly believed that Aziza would not be cared for if she was no longer alive and believed that her only option to prevent this was to end her daughter's life also. In statements provided to the Court, both Mr Beck and Mrs Devenney advised that Mrs Beck had made comments that she would have to take her daughter "*with her*" if she was to end her life as she held concerns for the child's welfare if she were to die.[55]

Mrs Beck's mental health treatment

70. Mental illness has also been highlighted as a significant contributor to maternal filicide, with mothers who commonly experienced depression or psychosis prior to or during the fatal incident.[56] One particular filicide study found that 67 per cent of mothers who had committed filicide were psychotic, and reported that depression and schizophrenia/psychosis were most commonly diagnosed among mothers who had committed filicide.[57] Women with psychiatric disturbances or depression, were also found to be more likely to suicide after killing their child.

71. Mrs Beck arrived in Australia in 2006 and had been raised in Myanmar.[58] During her childhood, Mrs Beck discovered her mother hanging following her suicide and had then unsuccessfully attempted to release her. A letter from her treating psychiatrist to her GP indicated that this experience had caused significant ongoing post traumatic symptoms for Mrs Beck.[59]

72. Exposure to suicide and/or suicide bereavement has long been identified as a risk factor for suicide. [60]

73. Mrs Beck is believed to have experienced her first episode of psychosis in 2015, resulting in a compulsory admission to Broadmeadows Inpatient Psychiatric Unit (BIPU) from 11 to 14 September 2015.[61] Her psychotic symptoms quickly resolved with a low dose antipsychotic

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[55] *Coronial Brief*, Statement of Mohamed Beck dated 20 February 2017, 4; Statement of Leanne Devenney dated 29 January 2017, 12

[56] Krischer, M. K., Stone, M. H., Sevecke, K., & Steinmeyer, E. M. (2007). Motives for maternal filicide: Results from a study with female forensic patients. *International journal of law and psychiatry*, *30*(3), 191-200.

[57] Resnick, P. J. (1969). Child murder by parents: a psychiatric review of filicide. *American Journal of Psychiatry*, *126*(3), 325-334.

[58] *Coronial Brief*, Statement of Mohamed Beck dated 20 February 2017, 2

[59] *Coronial Brief*, Letter from Dr. Roger Chau, Consultant Psychiatrist to Dr Geok Ng dated 31 March 2016, 102

[60] The ripple effect: understanding the exposure and impact of suicide in Australia, Suicide Prevention Australia, 2016, 7

[61] *Coronial Brief*, Statement of Dr Vinay Lakra dated 17 August 2017, 161

(olanzapine 5 mg) and she was diagnosed with Brief Psychotic Disorder – abrupt onset.[62] Due to her positive response to treatment and improved mental state, Mrs Beck was made a voluntary patient and discharged from BIPU. Mrs Beck was advised to continue taking antipsychotic medication for one year and to follow-up with her GP, Dr Ng.[63]

74. On 29 February 2016, Mrs Beck experienced a relapse of her psychotic symptoms and presented to her GP, reporting suicidal thoughts. In response, Dr Ng increased Mrs Beck's olanzapine dose to 15 mg and made an urgent referral for a review with a private psychiatrist, Dr Chau.[64]

75. Dr Chau conducted an assessment on 31 March 2016, with Mrs Beck and her husband present. At the time of assessment, Mrs Beck reported compliance with her increased dose of olanzapine, and advised that her psychotic symptoms and homicidal and suicidal ideation had resolved.[65] Dr Chau considered that her homicidal and suicidal ideation were a symptom of her psychosis, and he believed her psychosis was appropriately controlled by the medication. Mrs Beck was described as having insight into her psychosis.

76. In his statement Dr Chau states that after giving Mrs Beck a prescription with five repeats for Zyprexa (Olanzapine) wafer 15 mg, '*Mrs Beck was advised to see Dr Ng for follow up.*' [66] Further, Dr Chau states '*The prescription had five repeats on it and I instructed that she must obtain further prescriptions from Dr Ng before the prescription ran out.*'[67]

77. Dr Chau provided a letter to Dr Ng with the following management advice:

> *In view of her homicide and suicidal thoughts, I strongly suggest that she must not lower the dosage of Zyprexa [olanzapine] below 15mg daily and certainly should never stop taking anti-psychotic medications.*[68]

78. The management plan provided by Dr Chau contained important information about Mrs Beck's need to take antipsychotic medication and the risks associated with non-compliance; however, it does not address social or psychological aspects of mental health.

79. The Royal Australian and New Zealand College of Psychiatrists (**RANZCP**) Referred Patient Assessment and Management Plan Guidelines state that a management plan involves;

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[62] Ibid
[63] Ibid
[64] *Coronial Brief,* Centreway Medical Centre Medical Records, 91
[65] *Coronial Brief*, Letter from Dr. Roger Chau, Consultant Psychiatrist to Dr Geok Ng dated 31 March 2016, 98-99
[66] *Coronial Brief*, 305
[67] Coronial Brief, 307
[68] Ibid

education, medication recommendations, psychotherapy, social measures, other non-medication measures (e.g. diet, exercise), indications for re-referral, and longer-term management.[69]

80. Given the recent diagnosis, frequent non-compliance with medication, social vulnerabilities and risk of suicidal and homicidal ideation if she were to relapse, Mrs Beck would have benefitted from a more detailed management plan. I note that no recommendations were given on strategies to promote medication compliance nor any advice on what Dr Ng should do if Mrs Beck were continually non-compliant with medication. Additionally, Dr Chau did not provide a description of the warning signs of a deteriorating mental state, or of an appropriate crisis plan should Mrs Beck's suicidal and homicidal ideation return. There were also no suggestions on how frequently Dr Ng should have contact with Mrs Beck or instructions for when Dr Ng should consider a re-referral to Dr Chau or a public mental health service.

81. It appears Dr Chau regarded the referral as a one-off assessment for opinion and management. In his letter to Dr Ng he does not specifically say he is handing back Mrs Beck's care to him. Further, Dr Chau acknowledged, '*In my letter to the referring doctor, I should have written in more detail (sic) fashion about my communication with the deceased and her husband after the assessment.*' [70]

82. Dr Chau stated:

'By 31 March 2016, when she presented to me, Mrs Beck's mental condition was under control with anti-psychotic medication. I then strongly emphasized to the couple that Mrs Beck must take her anti-psychotic medication regularly and in no circumstance to reduce the dosage or stopped (sic) taking anti-psychotic medication without close supervision by mental health professionals.

If Mr Beck observed any signs or symptoms that suggested recurrence of psychotic breakdown despite taking anti-psychotic medication, Mr Beck must take Mrs Beck to hospital for in-patient treatment.

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[69] Available online at: https://www.ranzcp.org/files/resources/college_statements/practice_guidelines/referred_patient_assessment_and_management_guideli.aspx

[70] *Coronial Brief*, 332

From my clinical experience, psychosis can recur even when patients are taking their anti-psychotic medications regularly.' [71]

83. When asked whether he developed a plan to support Mrs Beck's compliance with medication Dr Chau stated:

'*The advice of taking anti-psychotic regularly was given in the presence of both Mr & Mrs Beck. This in itself is a powerful strategy in enhancing compliance. Mr Beck, being the principal carer of Mrs Beck, would remind Mrs Beck to take her anti-psychotic medication. Mr Beck would be the first person to detect recurrence of Mrs Beck's psychotic condition.*' [72]

84. The evidence is somewhat inconsistent. Dr Ng's understanding of the referral appears to differ from Dr Chau's. In his statement, Dr Ng refers to his referral of Mrs Beck to Dr Chau on 29 March 2016 as lasting for multiple and necessary consultations for a twelve-month period. [73] Further, in his statement he appeared to believe that Mrs Beck would continue to attend a psychiatrist. However, he appeared to take a role in Mrs Beck's continuing mental health care as on 12 April 2016 he wrote a prescription for olanzapine with five repeats.

85. Dr Ng indicated that when he assessed Mrs Beck on 10 October 2015, 6 November 2015 and 17 December 2015 he advised about the importance of continuing medication and if there was deterioration, Mrs Beck should attend public hospital emergency at Epping or Broadmeadows Mental Health Unit. On 29 February 2016 when Mrs Beck had a flare up, he urgently referred her to Dr Chau. He last saw her on 20 June 2016 when she was fully stabilised. As Mrs Beck was considering a further pregnancy, Dr Ng referred her to another psychiatrist Dr Datta, regarding the '*safety of medication in pregnancy as well as monitoring and treating her psychosis...Hence she had two psychiatrists provided for her as support services.*' [74]

86. The evidence is unclear as to which doctor was responsible for Mrs Beck's continued psychiatric management.

87. The available evidence suggests that responsibility was placed on Mr Beck to monitor his wife's mental state and medication compliance.[75] Mr Beck reported that six months prior to her death, Mrs Beck began adjusting her medication dose without medical advice; sometimes

[71] *Coronial Brief*, Letter from Dr Roger Chau dated 11 February 2018, 309
[72] *Coronial Brief*, Letter from Dr Roger Chau dated 11 February 2018, 310
[73] *Coronial Brief*, Statement of Dr G H Ng dated 1 February 2018, 339
[74] *Coronial Brief*, Letter from Dr G H Ng dated 1 February 2018, 340
[75] *Coronial Brief*, Letter from Dr Roger Chau dated 11 February 2018, 309

decreasing and sometimes increasing.[76] Mr Beck advised that in the weeks prior to her death Mrs Beck was *"having those thoughts again"* and he advised her to increase her medication.[77] Although Dr Chau and Dr Ng state they impressed on both Mr and Mrs Beck the importance of the medication compliance, it appears Mr Beck did not appreciate the risks of Mrs Beck reducing her medication or becoming non-compliant, or what to do in response to her non-compliance.

88. In this case it was justifiable for Dr Chau to refer Mrs Beck back to her GP for management as she was reportedly compliant with her medication, stabilised on an increased dose of antipsychotic medication, and no longer reporting or evidencing psychotic symptoms. Unfortunately, his referral of care back to Dr Ng was not clearly communicated to Dr Ng in his letter dated 31 March 2016 and the management plan provided was brief and focussed only on prescribing medication. Clearer communication and a more comprehensive management plan may have assisted Dr Ng in being more proactive in providing ongoing treatment and management of Mrs Beck's significant mental health issues and associated risks.

89. The last known contact Mrs Beck had with a health practitioner was on 19 December 2016.[78] Mrs Beck presented to GP, Dr Afshan Mian, informing that her that her usual GP was not available and requesting a prescription for olanzapine. Mrs Beck provided Dr Mian with incorrect information advising that she was prescribed olanzapine for depression.[79] Dr Mian provided Mrs Beck with a single 28-day script for 15mg olanzapine. No repeats were given. Olanzapine is an atypical anti-psychotic therapeutically indicated for the treatment of psychotic disorders or Bipolar disorder. It can be prescribed off label as an adjunct pharmacotherapy for depression if other first line antidepressants have been unsuccessful.[80]

90. Given the unusual prescribing of olanzapine for depression, it would have been appropriate for Dr Mian to better understand the nature of Mrs Beck's mental health issues. According to the Department of Health and Human Services, medical practitioners are not to prescribe a Schedule 4 medication merely because another prescriber has done so and must take reasonable steps to ensure that a therapeutic need exists.[81]

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[76] *Coronial Brief*, Statement of Mohamed Beck dated 20 February 2017, 3
[77] Ibid, 4
[78] *Coronial Brief,* Letter from Dr Afshan Mian dated 18 March 2018, 321
[79] Ibid
[80] Royal Australian and New Zealand College of Psychiatrists clinical practice guidelines for mood disorders. Australian and New Zealand Journal of Psychiatry 2015, 49(12), pg 1-185.
[81] https://www2.health.vic.gov.au/public-health/drugs-and-poisons/medical-practitioners/legislation-permits

91. There is no indication in the medical records or correspondence from Dr Mian that she enquired about Mrs Beck's mood or mental state on 19 December 2016. This appears to be a missed opportunity to identify Mrs Beck's declining mental state or possible suicidal/homicidal ideation; however, it is not possible to draw a direct causal link between the lack of mental state assessment and Mrs Beck's death nearly six weeks later. Dr Mian was not Mrs Beck's usual doctor, and from the information provided to her, believed Mrs Beck was appropriately engaged with another GP and required the medication until Mrs Beck could be seen by her regular GP.[82] I accept Dr Mian acted in the utmost good faith believing Mrs Beck to be under the continuing care of her treating practitioner who was on leave over the Christmas/New Year period.

92. Dr Chau gave Mrs Beck a prescription containing five repeats on 31 March 2016. On 12 April 2016 Dr Ng provided Mrs Beck with a prescription containing five repeats. On 19 December 2016 Dr Mian provided her with a script for 28 days. The Pharmaceutical Benefits Scheme, (PBS) records indicate Mrs Beck regularly attended Friendly Pharmacy to collect her prescribed medication, namely, 24 March 2016, 4 April 2016, 5 May 2016, 18 May 2016, 17 June 2016, 20 July 2016, 30 August 2016, 7 October 2016, 21 October 2016 14 November 2016, 10 January 2017. It appears Mrs Beck never filled the script provided by Dr Mian. Therefore, Mrs Beck had access to 364 days of 15 mg olanzapine doses and last attended the pharmacy on 10 January 2017, meaning she should have had olanzapine available at the time of her death.

93. Medication compliance is a constant challenge to health professionals and a recognised public health issue. It is particularly common in individuals with psychotic disorders and this is attributed to factors such as forgetfulness, poor insight and the negative side effects of antipsychotic medications. There is a limited evidence base for strategies to promote medication compliance and the consensus is that strategies need to be tailored to the individual. Available options to promote medication compliance in patients include; a strong therapeutic alliance, psychoeducation, motivational interviewing and cognitive-behavioural therapy, involving family members, and utilising environmental or technological supports.

94. Mrs Beck's postmortem toxicology indicated the presence of olanzapine at a level of 0.1 mg/L. This is consistent with ingestion of the drug itself. It is not possible to speculate on the amount of the dose consumed, it could be consistent with 15 mg. Olanzapine is unstable postmortem. It has a long half-life and it may be that Mrs Beck has taken the olanzapine a few

[82] *Coronial Brief,* Letter from Dr Afshan Mian dated 18 March 2018, 321-322

days prior or close to the time of her death. The efficacy of anti-psychotic medication is dependent upon the regularity of dosage and needs to be taken regularly at the appropriate dose.[83]

95. Mr Beck stated that in recent times (prior to her death) Mrs Beck had been well. '*In the last couple of weeks Aisha said to me she was having those thoughts again. I said to up her medication and to call me. She would always worry and at times express thoughts of suicide, but nothing I was overly concerned about.*' [84]

96. During his last contact with Mrs Beck, Dr Ng had no immediate concerns regarding her mental state or level of risk, and patients have the right to disengage with health practitioners as they choose. Mrs Beck was referred to another psychiatrist which she chose not to follow up. There is no obligation on GPs to follow-up with patients in such circumstances. The management plan from Dr Chau did not provide Dr Ng with guidance regarding the frequency with which Mrs Beck should be seen. This case however highlights the importance of more assertive measures in managing patients with mental health conditions and proactive monitoring of their use of psychotropic medication.

97. That said, in this case it appears Mrs Beck did have sufficient scripts for olanzapine which she filled regularly at a pharmacy. The toxicology results at the time of her death confirm she had recently taken olanzapine, although the dosage is unknown it could have been 15 mg.

98. I am unable to determine whether Mrs Beck was fully compliant with her medication regime at the time of her and Aisha's death. I note Dr Chau indicated that psychosis can recur even when patients are taking their anti-psychotic medications regularly.

99. I am satisfied Mrs Beck killed Aziza and took her own life whilst in the midst of a psychotic episode.

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[83] Email from Associate Professor Dimitri Gerostamoulos, Head, Forensic Sciences & Chief Toxicologist, Forensic Services, VIFM, dated 4 May 2021

[84] *Coronial Brief*, Statement of Mohamed Beck dated 20 February 2017, 22

RECOMMENDATIONS PURSUANT TO SECTION 72(2) OF THE ACT

Improvements to General Practitioner's patient management

100. It is not uncommon for GPs to be the only support and treatment provider for people with mental health issues. According to the Royal Australian College of General Practitioners (**RACGP**), mental health is the most common health issue managed by GPs.[85]

101. In circumstances where GPs are treating patients who have mental health issues and are identified as being high risk of harm to themselves and/or others, there ought to be more assertive follow-up if such patients disengage from treatment and/or are non-compliant with medication. The current model of care does not encourage or facilitate assertive follow-up by GPs if a patient ceases to attend appointments. I confirm that the prevention opportunity in this case appears to be enhancing the ability of GPs to provide assertive mental health care.

102. As such, I **recommend** that the RACGP consider issuing or updating practice guidelines to GPs treating patients who are prescribed psychotropic medication to incorporate a flag or alert in their patient management software systems to prompt a follow-up for patients who require a repeat script or mental health review.

Improvements to the Medicare system to support GPs treating patients with mental health conditions

103. Research indicates that almost half (45%) of the adult population in Australia will experience a mental health issue in their lifetime, with one in five people experiencing a mental illness in any given year. Mental health is particularly prevalent in populations such as Aboriginal and Torres Strait Islander people, youth in remote areas and low socioeconomic areas.[86] It is therefore unsurprising that mental health is the most common reason patients visit their GP.[87]

104. The RACGP confirms that GPs are usually the first port of call for people seeking help with a mental illness. Patients with undiagnosed mental illness often present to their GP with physical symptoms – and determining the underlying mental health issues takes time.

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[85] Royal Australian College of General Practitioners. General Practice: Health of the Nation 2018. Found at https://www.racgp.org.au/FSDEDEV/media/documents/Special%20events/Health-of-the-Nation-2018-Report.pdf

[86] Miller I, Camargo CA, Arias SA, et al. Suicide prevention in an emergency department population: The ED-SAFE Study. *JAMA Psychiatry.* 2017;74(6):563–570

[87] Australian Commission on Safety and Quality in Health Care. Safety and Quality Improvement Guide Standard 6: Clinical Handover (October 2012). Sydney: ACSQHC, 2012. Available at www.safetyandquality.gov.au/sites/default/files/migrated/Standard6_Oct_2012_WEB.pdf

However, the Medicare system does not support mental health consultations lasting more than 40 minutes.

105. Research indicates that GPs have managed and continue to manage a breadth and complexity of mental health issues in their patients. Australians collectively visited their GP for mental health issues approximately 18 million times in 2015–16.[88] However, Medicare data indicates that only 3.2 million Medicare-subsidised mental health specific GP services were provided.[89] The RACGP note that this inconsistency could be that GPs are billing an item 44 (Level D) consultation (a consultation lasting more than 40 minutes) instead of the designated mental health item numbers.

106. I confirm that Mental health services need to be supported by Medicare. Item numbers need to reflect the complexity of the services provided by GPs, including the time taken to assess and diagnose our patients; create a health plan and coordinate care; liaise with other health providers; and complete the paperwork and reporting.

I endorse RACGP proposals to introduce additional Medicare item numbers to ensure payments to GPs accurately reflect the complexity and length of services provided to their patients with mental health conditions. I **recommend** that the Australian Government consider the RACGP proposals to change to the Medicare system to add a specific item number for longer sessions for patients with mental health conditions and funding for telehealth consultations for patients who have been prescribed psychotropic medication

FINDINGS AND CONCLUSION

89. Having investigated the death, without holding an inquest, I make the following findings pursuant to section 67(1) of the Act:

a) the identity of the deceased was Aisha Beck, born 1 June 1977;

b) the death occurred on 29 January 2017 at 2 Ashkanasy Avenue, Pascoe Vale, Victoria, from a gunshot wound to the head; and

c) the death occurred in the circumstances described above.

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[88] Australian Institute of Health and Welfare. Mental health services in Australia. Canberra: AIHW, 2018. Available at https://www.aihw.gov.au/reports-data/health-welfare-services/mental-health-services/overview

[89] Ibid

90. I convey my sincerest sympathy to Mrs Beck's family.

91. I direct that a copy of this finding be provided to the following for their information:

(a) Detective Senior Constable Paul Alexander Kelso, Coroner's Investigator, Victoria Police;

(b) Dr Roger Chau, Consultant Psychiatrist;

(c) Dr Afshan Mian, Medical Practitioner;

(d) Mr John Arranga, Ball + Partners;

(e) Dr Geoffrey Geok Hua Ng, Medical Practitioner; and

(f) Ms Caroline Touhey, Avant Law.

92. I direct that a copy of this finding be provided to the following for their action:

(a) Dr Anita Munoz, Victorian Chair, Royal Australian College of General Practitioners; and

(b) The Honourable Linda Reynolds, Minister for Government Services, Services Australia, Australian Government.

Signature:

CAITLIN ENGLISH
DEPUTY STATE CORONER
Date: 5 May 2021