IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2018 2681

FINDING INTO DEATH WITHOUT INQUEST

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

Findings of:	**MR JOHN OLLE, CORONER**
Deceased:	**BRENDON CRIPPEN**
Date of birth:	**11 NOVEMBER 1990**
Date of death:	**6 JUNE 2018**
Cause of death:	**1(A) EFFECTS OF FIRE**
Place of death:	**TEAL POINT, VICTORIA 3579**

INTRODUCTION

1. Brendon Crippen was the second child of Brett Crippen and Sharon Gackenheimer. Brendon had an older sister Brianna and a younger sister Caitlyn.

2. Brendon's mother Sharon described Brendon as a happy child. He was also described as a smart and independent adult who largely kept to himself.

3. When Brendon was two years old, his parents separated. Brendon stayed primarily with Sharon and although he continued to spend time with Brett, it was for short periods of time due to Brett suffering from alcoholism.

4. When Brendon was six years old, he witnessed his older sister Brianna die after being struck by a car on their way to school. He was close to Brianna in both age and relationship and did not receive any counselling after Brianna died.

5. Sharon met her current partner Paul Shaw in 1997 when Brendon was seven years old. Sharon and Paul have five children together. Sharon believed Brendon became more isolated when she met Paul and had children with him.

6. When Brendon was 14 years old, Brett took his own life. Sharon believes Brendon was angry and let down by Brett's death, and suffered from depression after his death. Brendon did not receive counselling after Brett died.

7. In 2008, the family moved to Teal Point, Victoria where they owned and ran a dairy farm. The move to the farm affected Brendon as he was leaving the school and friends he liked. Brendon eventually moved out of the farm in 2009 and spent the next few years living and working in New Zealand (NZ), Tasmania and Victoria.

8. Brendon was first diagnosed with psychosis schizophreniform in July 2017 and was later diagnosed with schizophrenia and schizoaffective disorder. Brendon had intermittent contact with mental health services in NZ, Tasmania, and Victoria from 2017 onwards. He absconded from a psychiatry unit in Tasmania shortly prior to his death.

9. On 6 June 2018, Brendon died from the effects of fire. At the time of his death, Brendon was 27 years old and was living at Teal Point, Victoria with Sharon, Paul and their five children.

THE CORONIAL INVESTIGATION

10. Brendon's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (the Act). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.

11. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

12. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

13. The Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Brendon's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

14. This finding draws on the totality of the coronial investigation into the death of Brendon, including evidence contained in the coronial brief. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities. [1]

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

Identity of the deceased

15. On 7 June 2018, Mr Brendon Crippen, born 11 November 1990, was identified using circumstantial evidence, dental record comparison and a statement of visual identification by his stepfather, Paul Shaw.

16. Identity is not in dispute and requires no further investigation.

[1] Subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. 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 as to those matters taking into account the consequences of such findings or comments.

Medical cause of death

17. Forensic Pathologist Dr Khamis Almazrooei from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an autopsy on 8 June 2018 and provided a written report of his findings dated 24 September 2018.

18. The autopsy revealed extensive thermal injury of 90% of the body surface area and evidence of sooty material present within trachea and bronchi. Dr Almazrooei noted that carbon monoxide and hydrogen cyanide were not detected which suggested that Brendon's death occurred rapidly. Aside from the effects of fire, no other injuries were identified that might have contributed to Brendon's death.

19. Toxicological analysis of post-mortem samples did not identify the presence of any alcohol or any commons drugs or poisons.

20. Dr Almazrooei provided an opinion that the medical cause of death was 'Effects of Fire'.

21. I accept Dr Almazrooei's opinion.

Circumstances in which the death occurred

22. On 13 April 2018, Brendon absconded from the Acute Psychiatry Unit at the Royal Hobert Hospital in Tasmania where he was subject to a treatment order. Upon his subsequent return to Victoria, Sharon noticed his mental health was deteriorating. Brendon was not as physically active as previous visits, was very quiet, spoke uncharacteristically slowly and would sit on the couch and stare into space for hours.

23. On 4 June 2018 Brendon entered Sharon and Paul's bedroom and asked if he could sleep in their bed. It appeared to Sharon that he wished to sleep in her bed like a small child and she told him to go back to his own bed.

24. On 5 June 2018, Brendon had a conversation with Sharon and Paul in which he asked about their plans for the farm and advised them to speak with his younger sister Caitlyn more often. During this conversation, Sharon spoke to Brendon about attending the Barham Medical Clinic for treatment for his mental illness. After Brendon agreed to attend the clinic, Sharon booked an appointment on 7 June 2018. On the same night, Brendon hugged Sharon twice which she considered unusual.

25. At approximately 6:07am on 6 June 2018, Paul rose out of bed and walked into the lounge room. He observed Brendon standing in front of the wood heater with both of his hands behind his back as if warming them. Paul noticed that the fire was almost extinguished. He also observed a candle burning in a round glass container approximately two feet away from Brendon on the floor of the lounge room. Paul retrieved a piece of wood and returned to the lounge room to place the wood in the heater. Brendon was still standing in the lounge room at this point.

26. Approximately thirty minutes later, Sharon commenced getting ready for the day when she heard their dog barking outside. She looked outside the window and saw their machinery and storage shed on fire. She yelled for Paul, who ran outside towards the southern part of the machinery shed to retrieve the tractor they had recently purchased. At this point, he could not see inside the burning section of the shed due to the smoke and early time of day.

27. Sharon ran inside the house to locate Brendon. She returned outside when she could not find him and picked up a hose to douse the flames. While she was doing this, she saw Brendon inside the burning section of the shed. He appeared to be cradling a bale of hay.

28. Upon hearing Sharon's screams, Paul ran towards Brendon, slid to the ground to shield himself from the flames, and looped a blue hay baling twine around Brendon's left arm. He began sliding backwards pulling Brendon out through the shed.

29. Sharon called 000 and was advised to commence Cardiopulmonary Resuscitation (CPR) on Brendon. However, it was evident to Paul that Brendon had died. His body was still, lifeless, and covered with severe burns.

30. Paramedics arrived at the scene and Brendon was pronounced deceased at 7.15am.

BACKGROUND OF CARE

31. Brendon lived in Tasmania, NZ and Victoria in the five years leading up to his death. Information was gathered from medical services that were in contact with Brendon during this period to understand his diagnosis, care and treatment leading up to his death.

<u>New Zealand</u>

32. Brendon travelled to NZ in 2013 where he lived for approximately four years. On 18 July 2017, the Nelson Marlborough District Health Board ("the Nelson Health Board") was notified of Brendon's behaviour by the staff of the backpackers in which Brendon lived. They

reported Brendon exhibited odd behaviour, such as staring off into space, not communicating, crying, laughing, and not eating for days at a time.

33. On 18 July 2017, Brendon was admitted under the NZ *Mental Health (Compulsory Assessment and Treatment) Act 1992* (NZ MHA). On admission, Brendon presented as psychotic, thought disordered and catatonic. He was diagnosed with psychosis schizophreniform.[2]

34. On 8 August 2017 Brendon was released from compulsory assessment under the NZ MHA. He was discharged and referred to Early Intervention Services for monitoring until his return to Australia Brendon was assessed at this time as stable and compliant with his medications.

35. In October 2017, Brendon returned to Victoria to live with Sharon and Paul and their five children. After working on the farm for two months, he travelled to Tasmania where his paternal grandparents lived.

Tasmania

36. In Tasmania, Brendon began work picking strawberries and resided intermittently at a caravan park in the Huon Valley ("the caravan park"). The manager of the caravan park noted Brendon's deteriorating mental state and contacted the Royal Hobart Hospital (RHH) Crisis Assessment Triage and Treatment (CATT) team.

37. On 18 January 2018, Brendon was admitted to the RHH Acute Psychiatric Unit where he was assessed and diagnosed with schizophrenia and made subject to a treatment order under the Tasmanian *Mental Health Act 2013* ("the Tasmanian MHA"). The RHH obtained extensive information from the Nelson Health Board and Brendon's immediate and extended family.

38. Brendon was discharged on 1 February 2018 and was referred to the Hobart and Southern Adult Community Mental Health Team (CMHT) for follow up. He stayed at the caravan park for two weeks. However, after leaving the caravan park and returning with no food or clothing, CATT were notified, and staff attended the caravan park with medication for Brendon. During this period, there were several team reviews about how to engage with Brendon and regular contact was made with his family and GP during this period. Repeated efforts were made by CHMT and CATT to contact Brendon however he was often difficult to reach.

[2] Schizophreniform disorder is characterized by the presence of the symptoms of schizophrenia but is distinguished from schizophrenia by its shorter duration, which is at least 1 month but less than 6 months. It can include delusions, hallucinations, disorganized speech, and disorganized or catatonic behaviour.

39. On 9 April 2018, Brendon was readmitted to the RHH Acute Psychiatric Unit due to his deterioration and failure to comply with a treatment order under the Tasmanian MHA, including non-compliance with oral antipsychotics and failure to attend appointments with a community psychiatrist. Brendon was deemed at risk of absconding and of further relapse due to non-compliance and lack of insight and capacity.

40. On 13 April 2018, the Tasmanian Mental Health Tribunal met and upheld Brendon's treatment order which was current until 29 April 2018. Brendon absconded from the RHH Acute Psychiatric Unit approximately two hours after the treatment order was upheld. He did not appear to have any medications with him. Tasmanian Police and the Tasmanian Mental Health Tribunal were notified he was absent without leave (AWOL).

41. Brendon telephoned the RHH the evening he absconded and told them he was safe in a hostel. The nurse on duty asked him to return to the ward, but he declined stating he did not want to be locked up or medicated. Upon further encouragement from the nurse, he stated he might return that night.

42. There is no reference in the medical records suggesting that Tasmanian Police were informed that Brendon had called the RHH and was likely staying in a hostel. Medical records also suggest that Brendon's family were not contacted following his abscondment.

43. On 15 April 2018, RHH Consultant Psychiatrist Dr Anil Rao planned to discharge Brendon because he had been AWOL for 48 hours. On the same day, a clinician at RHH telephoned Brendon who said he was in Melbourne and did not intend to return to Tasmania. Brendon appeared reluctant to give an address however stated his grandparents' address in Ringwood North, Victoria. He informed the clinician that he did not have a community psychiatrist or case manager. His diagnosis at this time was recorded as schizoaffective disorder.[3] There are no records suggesting Brendon's family were informed about the decision to discharge Brendon.

44. On 15 April 2018, a clinician at RHH sent a fax to the CHMT and Tasmanian Mental Health Service Helpline informing them Brendon was in Victoria.

45. On 20 April 2018, Acting Clinical Leader of CMHT contacted the Eastern Health Community Adult Mental Health Program ("Eastern Health") and faxed the transfer of care form, progress

[3] Schizoaffective disorder is a combination of the symptoms of schizophrenia and a mood disorder. The main types of associated mood disorder include bipolar, and unipolar. Diagnosis is only made over several illness cycles and can be difficult because the symptoms of schizoaffective disorder are so similar to that of schizophrenia and bipolar disorder. Essentially, the person will experience depressed moods, psychotic symptoms, and/or symptoms of mania.

reports and Brendon's medication charts while he was an inpatient at the RHH. The fax also contained a Tasmanian MHA Failure to Comply notice and the Tasmanian Mental Health Tribunal treatment order. The covering letter stated it was an information only contact.

Victoria

46. On 23 April 2018, Senior Nurse Kenneth Soiza from the Murrnong Clinic at Eastern Health scanned the information faxed by CMHT and called the triage service to advise them of the information. Nurse Soiza also called Brendon and left a message asking him to contact Eastern Health. Nurse Soiza made further attempts to contact Brendon's grandparents in Victoria and left a message noting that Eastern Health were aware Brendon was in Victoria but were unable to contact him.

47. On 24 April 2018, Senior Nurse Soiza spoke with Brendon's grandparents in Victoria. They were advised that Eastern Health did not have a referral for Brendon but to make contact if they were concerned. The medical records contain a detailed text message sent to Brendon's grandmother which included contact details for psychiatric triage services, and advice for Brendon to see a GP for his medications.

48. Upon absconding from the RHH, Brendon received no further mental health treatment prior to his death.

CPU REVIEW

49. I sought the assistance of the Coroners Prevention Unit (CPU)[4] Health and Medical Information Team (HMIT), who assisted me with reviewing Brendon's care in Tasmania and Victoria, the information shared between the relevant mental health services, and the impact, if any, interstate agreements would have had to the management of Brendon's care.

Transfer of care requirements under the Tasmanian MHA

50. Dr Aaron Groves, the Chief Civil Psychiatrist and Chief Forensic Psychiatrist of Tasmania, provided a statement detailing the transfer of care arrangement requirements under the Tasmanian MHA when a patient subject to the Tasmanian MHA absconds from an inpatient

[4] The Coroners Prevention Unit (CPU) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the Coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. The CPU also reviews medical care and treatment in cases referred by the coroner. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.

unit, and in circumstances of discharge of a patient who is leaving Tasmania to reside in Victoria.

51. Section 61 of the Tasmanian MHA applies to a patient who is AWOL. Dr Grove explained that when a patient is AWOL, there is a requirement for the treating medical practitioner to notify the Tasmanian Mental Health Tribunal. The treating medical practitioner may also alert the Commissioner of Police, which Dr Groves explained is discretionary. In Brendon's case, notifications were made to the Tasmanian Mental Health Tribunal and the Commissioner of Police.

52. Dr Groves also detailed Chapter 4 of the Tasmanian MHA which provides that the Minister for Mental Health and Wellbeing may, on behalf of Tasmania, enter into interstate transfer agreements and interstate control agreements.

53. An interstate transfer agreement is an agreement, between the Minister and the Minister's counterpart in another State or Territory, providing for the interstate transfer on humanitarian grounds of patients. An interstate control agreement is, in turn, an agreement between the Minister and the Minister's counterpart in another State, providing for the apprehension, detention and return of certain categories of patients. This includes involuntary patients who abscond from an approved hospital where they are being lawfully detained and are found at large in a participating jurisdiction that Tasmania has entered into an agreement with.

54. Tasmania does not have interstate transfer or interstate control agreements with Victoria, or any other jurisdiction.

Interstate agreements

55. Victoria has ministerial, civil and forensic agreements with the Australian Capital Territory, New South Wales, Queensland and South Australia. While these agreements vary, they include interstate assessment, planned interstate transfers, interstate apprehension, and return of compulsory patients who are AWOL in another state.

56. CPU requested a statement from Dr Segal, Consultant Psychiatrist and Clinical Head of Eastern Health regarding the appropriateness of Eastern Health's actions in response to the referral from CMHT, and the impact an interstate agreement between Tasmania and Victoria may have had in the management of Brendon's care.

57. Dr Segal commented:

> "Had a cross-border arrangement been in place of the type whereby an apprehension order made under the Mental Health Act in Tasmania was to be recognized as valid in Victoria, this would have compelled Eastern Health to have acted in accordance with the order and to enact apprehension based follow-up protocols accordingly".

58. He further stated that such an agreement would have facilitated the role of Victoria Police in seeking, detaining, and presenting Brendon to a mental health facility for assessment.

59. Dr Segal explained that a interstate agreement would have resulted in the referral being submitted to Eastern Health's triage services for action, which would most likely have resulted in the Crisis Assessment Triage and Treatment team responding by way of community outreach as well as referring to Victoria Police for assistance. Additionally, Dr Segal stated that if an interstate agreement was in place, Eastern Health's response would have included contacting the referring agency and requesting additional information to be provided to assist Eastern Health establish the level of risk and degree of urgency of clinical response required.

60. An interstate control agreement between Tasmania and Victoria would allow for direct contact to be made with a mental health service in the state in which the patient is known to be. This would mean the relevant mental health service would have a commitment to make face to face contact with the patient and assess the need for ongoing care and treatment or as otherwise requested.

61. A state-based agreement may therefore have resulted in clearer follow-up with Brendon by Eastern Health.

<u>Transfer of information between CMHT and Eastern Health</u>

62. As outlined in paragraph 46, the fax sent to Eastern Health was an information only contact. It included a transfer of care form, progress reports, Brendon's medication charts, and his treatment order under the Tasmanian MHA. Upon receiving the fax, Senior Nurse Soiza forwarded the information to Eastern Health's triage team in the event Brendon's family decided to make contact. Attempts were also made to speak to Brendon and his family.

63. Dr Segal supported the actions of Senior Nurse Soiza as appropriate in the circumstances of the 'information-only' referral provided by CMHT. Dr Segal stated that the information received from CMHT suggested Eastern Health was provided with the information in-case there was contact made in relation to Brendon Crippen.

64. Dr Segal stated that the request for active follow-up usually rests with the referring agency, in this case CMHT, based on their clinical knowledge and experience with the client. The act of absconding from a mental health facility alone was not considered by Eastern Health as sufficient to suggest that active follow up was required. However, Dr Segal stated that if the nature of the clinical information provided highlighted the clear and imminent risk of harm to the client or to others, even if for information sharing purposes only, it would have been reasonable for the service receiving the referral to act upon it appropriately.

65. Dr Segal stated that an active follow up would have been facilitated by Eastern Health if the following had been received:

    (a) A request for follow-up, together with provision of appropriate clinical information highlighting the need for same

    (b) A phone call or correspondence from the responsible Tasmanian Consultant Psychiatrist to one of the Consultant Psychiatrist's at Eastern Health

    (c) Contact from the Clinical Director of Mental Health at RRH to the Clinical Director of Mental Health at Eastern Health

    (d) A phone call from the Chief Civil Psychiatrist of Tasmania to the Chief Psychiatrist of Victoria requesting follow up.

66. Dr Segal concluded that while an interstate agreement was not in force, there were other options available that would have led to appropriate follow-up with Brendon and his local mental health service.

Conclusion

67. Brendon Crippen was acutely unwell when he absconded from the RHH and had immediately prior to his absconding met the criteria under the Tasmanian MHA for a treatment order until 29 April 2018.

68. Considering Brendon had no medications, was still subject to a treatment order under the Tasmanian MHA, his serious mental illness diagnosis and that he was likely psychotic, active follow-up and frequent contact with mental health services was crucial to the management of Brendon's care. In these circumstances, the support Brendon received after absconding from the RHH was inadequate to manage his mental health effectively.

69. Following the review conducted by CPU, I am satisfied that while an interstate agreement may have resulted in more action to contact Eastern Health with an explicit request to review Brendon, it was not necessary to achieving the same outcome.

FINDINGS AND CONCLUSION

70. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:

    (a) the identity of the deceased was Brendon Crippen born 11 November 1990;

    (b) the death occurred on 6 June 2018 at Teal Point, Victoria from effects of fire; and

    (c) the death occurred in the circumstances described above.

71. Having considered all the circumstances, I am satisfied that Brendon intentionally took his own life.

RECOMMENDATIONS

Pursuant to section 72(2) of the Act, I make the following recommendations:

1. For the Chief Psychiatrist of Victoria to:

    (i) Work with the Chief Civil Psychiatrist of Tasmania to review the need for a cross-border agreement relevant to the Mental Health Acts of both states; and

    (ii) Raise awareness of the expectation of contemporary clinical practice in arranging for follow-up and/or transfer of care with mental health services of a client known to be in the other state.

I convey my sincere condolences to Brendon Crippen's family for their loss.

Pursuant to section 73(1A) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

I direct that a copy of this finding be provided to the following:

Brendon Crippen's family, senior next of kin;

Investigating Member, Victoria Police;

Dr Aaron Groves, Chief Civil Psychiatrist of Tasmania; and

Dr Neil Coventry, Chief Psychiatrist of Victoria.

Signature:

MR JOHN OLLE

CORONER

Date: 31 August 2021

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.
