CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Brian Liston
Hearing dates:	11 - 13 July 2022; 20 July 2022
Date of findings:	4 August 2022
Place of findings:	NSW Coroners Court - Lidcombe
Findings of:	Magistrate Elizabeth Ryan, Deputy State Coroner
Catchwords:	CORONIAL LAW – fatal stabbing - attacker not guilty by reason of mental illness - adequacy of mental health care in community.
File number:	2105/363864
Representation:	Counsel Assisting the inquest: D Ward SC i/b NSW Crown Solicitor's Office. Sydney Local Health District: R Cheney SC i/b Hicksons Lawyers. Dr A MacDonald: J Harris of Counsel i/b Avant Law.

Findings:	**Identity** The person who died is Brian Liston **Date of death**: Brian Liston died on 10 December 2015. **Place of death**: Brian Liston died at Camperdown, NSW 2042. **Cause of death:** The cause of Brian Liston’s death is stab wound to the heart. **Manner of death:** Brian Liston died as a result of an unprovoked knife attack by a known person.

1. 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 the date and place of the person's death, and the cause and manner of death.

2. In addition, the Coroner may make recommendations in relation to matters which have the capacity to improve public health and safety in the future, arising out of the death in question.

3. These are the findings of an inquest into the death of Brian Liston.

Background

4. Brian Liston was aged 51 years when he died on the night of 10 December 2015.

5. Shortly after 8.30pm that evening, Brian was fatally stabbed while he waited at a bus stop on Salisbury Road in Sydney's inner awest area. Many people tried to help him, but tragically he could not be saved. He was pronounced deceased at nearby Royal Prince Alfred Hospital.

6. The man who stabbed Brian is William Cahill. Mr Cahill is a person who suffers severe longstanding schizophrenia which is largely treatment resistant. At the time of his attack upon Brian, Mr Cahill was being treated for this condition in the community. Mr Cahill did not know Brian and he had no rational basis to attack him.

7. Mr Cahill was charged with Brian's murder. At a special hearing in the NSW Supreme Court, he was found not guilty by reason of mental illness. On 17 October 2017 His Honour Justice G Bellew directed that he be detained in an appropriate correctional facility, or in such facility as the Mental Health Tribunal determined, until release by process of law.

8. The principal issue at the inquest was whether the mental health care which Mr Cahill was receiving in the community was adequate. Should those who were treating him for his condition have been aware of the risk he presented on the evening of 10 December 2015? And was he receiving the kind of intensive care and support which might have prevented this terrible attack?

9. At the inquest the Court heard evidence from those who witnessed the fatal attack, and from Mr Cahill's treating team. In addition, the Court was assisted with an expert report from clinical toxicologist Associate Professor Jonathan Brett, and with reports and oral evidence from the following specialists:

    - Consultant forensic psychiatrist Dr Danny Sullivan, Executive Director of Clinical Services at the Victorian Institute of Forensic Mental Health

- Forensic psychiatrist Associate Professor Matthew Large, Clinical Director of Eastern Suburbs Mental Health Service, Prince of Wales Hospital.

Brian Liston's life

10. Brian was born on 28 January 1964, into a large family whom his wife Maggie described as '*the bedrock of his early life'*. He loved and respected his parents Tom and June Liston. Brian had sisters Bernadette, Therese, Catherine, Gabrielle and Frances, and brothers John and Michael. There was a double blow for the family when John died in May 1916, just four months after Brian was killed.

11. Brian studied education at university and became a devoted and much loved teacher. He formed deep and long connections with his many friends. He wrote poetry, played music, and coached cricket.

12. Above all Brian loved his wife Maggie and his two children Freda now aged 18 and Laurie, now 15. In a deeply moving tribute to Brian, Maggie said that he would have done anything to stay in their lives.

13. It is evident that Brian was deeply loved. His wife Maggie, his children and many of his siblings attended each day of the inquest, either in person or via AVL link.

The issue at inquest

14. The key issue at inquest was whether those who were treating Mr Cahill in the community ought to have been aware of the risk which he presented on 10 December 2015.

15. This was an issue of great importance to Brian's family. They needed to know if Mr Cahill's sudden deterioration into extreme violence that night ought to have been foreseen by his community treating team. If so, could this have prevented Brian's tragic and senseless death?

16. It is natural that there would be questions as to how this terrible attack occurred. Mr Cahill was known to have a severe and enduring mental illness, and there had been at least some instances of aggressive behaviour in the past. Was his community treating team sufficiently experienced in assessing his risk for violence? And was he receiving the kind of intensive support, monitoring and medication that might have prevented his deterioration into extreme violence that evening?

17. These were all legitimate questions, to which the inquest sought answers.

18. These questions are also of significant public importance. If there were deficiencies in Mr Cahill's mental health treatment, identifying these could help to prevent future such deaths.

19. The prominence of these issues at the inquest meant that most of the evidence focused upon Mr Cahill, his mental illness, and the treatment which he received for it.

Mr Cahill's background

20. William Cahill's life and background stands in strong contrast to that of Brian. At the time he attacked Brian he was 28 years old and had long been estranged from his family. Due to the severity of his mental illness, he lived a solitary life with no real friends and minimal prospects of getting meaningful work or of forming relationships.

21. Mr Cahill had displayed symptoms of mental illness since his teenage years. After an inpatient hospital admission in 2007 he was formally diagnosed with paranoid schizophrenia and autism spectrum disorder.

22. Over the following years Mr Cahill had many hospital admissions, interspersed with periods of living in the community. He did not like his prescribed medication of clozapine and said that it left him feeling too sedated. His non-adherence to his medication led to repeated episodes of serious relapse and return to hospital.

23. A particularly lengthy admission in Concord Centre for Mental Health lasted from February 2013 to March 2014. The hospital records described this admission as '*indicative of serious and treatment resistant mental illness'.* It was emphasised that when discharged he would require careful monitoring to ensure he took his medication. The discharge notes also recorded that Mr Cahill was at risk of *'…exploitation (has been targeted by older males in past)'.*

24. It is important to note that even when fully compliant with his medication Mr Cahill was severely affected by his illness. It significantly impaired his cognitive abilities, and created what Dr Sullivan described as '*prominent and persisting deficits in his adaptive functioning'*.

25. Due to the severe impacts of his illness Mr Cahill was under the care of a Public Guardian, who had been appointed to make decisions for his money, accommodation and other services. A functional assessment conducted in April 2013 found that in half the skills assessed, Mr Cahill was either partially or fully dependent on others. Thus, he was unable to live in the community without significant assistance with his health care, finances, accommodation, housework, and self-care. In addition, he displayed the 'blunted affect' that is sometimes associated with schizophrenia, meaning that he typically had little facial expression, and little warmth or empathy when interacting with people. This increased his social isolation.

26. A second important feature of Mr Cahill's schizophrenic illness was the very occasional incidence of misidentifications. These involve a belief that the identity of a person, object or place has somehow changed or has been altered. In Mr Cahill's case, occasionally when he saw a person he believed they were someone else whom he knew.

27. Thus, when Mr Cahill was in Concord Hospital, he had attempted to strangle a staff member in the belief that they were his brother. Then in April 2014 he punched a staff member of the Concord Mental Health team, afterwards saying: *'I didn't mean it. I thought you were my mum'.*

28. On 13 June 2014 Mr Cahill was charged with criminal offences after he assaulted a woman and stole her handbag. He was refused bail and became a remand inmate at Silverwater Correctional Centre. While in custody Mr Cahill was mainly held in the Darcy Place of Detention, an area of the prison reserved for inmates with chronic and severe mental illness.

29. On his release from prison in November 2014 Mr Cahill was accepted for community care by the Croydon Assertive Outreach Team.

30. On 22 December 2014 Mr Cahill's care was transferred to the Mobile Assertive Treatment Team, which operates within the Camperdown Community Mental Health Centre. He remained under their care until he was arrested for Brian's murder on 11 December 2015. The care which this team provided to Mr Cahill was a central focus of the inquest and will be more fully described at a later stage in these findings.

31. At the time of his attack on Brian Mr Cahill was subject to a Community Treatment Order [CTO] for his schizophrenia, made by the Mental Health Review Tribunal. This was to be in place at least until May 2016. The CTO required that he receive certain anti-psychotic medications, which will be described below.

32. I will now summarise the events surrounding Mr Cahill's fatal attack upon Brian, and their aftermath.

The events of 10 December 2015

33. On the afternoon of 10 December 2015 Mr Cahill called in to the Camperdown Community Mental Health Centre to see his care coordinator, Mr David Ball. He had not received an expected payment from the NSW Trustee and Guardian, which he would need for a shopping trip with Mr Ball which had been scheduled for the following day. Mr Ball was not there, but his colleague Tamara Suzuki spoke with Mr Cahill, then made enquiries with the NSW Trustee and Guardian. Mr Cahill thanked her for her assistance and left.

34. Ms Suzuki had met Mr Cahill previously. On this afternoon she saw nothing in his behaviour or demeanour to indicate that he was becoming acutely unwell. He was not agitated, irritable, or moody.

35. At about 8.30pm that evening Brian Liston was waiting at a bus stop on Salisbury Road, Camperdown. He had been attending a German class nearby and was on his way home to his wife and children.

36. The events that followed were brief but horrific.

37. Two people in a parked car saw Mr Cahill come out of his building and walk towards the bus stop where Brian was sitting. One of the observers, Ms Terina Toko, saw Mr Cahill use his right hand to swing a knife towards Brian's chest. She heard Brian scream: '*Why are you doing this?'*

38. Brian ran a short distance but fell over on the street's median strip. As Ms Toko watched in horror, Mr Cahill followed Brian, leaned over onto him and stabbed him numerous times as he lay on the ground, crying out for help.

39. Another observer, Mr Paramjeet Pal, ran to the scene and saw Brian covered in blood. Mr Pal shouted to others to call police and an ambulance. Mr Cahill was by now across the road, slashing his knife in the direction of another man, Mr Coiln Semaan. Mr Semaan had observed what was happening from his car. He had exited his car and was yelling at Mr Cahill: '*Get off him! Get off him!'*

40. Still holding his knife, Mr Cahill turned and walked away from Mr Semaan. Courageously, Mr Pal ran after him and kicked him in the back. In response Mr Cahill turned and lunged at Mr Pal, slashing his knife in a criss-cross motion in his direction. He then turned and again walked away.

41. Mr Pal and another man followed, repeatedly telling Mr Cahill to drop his knife. Mr Cahill turned to look at them, then threw the knife under a tree. Mr Pal took hold of him and told him to sit on the ground and wait for the police to arrive. Mr Cahill did so. He remained there until police arrived and placed him under arrest.

42. Significantly, in their statements to police many observers described Mr Cahill as having a '*blank'* or *'expressionless'* face throughout the entire episode, and saying nothing.

43. Bystanders sat with Brian while they awaited the ambulance, trying to comfort him. He was taken to hospital in a critical condition, in hypovolaemic shock from blood loss. Despite the best efforts of the emergency team, he could not be saved and he was pronounced deceased at 9.58pm.

The cause of death

44. An autopsy was performed by forensic pathologist Dr Istvan Szentmariay. He found the cause of Brian's death to be a stab wound to the heart. Brian had sustained this wound over his left upper chest when the knife entered his chest cavity, then continued through the upper lobe of his left lung and into the sac around his heart. The knife stab terminated in the lumen of Brian's left ventricle. This injury caused *'abrupt and severe blood loss'.*

45. Dr Szentmariay identified numerous other sharp force injuries, including defensive-type injuries to Brian's hands. Most of these were superficial, but they had contributed to his blood loss.

46. The knife with which Mr Cahill had stabbed Brian was a kitchen knife with a 15cm blade.

The police interview with Mr Cahill

47. Mr Cahill participated in an electronically recorded interview with police in the early hours of 11 December 2015. He was accompanied by a support person.

48. At the inquest the interview recording was played in court. It can be seen that Mr Cahill's speech and responses are slow. There are lengthy pauses in the interval between question and answer, following which Mr Cahill frequently says '*Pardon?*' and the question is repeated to him. His face is generally blank, and neither it nor his voice express any particular emotion. According to Dr Sullivan and Mr Cahill's then treating psychiatrist Dr Andrew McDonald, who each viewed the interview recording, these features are characteristic of the blunted affect seen in many people who suffer severe schizophrenia.

49. In the interview Mr Cahill told police that he believed he was *'going to gaol for a while for stabbing someone'*. When he was asked if he knew who he had stabbed, he replied:

    'Um, I think it was someone of John Bochman's family'.

50. There is no connection whatsoever between John Bochman and Brian Liston. John Bochman is a person with whom Mr Cahill had previously shared a house. The nature of his involvement with Mr Cahill in unclear, but it would appear that Mr Cahill came to distrust and dislike him.

51. Notably, some of Mr Cahill's answers displayed what was later described by clinical psychiatrist Dr Richard Furst as '*textbook examples of thought disorder*'. The following exchange took place about midway through the interview:

    Q. *Do you remember if he [Brian] said anything?*

A. *Ah, something about crystal meth, found a trap, got evil there, didn't even know him or something. And I think it was something to you people.*
Q. *Sorry can you repeat that? I didn't catch that.*
A. *Something crystal meth, got the trap, and it was something about you people'.*

52. At an earlier point in the interview, Brian told police about looking out of his window and seeing *'a good looking lady'* at the bus stop. He continued:

'And then half an hour later I had another look and I, there's someone else there …but then I looked another time and um, just went haywire'.

The criminal proceedings and outcome

53. The criminal proceedings against Mr Cahill culminated on 16 October 2017 in a special hearing in the Supreme Court of NSW, before his Honour Justice Geoffrey Bellew.

54. The task for his Honour was to determine, pursuant to section 19 of the *Mental Health (Forensic Provisions) Act 1990,* whether it could be proved to the criminal standard of proof that Mr Cahill had committed the offence of murder or any other offence as an alternative to murder.

55. Before the Court was a large amount of psychiatric evidence which had been provided by psychiatrists Professor David Greenberg, Dr Adam Martin, and Dr Richard Furst. All had examined Mr Cahill after his arrest.

56. Their unequivocal evidence was that Mr Cahill suffered severe schizophrenia which failed to respond to different classes of antipsychotic medication, and that he had very poor insight into his condition or his need for treatment. In the further opinion of Dr Furst and Dr Martin, at the time of his attack on Brian Mr Cahill was suffering a defect of reason, such that he was unable to reason that his actions were wrongful.

57. Noting the absence of medical challenge to this evidence, Bellew J concluded that at the time he had stabbed Brian, Mr Cahill was mentally ill and did not know that what he was doing was wrong. He was therefore not guilty of the offence or an alternative to it, by reason of mental illness.

58. I will now turn to the central issue at the inquest, namely the adequacy of Mr Cahill's mental health care in the community. I will preface this with the expert psychiatric evidence heard at the inquest regarding the nature and severity of Mr Cahill's illness, and the clinical and psychosocial supports which Dr Sullivan and Associate Professor Large considered that he needed.

The severity of Mr Cahill's mental illness

59. In their reports and evidence Dr Sullivan and Associate Professor Large confirmed Mr Cahill's diagnosis of severe and treatment resistant schizophrenia.

60. Furthermore, Dr Sullivan commented that Mr Cahill *'had limited insight into his illness',* and that it was *'very likely that [he] will not of his own volition take medication without direct supervision and prompting, or a framework of support and intervention'.* Mr Cahill's response to medication throughout 2015 was, he stated, better characterised as assent rather than consent.

61. Dr Sullivan and Dr Large were also agreed as to the very severe impacts Mr Cahill's illness had on his level of functioning, and the high level of support he needed to survive in the community. His illness was severe and enduring, and his adaptive functioning was extremely impaired. Associate Professor Large described him as living in '*profound disability'*. In his report Dr Sullivan, commenting on the aim that Mr Cahill live independently in the community, stated that:

    'Given his level of functioning, it remains to be seen whether this was overly ambitious: that is, even with optimal control of mental health symptoms and compliance with medication, Mr Cahill may not have been able to manage independent living. He required high levels of support, prompting and supervision.'

62. Notwithstanding these very severe deficits, Dr Sullivan and Associate Professor Large agreed that in the period leading up to to Mr Cahill's attack on Brian, there did not exist the legislative grounds to detain him in a mental health facility on an involuntary basis. His behaviour could not have been characterised as a risk to himself or to others that could not have been managed adequately in the community.

63. From the evidence of Dr Sullivan and Associate Professor Large, it can be concluded that in order for Mr Cahill to remain mentally stable while living in the community, it was critical to ensure that he was compliant with his medication, and that he was provided with an intensive level of support with his day to day living.

The Mobile Assertive Treatment Team

64. When Mr Cahill was released from prison in November 2014, he had been given temporary accommodation at a general boarding house in Dulwich Hill. He had no supports there and he was frequently distressed by visits from fellow residents demanding money and cigarettes from him. His community treatment team was aware that this accommodation was far from ideal, but at the time nothing more suitable was available.

65. Soon afterwards Mr Cahill's care was transferred to the Mobile Assertive Treatment Team [MATT] which was based in Camperdown. MATT provides clinical and psychosocial assistance and case management for people with persistent mental disorders, who require an intensive level of support to remain living in the community. In the words of Ms Tamara Suzuki, a former team leader at MATT:

> *'The focus of the MAT team is to make more frequent and assertive efforts to engage consumers in their home and community settings to stabilise their health, identify and achieve their social and vocational goals, and attain greater autonomy…'*

66. MATT's clients all have mental illnesses which, like Mr Cahill's, are enduring and severe. In order to live in the community they require a high level of assistance, not only with their mental health but also with their finances, housing, general health care, shopping and in some cases, their self-care.

67. Mr Cahill's treating psychiatrist was Dr Andrew McDonald, who is the Director of Mental Health Clinical Services at the Sydney Local Health District [SLHD]. In 2015 he was providing consultancy services to MATT.

68. At the inquest Dr McDonald explained the features which make the MAT team different from many other models of community mental health care. MATT is a multidisciplinary team, with a combination of medical staff and care coordinators who have qualifications in nursing, occupational therapy, psychology and social work. Each MATT client has a designated care coordinator, who is generally allocated a maximum case load of 10 to 12 clients. This is significantly lower than a standard care coordinator, and reflects the high level of support needed by individual MAT team clients.

69. Furthermore, a key reason why clients are referred to MATT is a history of poor adherence to prescribed medication. MATT staff are experienced in detecting non-adherence behaviours in their clients, and are expected to act assertively in response. Steps may include increasing the frequency of medication supervision visits and of blood testing for medication concentrations.

The role of Mr David Ball

70. Mr David Ball was Mr Cahill's care coordinator at MATT. Mr David Ball is a Registered Nurse who specialises in the provision of clinical mental health care for people in the community.

71. Over the following twelve months Mr Ball had very frequent contact with Mr Cahill and came to know him well. Counsel Assisting aptly described Mr Ball as:

'… the most consistent presence in William's life at that time and probably knew him better than anyone else across 2015'.

72. Mr Ball saw Mr Cahill regularly, sometimes on a daily basis, and supported him in multiple aspects of his life. His interactions with him included the following:

    - He visited Mr Cahill three nights a week and at times more frequently, to directly supervise his medication (occasionally this task was performed by another MAT team member)

    - He attended Mr Cahill's mental health and psychiatric reviews

    - He prepared documentation for Mr Cahill's hearings at the Mental Health Review Tribunal, and accompanied him to the hearings

    - He liaised with Mr Cahill's Public Guardian and attended their meetings

    - He took Mr Cahill to meetings with police and with Legal Aid lawyers in relation to the June 2014 charges of assault and robbery

    - He arranged an assessment of Mr Cahill for a high support housing and accommodation package, which was approved but had not yet commenced in December 2015.

73. In addition, Mr Ball regularly made welfare visits to Mr Cahill at his home and assisted him with shopping and outings. By way of example, he had arranged to go with Mr Cahill on a shopping trip for video games on 11 December 2015, the day following the fatal attack.

74. Importantly, Mr Ball was closely involved in Mr Cahill's move in May 2015 from the Dulwich Hill boarding house to an apartment in Church Street, Camperdown. This change of accommodation was considered to be important for Mr Cahill's mental stability.

75. The Camperdown apartment is one of twelve which are managed by the Metro Community Housing Cooperative. This agency provides transitional housing for people with chronic mental health conditions. Importantly, the apartment was located within easy walking distance of Camperdown Community Mental Health Centre, where Mr Cahill's MAT team was located. It was intended that Mr Cahill would live in the Camperdown apartment until appropriate public housing was found for him.

76. Before addressing the overall adequacy of the care provided by the MAT team, I will examine the evidence in relation to a key component of that care: namely, the steps they took to ensure that Mr Cahill received an appropriate amount of his anti-psychotic drug clozapine.

Mr Cahill's prescribed medication of clozapine

77. Mr Cahill's medication regime consisted of oral clozapine taken nightly, and fortnightly Clopixol (zuclopenthixol) depot injections.

78. Clozapine is an anti-psychotic medication which is primarily used to treat patients like Mr Cahill who do not respond to other anti-psychotic drugs. Zuclopenthixol is also an anti-psychotic medication. At the inquest Dr McDonald explained that abrupt cessation of clozapine carries the risk of rebound episodes of psychosis. Given Mr Cahill's history of non-compliance with clozapine, Dr McDonald thought it prudent to also prescribe zuclopenthixol as a precaution.

79. In order to monitor Mr Cahill's compliance with his clozapine medication, at regular intervals the MAT team arranged for his blood to be tested for clozapine concentration. However, the court heard that one of the challenges of clozapine monitoring is a lack of clarity as to the therapeutic range of clozapine concentrations.

80. In his report, clinical toxicologist Associate Professor Brett explained that although there exists a national guideline for appropriate clozapine dosing, there is in fact a wide range of individual variation in patient response to it. The lack of clarity means that blood testing for clozapine levels is not a reliable indicator of whether a person is receiving an appropriate amount. Best clinical practice is to base dosage on observations of clinical response, and supplement these with blood level testing. Thus:

    'Clozapine plasma concentrations are best used in conjunction with clinical observations, and decisions about dose should not be made solely on plasma concentrations'.

81. Associate Professor Brett commented further:

    'In the presence of an adequate response, clozapine concentrations close to the lower end of the therapeutic range may be sufficient'.

82. Associate Professor Large concurred with this opinion.

83. A further difficulty with use of clozapine is that patients are at risk of side effects such as lowered white cell counts, cardiovascular disease, and inflammation of the heart muscle. For this reason, Mr Cahill was required to have monthly full blood count tests to assess for toxicity. His treating team were well aware that due to its adverse side effects, clozapine should be prescribed at the lowest level consistent with clinical response.

Mr Cahill's clozapine levels

84. When Mr Cahill came into the care of the MAT team, a team member immediately commenced visits three nights per week to ensure that he took his clozapine medication. The team member would first observe him take his oral dose. They would then remain for a period of time, to ensure that the medication had been swallowed properly. This also provided an opportunity to assess Mr Cahill's mental state, and to make plans with him.

85. On 10 April 2015 a blood test showed that Mr Cahill's clozapine levels were lower than the generally accepted therapeutic range. This raised the possibility that he was not complying with his medication on the other four nights of the week. His care coordinator Mr Ball therefore increased his medication supervision to nightly visits, to investigate for this possibility.

86. This response was endorsed by Dr McDonald when he first reviewed Mr Cahill, on 17 April 2015. Dr McDonald noted that it was consistent with MATT's approach of assertive intervention when non-compliance was suspected.

87. Dr McDonald's first review of Mr Cahill took place in Mr Cahill's then accommodation at the Dulwich Hill boarding house. Dr McDonald found Mr Cahill to be physically dishevelled, with little engagement and a generally unhappy mood and appearance. His form of thought was not disordered, but he '….*acknowledged persecutory and referential experiences in public',* which Dr McDonald defined to the court as a belief that people were looking at him and might want to harm him. He noted however Mr Cahill denied feeling the impulse to respond to these beliefs in an antisocial or aggressive manner. Dr McDonald noted Mr Cahill's history of poor medication compliance and agreed that it was appropriate for the MAT team to introduce nightly supervision.

88. But despite the increase to nightly supervision visits, when Mr Cahill was next tested on 30 April 2015 his clozapine levels showed only a small improvement. His treating team therefore concluded it was unlikely that the low levels were due to him not being compliant. Mr Cahill was a heavy smoker of cigarettes, and it is well known that tobacco smoking can result in lower than expected concentrations of clozapine.

89. When Dr McDonald next reviewed Mr Cahill on 15 July 2015, he considered that despite the low clozapine levels Mr Cahill's mental state was stable. Mr Cahill expressed himself to be '*much happier'* living in his Camperdown apartment. He also told Dr McDonald that he was no longer having '*referential experiences'*, which Dr McDonald considered to be a clinical improvement.

90. In view of this, Dr McDonald decided to continue Mr Cahill's medication at its current dose. Since the nightly supervision regime had not been of any real

benefit, Dr McDonald directed that the supervision visits drop to the standard of at least three nights per week.

91. Dr McDonald's final review of Mr Cahill took place on 21 October 2015. Again, Mr Cahill did not appear to have been experiencing distressing referential episodes from neighbours or people in the street. He was calm and cooperative, and did not display the distraction, agitation or perplexity which usually accompanied psychotic relapse. Dr McDonald concluded there were no acute risks, and that Mr Cahill had maintained positive progress.

Did the MAT team respond appropriately to Mr Cahill's low clozapine levels?

92. There was no dispute that Mr Cahill's clozapine levels throughout 2015 were consistently lower than the generally accepted therapeutic concentration for this medication.

93. It cannot be known whether this feature contributed to Mr Cahill's catastrophic deterioration on the evening of 10 December 2015. However, it was reasonable to examine whether his treating team responded appropriately to it. In the face of his persistently low clozapine levels should they have maintained the increased supervision visits, and perhaps considered increasing Mr Cahill's dose?

94. Neither Dr Sullivan nor Associate Professor Large was critical of the decision of the treating team to increase the frequency of Mr Cahill's supervision visits, and subsequently to step down to three nights per week. The trial of nightly supervision had demonstrated no clear benefit. They endorsed Dr McDonald's conclusion that if medication non-compliance had been the reason for the low levels, it would be expected that these would have significantly increased over the period of nightly supervision.

95. I note that Mr Ball also thought it unlikely that Mr Cahill was not complying with his clozapine. He had formed the view over the time he worked with Mr Cahill that while he may not have understood his clinical need for clozapine, he did appreciate its sedating effects at night and was generally anxious to ensure he had sufficient supplies of it.

96. Mr Ball and Dr McDonald had a further reason for concluding that non-compliance was not the explanation, and that therefore there was no benefit in continuing nightly supervision. Over the period they had worked with Mr Cahill his clinical presentation had generally been satisfactory. He was mostly calm, polite and cooperative. Had he not been compliant with his medication they would have expected to observe higher levels of distraction and distress.

97. If it is accepted that non-compliance was not the likely explanation of Mr Cahill's low clozapine levels, should the team have considered increasing his clozapine dose?

98. It is clear that Dr McDonald gave consideration to this course but decided against it. He was aware that the therapeutic range for clozapine is a guide only, and that patient response is variable.

99. When questioned on this point, Dr McDonald like Associate Professor Brett adverted to the importance of assessing a person's clinical response when deciding whether to increase their clozapine dose. Dr McDonald had reviewed Mr Cahill on 15 July and 21 October and had observed ongoing stability and a reduction in psychotic symptoms. In his opinion an increase in medication was not justified, in particular having regard to the need to prescribe it at the lowest level consistent with a reasonable therapeutic response.

100. At the inquest Dr Sullivan and Associate Professor Large agreed that the patient's clinical response to clozapine was very important, and that Dr McDonald had been entitled to place reliance on this in deciding not to increase Mr Cahill's dose. As his mental state appeared to be stable and there were no symptoms of active psychosis, there was little justification to increase it. They concluded that the MAT team had responded appropriately to the issue of Mr Cahill's low clozapine levels, and indeed to the overall management of his medication.

101. The expert evidence on this issue was unchallenged. It was provided by specialists whose qualifications and experience are such that a court would place significant weight on their opinion. I have also taken into account that those who were making decisions about Mr Cahill's medication were experienced and competent clinicians, and members of a team that was expert in the assertive management of severely ill patients.

102. Accordingly, I find that the MAT team's management of Mr Cahill's medication was consistent with good clinical practice. This includes the steps they took in response to his low clozapine levels.

Was the overall care provided by the MAT team adequate?

103. In these findings I have described at some length the support and supervision which the MAT team provided to Mr Cahill. It is important that I do so. In the grip of a psychotic episode Mr Cahill used extreme violence, at a time when he was in their care. The consequences were devastating.

104. Dr Sullivan and Associate Professor Large reviewed the evidence of the MAT team's care and provided written reports and oral evidence at the inquest. They were not critical of the care provided to Mr Cahill.

105. In the opinion of Associate Professor Large, throughout 2015 Mr Cahill was '*well supported by his treating team who provided a high standard of intensive community care.'*

106. Dr Sullivan agreed, stating that the care and support which the MAT team provided to Mr Cahill was adequate and appropriate. The team members were qualified clinical professionals, well placed to accurately assess his level of compliance with medication and his general mental state. In Dr Sullivan's opinion it was '*difficult to make a case for any more restrictive management plan'* of supervision, given his compliance with their visits and his general behaviour.

107. I accept the expert evidence on this question, together with the evidence given by the primary members of Mr Cahill's treating team, Mr Ball and Dr McDonald. They impressed as clinicians who are experienced and qualified in assertive mental health care.

108. As Mr Cahill's care coordinator, Mr Ball provided Mr Cahill with a high frequency of contact, assessment and support which extended well beyond the clinical management of his mental condition, and to a degree not commonly seen in coronial cases involving people who live with serious mental illness. I am satisfied that he and the MAT team provided Mr Cahill with the kind of intensive care and support which he required.

109. I should note that it was evident that Brian's death had shocked and saddened Mr Ball and Dr McDonald. At the inquest they expressed sincere sympathy to his family.

Could Mr Cahill's deterioration on 10 December 2015 have been predicted?

110. In the eight days preceding Brian's death, Mr Cahill had personal contact with MAT team members on four separate occasions, as well as on the afternoon of 10 December itself. Yet no one saw anything of concern in his behaviour or presentation. Mr Ball had himself carried out Mr Cahill's medication supervision visit on the evening of 9 December, finding him '*polite'*, '*settled*' and much as usual. This was the last time he saw him.

111. It is difficult to understand how Mr Cahill could have behaved with such violence that night, without there having been any sign of mental deterioration in the preceding hours or days. This knowledge must have been a source of great anguish for those who loved Brian.

112. Acknowledging this confounding fact, at the inquest Dr Sullivan said that he had paid particular attention to the MATT notes in the month leading up to the attack, but they had revealed *'no overt abnormalities of mental state'*. He felt confident that had any signs of deterioration been present, the MAT team members would not have overlooked them.

113. Dr Sullivan concluded that Mr Cahill's attack on Brian was:

> *' …an unpredictable outburst of homicidal violence which was directed at a stranger, premised on a severe and enduring psychotic illness'.*

114. Associate Professor Large agreed, describing the tragedy as *'an event that is as rare as it is terrible'.*

115. Seeking to explain the unpredictability of Mr Cahill's attack, at the inquest both spoke about his occasional episodes of misidentification and why these had not raised significant concerns for the MAT treating team.

116. Dr Sullivan explained that severe schizophrenia affects all parts of a person's cognitive functioning, including the ability to recognise faces. He noted that over the years Mr Cahill had also had episodes of feeling anxious with '*inchoate feelings of being unsafe'.* But although his history showed episodes of delusional misidentification, these were occasional and fleeting. They were not prolonged, they did not appear to be driven by sustained delusional beliefs, and they did not focus upon a particular individual.

117. Dr Sullivan commented that patients as unwell as Mr Cahill were often persistently aggressive, and their symptoms were often worsened by substance abuse.

118. But Mr Cahill was neither persistently aggressive nor subject to persistent misidentifications. Nor did he use illicit drugs. Although his clinicians were not oblivious to the risk he presented, there was no specific symptom which caused them to feel alarm.

119. Associate Professor Large added that according to research, it was extremely rare for persons with mental illness to perform acts of violence upon others when they themselves were receiving treatment, as Mr Cahill was. He commented that:

120. '*Stranger homicide by people with psychosis or schizophrenia is one of the rarest adverse events associated with severe mental illness …. Stranger homicides by people with currently treated schizophrenia (like Mr Cahill) are even more rare.'*

121. Associate Professor Large's research indicated that the incidence of stranger homicide, perpetrated by persons with mental illness under treatment, was in the order of one in several million.

122. It is hard to know how Brian's family might have felt on hearing this evidence. It may have been of comfort to learn how rare such tragic episodes are. But it must

also have been heartbreaking to know that Brian, their beloved husband, father and brother, was that one in several million.

The question of recommendations

123. Despite the tragedy of Brian's death, the evidence at the inquest does not point towards the making of any recommendations which could feasibly be made. There was no deficiency in the care which was provided to Mr Cahill by the MAT team, either at an individual or a systemic level. On the contrary, the support which this service supplied was of a high level and was provided by clinicians who were both competent and caring.

124. The court heard evidence that the Camperdown apartments now offer a higher level of support than was the case when Mr Cahill lived there. A support worker is resident at the apartments on a 24 hour basis to assist residents with their daily living.

125. It is encouraging to hear that this additional support is available to vulnerable residents. It cannot be said however that had this support had been available to Mr Cahill, it would have averted the tragedy of Brian's death. As Mr Ball and Dr McDonald noted, the resident support person does not provide clinical support; nor is there any certainty that they would have noted signs of deterioration in Mr Cahill's mental state that particular evening.

126. The evidence at the inquest did appear to highlight a gap in the available support for people like Mr Cahill, who throughout most of 2015 was not so acutely unwell as to meet the legal requirement for involuntary detention, but who required intensive support in order to survive in the community. In his evidence Dr McDonald identified the need for more placements and services for people caught in this situation. This also was an issue of concern raised by members of Brian's family.

127. It is beyond the scope of this inquest to make any recommendations directed to this issue. However, it is a matter which deserves serious consideration within the community, and amongst health care services and those who provide their funding.

Conclusion

128. Brian's death was shocking and profoundly sad. He was deeply loved and is deeply missed by his family and many friends. I hope that this inquest has helped to resolve questions and concerns that may have been adding to their distress over his loss.

129. I thank Counsel Assisting and the Crown Solicitor's Office for the high standard of their assistance in this inquest. I extend my appreciation to the witnesses and

to the legal representatives appearing in the inquest, and the Officer in Charge Detective Tania Curic.

Findings required by s81(1)

130. As a result of considering 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 is Brian Liston

Date of death:
Brian Liston died on 10 December 2015.

Place of death:
Brian Liston died at Camperdown, NSW 2042.

Cause of death:
The cause of Brian Liston's death is a stab wound to the heart.

Manner of death:
Brian Liston died as a result of an unprovoked knife attack by a known person.

I close this inquest.

Magistrate E Ryan
Deputy State Coroner
Lidcombe

4 August 2022