

Introduction

The circumstances of the death of Nicholas Waterlow and his daughter Chloe Heuston can be best described as a love story that, like so many love stories, ends in tragedy.

Everyone knew Nicholas Waterlow, as Nick and I will refer to him by that name in these findings. Nick was described as being a passionate man who loved to celebrate life. He had a passion for contemporary art but had a love for art of all kinds. He was described as being a man who could see contemporary art in the context of the history of art.

Nick was also a talented curator whose work included internationally acclaimed exhibitions and three Sydney Biennials. He was well respected for his mentorship of countless students at the University of New South Wales College of Fine Arts and was also the director of the College's Ivan Dougherty Gallery.

Juliet Darling, Nick's partner of many years, spoke of him in the following terms:

'He had the virtues I most value of kindness and humility. He was a very open man. Many people loved that about him. He was a very brave man. He held no grudges. He could really and truly love people who did not love him. He was a person who did not say a bad thing about others.'

Nick had three children, two sons and a daughter.

Chloe Heuston was Nick's only daughter. I will refer to her as Chloe. She was the mother of three young children. Her husband Ben wrote that she was:

'A person who always had a smile, a laugh, a cupcake or a quiche for others'.

At Chloe's funeral Fr Steve Sinn SJ summed up her friends memories of her in the following words:

'You could say that she taught us to seek out the joy in life, to look in every dark corner because somewhere its there. She would have found

it, she taught us not to hold back and to accept people as they are, to appreciate one another. Above all, she taught us the power of unconditional love and acceptance that is friendship.'

Antony Waterlow was the son of Nick and the brother of Chloe. I will refer to him as Antony.

Nick and Chloe died as a result of injuries they received when attacked by Antony at Chloe's home at Clovelly on 9 November 2009.

For some years there had been difficulties in the Waterlow family arising from the mental health issues suffered by Antony. In November 2009 Chloe's husband, Ben Heuston, was overseas for some weeks due to work commitments. Chloe had invited Nick and Antony to have dinner at her home during her husband's absence. This was done in an attempt to re-establish family harmony. Nick and Chloe cared very deeply for Antony however, due to his mental health illness, he was unable to reciprocate that affection.

Tragically during dinner on 9 November 2009 Antony armed himself with a knife and attacked Nick and Chloe causing their deaths. Chloe's young daughter also sustained serious injuries.

Role and Function of the Coroner

The Coroners Act 2009 (the Act) governs the role and function of the Coroner.

The objects of that Act are set out in Section 3 and include the jurisdiction:

*(c) to enable coroners to investigate certain kinds of deaths in order to determine the identities of the deceased persons , the times and dates of their deaths and the manner and cause of their deaths, and
(e) to enable coroners to make recommendations in relation to matters in connection with an inquest*

The *certain kinds of death* that a coroner is able to investigate are *reportable deaths*.

Section 6 defines a *reportable death* as including one where a person died a *violent or unnatural death* or under *suspicious or unusual circumstances*.

Section 35 requires that all *reportable deaths* be reported to a coroner.

Section 18 gives a coroner jurisdiction to hold an inquest where the death or suspected death of an individual occurred within New South Wales or where the person who has died, or is suspected to have died, was ordinarily a resident of New South Wales.

Section 27(1)(b) provides that if it appears to a coroner that a person died or might have died as a result of a homicide then an inquest is mandatory.

Section 81(1) sets out the primary function of the coroner when an inquest is held. That section requires, in summary, that at the conclusion of the inquest the coroner is to establish, should sufficient evidence be available, the fact that a person has died, the identity of that person, the date and place of their death and the cause and manner thereof.

Sections 78(1)(a) and (2) provide that where it appears to the coroner conducting an inquest that a person has been charged with an indictable offence, and the indictable offence raises the issue of whether the person caused the death with which the inquest is concerned, then the coroner may commence or continue the inquest but only for the purpose of taking evidence to establish the identity of the deceased and the date and place of their death after which the inquest must be suspended.

Section 79 of the Act provides that where an inquest has been suspended in accordance with Section 78 and the relevant charges have been finally determined then the coroner who suspended the inquest has the discretion to either dispense with the resumption of the inquest or, subject to a direction by the State Coroner not to do so, to resume the inquest.

Section 82 (1) of the Act provides that a coroner conducting an inquest may make such recommendations, as he or she considers necessary, or desirable, in relation to any matter connected with the death with which the inquest is concerned. The making of recommendations are discretionary and relate usually, but not necessarily only, to matters of public health, public safety or the conduct of services provided by public instrumentalities. In this way coronial proceedings can be forward looking, aiming to prevent future deaths.

History of the Coronial Proceedings

The deaths of Nick and Chloe were reported to the Office of the State Coroner on 9 November 2009. On 27 November 2009 Antony was arrested and subsequently charged with indictable offences. An inquest touching the deaths of Nick and Chloe was commenced before me on 12 February 2010. Having considered the evidence then available I found that a known person had been charged with an indictable offence and, having made findings as to the identity of Nick and Chloe and the date and place of their deaths I suspended the respective inquests.

Antony was tried before His Honour Justice Hidden between 12 and 13 April 2011 with His Honour giving judgement on 13 April 2011. His Honour set out the following history:

At the time he killed his father and sister Antony Waterlow was 42 years old. He lived in a boarding house and had suffered paranoid schizophrenia for nearly a decade. He described a long-standing, systematised, persecutory delusion concerning a worldwide 'internet based campaign of harassment,' originally orchestrated by his family, designed to destroy him. He believed people could use 'secret technology' to control his thoughts and he experienced auditory hallucinations of comment and command, which at times 'impelled' him to commit suicide.

Over the years, Mr Waterlow had exhibited bizarre, aggressive, threatening or intimidating behaviour directed primarily at his family. On one occasion, he had been physically violent to his brother and had repeatedly threatened to kill family members and other close associates.

Between 2004 and 2007, numerous doctors, including several psychiatrists, saw Mr Waterlow. At some of these consultations, his

family and friends expressed concern about his aggression. At no time, however, did Mr Waterlow see himself as unwell. He always resisted treatment, and though involuntary detention was considered, it was never undertaken. Mr Waterlow refused to take, and never received, antipsychotic medication.

In the period leading up to the killings, he came to believe that either there was a campaign to make him kill himself or that he would be murdered. In November 2009, he and his father went to his sister's house. Shortly after arriving, Mr Waterlow thought that he heard his father and sister say something that convinced him they were about to use their powers of mind control to cause him to have a heart attack or something similar. Following this, presumably in a perceived act of self-defence, he seized a kitchen knife and stabbed them repeatedly.

Justice Hidden outlined the issues to be determined at trial saying:

The accused, Antony Waterlow, has been tried before me, sitting without a jury, for the murder of his father, Nicholas Waterlow, and his sister, Chloe Heuston, and also for the reckless infliction of grievous bodily harm upon his niece, a child whom I shall not name. The offences are alleged to have been committed in the course of a violent incident in 9 November 2009. The accused has pleaded not guilty to each charge but the only issue is whether he was mentally ill, in the sense in which that expression is used in the criminal law, at the time.

Having considered the evidence before him, including the opinions of three forensic psychiatrists, his Honour reached the following conclusions:

Clearly, the accuser's attack upon his father and sister was without any rational motive and was the product of his mental illness. The injury to the child was inflicted during that psychotic episode and, no doubt, was caused by a blow with the knife intended for her mother. All three forensic psychiatrists diagnosed him as suffering from paranoid schizophrenia. As I have said, applying the requisite legal test, all three supported the defence of mental illness. Accordingly, on each count on the indictment, I find the accused not guilty by reason of mental illness.

Justice Hidden also had evidence before him that established that since Antony had come into custody in November 2009 he had had the benefit of appropriate medical treatment and that had stabilised his mental health

condition. That stability was, of course, the result of compliance with a regime of medication and its continuation is dependant on such compliance.

His Honour noted that during the course of the trial Antony had given short evidence during which, in His Honours view, he had demonstrated insight into his illness and, in particular, his condition at the time of the offences. Justice Hidden considered that Antony had expressed genuine remorse for his actions.

His Honour ordered that Antony be detained under Section 39 of the *Mental Health (Forensic Provisions) Act 1990*.

On 3 February 2012 the Director of Public Prosecutions advised the Registrar of the State Coroner's Court that the proceedings that led to the suspension of the inquest had been finally determined (see Coroners Act 2009, Sections 79 (3) and (4)). It was then necessary for me to determine whether or not the inquest should be resumed or the resumption of the inquest dispensed with (see Section 79(1)).

Having consulted with the Officer in Charge of the investigation into the deaths of Nick and Chloe and corresponded with members of their family I considered that there were outstanding coronial issues that justified the resumption of the inquest and in January 2012 gave notice of my intention to do so in accordance with Section 79(2A) of the Act. I did not receive a direction from the State Coroner not to resume the inquest (Section 79(5A)). The inquest was resumed on 18 February 2013.

The Resumed Inquest

Section 81(1) of the Act requires that a coroner, at the conclusion of an inquest, make findings, if sufficient evidence is available, as to the identity of the deceased person, the date and place of their death and the cause and manner thereof. On 12 February 2010 I had made findings as to Nick and Chloe's identity and the date and place of their death. Following the

Judgement of Justice Hidden on 19 April 2011 the cause and manner of death was well established. The requirements of section 81(1) were thus sufficiently established. The purpose of the resumed inquest was therefore to determine whether or not there were any recommendations connected with the death of Nick and Chloe that were necessary or desirable to be made in accordance with Section 82 of the Act.

In her submission as to why the inquest should be resumed Juliet Darling spoke eloquently of what she saw as limitations of the current mental health legislation. It was her view that there were recommendations for change that could be made and that were in the public interest. In her submission she wrote:

Nick was killed by his son Antony Waterlow in a violent attack. Antony stabbed Nick and his sister Chloe Heuston repeatedly, while suffering a psychotic illness for which he could have been treated. He had a long illness of psychotic symptoms and violent behaviour, however he did not believe that he had a mental illness and refused to take medication.

While the Mental Health Act 2007 allows for the treatment of persons with mental illness without consent under certain circumstances, Antony was never admitted as an involuntary patient (despite repeated efforts by Nick, Chloe and others to obtain treatment for him) and as a result, he never received psychiatric treatment of any kind.

These murders could have been prevented. Antony Waterlow should have been scheduled and treated. And sadly, this is not the only example of a failure to treat a person with psychosis, with tragic consequences.

Given this, I believe it would be in the public interest for you to make two recommendations in this case.

The first should relate to the provisions for involuntary treatment of persons with mental illness, as exemplified by the circumstances of Nick's death. In particular, I suggest that the failure to secure treatment for Antony, which might have prevented the killings, was due at least in part, to the statutory criteria for involuntary treatment which requires that doctors should assess whether a person is at risk of "serious harm" to themselves or others. I believe the harm criteria should be deleted from the Mental Health Act 2007, and replaced with provisions that allow treatment of persons with mental illness, who lack insight into their condition and capacity to make treatment decisions, to be treated by doctors involuntarily where it is their best interest to do so.

Secondly, the circumstances of Nick's death demonstrate how important it is for doctors to take seriously, the reports of family members and carers when assessing patients for hospital treatments. Antony tended to present well at hospital and repeated accounts of Antony's psychotic symptoms and erratic, threatening behaviour at home, were not given sufficient weight by his doctors. I believe you should recommend that mechanisms be put in place to ensure that these kinds of reports are appropriately taken into account when assessing patients for inpatient treatment.

Having considered the submissions of Ms Darling and other members of the affected families I considered it appropriate to resume the inquest for the purpose of considering whether or not the factual circumstances that led to the death of Nick and Chloe suggested the need for amendments to the relevant Mental Health legislation. In order to consider this matter it was necessary to examine the mental health history of Antony and any treatment he received from mental health professionals.

Antony's Mental Health History

To assist this consideration I had available to me Antony's medical records, evidence from Juliet Darling and Gaye Bell, a friend of Antony's, as well as a number of treating medical practitioners. In addition I had assistance by way of reports and evidence from three expert psychiatrists who had reviewed the medical assistance provided to Antony Waterlow and were able to provide their opinion as to the appropriateness of that medical care as well as other issues relating to the treatment of persons with mental illness in general. I will make reference, in general terms, to period prior to October 2006 however after that I will examine the history in more detail.

Antony was one of three siblings. His mother Rosemary O'Brien passed away in 1998. The first suggestion that Antony may have been suffering from mental health issues appears to have been in about 2000. At that time he was drinking excessively and displaying increasingly erratic behaviour and beginning to show signs of paranoia.

In 2003 Antony was undertaking an acting course at Randwick. He had previously completed acting training in London. Through the Randwick course Antony Waterlow met Gaye Bell, a fellow student. Antony and Gaye Bell became friends.

Very early in their friendship Antony told Ms Bell that he was being bullied and harassed. He mentioned that he had heard people talking about his body and this resulted in him using his closet to dress or change. He also told her that he thought people were photographing him through the pinholes of Venetian blinds. At first Ms Bell believed that Antony was being genuinely threatened.

At the time Antony was required to move accommodation and asked if Ms Bell and her husband might be able to put him up for a couple of weeks while he found appropriate accommodation. They generously agreed. He was to remain with the Bells for some three years.

After Antony moved in with them Ms Bell began to become concerned as to his mental health. Whilst he was likeable and not aggressive towards herself or her husband he was verbally aggressive towards other people. In addition he was often told to leave venues because of his behaviour. He also reported to her that he heard voices of persons who were persecuting him. He told Ms Bell that he was also having arguments with his family and had previously had family counselling sessions that had not been successful because his family had *ganged up* on him.

Ms Bell wondered if Antony was suffering from Schizophrenia and suggested this to him. He rejected the idea and said that a psychotherapist or psychologist had told him that he was not schizophrenic. By 2004 Ms Bell was, however, sufficiently concerned with Antony's mental health that she made an appointment with Nick to discuss her concerns. Ms Bell and Nick discussed how they might together assist Antony.

Following this meeting Antony had a number of sessions with a psychiatrist Dr Nikki Rogers. Ms Bell accompanied him on at least one occasion when he

saw Dr Rogers. Dr Rogers suggested that it would be appropriate for Antony to be medicated however he refused and would not attend any other appointments. Dr Rogers recorded the following observations:

Disturbed, depressed, anxious and psychotic at his first two sessions – he refused the notion of meds and subsequently failed to attend.

On 27 April 2004 Dr Rogers referred Antony to the St Vincent's Mental Health Service because he had failed to attend appointments and had declined to receive treatment.

On 28 April 2004, as a result of this referral, the St Vincent's Acute Care Team (ACT) visited Antony at home. M Jones noted he:

Now feels paranoid, hears voices – derogatory comments about him and believes that people are watching him/ picking on him because he is vulnerable.

He reported no ideas of harm to self or others and no history of same. He did report history of M/I in the family and said his father and cousin suffered from depression. He told the assessor he was on the antidepressant Cipromil, but he refused to take anti-psychotics because of the side effects he had read about on the Internet.

The preliminary diagnosis of the ACT was that Antony was:

Depressed with some psychotic features.

He was strongly advised that it was in his best interest to consider anti-psychotics and to see his private psychiatrist. He was also given the contact details of the ACT.

Notwithstanding the advice and assistance given to him Antony did not accept that he was suffering from any mental health conditions or illnesses. His health and his life circumstances, however, continued to deteriorate.

By late 2004 Antony's behaviour became more violent and bizarre. He was arrested and charged with two counts of malicious damage in circumstances where he was intoxicated and acting erratically. He also claimed that neighbours were running cables above him, talking about him, blowing smoke into his room, listening to him and filming him.

In the years that followed there were numerous incidents that suggested Antony's mental health was deteriorating. Ms Bell, in whose home he resided, was able to give examples of such incidents. On one occasion Ms Bell was awoken by Antony banging loudly on the neighbours door, on another he ran up and down the street screaming obscenities while on yet another he was standing at the party wall between their home and the neighbours making stabbing motions with a large kitchen knife. Antony was always angry with the neighbours who, he thought, were persecuting him. It is a tribute to the concern and affection that Ms Bell and her husband felt for Antony that, in spite of all of this, they allowed him to remain as a guest in their home. Many people would not have done so.

In April 2006 Antony travelled to London to stay with his grandmother. Whilst he was there his behaviour was a cause for concern. He was described as being paranoid, angry and aggressive. At a family dinner he became so aggressive towards some relatives that his grandmother was forced to intervene. After this incident Antony's grandmother reported that she was scared of him and asked him to return to Australia. He arrived back in Sydney in October 2006.

Nick and Chloe had been in contact with family in England and were aware of the difficulties that arisen during Antony's visit. Ms Bell was also aware of what had occurred. Notwithstanding this the Bells agreed that Antony could continue to reside with them. Nick, however, held some concern for Ms Bell's welfare and insisted that her husband be at home when he arrived. Nick and Chloe also sought to make arrangements for Antony to receive a mental health assessment.

On 15 October 2006 Chloe contacted the ACT. She reported that her brother had a history of schizophrenia, that on a recent trip to the UK he had threatened to kill members of the family, including her. She also reported that he had assaulted his brother Luke some six months previously.

The ACT responded quickly to this information. The next day Louise Costanzo contacted Chloe to confirm the information. Chloe did so and also advised that she was personally afraid of Antony. Ms Costanzo also spoke to Gaye Bell. Ms Bell confirmed that she thought Antony needed assistance.

On 17 October 2006 Nick phoned Ms Costanzo to inform her that he had seen Antony that day, that he was hostile and *had threatened to use a knife on him*. Following this Ms Costanzo contacted Antony in order to arrange an assessment. Antony was reluctant but agreed when told that if he didn't agree the police would be contacted. That assessment occurred on 18 October 2006 after which Antony was referred to Dr Andrew Wilson, a psychiatrist.

Dr Wilson assessed Antony on 6 November 2006. He noted:

Has likely history/presentation of psychotic symptoms:-persecutory deliriums in relation to family 'organising a game' against him...states has been called derogatory phrases in pubs –'faggots' and 'paedophile' and people have stated to him referenced on the internet re this – he believes family are behind this.

Dr Wilson's clinical impression was of a *probable psychotic illness, likely schizophrenia*. Dr Wilson recorded a care plan as follows:

- 1. Psycho-education re the value of antipsychotics (further appointment made for this),*
- 2. If he refuses this or is non-compliant then care plan would need to review this,*
- 3. Need to organize an MRI/EEG.*

In the second week of November 2006 there were further threats of violence made by Antony – this time towards Gaye Bell and her husband. He had accused them of acting with his family to destroy his reputation. He had also told Gaye Bell that *it was getting to the point where he would have to kill*

someone. Gaye Bell reported this to Ms Constanzo on 17 November 2006 and, as a result, Antony was asked to attend for a further assessment. This resulted in him coming into the care of Dr Peter McGeorge, a senior psychiatrist and Clinical Director of the St Vincent's Mental Health Service, together with Dr Powell, a psychiatric registrar under Dr McGeorge's supervision.

Dr McGeorge and/or Dr Powell subsequently saw Antony on 17, 24, 27, 28 and 30 November 2006, 7, 22 and 27 December 2006 and 4 January 2007. Both Dr McGeorge and Dr Powell gave evidence during the course of the inquest and the assistance they provided to me as to their thinking during the course of treating Antony is greatly appreciated.

The therapeutic decisions made, and available to, Dr McGeorge and Dr Powell in their care of Antony was also reviewed at the inquest by consultant psychiatrists Michael Giuffrida, Christopher Ryan and Anthony Samuels who each gave evidence concurrently after considering, in conference, a number of questions posed to them by Counsel Assisting.

Schizophrenia

In order to be able to consider Antony's medical history it is necessary to have a general understanding of the illness schizophrenia.

Schizophrenia is a mental illness that affects about one person in every hundred in the population. Schizophrenia interferes with the mental functioning of a person and, in the long term, may cause changes to a person's personality. First onset is usually in adolescence or early adulthood however it can develop in older people. Some people may experience only one or more brief episodes in their lives however, for others, it remains a recurrent or life-long condition.

The onset of schizophrenia may be rapid with acute symptoms developing over several weeks or it may be slow, developing over months or even years.

During onset the person often withdraws from others, gets depressed and anxious and develops extreme fears or obsessions.

The major symptoms of schizophrenia include delusions, hallucinations and thought disorder. Delusions are false beliefs of persecution, guilt or grandeur or being under outside control. People with schizophrenia may describe plots against them or think that they have special powers and gifts. Sometimes they withdraw from people or hide to avoid imagined persecution.

Hallucinations most commonly involve hearing voices. Other less common experience can include seeing, feeling, tasting or smelling things which to the person are real but which are not actually there. Thought disorder is where the persons speech maybe difficult to follow, for example, jumping from one subject to another with no logical connection. Thoughts and speech may be jumbled and disjointed. The person may think someone is interfering with his or her mind. Other symptoms of schizophrenia include loss of drive, blunted expression of emotions, social withdrawal, lack of insight or awareness of other conditions and thinking difficulties.

No single cause of schizophrenia has been identified however there are several factors that are believed to contribute to the onset of the illness in some people. These include genetic factors and biochemical imbalance. It is also well recognised that stressful incidents often precede the onset of schizophrenia and the use of some drugs, especially cannabis and LSD, is likely to cause the onset of or a relapse in schizophrenia.

As can be seen schizophrenia is a significantly disabling illness. It does not, however, cause intellectual disability. In fact persons of high intellectual capacity can suffer from the illness. People with schizophrenia are generally not dangerous either. This is especially the case when they are receiving appropriate treatment. There are, however, a minority of people with the illness who become aggressive when experiencing an untreated acute episode because of their fears. This is usually expressed to family, friends or others who are close to them and rarely to strangers.

The most effective treatment for schizophrenia involves medication, psychological counselling and help with managing the impact of the illness on everyday life. It is important to recognise that schizophrenia is an illness like many physical illnesses. For example, just as insulin is a lifeline for a person with diabetes, anti-psychotic medications are a lifeline for persons with schizophrenia. In addition, as with diabetes, some people suffering from the illness will need to take medication indefinitely in order to prevent a relapse and to keep symptoms under control.

Mental Health Act 2007

It is also important for the purpose of our investigation, and our understanding of the therapeutic decisions made by those seeking to assist Antony Waterlow, that there be some understanding of the legislation enacted to assist in the care and treatment of persons suffering from mental illnesses.

The relevant legislation is currently the *Mental Health Act 2007*. Prior to the current legislation the applicable legislation was the *Mental Health Act 1990*. That Act was repealed with effect from 16 November 2007. For the purpose of our consideration the two pieces of legislation are not relevantly different so I will refer only to the current legislation.

The Objects of the Mental Health Act are found in Section 3. They are as follows:

- (a) to provide for the care, treatment and control of persons who are mentally ill or mentally disordered, and*
- (b) to facilitate the care, treatment and control of those persons through community care facilities, and*
- (c) to facilitate the provision of hospital care for those persons on a voluntary basis where appropriate and, in a limited number of situations, on an involuntary basis, and*
- (d) while protecting the civil rights of those persons, to give an opportunity for those persons to have access to appropriate care, and*
- (e) to facilitate the involvement of those persons, and persons caring for them, in decisions involving appropriate care, treatment and control.*

The objects identify the framework under which the Act is to be interpreted and it is important to note that they emphasise the need to protect the rights of the individual to, where possible, determine the nature and character of any treatment they are to receive and that involuntary treatment is only to be used in a *limited number of situations*.

Chapter 3 of the Act deals with involuntary treatment. Section 12 (1) sets out the restrictions on the detention of persons. That section provides:

12 General restrictions on detention of persons

(1) A patient or other person must not be involuntarily admitted to, or detained in or continue to be detained in, a mental health facility unless an authorised medical officer is of the opinion that:

- (a) the person is a mentally ill person or a mentally disordered person, and*
- (b) no other care of a less restrictive kind, that is consistent with safe and effective care, is appropriate and reasonably available to the person.*

The definition of mentally ill and mentally disordered persons is to be found in Sections 14 and 15 of the Act. Those sections provide as follows:

14 Mentally ill persons

(1) A person is a mentally ill person if the person is suffering from mental illness and, owing to the illness, there are reasonable grounds for believing that care, treatment or control is necessary:

- (a) for the person's own protection from serious harm, or*
- (b) for the protection of others from serious harm*

(2) In considering whether a person is a mentally ill person, the continuing condition of the person, including the likely deterioration of the person's condition and the likely effects of any such deterioration, are to be taken into account.

15 Mentally disordered persons

A person (whether or not the person is suffering from a mental illness) is a mentally disordered person if the person's behaviour for the time being is so irrational as to justify a conclusion on reasonable grounds that temporary care, treatment or control of the person is necessary:

- (a) for the person's own protection from serious physical harm, or*
- (b) for the protection of others from serious physical harm.*

There are a number of circumstances by which a person might become the subject of involuntary treatment regimes and one such route is by the issue of a certificate by a medical practitioner or an accredited person. Section 19 deals with that process and provides:

19 Detention on certificate of medical practitioner or accredited person
(1) A person may be taken to and detained in a declared mental health facility on the basis of a certificate about the person's condition issued by a medical practitioner or accredited person. The certificate is to be in the form set out in Part 1 of Schedule 1

(2) A mental health certificate may be given about a person only if the medical practitioner or accredited person:

- (a) has personally examined or observed the person's condition immediately before or shortly before completing the certificate, and*
- (b) is of the opinion the person is a mentally ill person or a mentally disordered person, and*
- (c) is satisfied that no other appropriate means for dealing with the person is reasonably available, and that involuntary admission and detention are necessary, and*
- (d) is not the primary carer or a near relative of the person.*

Presentations

On 17 November 2006 Dr Peter McGeorge, together with Dr Powell, reviewed Antony. These doctors were to play a important role in his care over the next couple of years.

Antony's presentation on that day provides some clue as to the complexity of his case. He attended for the interview on time. He was noted to be "*slightly suspicious and apprehensive*" but was otherwise "*polite, calm and engaging*". He admitted that he had become increasingly paranoid over the past few months, and that his behaviour had at time been "*irrational and unreasonable*". He accepted that his behaviour may have come across as threatening to people he lived with, especially when drinking.

Antony described his relationship with his father as "*verbally and physically abusive*". Although it would not have been evident to the doctors on that day, all evidence suggests that this allegation was absolutely false. Nick was

known as a gentle man and had demonstrated love and care for Antony. It appears that feeling was part of the delusions Antony experienced.

It was noted that he was articulate and well spoken. The doctors recorded that he appeared to suffer from:

- *Persecutory ideation regarding feeling unsafe and thinking people he lived with do not like him*
- *Some ideas of reference*
- *No obvious delusions*
- *No suicidal ideation*
- *Agrees had been threatening but denied homicidal ideation..*

The doctor's diagnostic impression was of *"increasing paranoia on a background of paranoid personality traits. May have underlying psychotic illness, although is currently not overtly psychotic"*. They developed a Care Plan that included:

- *Organic work up*
- *Psych- education given re psychosis and medication*
- *Trial of medication - quetiapine*
- *For further review*

On 24 November 2006, the diagnostic impression was of a *"possible paranoid personality disorder may have underlying psychosis. Currently engaging"*.

Antony had not been in to have blood test as requested, and would not agree to take anti-psychotics. The Treatment Plan included continuing to encourage him to trial anti-psychotic medication.

On 27 November 2006, Dr Powell spoke with Gaye Bell who said that Antony was blaming her and her husband for certain events, claiming that they were torturing him and had cameras throughout the house. He was expressing hatred towards his family and Ms Bell and she and her husband were frightened in their house. That same day, when Dr Powell called Gaye Bell back to arrange an appointment with Anthony, he heard him accusing Ms Bell that she had been telling everyone he was homosexual and that they were abusing him.

On 28 November 2006, Dr Powell conducted a further assessment of Antony with Gaye Bell present. Ms Bell recalled the events of the past few weeks, and explained that Antony had been asked to leave parties because he was verbally aggressive and his friends had become worried about him.

He was noted to have normal speech and mood, *“but he was illogical at times, and tangential, he had ideas of reference and persecution”*. Antony spoke of how the neighbours were using cameras to video him and he was convinced Gaye Bell had been telling people he was homosexual.

On mental state examination, the diagnostic impression was of *“probable underlying psychosis, moderate risk of harm to others especially if intoxicated with alcohol”*.

The Treatment Plan developed that day was to:

- *trial a dose of a low level anti-psychotic called Abilify for one night.*
- *Antony advised to abstain from alcohol*
- *To be reviewed the next day*

Antony missed an appointment with Dr Powell on 29 November 2006, but he attended on time the following day. He explained that he had not taken the Abilify and he was adamant that he did not want any anti-psychotic medication. He acknowledged that he needed help and was willing to try therapy with a psychologist. He told Dr Powell that as doctors, they had an agenda and were trying to push medication on him.

Dr Powell made a note that Antony did not express any ideas of self harm or harm to others and that there was no deterioration in his mental state. The Treatment Plan recorded that day included:

- *discussion with Dr McGeorge*
- *not for anti psychotics at that stage*
- *continue to strongly advise the utility of medication*
- *further review in week’s time*

On 7 December 2006, Dr Powell reviewed Antony as planned. It appears that he recounted a story of being on a sailing trip for the past 2 days with a friend

who he believed to have a mental illness. He reported that the friend had drunk heavily and passed out, leaving him to steer the boat and that on other occasions the friend had tried to steer the boat into other boats. He suggested that he and the male had fought and punched each other and the trip ended with the boat was towed away by the Water Police. There is no indication in the notes as to whether Dr Powell believed that story, but it is apparent now that it was completely false- there was no boat trip and no such events took place.

Antony reported that he thought his paranoia had decreased. However he also reported hearing the neighbours talking about him at times, although not anything specific. The notes record, among other things:

- *usual presentation*
- *well kempted, bearded*
- *no obvious delusions*
- *reports noises from the neighbours which intimidate him*
- *oriented as to time, place*
- *remains insightful to a fairly high level*
- *no change.*

At an appointment with the clinical psychologist, Ms Phipps, on 15 December 2006, Antony presented as punctual, pleasant and appropriate throughout the interview. He identified goals as including mood/anger management and managing paranoia. He did not feel that he had a psychotic illness and did not want medication. He did feel he suffered from depression and found Citalopram helpful. He was happy to attend weekly meetings.

That information was passed on to Dr Powell. His presentation at the meetings with Ms Phipps tells of the complexity of this case, and possibly, of Antony's ability to hide the true extent of his illness. At the majority of the meetings between Antony Waterlow and Ms Phipps, from December 2006 through to February 2007, he was similarly pleasant, appropriate and cooperative.

The contrast between that behaviour and his behaviour towards family and friends at the time is stark. On 21 December 2006, Nick called Dr Powell,

expressing his concern that Antony was aggressive towards him. He told Dr Powell that his son might be a risk and that a period of involuntary treatment may be warranted. Dr Powell then called Gaye Bell, who told him that Antony Waterlow had been catatonic the previous night for 15 minutes and was verbally aggressive. She was concerned that Antony was becoming more paranoid and more aggressive. Gaye Bell was worried about the neighbours over the next few days, because Antony Waterlow was being left alone and he had become quite paranoid about them.

The same day, the ACT met with Dr Powell to discuss the information received. A decision was made to visit Antony with a view to engaging or scheduling him, and to commence him on medication *“if he was agreeable”*.

On 22 December 2006, both Drs Powell and McGeorge reviewed Antony. He reported grievances with Gaye Bell and her husband and added that he felt threatened by Ms Bells' husband. He agreed that he had been verbally aggressive towards him, but he thought that was justified. He again reported problems with the neighbours.

The mental state examination (MSE) record noted, among other things:

Normal speech, angry mood, persecutory ideation involving Gaye/Graham and neighbours, judgment impaired, but nil perceptual disturbance admitted”. The note also suggests that he had “difficulty controlling anger at times, but does not have a clear intent to harm anyone.

The plan was to continue to try to engage Antony in the community, and not to involuntarily schedule at that stage. The diagnostic impression was that Antony:

continued to have strong persecutory ideas, and had difficulty controlling his anger, although there was no definitive diagnosis that he was suffering from a paranoid psychotic illness.

On 27 December 2006, Dr Powell again met with Antony. This was at a time when Ms Bell and her husband were away and he had the home to himself. He assessed the situation as possibly improved. The MSE included the

comments:

- *Appears more relaxed and less suspicious than last assessment*
- *Level of paranoia remains – believes entire family are using him as a scapegoat for all their own shortcomings.*
- *Nil reported disturbance*
- *Stable*
- *Risk of harm to self or others has not become greater. If anything, things have eased somewhat since Antony had been living alone.*
- *Continued to recommend trial of anti psychotic*

On 2 January 2007, there were, however, further signs of deterioration. Dr McGeorge and RN Fubelli had attended for a home visit but Antony was absent. Ms Bell informed them that she was concerned for his mental health. The next day he made contact and agreed to come in. An assessment conducted on 4 January 2007.

Ms Bell contacted Dr McGeorge and stated that although she was not worried for her personal safety, she was however worried about Antony's mental state to the point where she could not continue to live with him. He had refused to take his medication and had threatened someone in the UK. Antony was reportedly angry about the visit by the ACT, saying he did not want to attend the community mental health team anymore.

On or about 4 January 2007 Dr McGeorge spoke with Dr Olav Nielssen and Dr Richardson, two senior psychiatrists at St Vincent's Mental Health Service from whom he sought a second opinion. Having had outlined to them Antony Waterlow's mental health history Dr Nielssen thought he should be detained involuntarily for treatment. Dr Richardson, on the other hand, advised Dr McGeorge not to detain Antony Waterlow unless there was an obvious and immediate threat made by the patient.

During an assessment on 4 January 2007 Antony was noted to be:

- *agitated and suspicious, but willing to cooperate in the interview*
- *no speech disorder*
- *mood mildly angry but contained*
- *no formal thought disorder*

- *no homicidal or suicidal thoughts*

At the end of the consultation on 4 January 2007 the treatment plan developed for Antony was that:

- *He would attend rehabilitation sessions with Ms Phipps,*
- *He would see Dr McGeorge on an 1-2 weekly basis to continue to engage him, build clinical trust and to monitor his mental state,*
- *Move out of his current accommodation,*
- *Dr McGeorge would encourage him to see the value of medication, and*
- *The ACT would respond as necessary if his symptoms worsened and/or this risks deteriorated*

Around that time Antony moved out of the Bell residence that he had shared with Ms Bell and her husband for the previous three years and went to live in a share house.

On 11 January 2007 Antony failed to attend his appointment with Dr. McGeorge. He did, however attend subsequent appointments with Ms Phipps on 24 January 2007 and 7 February 2007. He then failed to attend a further appointment on 14 February 2007. When Ms Phipps followed up his failure to attend another resident at the location informed her that he had left the location. In fact at the end of January 2007 Antony had moved to a property at Colo in the Blue Mountains west of Sydney. This was outside the St Vincent's Mental Health Service catchment area.

Dr McGeorge did, however, continue to concern himself with Antony's circumstances. On 15 May 2007 he had a telephone conversation with Nick in which Nick expressed his concerns. That conversation led to a meeting with Nick and Gaye Bell on 17 May 2007.

During that meeting Ms Bell gave Dr McGeorge a letter that she had composed on 15 January 2007 outlining her observations and concerns as to Antony's mental state. Dr McGeorge gave evidence that the matters recorded therein had shown a significant deterioration in Antony's mental state and that:

Given the severity of the symptoms I would expect that psychotic

symptoms would be detected on face-to-face assessment. That would cause me to revisit the issue of scheduling.

As it turned out Dr McGeorge did not see Antony again until 5 October 2007. During that consultation Dr McGeorge turned his mind to the question as to whether or not Antony should be scheduled however he concluded:

I did not feel able to compulsorily detain him given:

- *He was not presenting signs of mental health,*
- *He did not appear an acute risk to himself and others,*
- *He had not been scheduled by the Nepean Mental Health Service,*
- *Justice Health had apparently not seen sufficient grounds to follow our advice to undertake a compulsory s33 MHA 1990 assessment, and*
- *I still only had hearsay evidence of some five months prior of him being delusional.*

In order to understand the third and fourth reasons given by Dr McGeorge it is necessary to record two other aspects of the Antony's mental health history.

The involvement of the Nepean Mental Health Service (NMHS) followed the meeting between Nick, Ms Bell and Dr McGeorge on 17 May 2007. At that meeting it was suggested that to enable Antony to be examined a friend or relative might request an assessment in accordance with Section 23 of the *Mental Health Act 1990*. Ms Bell did make that request. Following receipt of the request, and on the basis of the information provide by Nick and Ms Bell, Dr McGeorge formed the view that Antony was psychotic and a serious risk to himself and others. Accordingly he arranged for the information provided, and the section 23 request, to be sent to the NMHS so as to enable a home visit to occur and a mental state assessment to be undertaken. The NMHS was the relevant service now that Antony was living at Colo. As a result Antony was contacted and authorised officers undertook a mental health assessment. The authorised officers did not consider that it was appropriate to involuntarily detain Antony for treatment at that time. There is no evidence available to me to suggest that the conclusion reached by the officers was inappropriate.

The possible Justice Health involvement occurred in September 2007. On 21

September 2007 Dr McGeorge met with Ms Bell and Ms Bridie Lander, a friend of Antony. Ms Lander reported an incident where Antony had, whilst intoxicated, threatened to rape her. He had, as a result, either been charged with an offence and/or an application had been made for an Apprehended Violence Order to be made to protect Ms Lander. Dr McGeorge had recommended that when Antony came before the court for those proceedings it be asked that he be referred by the Magistrate for a compulsory assessment in accordance with Section 33 of the Mental Health Act 1990. This, for various reasons that do not need to be canvassed in these findings, did not happen.

Dr McGeorge did not have any further involvement with Antony although he did have a further meeting with Nick, Ms Bell and other family members of the family on 10 December 2007. At that meeting he was told that the family were still concerned as to Antony's wellbeing. At the time however they did not know his whereabouts. It was Dr McGeorge's recollection that there was discussion as to how members of the family should respond if or when Antony made contact with them.

As far as the available evidence is concerned it would appear that between 5 October 2007 and 9 November 2009 Antony did not have any further contact with mental health professionals or receive any medical treatment for a mental health condition. In fact Antony became increasingly reclusive during this period.

It is apparent from an examination of Antony's clinical record that throughout his involvement with Dr McGeorge and other members of the MHS the question of whether or not there were reasonable grounds for believing that the care, treatment or control of him was necessary for his own or others protection was repeatedly considered. Each time this was considered it was concluded that the requirements of the legislation had not been met. I accept that this was the case.

That conclusion was, of course a matter of judgement, it was open to other professionals to disagree as they did. This was shown by the differing advice

given to Dr McGeorge by Dr Olav Nielssen and Dr Richardson 4 January 2007 that has already been referred to above. It is also shown by the differing opinions expressed by Dr Giuffrida, Dr Ryan and Dr Samuels in the evidence given during the course of the inquest.

Dr McGeorge gave evidence at inquest. I found his evidence to be both thoughtful and candid. It appeared as if he had been quite affected by the tragedy that had unfolded. He had had contact with both Nick and Chloe. Dr McGeorge outlined his thinking at the various stages of his association with Antony and the conclusions he had reached. He indicated that he was at all times of the opinion that optimal treatment for Antony involved anti-psychotic medication. At no stage, however, was he able to get him to agree to the use of such medication. Antony did, however, continue to engage with him and other members of the mental health service.

Dr McGeorge considered that while this was occurring, and there was no acute concern for the wellbeing of him or others, the development of the therapeutic relationship and the possibility of him agreeing to commence anti-psychotic medications at some time in the future was preferable to the disruption of the relationship that would occur if involuntary treatment were to occur.

The evidence of both Dr Ryan and Dr Samuels was that the clinical decisions of Dr McGeorge were not unreasonable in the circumstances. Dr Giuffrida came to a different conclusion.

Dr Anthony Samuels was qualified by the Chief Executive, South Eastern Sydney Illawarra Area Health Service (SESIAHS) and the Executive Director, St Vincent's Hospital as part of a team to undertake a review into the clinical management and care provided to Antony. The other member of the review team was the Area Director Mental Health SESIAHS A/Professor Beth Kotze. In undertaking their review access was provided to all clinical records and Dr McGeorge was interviewed.

The conclusions of the review team can be summarised as follows:

From a diagnostic point of view, the reviewers felt that the longitudinal picture was clearly that of a chronic psychotic illness, most likely schizophrenia, which was periodically exacerbated by substance abuse.

In the opinion of the reviewers, the treatment given to Mr Waterlow was exemplary.

The only question in the minds of the reviewers was whether or not an assertive early intervention in the form of involuntary treatment under the Mental Health Act and forced antipsychotic treatment in the Caritas psychiatric unit would have altered the course of these tragic events. The reviewers were (however) satisfied that the approaches to Mr Waterlow were well considered and thoughtful.

On balance, the treating team felt it important to forge a therapeutic alliance with Mr Waterlow. He was adamantly opposed to medication. It was always the hope of Dr McGeorge and the treating team that he would ultimately be persuaded to take some medication. It was felt that if he was scheduled into St Vincent's Hospital against his will and given enforced medication, this would absolutely fracture any therapeutic alliance with Mr Waterlow, alienate him and make it more difficult to treat and follow up over the longer term.

Of course, with hindsight, involuntary admission, enforced medication and possibly a community treatment order might have been a more optimal approach, but nevertheless the clinicians who were involved in his care at this time carefully considered these options and on balance felt that attempting to work with him to form a therapeutic alliance, to give him alternatives to medication, to educate him about his illness, to attempt strategies to improve his insight, to encourage him to cease use of drugs and alcohol were strategies that in the long term would be more productive.

Dr Giuffrida reviewed to the course of Antony's involvement with the mental health services. He noted that on 30 November 2006 Antony attended an appointment with Dr Powell. He informed Dr Powell that he had not commenced a trial dose of Abilify as requested and said that he was 'adamant that he does not want to take medication.' Antony said that he was, however, willing to engage in therapy with a psychologist. Dr Powell at the time made a further note that read:

'Not for SII at this point. Continue to keep engaged with services- strongly advise? utility of medication to Anthony – continue to give psychoeducation – link with rehab.'

Dr Giuffrida noted that there was, at that time, a consideration of whether or not a Schedule II Certificate to detain Antony as an involuntary patient was considered. Dr Giuffrida thought that it should have occurred. He said:

It is difficult to understand why at this point given that Mr Waterlow had continued to deteriorate in his psychotic illness and adamantly refused to take medication and after a consideration for involuntary detention was discussed why that did not happen.

In a further elaboration of his views he stated in his report that:

Mr Waterlow suffered from a long standing, gradually escalating paranoid schizophrenic illness that remained untreated for many years from a point at which it could have been first identified in 2004. I have no doubt that Mr Waterlow suffered from a severe and deteriorating schizophrenic illness from 2006 onwards. There is nothing to suggest that Mr Waterlow's condition spontaneously remitted or was relieved at any time and it is highly unlikely to have been relieved spontaneously without treatment, which he did not have.

Dr Giuffrida was asked to comment on his expectation as to the seriousness of Antony's illness in the six months prior to 9 November 2009. He said that in his opinion:

There was no reason to consider that Mr Waterlow's schizophrenic illness would have been any less severe than it had been over the previous three years leading up to the deaths of Chloe Heuston and Nicholas Waterlow. Mr Waterlow's mental illness would in my view have been considered to be very to extremely severe given that it was likely that he was constantly tormented by derogatory, threatening and commanding hallucinations, which reinforced his delusional fears and caused him to entertain violent thoughts of harming or killing members of his family and two friends. He was in any event grossly disabled by it in his ability to function at all competently. That is in affect, as severe as paranoid schizophrenia becomes.

Dr Ryan agreed with Dr Giuffrida on this point. Having reviewed the information available to him and described two ways of assessing the severity of schizophrenia Dr Ryan concluded that:

Using either method of estimation of the severity of Mr Waterlow's condition, I think most psychiatrists would believe him to have been severely unwell.

Discussion:

The history outlined above shows that there is no doubt that for many years Antony suffered an increasingly debilitating mental health condition. His quality of life was severely restricted. In the 18 Months prior to the events of 9 November 2009 he was living in a boarding house and was receiving a Newstart allowance due to having been unemployed for some years. For some or all of this period he had been suffering from auditory hallucinations, hearing people talking about him and persecutory delusions, believing that there was a conspiracy originated by his family to ruin his life and that he had a 'profile' on the internet.

Dr Nielssen's report (prepared for the criminal trial) referred to him being in a state of *constant paranoia* and that he believed that he *could be killed at any time*. Dr Wilcox's report (also prepared for the criminal trial) noted that he had experienced *constant unrelenting voices (auditory hallucinations) for five or six years*. Dr Wilcox's history notes that in the period leading up to 9 November 2009 Antony was *in a state of constant fear* and that he *hardly slept* fearing that when he was asleep *he was being sexually assaulted and that his dreams were being manipulated*.

To say that Antony's existence was *miserable* as a consequence of his condition would hardly be an adequate description. That it could have been significantly ameliorated by medication is, as the situation following the deaths of Nick and Chloe have shown, undoubted. Unfortunately Antony's refusal to agree to him being medicated and the absence, in the mind of the treating practitioners, of circumstances that could have led to him being compulsorily medicated resulted in the tragic deaths of Nick and Chloe.

What can we learn from this tragedy?

The evidence available shows that in the two years prior to Nick and Chloe's death Antony had no contact with mental health professionals in spite of his apparently worsening mental health. He also appears to have had little

contact with family members who the subject of his paranoia and delusions. This is consistent with the nature of schizophrenia where, as I have previously noted, if the condition results in aggression it is usually expressed to family, friends or others who are close to them and rarely to strangers.

Dr Wilcox expressed the opinion that in the period leading up to Antony's attack on Nick and Chloe both his delusions intensified and hallucinations became more frequent. In many ways by inviting Antony to dinner on 9 November 2009, which was due to their love and concern for him, Nick and Chloe were unknowingly placing themselves in a very dangerous position. This is why at the beginning of my finding I described Nick and Chloe's deaths as being a love story with a tragic ending.

I have examined the mental health care that was provided to Antony by various professionals in the period between 2004 and 2007 in some detail. There is no doubt, and I accept, that at all times the relevant practitioners considered that anti-psychotic medication would be of assistance to Antony. There is equally no doubt that at no time was Antony prepared to agree to the use of such medication.

In such circumstances the only way that Antony would have the benefit of such medication would be if he were compelled to accept such medication. This would have required the making of orders under the Mental Health Act. This brings us to the question that was raised by Juliet Darling in her request for the resumption of the inquest namely is that legislation adequate in order to deal with circumstances such as occurred in this case?

The expert psychiatrists qualified to assist me in this regard have identified two alternative approaches to this issue. Dr Ryan in his report and during evidence outlined an alternative approach to the provision of mental health care and a need to change the basis for involuntary detention. This is the approach suggested by Juliet Darling

I have already outlined the current basis for involuntary detention above. Dr

Ryan provided an outline as to why he, and others within the profession, consider that the current system discriminates against persons solely on the basis of their mental health and consequently is not consistent with the United Nations Convention of the Rights of Person's with Disabilities which Australia ratified following the enactment of the Mental Health Act 2007.

Dr Ryan notes that the Mental Health Act makes no reference to a patient's decision-making capacity. This, he presumes, is the explanation for the lack of any mention of that matter in Antony's clinical notes. He also notes that it is well established at common law, outside the realm of mental illness, a person with decision making capacity may refuse medical treatment even if the decision is *not sensible, rational or well considered and even if refusal will likely lead to death or serious injury*. It is also well established that if a person does not have decision-making capacity their decision can be overridden, as it will not be taken to reflect genuine free choice. In such cases an application might be made in accordance with the Guardianship Act 1987.

Dr Ryan analysed the provision of medical treatment in Antony's situation in this regard in the following manner:

If instead of suffering schizophrenia, Mr Waterlow had suffered a medical illness, say hypothyroidism, it is likely that the approach to his refusal of treatment would have been quite different. His doctors would have come to any consultation with the presumption that he had decision-making capacity. However, his refusal of treatment, coupled with the knowledge that hypothyroidism may cause cognitive problems that may interfere with an individual's decision-making capacity, would have prompted a formal review of that capacity. If, on this review, he was found to retain decision-making capacity his decision to refuse treatment would have been respected, but if he had been found to lack decision-making capacity, it is likely that the provisions of the Guardianship Act would have been invoked to allow Mr Waterlow access to unconsented treatment.

We know however that at all, or almost all, clinical encounters, Mr Waterlow believed he did not have schizophrenia or any other psychotic illness, and that his perceived experiences of persecution reflected the reality of the world around him. It seems likely that it was on this basis – the delusional belief that he was in fact being persecuted – that he refused antipsychotic medication. If this assumption is correct then it is reasonable to say that with regard to a decision to accept antipsychotics, Mr Waterlow lacked, at least, the

ability to use and weigh relevant information as part of the process of making the decision, and as such lacked decision-making capacity as defined by common law. While he would have gone on to receive unconsented treatment had his lack of capacity been due to hypothyroidism, the fact that his lack of capacity was due to schizophrenia, meant that the usual avenue to receive effective treatment – the treatment that was likely to restore his decision making capacity – was not open to him.

Based on the above analysis Dr Ryan recommended that consideration be given to the amendment of the Mental Health Act so as to remove the requirement that clinicians make some estimate of a mentally ill person's risk of *serious harm* and that this be replaced by capacity-based provisions that mirror treatment refusal laws for people without mental illness.

In this respect there was disagreement within the profession. Dr Giuffrida, for one, is of the opinion that the present legislation is best retained in its present form. Dr Giuffrida accepts that there is some merit in the concept of a capacity test however he argues that the notion of capacity is already inherently in the mental health legislation for involuntary detention. He suggests that:

In so far as the definition of mental illness within the Act implies that if a person is found to be a mentally ill person within the meaning of the Act, then that person effectively lacks the capacity to understand that they have such a mental illness and cannot accordingly properly understand why and by what means they need to be treated.

Dr Guiffrida sees the problem as not being one with the current legislation but with the misunderstanding or misinterpretation of the legislation. He describes the problem, as he sees it, as follows:

The problem is not the legislation as such but the tendency of some doctors to raise the threshold as to what they consider constitutes mental illness and risk of harm, to the point where they determine that a person is not schedulable.

As to the proposed use of the capacity test Dr Guiffrida suggests that it is inappropriate in the case of mental illness. He suggests that:

Whilst the capacity test is entirely appropriate in those suffering from dementia or intellectual disability and that is already provided by the

Guardianship legislation, it is my view simply inappropriate to the mentally ill unless they are so grossly disorganised and thought disordered to the point of incoherence.

The reason that this is the case, Dr Guiffrida argues, is because of the very nature of mental illness itself. It is because a mentally ill person's capacity to understand the nature of their illness, and the need for treatment, will vary in response to the treatment itself. It is in the very nature of psychiatric disorder that cognitive and therefore legal capacity is nebulous and constantly shifting in response to all of the circumstances in which the patient finds themselves. He points out that in the forensic setting:

Patients who are initially considered to be unfit to plead and for trial are routinely treated to capacity at which point, with a capacity test of involuntary detention, the person may achieve legal capacity to refuse further treatment.

Antony's situation is a case in point in this regard. As I have mentioned before following the events of 9 November 2009, and him receiving medication in custody, Antony was found by Justice Hidden at his trial to have insight as to his condition.

The debate within the medical profession, and elsewhere, as to most appropriate tests to be applied in respect of compulsory treatment of the mentally ill is not something that can be resolved by me in this case. That will eventually be a matter for the Parliament. The evidence before me shows that there are legislative proposals before the Victorian, Tasmanian and Australian Capital Territory Legislatures that provide various models to be considered by those responsible for deciding how best to resolve this difficult issue.

The best that I as a coroner can do by examining the evidence in this case is identify difficulties that arose in providing mental health care to Antony which, had it been provided, might have prevented the deaths of Nick and Chloe.

Some issues that are immediately apparent were firstly the frustrations Antony's family and friends experienced in their efforts to have him receive appropriate medical treatment in circumstances where the relevant medical

and other practitioners, who agreed that it was necessary for Antony to be medicated with anti-psychotic medication, did not consider that they were able to use the compulsive powers of the Mental Health Act, secondly the importance that the clinicians placed on the rising level of violence and aggression that family and friends were experiencing and were reporting and finally the fact that Antony's condition was worsening due to the absence of treatment by medication to the point that his quality of life could only be described as being *miserable*.

At the conclusion of the inquest a number of possible recommendations were suggested by Counsel Assisting that could be made in accordance with Section 82 Coroners Act 2009. The recommendations suggested were as follows:

1. *An amendment to the Mental Health Act 2007, so that it expressly states that in determining whether to schedule a mentally ill patient pursuant to s. 14(1)(a), the term 'for the person's own protection from serious harm,' should be understood to include the harm caused by the mental illness itself.*
2. *An amendment to the Mental Health Act 2007, so that it expressly states that in determining whether to schedule a mentally ill patient pursuant to s.14 (1)(a), the term 'for the protection of others from serious harm' should be understood to include 'for the protection of others from serious emotional harm.'*
3. *An amendment to the Mental Health Act 2007, to delete the reference to 'physical' harm in sections 15(a) and (b) and to specify that the term 'for the person's own protection from serious harm,' should be taken to include the harm caused by the mental illness itself, and the term 'for the protection of others form serious harm' should be understood to include ' for the protection of others form serious emotional harm.'*
4. *That schedule 1 to the Mental Health Act 2007 be amended to remove any ambiguity in Part 1(1) of the Form, with respect to the test that must be met before a patient can be scheduled.*
5. *The design and distribution of an information booklet setting out advice for families, carers and friends attempting to support persons suffering from mental illness/disorder, who have been threatened by or are fearful of a person who may be suffering a mental illness/disorder.*
6. *The allocation of services (including a facility, staff and training) to provide mid-term care to patients suffering from a non-acute psychosis, that need in-patient facilities but are not suitable for short-term acute care.*

The first four suggested recommendations sought to address the concern highlighted in this case that at times it appeared to be thought that it was not

possible to schedule Antony even though it was apparent that his psychosis was becoming more pronounced and his quality of life, and that of his family and friends, was being seriously affected. I consider that the it would be appropriate for such changes to be considered in order to assist in clarifying the tests to be applied.

I consider that the fifth suggestion is also worthy of consideration. In this case it is clear that those seeking to help Antony experienced a considerable frustration in understanding how they could do so and even though it is apparent that Dr McGeorge and other members of the mental health team made considerable effort in communicating with family sometimes being able to readily access a guide can provide support and information when the practitioners are not readily available.

The final suggestion deals the circumstances where it would be beneficial to provide inpatient care for a patient but the level of care required is not such as to require the provision of acute hospital facilities. This was an issue that Dr McGeorge considered at various stages in his treatment of Antony. He was concerned that were it to have been appropriate for Antony to have been scheduled the pressure on acute beds at the St. Vincent's facility was such that it was likely that when Antony was stabilised he would be discharged and for that to occur would not have been helpful.

The provision of resources within the health system to support persons suffering from mental illnesses or disorders is a matter of political and economic controversy. Resources available for mental health care are the subject of competing demands and a coroner examining the circumstances of a particular death or event is not in a position to make recommendations that are useful as to the application of scarce resources even where, as in this case, the proposal is one that would obviously be of benefit to the relevant patients. In the circumstances I do not consider that it is appropriate to make the recommendation suggested.

There is however one other matter where I consider a recommendation might

usefully be made and where the circumstances of this case appears to highlight a systemic problem. In Antony's case there was no doubt that he suffered from a psychotic illness for a number of years. There is also no doubt that the mental health practitioners involved with his care were unanimous that the treatment of his illness required the use of anti-psychotic medication. The subsequent history has proved that this was the case.

Unfortunately it was not considered, during the time during which the mental health professionals were treating him, that the compulsive powers of the *Mental Health Act* that would have resulted in him being admitted to a mental health facility were available. This raises the question of whether or not there are changes that might be made to the *Mental Health Act* to deal with situations of this kind?

One matter that appears to me to have some merit would be to bringing about a greater awareness to of the usefulness and availability of Community Treatment Orders (CTO's) in such situations.

Section 51(1) Mental Health Act provides that the Tribunal may make a CTO *authorising the compulsory treatment in the community of a person*. Prior to 11 November 2007 such orders were known as Community Counselling Orders (Section 118 mental Health Act 1990). Unfortunately prior to the commencement of the Mental Health Act 2007 on 16 November 2007 only the Tribunal or Magistrate holding an inquiry into the admission to, and detention of, a mentally ill person in a hospital could make such orders.

Then, as is the case at present, it was common that following a person being compulsorily hospitalised they might be discharged into the community on an order that, among other things, required the patient to take medication that has been prescribed. This is done in order to ensure the patient's condition is maintained whilst they are cared for in the community.

Unfortunately at the time practitioners were seeking to assist Antony the legislation did not allow for such an order to be made without a patient being

first the subject of compulsory detention in a hospital. That is no doubt why there is no consideration of such an order in the treatment notes that are available.

The Mental Health Act now, however, does not require that a person be an involuntarily patient prior to a CTO being made. Section 51(3) provides as follows:

(3) An application may be made about a person who is detained in or a patient in a mental health facility or a person who is not in a mental health facility.

Section 51(2) provides that any of the following may make an application to the Tribunal for the making of a CTO:

- (a) the authorised medical officer of a mental health facility in which the affected person is detained or is a patient under the Act,
- (b) a medical practitioner who is familiar with the clinical history of the affected person,
- (c) any other person prescribed by the regulations.

Regulation 8(b) of the *Mental Health Regulation 2013* prescribes that a primary carer is a prescribed person in accordance with Section 51 (2)(c) *Mental Health Act*.

Were such provisions to have been applicable at the time Antony was being treated by the various mental health practitioners Dr McGeorge, and other practitioners, would have, had they considered it appropriate, been able to make such an application. Nick and Chloe would, and Gaye Bell may, have also been able to make an application as they met the definition of primary carer.

Such orders might be made where the persons condition is such, as was the case with Antony, as to prevent their acceptance of the need for medication and where the failure to be medicated is likely to lead to a worsening of the condition from which they suffer. Were such an opportunity to have been available in Antony's case, I would think that because of their concern for Antony, Nick and/or Chloe would probably have made such an application had Antony's treating professionals not done so.

A carer able to avail him or herself of such a procedure would assist in relieving much of the frustration that Nick, Chloe and others experienced in trying to support Antony. They need, however, to be aware of the availability of such an order. I consider that it would be in the public interest if the availability of such a procedure were to be more widely publicised. I propose to make a recommendation in accordance with Section 82 to that effect.

Magistrate P.A.MacMahon

Deputy State Coroner

10 January 2014

