CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of FW
Hearing dates:	13-16 March 2018
Date of findings:	26 April 2018
Place of findings:	NSW Coroners Court - Glebe
Findings of:	Magistrate Elizabeth Ryan, Deputy State Coroner
Catchwords:	CORONIAL LAW – self-inflicted death – bipolar affective disorder – Community Treatment Order made in Victoria – whether enforceable in NSW – adequacy of psychiatric care in NSW - recommendations.
File number:	2014/00264839
Representation:	Mr I Harvey, Counsel Assisting, i/b the Office of the General Counsel, NSW Department of Justice. Ms N Hodson of Counsel for Dr K George, J Field, S Sculley and Eastern Health District Victoria, i/b Lander and Rogers. Ms K Bourke of Counsel for Dr M Alsabti i/b i/b MDA National. Mr M Byrne of Counsel for Ms D Hall, i/b Nurses and Midwives Association. Ms L Boyd for Murrumbidgee LHD and Adam Phillips NSW Health, i/b the Crown Solicitor's Office. The W family.

Findings:	**Identity** The person who died was FW, born on 5 June 1935. **Date of death**: FW died on 7 September 2014. **Place of death**: FW died at 6 Bruton Street Tocumwal NSW. **Cause of death:** FW died from external neck compression as a result of hanging. **Manner of death**: FW hanged himself with the intention of ending his life.

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Section 81(1) of the *Coroners Act 2009 (NSW)* [the Act] requires that when an inquest is held, the Coroner must record in writing his or her findings as to various aspects of the death.

These are the findings of an inquest into the death of FW.

The Inquest

An inquest is different to other types of hearings. It is neither criminal nor civil in nature. It does not determine whether a person is guilty of an offence and does not make determinations and orders that are binding on parties.

The Coroner is required to confirm that a particular death occurred and make findings as to the identity of the person who died, the date and place of death, and the cause and manner of the death. In addition under section 82 of the Act the Coroner may make recommendations that are necessary or desirable in relation to any matter connected with the death, including health and safety.

Introduction

1. Mr W aged 79 years died at his home in Tocumwal, a small town in the southern Riverina region of NSW. On the morning of 7 September 2014 a passerby noticed Mr W's body hanging from the roof rack of his car, which was parked in the laneway next to his house. Emergency services were immediately called but Mr W could not be revived.

2. For most of his life Mr W had lived in Melbourne. In 2004 he had been diagnosed with bipolar affective disorder, a chronic and severe mental health condition. People who experience it can have periods of deep and prolonged depression alternated with episodes of excessively elevated mood known as mania or hypomania.

3. Mr W had a history of not using his medication, and at the time of his death he was subject to a Community Treatment Order [CTO] which had been made in Melbourne. Mr W's CTO required him to have regular psychiatric reviews and receive fortnightly injections of his antipsychotic medication. However for reasons which are discussed below, the CTO was never implemented when Mr W moved from Melbourne to NSW after it was made.

4. This inquest has focused on whether appropriate arrangements were made for continuing Mr W's psychiatric care once he moved to NSW, and the extent to which (contributed to his death?).

The autopsy report

5. An external post mortem examination was conducted by forensic pathologist Dr Brian Beer. The cause of death was found to be external neck compression caused by hanging.

6. Toxicological analysis of Mr W's post mortem blood samples detected non-toxic levels of the sedative Nitrazepam (brand name Mogadon) and the anti-depressant Mirtazapine. No traces of Mr W's prescribed bipolar medication were detected.

Issues at inquest

7. The issues which arose for consideration at the inquest were as follows:

How did those responsible for Mr W's treatment at PJC and at DCMHS view his status?

Mr W's life

8. Mr W was born in Melbourne on 5 June 1935. When he finished school he trained as a plumber, going on to establish a large plumbing business. He married his wife S in 1957 and they had seven children: A, S, G, C, J, G and A.

9. In her statement to the inquest A described a happy and busy life growing up with her parents and brothers and sisters. Throughout their childhood Mr W and his wife took the children on school holidays caravanning and sailing, and Mr W was active in sports of golf, fishing and water skiing. Eighteen grandchildren were born into the family, and FW and S spent many happy times at their large family gatherings.

10. SW attended each day of this inquest, as did A and G. At the close of the evidence A spoke about her father's life, and read to the Court a statement which her brother G had prepared. Son SW also provided a written statement for the coronial brief. All expressed their pain and profound sadness that their father had died alone and depressed, and without the psychiatric help that he required. They spoke too of their perception that mental health laws do not do enough to ensure that mentally ill persons comply with their medication, and the deeply distressing impacts of this upon themselves as carers and families.

Mr W's mental health history

11. Mr W was first diagnosed with bipolar affective disorder at a relatively late stage in his life, at the age of 68 years. From 2004 until 2013 his condition was generally managed with medication and with the support of his family, in particular his wife S who was his main carer.

12. In 2008 Mr W required an involuntary admission to the Peter James Centre [PJC]. PJC is a residential aged care centre in Melbourne which also provides inpatient psychiatric care. However for the most part Mr W was able to live a regular life with his wife, meeting friends, going on holidays at Sorrento Beach, and playing lawn bowls each week. Importantly he was able to enjoy the love and company of his children and grandchildren at frequent family gatherings.

Mr W's 2013 admission and aftermath

13. In early 2013 Mr W began to relapse into hypomanic behaviour. His family and friends became alarmed by his reckless overspending, verbal aggression and inappropriate interactions with people inside and outside the family circle. They suspected he was not using his medication. As he was not willing to stay in hospital, on 20 March 2013 he was admitted as an involuntary patient in the acute aged psychiatric unit at PJC.

14. Here Mr W came under the care of Dr Kuruvilla George, a consultant psychiatrist and the Director of Aged Persons Mental Health. Dr George assessed Mr W to be in the hypomanic phase of his illness.

15. By 23 April 2013 Dr George was of the opinion Mr W's mental state and behaviour had significantly improved. He was discharged home, to be managed by a community mental health team.

16. A key member of the community team was Registered Nurse Jean Field, a psychiatric nurse and senior clinician with the Aged Psychiatry Assessment Team at PJC. Ms Field had been Mr W's most consistent case worker since 2008, and over the years she had provided him with significant support. She also had regular contact with his family.

17. Unfortunately throughout 2013 Mr W continued to behave in a disturbed and often aggressive manner. He freely told his daughter A and his sons that he was not taking his bipolar medication and had no intention of taking it. In his letter to the Court his son G described how his father loved the feeling of being elated; thus he reacted with hostility and aggression when his family tried to have measures put in place to ensure he took his medication. By May 2013 Mr W's children had become so concerned for the safety and welfare of their mother S that they arranged for her to move out of the family home. Mr W continued to live there on his own.

Mr W's 2014 admission and the CTO

18. Mr W was re-admitted to PJC on an involuntary basis on 17 January 2014. Dr George assessed that Mr W was again displaying clinical symptoms of hypomania. As he was unwilling to remain in hospital he was placed under an Involuntary Treatment Order.

19. Mr W appealed his status as an involuntary patient and on 10 February 2014 his case came before the Victorian Mental Health Review Board.

20. Dr George's report to the Board detailed that following admission Mr W's behaviour had settled with administration each night of sodium valproate 500mg and the drug Risperidal Consta 25mg, delivered by way of fortnightly intramuscular injections. Risperidone is an antipsychotic medication used to treat the symptoms of bipolar disorder and schizophrenia. Valproate is also used to treat bipolar disorder, as a mood stabiliser to prevent recurrence of mania or depression.

21. Dr George's report also referenced Mr W's history of non-compliance with his medication and his declared intention of not taking it once he was discharged.

22. The Board determined that Mr W's continued treatment as an involuntary patient was necessary, but agreed that his condition could safely be managed in the community with a twelve-month Community Treatment Order [CTO]. A CTO is a legal order which sets out the terms under which a person must accept medication, therapy and other services while living in the community. Thus Mr W's status continued as an involuntary patient albeit not one who was detained in a facility.

23. Dr George prepared and signed the CTO on 17 February 2014, as well a compulsory Treatment Plan which the CTO was designed to support. Mr W's Treatment Plan required him to have regular psychiatric reviews and to receive sodium valproate and fortnightly injections of Risperidone.

The transfer of Mr W's care to DCMHS

24. Dr George's team was aware of that on discharge from PJC. Mr W planned to leave Melbourne and move to the NSW town of Tocumwal, about three and a half hours' drive away. In 2013, feeling estranged from his wife and family, he had bought a house there and had decided to live in it on his own.

25. Dr George's team therefore needed to transfer Mr W's psychiatric care to an appropriate service in the Riverina region. They identified the Deniliquin Community Mental Health Service [DCMHS] as the NSW health centre to which Mr W's psychiatric care could be transferred.

26. DCMHS is a declared mental health facility, managed by the Murrumbidgee Local Health District. It is authorised to apply for and administer CTO's under the *Mental Health Act 2007 (NSW).* It is not authorized to receive inpatients; such patients must be referred to Albury Hospital.

27. A GP practising in Tocumwal, Dr Maher Alsabti, was identified as suitable for administering Mr W's fortnightly injections of Risperidone.

28. On 17 February 2014 Dr George arranged transfer documents to be faxed to DCMHS. These included a five-page Discharge Summary. It described Mr W's history of non-compliance with medication, and noted that at his most recent admission he had *'… presented with symptoms of hypomania due to non-compliance with medications'.*

29. The Discharge Summary noted that Mr W had been placed on a CTO involving administration of valproate and fortnightly injections of Risperidone. It concluded:

    '*Patient … will have follow up with Mental Health Services in Deniliquin Victoria (sic). He will also need to contact Dr Maher Alsabti (GP) in Tocumwal for regular review and depot risperidone injection.'*

30. Dr George also sent to DCMHS a copy of Mr W's CTO, and a form titled 'Transfer of an Involuntary Patient to Another Approved Mental Health Service'. This described Mr W as an involuntary patient who was subject to an involuntary treatment order.

31. The Transfer form completed by Dr George referred to Dr Paul Friend as the *'delegated/authorized psychiatrist consulted'* in relation to the Transfer. Dr Paul Friend is a psychiatrist and visiting consultant who provides part time services to Albury and Deniliquin Community Mental Health Services. He has no record or recollection of a conversation with Dr George about Mr W, and was never asked to perform a psychiatric review of him. Dr George himself was unable to recall whether he had spoken about Mr W to Dr Friend.

32. Dr George told the Court he was of the understanding that as a NSW health service, DCMHS was not bound to administer the Victorian CTO. However his expectation was that at the earliest possible time DCMHS would arrange a psychiatric review of Mr W to determine an appropriate management plan. He expected that until the review took place the Treatment Plan he had prepared would continue to be implemented, including Mr W's fortnightly risperidone injections administered by his new GP.

33. Dr George thus envisaged that DCMHS and Dr Alsabti would be jointly involved in Mr W's psychiatric care in Tocumwal, implementing the two key elements of his Treatment Plan: administration of medication and regular psychiatric reviews.

The care received by Mr W in NSW: Dr Alsabti.

34. After Mr W arrived in NSW in February 2014 neither Dr Alsabti nor any other clinician administered Risperidone to him. Nor did Dr Alsabti or any other clinician take steps to monitor whether Mr W was using his adjunct bipolar medication Epilim.

35. Dr Alsabti established the Rao Medical Practice in Tocumwal in 2007. His professional experience had included a period spent in the area of psychiatric medicine.

36. Dr Alsabti has no independent recollection of Mr W and he relied on his medical records to assist the inquest. He agreed it was likely he had received and read Mr W's Discharge Summary from PJC, as well as information that Mr W's next Risperidone injection was due on 24 February. Dr Alsabti agreed that on the face of it, this material represented a request that he continue Mr W's treatment of Risperidone injections. Indeed it would be difficult to interpret them any other way.

37. Between 24 February and 5 August 2014 Mr W attended Rao Medical Practice on ten occasions, usually seeing Dr Alsabti. The practice's records confirm that at no time was he prescribed or administered any Risperidone. In fact they do not refer to the subject at all.

38. In his evidence at the inquest Dr Alsabti seemed at a loss to account for the fact that despite the documents he had received, he had never given Mr W any Risperidone. Dr Alsabti merely commented that normally he would have expected a verbal communication from the treating clinician of the transferring service.

39. Dr Alsabti prescribed a number of other medications to Mr W. These were Mobic a non-steroidal anti-inflammatory drug; Mogadon a sedative drug for sleeping problems; the antidepressant mirtazapine (brand name Avanza); and Mr W's adjunct bipolar medication Epilim.

40. Dr Alsabti did not prescribe Epilim to Mr W until 6 May, some three months after Mr W's arrival in Tocumwal, and then at a dosage significantly lower than that recommended by Dr George in his Discharge Summary.

41. The extent of Mr W's compliance with his Epilim is unclear. It is possible that during the period February to May Mr W had access to supplies of Epilim left over from his PJC admission. This is difficult to judge, as there is no evidence of an initial assessment by Dr Alsabti listing Mr W's current medications. Nor during his six-month involvement with Mr W did Dr Alsabti direct any blood tests to monitor his compliance with Epilim.

42. On 29 April Mr W reported to DCMHS that Epilim was one of his current medications. And there is some evidence Mr W was using Epilim in late August 2014: blood tests performed when he visited Melbourne at that time showed the presence of valproic acid.

43. However the evidence establishes Mr W was not using Epilim at the time of his death. This was the opinion of expert toxicologist Dr Judith Perl, who noted that Mr W's postmortem blood samples did not show the presence of any valproate. In her opinion the toxicology results indicated he had not used Epilim for a couple of days prior to his death and possibly longer.

The care received by Mr W in NSW: DCMHS

44. Mr W never received a psychiatric review in NSW. In fact after he arrived in Tocumwal he did not receive a mental health assessment of any kind for almost eleven weeks.

45. At DCMHS Mr W's assessment was assigned to Ms Dawn Hall, then a Registered Nurse and Clinical Leader of the service's Adult Mental Health teams. Ms Hall had many decades experience as a nurse and had worked at DCMHS for the past 13 years, performing assessments of clients and preparing Care Plans for them. She retired from paid work in December 2016.

46. Neither Ms Hall nor anyone from DCMHS had any contact with Mr W until 28 April. Ms Hall had difficulty making contact with him: the mobile phone number supplied by PJC provided no connection, and her letter to his new address went unanswered. She contacted PJC requesting confirmation of the contact details.

She also asked Rao Medical Practice to request Mr W to contact her when he attended there; however Mr W did not do so.

47. After these attempts failed DCMHS made no further efforts to locate Mr W for several weeks. This was despite concerned calls made to their service by Ms Field and Mr W's daughter A, as follows.

48. On 19 February in a phone call to 'Kerry' of DCMHS, Ms Field provided further background to Mr W's care and warned of his '*risk of non-compliance with medication and the risk he posed when his mood was elevated'*. Ms Field also made suggestions for finding Mr W, including making contact with the W family and asking the Tocumwal police to try to make contact with him. It does not appear DCMHS attempted any of these actions.

49. On 7 March 2014 Mr W's daughter A spoke by phone to an unidentified DCMHS staff member. She expressed strong concern that her father did not seem to be having his depot injections. This call did not prompt renewed efforts by DCMHS staff to make contact with Mr W.

50. On 28 April Jean Field rang Ms Hall to pass on more family concerns about Mr W's condition. Ms Hall finally obtained an operational phone number for Mr W. This led to her first contact with Mr W the following day.

51. In all Ms Hall had three face to face meetings with Mr W, which took place on 29 April, 21 May and 18 June.

52. At their first meeting on 29 April Ms Hall reviewed the PJC Discharge Summary with Mr W. She found he displayed low mood, was missing his family, and was questioning whether he should have isolated himself from them. He denied any plans to harm himself. Ms Hall considered he had *'poor insight, does not believe he is 'as bad as other people with real bipolar disorder'',* and *'stated that he did not know why he had been hospitalized.*' She noted he had not had any Risperidone since he was discharged from PJC.

53. Ms Hall told the Court she had been concerned to learn that Mr W was not receiving his Risperidone. She had strongly encouraged him to see psychiatrist Dr Friend for a medication review. But Mr W did not want to do this, as he had no desire to receive his injected Risperidone.

54. For reasons which are discussed below, Ms Hall did not believe she could compel Mr W to attend an appointment with a psychiatrist. She was unable to recall if she had discussed with Dr Alsabti her concerns about Mr W's lack of medication. There is no record of any such discussion.

55. At their next meeting on 21 May Ms Hall found Mr W's depressive symptoms to be persisting, although he denied suicide ideation. She diagnosed that he was in the depressive phase of his bipolar affective disorder.

56. On 18 June Ms Hall had her third and final meeting with Mr W. She thought his mood had improved somewhat and noted that he '*continues to see local GP as needed'*. At this meeting Mr W agreed to have DCMHS's service request closed.

57. Ms Hall completed a Discharge Summary in relation to Mr W and sent a copy to Dr Alsabti. She noted that Mr W had not developed any insight into his mental illness. However he was '*by now euthymic in mood'* and satisfied with his medications. In short, there was *'no indication for case management at this time*'.

DCMHS's understanding of Mr W's CTO

58. A significant issue in this inquest is the way in which DCMHS viewed Mr W's Victorian CTO, and the implications of that understanding for their ongoing care and treatment of him.

59. Ms Hall recognised that Mr W had a well established and enduring mental illness, with episodes of relapse due to non-compliance with his medication. She knew he had recently been an involuntary patient in Melbourne for this reason, and was subject to a current CTO.

60. Nevertheless after he arrived in Tocumwal she had at all times regarded Mr W as a voluntary client, under no legal obligation to comply with a CTO made in another State which obliged him to engage with a mental health service or with a treating psychiatrist, or to take prescribed medication. Although she recognised all these measures were important to his mental health, she believed there was no power in NSW to compel him in relation to them.

61. The reason for this is that on 20 February 2014 Ms Hall had enquired with the NSW Mental Health Review Tribunal about the status of Mr W's Victorian CTO. She was advised it could not be enforced in NSW, and that the appropriate action was for DCMHS to assess Mr W and decide whether to seek a CTO under NSW mental health law.

62. Ms Hall had given some consideration to seeking a CTO from the NSW Mental Health Tribunal, but had decided against it. She explained that she was required to assess Mr W on the basis of his presentation on 29 April. At this time she did not think he was mentally disordered to the extent she believed would be necessary to justify an application. She knew she did not have the advantage of the lengthy involvement with Mr W which the PJC clinicians had.

63. To the Court Ms Hall expressed sincere regret that she had not been able to treat Mr W as a person who was subject to a CTO. In her view it would have beneficial for him if she had been able to enforce the compulsory conditions to which he was subject in Victoria, at least until he had been properly re-assessed in NSW. She suggested that in circumstances where a person subject to a CTO moved into another State, the interstate CTO should be accepted in the receiving State so there was a compulsory Treatment Plan already in place for the new mental health service to administer.

64. Ms Jean Field told the inquest that after Mr W moved to Tocumwal she believed he was being case managed by DCMHS in accordance with his CTO. Therefore it came as a shock to learn in a phone call on 21 August that Mr W's CTO was not being enforced in NSW, that he had not been receiving his Risperidone injections, and that DCMHS had in fact discharged him from their service.

Outline of issues

65. The cause of Mr W's death and its time and place are disclosed on the evidence. Mr W died on the morning of 7 September 2014 at Tocumwal, NSW. Dr Beer's autopsy report establishes that Mr W's death was caused by external neck compression as a result of hanging. The evidence amply supports the conclusion that Mr W's death was an act which he carried out with the intention of ending his own life.

66. The focus of the inquest has been on the circumstances of Mr W's death: specifically the adequacy of the psychiatric care which he received in NSW and whether it contributed to his death. A related issue is the question of whether the perceived unenforceability in NSW of Mr W's CTO was a circumstance which contributed to his death.

Expert evidence of Dr Peter Whetton

67. The Court heard evidence from Dr Peter Whetton, a psychiatrist with extensive experience in private and hospital psychiatric practice. He had been asked to provide his expert opinion on the appropriateness of the Treatment Plan prepared for Mr W, and the adequacy of the care and treatment which he subsequently received.

68. Dr Whetton considered that the arrangements made for transfer of Mr W's care to NSW were appropriate and adequate. In his view the Treatment Plan prepared by Dr George was in keeping with what he himself would have recommended for such a patient.

69. In Dr Whetton's opinion Mr W needed to have been seen promptly by a psychiatrist on his arrival in Tocumwal. This was particularly important given the recency of his involuntary admission and his history of medication non-compliance.

70. Thereafter Mr W needed to have been regularly reviewed by a psychiatrist. Dr Whetton explained that prescribing medication for bipolar affective disorder could be complex because of the need to manage successive hypomanic and depressive phases. In addition a psychiatrist could be expected to have a specialist's understanding of the severity and complexity of Mr W's illness, and the need for vigilant monitoring of his compliance.

71. Until that psychiatric review could take place, a clinician caring for Mr W needed to take as his or her starting point the Treatment Plan under the Victorian CTO. Dr Whetton explained that Mr W required mood stabilisers such as valproate, and antipsychotic agents such as risperidone. For patients with non-compliance

issues like Mr W, risperidone had the added benefit of being able to be delivered by intramuscular injection.

72. Dr Whetton was strongly of the view that when Mr W left Melbourne he needed to continue to be subject to a CTO:

    'With his history the greatest chance of maintaining some stability would have been with the continuation of the mood stabilizer such as valproate and in his case an injectable form of medication such as the risperidone. From the history of Mr W this would only have been achieved with a community treatment order being implemented in NSW'.

73. In her evidence to the inquest Ms Field too emphasised the importance to Mr W's mental health of strictly monitored medication and regular access to a psychiatrist. In her view, at the time of his 2014 discharge from PJC his risk profile was such that these needs were unlikely to be met by anything less than a compulsory order such as a CTO.

Was the care and treatment of Mr W in NSW adequate?

74. It was not submitted on behalf of any party that the care and treatment Mr W received in NSW was adequate. The evidence was significantly to the contrary.

75. For a number of years Mr W had suffered a severe mental illness, the management of which required a high degree of clinical oversight and family support. The evidence amply establishes that he lacked insight into his mental illness and for significant periods of time could not be relied on to make his own decisions about his mental health treatment.

76. At the time Mr W moved to NSW his treating team at PJC held a well grounded opinion, fortified by a finding of the Victorian Mental Health Board, that the minimum requirement for maintaining his health and safety was involuntary treatment, being a CTO conditioned on fortnightly injections of medication and regular psychiatric review. Mr W's level of risk was thus considered sufficiently high to justify treating him as an involuntary patient who could be brought back into detention if he breached either of these requirements.

77. Dr Whetton's expert evidence provided confirmation that without a CTO in place Mr W's clinical need for ongoing medication and regular psychiatric review was unlikely to be met.

78. Mr W's family took comfort from the CTO, believing it would ensure he received the oversight needed to maintain his mental health once he removed himself to NSW.

79. Yet after Mr W arrived in NSW in February 2014 the level of care he received fell far below what is described above. At no time was his mental health reviewed by a psychiatrist. He did not see a mental health clinician for almost eleven weeks, and was discharged from this service after only three meetings. He was administered no Risperidone. At the time of his death he was not using his

adjunct medication Epilim, and no steps were taken during his time in NSW to monitor his compliance with it. In summary he was receiving neither of the two elements of care considered critical to his mental health: psychiatric review and appropriate medication.

80. It may be said these deficiencies were largely the result of Mr W's own decision to decline such services. But that is to miss the point that his judgement about such matters was impaired as a result of his mental illness, the very circumstance which required the making of compulsory treatment orders. The evidence about Mr W's mental health amply demonstrated that at the time he moved to NSW it was not appropriate for him to be allowed to make his own decisions about his psychiatric treatment.

81. Deficient as Mr W's psychiatric care in NSW was, in my view it is not open to find that his death would not have occurred had he received appropriate care. It is well understood that bipolar affective disorder carries a high risk of suicide. In addition it is acknowledged Mr W was facing significant stress in 2014. He was feeling isolated from his family and friends and in August 2014 was facing the possibility of charges for alleged breach of an intervention order that had been obtained some months earlier to protect S. A handwritten note found after his death indicates he may have been further distressed by a mistaken belief he was suffering terminal cancer.

82. Nevertheless the evidence, in particular that of the expert witnesses, establishes that at the time of his death Mr W was in the depressive phase of his bipolar illness and was not receiving the medication and therapy he needed. Had he received appropriate care this would likely have enhanced his capacity to manage his emotional response to his situation. I note Dr Whetton's opinion that Mr W's state of mind may have stabilised in NSW if he had been provided with the treatment which his CTO was intended to deliver.

83. It would be difficult to criticise DCMHS for failing to ensure Mr W received his medication injections and have psychiatric reviews. From the outset Ms Hall believed, on the basis of advice from the NSW Mental Health Tribunal, that he could not be compelled to accept these services. This issue is further addressed below.

84. In my view however criticism is due for the lack of priority which DCMHS gave to bringing him under their supervision after his arrival in NSW. DCMHS clinicians were aware of the severity and complexity of his mental illness, his recent involuntary admission, his long history of non-compliance, his risk of relapse, and the existence of his CTO and its conditions. The service was on further notice of his risks from phone calls staff members had received from concerned family members and Ms Field. His risk profile thus warranted a high priority in terms of ensuring he received an expert assessment at the earliest possible time. This did not happen.

85. A similar lack of urgency characterised the approach Dr Alsabti brought to Mr W's treatment. He was in a position to know of Mr W's risks. Yet there is no evidence he was concerned about Mr W's failure to receive his medication or

even if he had a conversation with him or with DCMHS about it. Certainly his patient notes contain no such record.

Did the state of the law and practice regarding interstate implementation of CTO's contribute to this inadequacy?

86. Mr W's case illustrates the inadequacy of the current legislative framework in NSW to facilitate the care of a person subject to a CTO in Victoria, upon that person's transfer to a NSW mental health service.

87. Mr W did not receive timely, appropriate and adequate care when he moved to NSW. A significant factor underlying the deficiencies in his treatment was the belief of those treating him in NSW that he could not be compelled to comply with the Treatment Plan of his Victorian CTO. This was also the view of Mr Adam Phillips, the Clinical and Regulatory Director of NSW Mental Health Services in his evidence to the inquest.

88. It was considered there would be an exception where a Victorian CTO was able to be implemented by a service located in Victoria. This might feasibly occur for example in border areas. There was no suggestion this was a practicable option for Mr W, with the relevant service located hundreds of kilometres from his Tocumwal home. Rather, Mr W's NSW clinicians were informed that the appropriate course of action was to consider seeking a CTO under NSW law.

89. The inadequacies of this course of action as an appropriate plan for Mr W's care are all too evident. Its efficacy depended on him receiving a timely psychiatric assessment by a suitably qualified medical practitioner upon his arrival in NSW. A critical factor in his failure to receive such an assessment was the perception of his NSW clinicians that he could not be compelled to undertake it if he chose not to. Yet it was Mr W's lack of insight into his own clinical needs which necessitated the coercive measure of a CTO in the first place. The approach which NSW clinicians believed they were bound to take, of assigning him the status of a voluntary patient, enabled him to put himself out of the reach of the services and medication he most needed.

90. As a further matter it is arguable whether the premise that interstate CTOs are not enforceable is correct. The NSW *Mental Health Act 2007* makes clear provision for the transfer to a NSW facility of a person who is involuntarily detained in another State: such a person is deemed to be an involuntary patient/person in NSW [section]. The situation is less clear where the transfer is of an involuntary patient who is not detained, but is subject to a CTO.

91. Section 184 of the NSW Act provides as follows:

(1) An interstate community treatment order may be recognised in this State as if it were a community treatment order made by the Tribunal under this Act … if the conditions for recognition set out in the regulations are met.

(2) An interstate community treatment order recognised under this section is taken to be a community treatment order made under this Act … and this Act and the provisions of the Mental Health (Forensic Provisions) Act 1990 apply accordingly, except as provided by the regulations.

92. The NSW *Mental Health Regulation 2013* does not contain any *'conditions for recognition'* as anticipated under s184(1). However it does expressly provide for a CTO made under Victorian mental health law to be an interstate CTO for the purposes of Chapter 8 (which includes s184) of the NSW Act. On the face of it therefore, NSW mental health legislation contemplates the recognition and application in NSW of interstate CTOs as though they were made under NSW law.

93. However s56(3) of the NSW Act specifies that a community treatment order has no effect '*while an affected person is detained in a mental health facility ... or is a voluntary patient'.* If therefore Mr W was to be properly viewed as a 'voluntary patient' when his care was transferred to NSW, his voluntary status operated to invalidate his Victorian CTO in NSW.

94. Yet it was as an involuntary patient that Mr W's care was transferred to NSW, albeit one who was able to receive his treatment in the community. This is evident from the Transfer form signed by Dr George on 17 February, which described him as an involuntary patient subject to an involuntary treatment order. Mr W's status as such was also confirmed by Allison Thorne, Mental Health Drug and Alcohol Director for the Murrumbidgee Local Health District, in her evidence to the inquest.

95. In light of the above it is unclear why Mr W was viewed as a voluntary patient on his arrival in NSW. Had he not been, it is arguable there was no impediment to his Victorian CTO being recognised and applied in NSW as though it had been made under NSW law.

96. It should be further noted that on 9 September 2011 the NSW and Victorian Ministers for Health entered a Memorandum of Understanding to provide for the interstate application of mental health laws. Recital B authorises the NSW Minister to enter into an agreement with the corresponding Minister of another State for: *'… the recognition, implementation and enforcement of community treatment orders of NSW in another State, or another State's in NSW'.*

97. In addition clause 6.3 of the Memorandum provides that where a person subject to a CTO proposes to relocate to another State:

'…the treating Facility and the proposed treating Facility in the destination State will act co-operatively to facilitate, as far as practicable, the smooth transition of the person's community treatment and care.'

98. Evidence at the inquest was that no agreements pursuant to Recital B have been entered into between the NSW and Victorian Ministers. Nor have any operational procedures been developed to give effect to the express intention of clause 6.3 that there be a '*smooth transition of …community treatment and care*' in such

cases. It should be noted that the Memorandum is currently under review by the NSW Ministry of Health.

99. Unfortunately the circumstances of Mr W's treatment and care once he arrived in NSW reflected a very different picture to that contemplated in clause 6.3 above.

Conclusion

100. The sad circumstances of Mr W's death highlight deficiencies in the law and procedures relating to care and treatment of transferred patients who are subject to CTOs.

101. The evidence heard at this inquest illustrates the need for legislative and administrative arrangements to be made, so that patients like Mr W whose mental health depends on the smooth transition of interstate CTOs receive the care they need.

102. It is for this reason I consider it necessary and desirable to make the recommendations to the NSW Ministry of Health which appear below. The recommendation to the Murrumbidgee Local Health District is directed to the need, highlighted in the evidence regarding DCMHS and Rao Medical Centre, for their clinical staff to better appreciate the care and treatment needs of transferred patients who are subject to interstate CTOs.

103. I hope this inquest has helped Mr W's family find answers to some of their questions about how they came to lose their much-loved husband, father and grandfather. Too often the families of those who struggle with mental illness suffer heartbreak and sorrow in their attempts to care for their loved ones. FW's family will always feel profound sadness for his loss and the way in which he died. But I am sure they will also be comforted by remembering the happiness which he brought to their lives over the years.

104. I thank all who have assisted in this inquest, including the W family, the witnesses, and the officer in charge of the investigation. I thank also the legal representatives for their assistance, and in particular the dedication and commitment of Counsel Assisting Mr Ian Harvey and of Mr Alexander Jobe of the Office of the General Counsel.

Findings required by s81(1)

As a result of considering all of the documentary evidence and the oral evidence heard at the inquest, I am able to confirm that the death occurred and make the following findings in relation to it.

Identity

The person who died was FW, born on 5 June 1935.

Date of death

FW died on 7 September 2014.

Place of death
FW died at his house at 6 Bruton Street Tocumwal, NSW St George Hospital, Kogarah NSW 2217.

Cause of death
FW died from external neck compression as a result of hanging.

Manner of death
FW died hanged himself with the intention of ending his life.

Recommendations

To the NSW Ministry of Health:

1. That the Minister consider reviewing the provisions concerning the interstate application of mental health laws contained in Chapter 8 parts 1,2 and 3 of the *Mental Health Act 2007* **(the NSW Act)** in the light of counterpart provisions in the *Mental Health Act 2014 (Vic)* with a view to proposing any legislative amendments that may be necessary or desirable to ensure that where a mental health patient (whether or not involuntarily detained or subject to an inpatient treatment order) is referred or transferred by a mental health facility in another state to a declared mental health facility in NSW **(the receiving facility)** and that patient is subject to a community treatment order **(CTO)** in that other state:

(a) the CTO shall take effect as a CTO made under the NSW Act which Act shall apply accordingly, except as provided by the regulations;

(b) any documents that are relevant to the referred or transferred person are obtained by the receiving facility from the interstate mental health facility, and;

(c) the provisions of s56(3) of the NSW Act do not apply to a person subject to an interstate CTO that takes effect hereunder unless the authorised medical officer of the receiving facility or the Tribunal otherwise orders.

2. That in any consideration of the revision of the Intergovernmental Memorandum of Agreement between NSW and Victoria dated 9 September 2011, the parties consider preparing or developing or authorising appropriate guidelines to accompany any revised agreement with respect to the relocation of mental health patients subject to a CTO from one jurisdiction to the other.

To the Murrumbidgee Local Health District:

1. That the Chief Executive Officer consider reviewing existing policies and clinical practices relating to the care, treatment and management of mental health patients

in community health care agencies, and that new policies or guidelines that may be necessary or desirable be formulated to ensure:

(a) that all clinical staff involved in receiving a patient subject to an interstate CTO upon transfer from an interstate mental health facility **(tranfereree)** are fully aware of the procedures for authorising and arranging receipt of the transferee;

(b) that relevant staff fully consider the care and treatment information provided by the interstate mental health facility and any other health professional concerning the transferee to inform the assessment of the care and treatment needs of the transferee and the formulation of any ongoing management plan for the transferee;

(c) that such staff be provided with all the information and training necessary to consult effectively with any general practitioner or other health professional involved in the treatment or proposed treatment of a transferee to ensure that there is a clear understanding of the treatment that the transferee requires and of any tasks that the general practitioner or health professional must undertake.

I close this inquest.

E Ryan

Deputy State Coroner
Glebe

Date 26 April 2018