CORONERS COURT OF THE AUSTRALIAN CAPITAL TERRITORY

Case Title:	**INQUEST INTO THE DEATH OF MARK RODNEY JOLLIFFE**
Citation:	**[2015] ACTCD 2**
Date of Findings:	30 June 2015
Before:	Coroner Dingwall
Legislation Cited:	*Coroners Act 1997* (ACT) s 13(1)(k) Mental Health (Treatment and Care) Act 1994 Mental Health (Treatment and Care) Act 1994 ss. 52(1)
File Number(s):	CD 44 of 2010

IN THE CORONERS COURT)
AT CANBERRA IN THE)
AUSTRALIAN CAPITAL TERRITORY) CD 44 of 2010

INQUEST INTO THE DEATH OF
MARK RODNEY JOLLIFFE

Reasons for Findings of Coroner Dingwall
Published on the 30th day of June 2015

1. Mr Mark Rodney Jolliffe ("the deceased") was found deceased at about 7.15am on Monday, 15 February, 2010. His death was reported to me, in my capacity as a coroner, and thereupon I commenced an inquest into his death.

The Legislative Scheme

2. The inquest into deceased's death was commenced by virtue of sub-paragraph 13(1)(k) of the *Coroners Act 1997* ("the Act"). This provision requires a coroner to hold an inquest where a person "dies in custody".

3. At the time of his death, the deceased was subject to a Psychiatric Treatment Order ("a PTO"), made on 20 August 2009 under the *Mental Health (Treatment and Care) Act 1994* ("the Mental Health Act") by the ACT Civil and Administrative Tribunal ("the ACAT"). The order was expressed to have effect for a period of six months from that date and the Tribunal ordered that it be reviewable prior to expiry. Accordingly, by virtue of s 3C(1) of the Act, the deceased's death was a "death in custody" for the purposes of the Act. The relevant part of s 3C (1) is as follows:

> **"3C Meaning of *death in custody***
>
> (1) For this Act, ***death in custody*** means the death of a person—
>
> …
>
> (d) while being taken into or detained in custody, or subject to an order, under the *Mental Health (Treatment and Care) Act 1994*; or
>
> …"

4. Sub-section 52(1) of the Act, requires the coroner holding an inquest to find, if possible-

> "(a) the identity of the deceased; and
> (b) when and where the death happened; and
> (c) the manner and cause of death; and
> (d) in the case of the suspected death of a person—that the person has died."

5. Sub-section 52(3) of the Act provides that, at the conclusion of an inquest, the Coroner must record his or her findings in writing. Section 52(4) gives the Coroner discretion to

comment on any matter connected with the death, including public health or safety or the administration of justice.

6. Section 55 of the Act sets out the procedure that a Coroner must follow if he or she is to make an adverse comment in relation to a person. I do not propose to make such a comment in this matter.

7. A coroner may make recommendations to the Attorney-General on any matter connected with an inquest. The relevant provision is as follows:

> "57 **Report after inquest or inquiry**
>
> …
>
> (3) A coroner may make recommendations to the Attorney-General on any matter connected with an inquest or inquiry, including matters relating to public health or safety or the administration of justice."

8. In addition to the above provisions dealing with the making of findings, comments and recommendations, which apply to all inquests, there are additional requirements when the inquest is in respect of a death in custody that are contained in ss 74 and 75 of the Act. They are as follows:

> **"74 Findings about quality of care, treatment and supervision**
>
> The coroner holding an inquest into a death in custody must include in a record of the proceedings of the inquest findings about the quality of care, treatment and supervision of the deceased that, in the opinion of the coroner, contributed to the cause of death.
>
> **75 Copies of reports of findings**
>
> (1) After the coroner has completed an inquest into a death in custody, the coroner must, in writing, report the findings to—
>
> (a) the Attorney-General; and
>
> (b) the custodial agency in whose custody the death happened and to the Minister responsible for that agency; and
>
> (c) the Australian Institute of Criminology; and
>
> (d) if the deceased was an Aboriginal or Torres Strait Islander person—an appropriate local Aboriginal legal service; and
>
> (e) any other person whom the coroner considers appropriate.
>
> (2) The coroner must make available a copy of a report of the findings into a death in custody to—
>
> (a) a member of the immediate family of the deceased or a representative of that member; and
>
> (b) a witness who appeared at an inquest into the death.

Circumstances of the Deceased's Death

9. The deceased's body was found at about 7.15am on Monday, 15 February 2010 on City Hill, Canberra City in the Australian Capital Territory. City Hill is a large grassed area which is completely circumscribed by Vernon Circle. There are a significant number of

trees growing in the area. His body was found hanging by the neck from a branch of one of these trees which was situated approximately 50 metres from the north bound lanes of Vernon Circle on the north western side of City Hill, in full view of the ACT Magistrates Court. There were three electrical extension cords wrapped around his neck and tied in a single knot. The other ends of the extension cords were wrapped around the fork of a branch, approximately two metres out from the trunk of the tree. The deceased's feet were 40 centimetres from the ground.

10. The deceased's backpack was located at the base of the tree from which he was found hanging. It contained personal possessions, including his ACT Drivers Licence, his Medicare card, a hard shell wallet containing $35.10 in cash, a St George ATM card, Mental Health ACT appointment cards and used ACTION bus tickets, the most recent being dated 14 February, 2010..

11. Officer's of the Australian Federal Police conducted a thorough examination of the area in which the deceased's body was found and the surrounding area. They also spoke to members of his family and two people who lived in the same block of units as him, and who had known him for about 18 months.

12. A search of the deceased's residence was conducted in the presence of his mother. Nothing of significance was found, in particular no suicide note was found. However, an unopened Australia Post envelope was located on the dining table. The envelope was opened and found to contain a letter addressed to the deceased notifying him of a hearing before the ACAT to be held on 18 February, 2010. The purpose of the hearing was to review the PTO that had been made by the ACAT on 20 August, 2009.

13. As a result of the investigations carried out by members of the Australian Federal Police, Constable Daniel Williams, the officer in charge of the investigation on my behalf, was satisfied that there were no suspicious circumstances surrounding the deceased's death, which he believed to be as a result of suicide.

14. At my direction, Dr Lavinia Hallam, a forensic pathologist, carried out a post mortem examination of the deceased's body and ordered toxicological analysis of a blood sample taken from his body. The results of the toxicological analysis revealed the presence of 0.04 milligrams per litre of Zuclopenthixol and approximately 2 nanograms per millilitre of tetrahydrocannabinol (cannabis).. The level of Zuclopenthixol was within a therapeutic range. The level of cannabis was below a concentration which would be expected following recent use and was consistent with his known level of usage.

15. In Dr Hallam's opinion the cause of the deceased's death was hanging.

16. The deceased's last contact with his Mental Health ACT Case Worker, Mr Sonney Morrison, was on Friday, 12 February 2010. Mr Morrison stated that during their discussion the deceased had expressed unhappiness about a PTO being in place but was noted to be complying with his medication regime. Mr Morrison did not consider him to be presenting as suicidal at the time.

17. The last contact the deceased had with a member of his family was when he had lunch with his mother, Mrs Eunice Jolliffe, on 5 February 2010. At that time, he appeared to Mrs Jolliffe to be his usual self and he gave no signs of concern to her.

18. The deceased was last sighted by Mr Stephen Foster and Mr Peter Benson at around 8.30am, or a bit later, on Saturday, 13 February 2010. Both Mr Foster and Mr Benson lived in the same block of units as the deceased and had known him for about 18 months. The deceased and Mr Foster had a cigarette and spoke to each other for 10 to 15 minutes. Neither Mr Foster nor Mr Benson observed anything about the deceased which caused them concern for his well-being. Mr Benson said that the deceased appeared to be happy when he saw him.

19. Inquiries made of ACTION computer records revealed that the bus ticket found in the deceased's backpack was a pensioner off-peak ticket which was validated on Bus 323 at 5.55pm on Sunday, 14 February 2010. Bus 323 was an express bus from Belconnen to Tuggeranong, via the City Bus Interchange, which normally departed at 5.49pm and was normally estimated to arrive at the City Bus Interchange at 6.15pm.

20. A copy of the deceased's bank statement for 14 February 2010 showed that a withdrawal of $20 was made from his account at a St George Automatic Teller Machine on City Walk at 6.25pm on that day. A $20 withdrawal was consistent with his known spending habits and a $20 note was found in his wallet.

21. The deceased was not seen in video surveillance footage of the area in which the ATM is located and there is no one who has been found, or come forward, who saw the deceased after 6.25pm on 14 February 2010.

22. The evidence satisfies me, on the balance of probabilities, that the deceased died sometime between 6.25pm on Sunday, 14 February 2010 and 7.15am on Monday, 15 February, 2010 as a result of hanging, which was self-administered with the intention of taking his own life.

The Deceased's Medical History

23. The deceased commenced using cannabis at age 16 and had been a regular user since that time. He had also used amphetamines and LSD. He had had eight admissions to The Canberra Hospital's Psychiatric Services Unit ('PSU") since 1998.

24. On 19 October 1994 the deceased was treated for depression. He had been depressed for a period of two years but had become worse prior to presenting at this time due to a relationship split with his girlfriend. He spoke of suicide and mentioned he would probably hang himself, as a friend from primary school had hanged himself. It was noted there were no indicators of schizophrenia at this time. He was prescribed Prozac and it was recommended that he seek counselling services.

25. On 24 January 1997, the deceased was admitted to Calvary Hospital due to psychotic behaviour, with thought disorder and auditory hallucinations. This was treated with Stelazinine which resulted in a quick recovery. He was discharged on 26 January 2010 with a diagnosis of probable drug induced psychosis from cannabis use and a differential diagnosis of schizophrenia.

26. Later that year, the deceased moved to Perth, Western Australia with his then girlfriend and obtained employment from a local taxi firm.

27. On 2 September 1997, the deceased was admitted to Sir Charles Gairdner Hospital, Perth. He presented with auditory hallucinations and developed the belief he worked

with the Claremont serial killer (this related to a well publicised series of murders around this time in the Claremont area in which taxi drivers were a primary focus of police investigations). His girlfriend reported an increase in the frequency of his cannabis and alcohol use. He had also been non-compliant with his medication (Stelazine).

28. The deceased was discharged on 12 September 1997 with a diagnosis of paranoid schizophrenia and was prescribed Risperidone. This was the first time he had been clearly diagnosed with schizophrenia.

29. The deceased separated from his girlfriend and returned to Canberra around February 1998.

30. On 3 April 1998, the deceased had an initial consultation with a Mental Health ACT Case Manager, Mr Huub Schwartz. Mental Health ACT is a Division of the ACT Health Directorate. The deceased informed Mr Schwartz that he was still taking his prescribed medications - risperidone and Prozac. He was still feeling depressed and suicidal about his relationship breakup in Western Australia. He indicated then that he wanted to give up smoking.

31. From that time, the deceased was admitted to hospital on a regular basis. The admissions were usually as a voluntary patient, after suffering a psychotic episode consisting of delusional thoughts of people attempting to harm him or family members. The psychotic episodes and hospital admissions occurred within a short time after the deceased had stopped taking his medication.

32. On these occasions, the deceased's mother had contacted PSU, or The Canberra Hospital Triage, reporting her concerns about his behaviour shortly after stopping his medication. The police had also attended on occasions when he was acting aggressively. His mother stated that although he would become aggressive and damage property, it was always to defend himself and others from his perceived attackers and he had never assaulted her during any of his psychotic episodes.

33. Over the years, the deceased's medication was altered as a result of various side effects. Risperidone made him pace in circles and was one of the reasons he would stop his medication. He also stopped taking his medication because he couldn't hear what the voices were thinking and therefore he was unable to defend himself against any attack.

34. In December 1998, the deceased's mother discussed with Dr Rod Morice, Consultant Psychiatrist at The Canberra Hospital, an option for the him to take part in some cognitive behaviour therapy to assist him with his non-compliance in taking oral medication. Dr Morice stated that there was a plan to commence psycho-education groups at Belconnen Mental Health. The psycho-education groups were designed to educate people suffering from mental illness about the need for medication, the positive effects medication can have and to provide them with a better understanding of the illness they suffered.

35. The deceased continued to have regular contact with his case manager and Dr Morice. However, he was not an active participant in any psycho-education programs. His mother maintained regular contact with Mental Health ACT regarding her concerns that he was depressed, lacked motivation and was neglectful of his self-care. He continued to deny any depression and any suicidal ideations. His medication was adjusted according

to his symptoms from time to time. He stopped taking Risperidone on 5 May 1999 and, within a week, he had stopped pacing in circles. Subsequent to that, he was placed on Flupenthixol and Cipramil. However, his mental health continued to decline due to his non-compliance with the oral medications.

36. On 1 August 2000, the deceased was admitted to PSU after suffering delusions which he said involved Satanists infiltrating Spence and Satan's team decapitating people and keeping their heads so as to learn their secrets. At the time, he had stopped taking his medication because, according to him, he had to remain vigilant and alert. A large knife was later found in his bag. He had brought this for protection against his perceived attackers. This incident was documented in the his mental health records and regularly brought up in Mental Health Tribunal hearings held under the Mental Health Act. He perceived these hearings to be further treatment of him as a violent criminal.

37. The deceased completed an Outward Bound adventure in December 2002.

38. Due to the progress he had made in managing his condition, a treatment plan was developed in March 2003 to slowly reduce the amount of Olanzapine medication from 30 mgs to 20 mgs and eventually down to 10 mgs.

39. The deceased's Mental Health ACT file was closed on 23 May 2003 and a letter was sent to his GP, Dr Jan Eriksson on 30 May 2003 advising her of this fact.

40. On 10 September 2003, the deceased was seen by Dr Christopher Corcos, Psychiatrist, Mental Health ACT. Dr Corcos noted that the deceased had not been properly advised of the safe alcohol limit for men and the requirements for B Complex vitamins. Dr Corcos diagnosed a personality disorder with hypervigilant narcissistic and avoidant traits and binge drinking alcohol addiction. He reserved judgment on schizophrenia until the deceased could refrain from drugs and alcohol for a period of 3 months.

41. By 20 October 2003, the deceased had come off his medication, was hearing voices and was concerned about the assessment provided by Dr Corcos. He had stated that he did not want his mother to attend an appointment with Dr Corcos to review his concerns.

42. The deceased's mother requested a second opinion, however, due to waiting periods for other psychiatrists, his Mental Health ACT Case Manager, Ms Kerry Crawford, suggested that he see a private psychiatrist.

43. The deceased started seeing Dr Lev Fridgant, Consultant Psychiatrist, on 23 January 2004. Dr Fridgant continued to see him every three to six months and treated him with 30 mgs of Abilify daily. Dr Fridgant noted his continued use of alcohol.

44. On 15 March 2005, the deceased's Case Manager, Ms Kerry Crawford, sent a letter to him advising of her intent to close his file as no contact had been made for three months. She recommended that he continue to see Dr Fridgant and that he consider the relapse prevention strategies discussed during mental health meetings. A letter was sent to Dr Fridgant advising of the action taken by Ms Crawford.

45. On 7 November 2005 Dr Fridgant requested Mental Health ACT to conduct a home visit due to his concerns over the decline in the deceased's mental health. Staff of Mental Health ACT attended that night, however, he was not at home. Subsequently, he was admitted to Calvary Hospital on 9 December 2005.

46. On 22 May 2006, Dr Fridgant sent a letter to the Mental Health Tribunal outlining his treatment history of the deceased and giving his support to an application for a PTO.

47. On 14 June 2006, the deceased commenced a two month drug and alcohol rehabilitation program at Kedesh House, Wollongong. The deceased left the program after one week. He continued to use cannabis after leaving the program.

48. On 18 July 2006, the deceased was admitted to The Canberra Hospital. He was assessed on 19 July 2006 in PSU and admitted overnight under an emergency detention order. An application was made to the Mental Health Tribunal for extension of the emergency detention period. The detention period was extended by seven days.

49. On 24 July 2006 the Mental Health Tribunal made a six month PTO which envisaged that, after discharge, the deceased would continue to be treated as an inpatient at Calvary Hospital. He was discharged from Calvary Hospital on 4 August 2006, with an arrangement that he would continue to attend appointments there as an outpatient.

50. After discharge from Calvary Hospital, the deceased missed several appointments. On 28 August 2006, Mental Health ACT sent him a letter outlining the intent of that service to take breach action against him if he continually failed to attend appointments.

51. On 1 September 2006, the deceased was located in Sydney.

52. On 7 September 2006, Mental Health ACT consulted Dr Fridgant who indicated that he was agreeable to administering depot medication to the deceased if needed.

53. On 13 September 2006, Mental Health ACT breached the deceased for non-compliance with the PTO. He had failed to keep an appointment on 12 September 2006 and was not available despite attempts made by staff of Mental Health ACT to see him on a daily basis from 2 September 2006.

54. On 22 September 2006, the deceased attended City Police Station and reported a sexual assault against him by staff members of PSU on 29 April 2006, while he was a patient in that unit. He further stated that two of the staff members involved were then residing in the group share accommodation in which he was then living. At that time, he stated that he had been off his medication for a week.

55. This complaint was investigated by members of the ACT Criminal Investigations Sexual Assault Team. An examination of Mental Health ACT records showed that the deceased was not admitted to PSU around 29 April 2006. The two alleged offenders were identified and found to have never been employed by Mental Health ACT, nor admitted as patients to PSU. The allegations were unfounded and the matter was not investigated further

56. On 7 November 2006, the deceased returned to Sydney, where his health continued to decline. On 5 December 2006, he was admitted to PSU after having been intercepted at Canberra on a bus trip from Sydney to Melbourne. The treatment plan proposed at that time was to administer Risperdal Consta by fortnightly injection.

57. On 7 December 2006, the deceased made a further request that Mental Health ACT not discuss his case with his mother and the treatment plan for Risperdal Consta fortnightly

injections commenced. Dr Fridgant and Dr Lean were consulted and agreed with the plan. Mental Health ACT was unable to administer a test dose due to his refusal to take oral medication.

58. On 13 December 2006, the deceased's mother requested information from Mental Health ACT and was advised that he did not want any information disclosed to her.

59. The PTO was due to expire on 25 January 2007. An application to continue the PTO was not made as the deceased had been had been discharged from the order on 3 January 2007, when he had moved to Melbourne. Prior to discharge, Mental Health ACT had extensive contacts with Victoria Mental Health to ensure continuity of care.

60. Whilst the deceased was in Melbourne, he stopped taking his medication. This eventually led to him being admitted as an in voluntary patient in Victoria on 13 June 2007, and placed on a Community Treatment Order on 19 June 2007. He was discharged from this order on 10 October 2007.

61. The deceased was involuntarily admitted to Werribee Mercy Hospital in August 2008, after a further psychotic episode resulting from non-compliance with his medication regime. His sister facilitated his return to Canberra, and admission to PSU, on 28 August 2008. Extensive communication occurred between Werribee Mercy Hospital, Mental Health ACT and his sister to ensure continuity of the care. Initially, there was confusion between the three parties as to the medication that had been prescribed for him. However, continuity was maintained through the discharge notes from Werribee Mercy Hospital.

62. On 4 September 2008, a six month PTO was made by the Mental Health Tribunal. Consequent upon this, he was required to receive fortnightly Clopixol injections. Regular checks were maintained through Mental Health ACT case management.

63. On 26 February 2009, the deceased's PTO was continued for a further six months. The ACAT sat in the Magistrates Court Building and the deceased had to wait in the Court's waiting area for three hours. He felt that, in this setting, he was being portrayed and treated as a criminal. This factor increased his dislike for being subject to a PTO. He continued to refuse to attend any mental health programs or recovery plans, and only remained compliant with his medication regime because the PTO was in place. He experienced no further psychotic episodes whilst compliant with his medication regime.

64. The deceased's last meeting with Mental Health ACT was on Friday, 12 February 2010. On this occasion he met his new Case Manager, Mr Sonney Morrison. He continued to have poor insight into his illness and firmly refused to participate in any psycho-education classes or recovery planning to improve his insight. He is quoted as saying that he "has had enough of going to PSU, so happy to just keep taking the med's whether I'm on an order or not".

65. When speaking to Mr Morrison, the deceased was polite, cooperative and engaging, with good eye contact and mood. He denied having any psychotic symptoms. He also denied having any suicidal, self harming or violent ideations. He was orientated as to time, place and person and his memory, concentration and judgment were intact. He denied anhedonia (the inability to experience pleasure from activities usually found enjoyable), lack of motivation and anergia (and ongoing lack of energy and inability to

carry out normal daily activities). He said that he was not experiencing any sleep disturbances and denied substance abuse.

Issues Raised by the Deceased's Family

66. The evidence presented to me during the inquest, and during the hearing, enables me to make the findings that I am required to make under s.52(1) of the Act.

67. However, the deceased's family have expressed a number of concerns about the care and treatment provided to him by Mental Health ACT. I turn to consider these concerns in the context of determining what, if any, recommendations should be made pursuant to s 52(4) and s 57(3) of the Act and what findings, if any, should be made under s 74 of the Act in relation to the quality of care, treatment and supervision of the deceased that, in my opinion, contributed to his death.

68. In a comprehensive 32 page document, dated 29 March 2010, provided to Constable Daniel Williams, the deceased's mother set out a number of areas of concern about, and criticism of, the treatment and care provided to him by Mental Health ACT. The document canvases events and alleged actions, or inactions, of Mental Health ACT spanning the years 1997 up to the time of his death in February 2010. It contains broad-ranging comments as to the adequacy and efficiency of mental health treatment and care provided to him.

69. Clearly, it is beyond the scope of this inquest, and indeed impermissible, for me to attempt to explore the breadth of issues raised by the deceased's mother. My focus must be on the treatment, care and supervision provided to him whilst he was subject to the PTO and any issues concerning that treatment, care and supervision, during that period, which may have contributed to his death, and in respect of which it would be appropriate for me to comment.

70. Prior to the hearing, it was agreed by Counsel for the family, Mr Bernard Collaery, that issues concerning the deceased treatment, care and supervision would be revised and limited to matters which it would be open for me to investigate and consider. This was done and, ultimately, three primary issues were raised by the family. These were forwarded to Mental Health ACT for consideration and comment. A response, dated 31 August 2011 was provided by Ms Katrina Bracher, Executive Director, Mental Health, Justice Health and Alcohol and Drug Services.

71. Set out below is each issue raised by the family and the response provided by Mental Health ACT.

1. Clinical Supervision and continuity of care by Mental Health ACT

72. The family considered that there should have been more appropriate supervision of the deceased, with continuity of management of the patient involving an identified clinical carer who had responsibility for his management.

73. The response by Mental Health ACT was as follows: –

> "In keeping with the National Standards for Mental Health Services 2010, Mental Health Services in the ACT endeavour to allocate a single clinical worker who is assigned as clinical manager to each consumer who requires

ongoing clinical management. We recognise that an allocated single worker develops a therapeutic relationship with consumers and that this promotes optical clinical outcomes.

"Unfortunately, workforce issues such as recruitment and retention face mental health services at an international, national and local level. Mental Health Services in the ACT have undertaken a number of activities to promote recruitment to our service to achieve continuity of care. These include the Post Graduate Nursing program, linkages with tertiary institutions, national recruitment drives and promotional attendance at health conferences.

"It is acknowledged that being able to have a continual clinical manager allocated to the care of an individual can be a challenge in the face of workforce pressures. The electronic record, recovery plan and clinical reviews assist in providing consistent care over time to consumers."

2. Clinical criteria for assessment of risk

74. The family sought clarification of how assessment of risk is conducted in relation to persons such as the deceased, and in particular, what are the clinical criteria to assess that risk.

75. The response by Mental Health ACT was as follows: -

"Mental Health Services follow best clinical practice guidelines based on current research literature. The risk assessment tool currently used determines the consumer's status of past and current and future assessment of risk of self harm or risk to others. The tool considers a group of so-called:

- 'static' factors including demographics, past history of suicidality, previous hospitalisation, substance use, childhood adversity among others,
- 'dynamic' factors such as current suicidal ideation, guilt feelings, active psychological symptoms, the presence of a suicidal plan, feelings of hopelessness and current anxiety or anger, and
- 'future risk' factors assesses the likelihood of future service contact, future stress and social support.

"Collateral information is sought, for example recent loss, the possibility of facing the courts and state of sobriety be (sic) taken into account. The final assessment remains a clinical judgment and is used to guide clinical care."

3. The non-provision of information to family members.

76. The family was concerned that at times they were not provided with information concerning the care provided to the deceased because of privacy issues, notwithstanding that a member of the family held an Enduring Power of Attorney.

77. The response by Mental Health ACT was as follows: -

> "All staff of Mental Health Services are subject to the legislative requirements under the *Health Records (Privacy and Access) Act 1997*. It is acknowledged that issues of consent, in particular sharing of information with identified carers or family members can be a challenge for clinicians. Our training has emphasised the need to actively seek information from family members and carers to assist in building context around a consumer's presentation. I understand there was ongoing contact with Mr Jolliffe's mother to provide updates on his attendance to the Belconnen Mental Health clinic for his fortnightly medication."

78. Following the first hearing, Counsel for the family made formal written submissions on behalf of the family. These submissions focused upon three issues and were responded to by written submissions made by Counsel for the ACT. I shall deal with the submissions in respect of each issue in turn.

The Decision to Apply for a Further PTO

79. The family are of the view that, because the deceased had frequently expressed his dissatisfaction with being subject to a PTO, if he was aware that he was required to attend an ACAT hearing on 18 February 2010, for the making of a further PTO, this knowledge may have caused him to take his own life.

80. As recently as 1 February 2010, the deceased had told Dr Cubis, his treating psychiatrist, that he did not want to a PTO. On this occasion, Dr Cubis noted that he was compliant with medication in order to avoid detention.

81. Counsel for the family conceded that there is no conclusive evidence that the deceased knew the date of the proposed ACAT hearing, but submitted that it is likely he was aware of the date fixed before the hearing. In this regard, Counsel for the family pointed to the fact that on 9 February, 2010 he had attended Belconnen Mental Health to receive his fortnightly injection of Clopixol, and again on 12 February, 2010 for a Case Management review. He noted that an entry in the deceased's patient notes made by his case worker, Mr Sonney Morrison, records a discussion which included reference to an "ongoing PTO" and an explanation given to him that the "CM will consider this overcoming (sic) six month period of new PTO".

82. On the basis of these notes, I am satisfied that the deceased knew of the upcoming ACAT hearing.

83. The issue which the family raises is, effectively, whether there had been a proper consideration by the deceased's mental health treating team before the decision was made to apply for a further PTO.

84. In oral evidence, Dr Len Lambeth, the Director of Clinical Services, Mental Health, Justice Health and Alcohol and Drug Services and the Chief Psychiatrist, said that he would expect there to be a team meeting before an application for a PTO is made.

85. Prior to the making of the order which was in force at the time of the deceased's death, a team review was held on 4 August 2009. However, his patient notes do not reveal the holding of a team review prior to the application for a further PTO made by Mr Ross Bowden, his then Case Manager, on 5 January 2010.

86. Counsel for the family noted that on 1 February 2010, subsequent to the making of the application by Mr Bowden, the deceased's treating psychiatrist, Dr Cubis, made the following note in his patient notes: –

> "… Stable affect. No specific risk. Insightless and believes only admitted because of dispute about medication. Motivation to take meds based on avoiding detentions. Believes he would be picked up if he doesn't take it. Doesn't want an order. Chronically delusional and will decompensate if he does not take medication. Likely to relapse at some point. Uncertain if require order to maintain this situation. Issue whether he should be maintained on an order to avoid relapse in future. Mainly depends on risk when he does relapse whether to sustain order. PTO lapses on the 19/2."

It was submitted this indicated that, at that time, Dr Cubis had not decided whether the PTO should be maintained, and suggests that a team meeting had not been held. It also suggests that Mr Bowden made the application for a further PTO without consulting Dr Cubis.

87. Counsel for the ACT conceded that there is no express reference in the notes to the holding of such a meeting. However, he noted, the issue is so clouded by the lack of any evidence that no conclusion can be drawn one way or the other. He noted that Dr Lambeth's evidence was that he would expect there to have been a team meeting before that PTO was sought and that this was the only evidence on the issue. He submitted that Dr Lambeth gave evidence based on his knowledge of the practices of Mental Health ACT and that one of these practices involves the holding of a team meeting before application is made for a PTO.

88. I agree with the submissions of Counsel for the ACT. I am unable to determine that a team meeting did not in fact take place. It is clear from reading the patient notes kept by Mental Health ACT that those working with the deceased worked as part of a team and had available to them the entries made by other members of the team from time to time. Accordingly, I am satisfied that, when Dr Cubis made his entry on 1 February 2010, he was aware that Mr Bowden had lodged the application with the ACAT. It was then some 18 days prior to the lapsing of the existing PTO. If Dr Cubis was of the view, at that time, that the ACAT should be asked to let the order lapse, I would expect that he would have made a relevant entry in the notes. He made no such entry.

89. In any event, I am prepared to make a recommendation that if team meetings are not held before every decision is made to apply for a PTO, or the continuation of a PTO, they should be held. I will also recommend that all team meetings be clearly recorded in the patient notes.

Continuity of treatment

90. Counsel for the family stated that the family was concerned about a lack of continuity of treatment provided to the deceased by Mental Health ACT. He noted that, according to the records, the last full psychiatric assessment of the deceased took place on 15 June 2009, eight months before his death. He submitted that there had been constant changes of staff involved in his treatment and that, close to the end of his life, a new case manager had been appointed.

91. Counsel for the ACT submitted to that the submission made by the family that the last full psychiatric assessment of the deceased was on 15 June 2009 ignores the fact that the deceased was seen by the same treating psychiatrist of 14 September 2009, 26 October 2009, 10 December 2009 and 1 February 2010. He noted that, whilst the records of these assessments were entitled "File Note" by the doctor, they in fact reflected a full psychiatric assessment of the deceased.

92. I am satisfied that the deceased was provided with continuity of treatment by Mental Health ACT. The same psychiatrist saw him between June 2009 and some 14 days before his death. He was also involved with a mental health treatment team over that time. It is the case that, over the significantly long period that he had been treated by Mental Health ACT, there were many changes in the staff assigned to his treating team. These changes are to be expected when a person is a patient over many years, given the nature of, and demands on, the services of Mental Health ACT. Having examined his records held by Mental Health ACT, I am satisfied that the treatment he was provided was not diminished at any time by changes of staff assigned to his treating team.

Participation of the Deceased in Decision-making Concerning Treatment

93. Counsel for the family stated that the family considered that the deceased had been maintained pharmacologically by exterior decision-making, in which he had little if any role. They feel that there was therapeutic control of him for the purposes of behaviour management, rather than committed treatment and reassurance. Counsel asserted that it is widely known the drugs used for behaviour management are powerful and are used for lengthy periods. He noted that there is a move within the United Nations Committee on the Rights of Persons with Disabilities ("the Committee") that calls for supported inclusive decision-making by persons who are likely to become subject to treatment orders. He noted that according to the minutes of the Sixth Session (19 – 23 September 2011), in its consideration of a state report submitted by Spain, the Committee expressed its concern that no measures had been taken by Spain to replace substitute decision-making with supported decision-making in the exercise of legal capacity. He noted that the Committee had recommended as follows:

> "That the State party review the laws allowing a guardianship and trusteeship, and take action to develop laws and policies to replace regimes of substitute decision-making by supported decision-making, which respects the person's autonomy, will and preferences. It further recommends that training be provided on this issue to all relevant public officials and other stakeholders."

94. In response to these submissions, Counsel for the ACT submitted that the assertions contained in the submissions made by Counsel for the family are unsupported by the evidence. He noted that there was no evidence that the deceased was maintained pharmacologically by exterior decision-making alone; that he had not participated in the decision-making concerning his treatment; that the treatment provided to him was for the purpose of therapeutic control of him rather than committed treatment and reassurances; and that "the drugs used for behaviour management are powerful and are used for lengthy periods".

95. I agree with the submissions of Counsel for the ACT. There is no basis for me to find that the treating team assigned to the deceased from time to time sought only to control his behaviour through drugs, or failed to discuss proposed treatment regimes with him

and seek his acceptance of, and participation in, such treatment regimes. Whilst it is the case that he was often resistant to such treatment and, at times non-compliant, that is not evidence that the treating team did not seek to involve him in the decision-making. Further, such resistance and non-compliance would not have been an acceptable basis for the treatment to have been withheld if the medical opinion was that it was necessary. In this regard, I note that the ACAT supported the need for such treatment to be given involuntarily.

96. I agree with the views of the United Nations Committee on the Rights of Persons with Disabilities in relation to the promotion of supported-decision making, even in respect of mental health patients. However, I am not satisfied that this approach was not followed in the case of the deceased and I would not agree with a proposition that decision-making in respect of the treatment to be provided to a mental health patient should be left solely to a patient, or his or her family. Clearly, a process that involves consultation with, and input from, the patient, and if appropriate his or her family, is the most desirable approach but, ultimately, the decision to treat, and the nature of the treatment, must be determined on the basis of the patient's best interests, guided by expert medical opinion.

Communication between Mental Health ACT and the deceased's family

97. The deceased's family raised a particular concern about the failure of Mental Health ACT to communicate his treatment plan and ACAT hearing developments to members of his family.

98. It is clear that on 6 October 2009, in a discussion with a member of his treating team, Ms Elloise Barry, the deceased stated that he did not want Mental Health ACT to discuss his case with his mother. Ms Barry made the following note in his patient progress notes –

> "Previous clinical manager was informing Mrs Jolliffe (mother) if Mark had presented to BMHT for depot, which I have also been doing. In the interests of upholding policy, I enquired if Mark was happy for me to continue speaking to his mother re depot. Mark expressed that he did not want the service discussing care with mother. I advised Mark that I would respect his wishes, and also advised that although I would not discuss his care, if Mark's mother wishes to contact the service to provide information than (sic) she is able to do so. Mark expressed that, "she does have a tendency to do that (chat)."

99. I note the that the Patient Progress notes reveal many occasions prior to this when the deceased's mother telephoned the treating team to advise them about events and circumstances concerning the his life, to advise that he had failed to take medication or to enquire as to whether he had received his medication. In turn, there are many occasions noted where a member of the treating team rang his mother to tell her that the deceased had presented for his depot medication and in relation to an upcoming ACAT hearing.

100. It is also clear that, on 19 November 2005, the deceased executed an Enduring Power of Attorney appointing his sister to be his attorney and that Mental Health ACT was in possession of a copy of the document from at least 2008.

101. Counsel for the family submitted that, notwithstanding the application of the Privacy Principles to a patient's health records by the *Health Records (Privacy and Access) Act 1997* ('the Health Records Act"), thus forbidding disclosure of a patient's health record to any person other than the patient, without his or her consent, it would have been open to Mental Health ACT to keep the deceased's sister informed of his treatment and care by virtue of the combined operation s 10 of the Health Records Act and s 45 of the *Powers of Attorney Act 2006* (" the Powers of Attorney Act").

102. The relevant parts of s 10 of the Health Records Act provide as follows –

> **"10 Statement of principle regarding right of access**
>
> (1) A consumer has a right of access, in accordance with this Act, to a health record that is—
>
> (a) a health record held by a health service provider; or
>
> (b) to the extent that it contains personal health information relating to the consumer, any other health record;
>
> as follows:
>
> (c) to the extent that the record contains factual matters, whenever the record was made;
>
> (d) to the extent that the record contains matters of opinion, if the record was created on or after the date of commencement of this Act.
>
> . . .
>
> (7) Where the consumer is a legally incompetent person, the right of access conferred by subsection (1) is exercisable on behalf of the consumer by a guardian of the consumer."

103. Section 45 of the Powers of Attorney Act provides as follows –

> **"45 Right of attorneys to information—enduring powers of attorney**
>
> (1) This section applies in relation to an enduring power of attorney if the principal has impaired decision-making capacity.
>
> (2) An attorney under the enduring power of attorney has a right to all the information (the ***available information***) that the principal would have been entitled to if the principal had decision-making capacity.
>
> (3) A person who has custody or control of the available information must disclose the information to the attorney if asked.
>
> (4) However, subsections (2) and (3) are subject to any contrary intention, or express limitation, in the enduring power of attorney."

104. Counsel for the family submitted that the combined effect of the two sections is that, if the deceased's sister had sought information from his patient records, Mental Health ACT would have been obliged to provide it to her. It was further submitted that the deceased's sister should not have been required to seek the information, but rather that Mental Health ACT ought to have identified that he lacked capacity and should have

therefore notified her and his family of developments in his care. It was further submitted to that if the family had been notified of his treatment plan, they would have assisted him in shaping decisions regarding his health and provided support to him,

105. The correctness of these submissions depends upon whether, at any stage, the deceased was a "legally incompetent person" (see s 10, Health Records Act) and a person who had "impaired decision-making ability" (see s 45, Powers of Attorney Act).

106. The phrase "legally incompetent person" is defined in the Dictionary to the Health Records Act as meaning a person who is subject –

> "(a) to an enduring Power of Attorney that has become operative; or
>
> (b) otherwise than as a person under the age of majority to a guardianship order ".

As there was no guardianship order in force in respect of the deceased, s 10 (7) of that Act could only have been applicable if the Enduring Power of Attorney executed by the deceased had "become operative".

107. The power of attorney would have "become operative" if, at any point, the deceased had "impaired decision making ability". Section 9 of the Powers of Attorney Act provides as follows –

> **"9 What are *decision-making capacity* and *impaired decision-making capacity*?**
>
> (1) For this Act, a person has ***decision-making capacity*** if the person can make decisions in relation to the person's affairs and understands the nature and effect of the decisions.
>
> (2) For this Act, a person has ***impaired decision-making capacity*** if the person cannot make decisions in relation to the person's affairs or does not understand the nature or effect of the decisions the person makes in relation to the person's affairs."

108. Counsel for the family submitted that, when, on 6 October 2009, the deceased declined to permit his mother to be informed about his care, he did not have the capacity to make decisions regarding such a matter. In this regard, he pointed to the following –

- He had been receiving a regime of Clopixol injections fortnightly and, on occasions, during the period in which he was receiving treatment, he had said to his mother that he felt "drugged up to the eyeballs".
- His medication regime was administered pursuant to a Psychiatric Treatment Order which had been last extended on 26 February 2009.
- Between February 2009 and February 2010 he was described as having "poor insight into his illness and categorically refused to participate in any psycho education classes or recovery planning to improve his insight".

109. It was submitted that these factors demonstrate that on 6 October 2009 his medication regime impaired his ability to:

- have a general understanding of what decision he needed to make and why he needed to make it;
- have a general understanding of the likely consequences of making, or not making, the decision; and
- understand, retain, use and weigh up the information relevant to this decision.

110. In my view, this submission is not supported by the evidence. There is simply no evidence that on 6 October 2010, or indeed at any time before or after that date, the deceased had impaired decision-making ability.

111. It is the fact that the deceased was involuntarily made subject to a PTO but the criteria for making such an order does not include that the patient has "impaired decision-making ability". The criteria for the making of such an order are set out in s 28 of the Mental Health Act. It provides as follows –

> **"28 Criteria for making psychiatric treatment order**
>
> The ACAT may make a psychiatric treatment order in relation to a person if—
>
> (a) the person has a mental illness; and
>
> (b) the ACAT has reasonable grounds for believing that, because of the illness, the person is likely to—
>
> (i) do serious harm to himself, herself or someone else; or
>
> (ii) suffer serious mental or physical deterioration;
>
> unless subject to involuntary psychiatric treatment; and
>
> (c) the ACAT is satisfied that psychiatric treatment is likely to reducethe harm or deterioration (or the likelihood of harm or deterioration) mentioned in paragraph (b) and result in an improvement in the person's psychiatric condition; and
>
> (d) the treatment cannot be adequately provided in a way that would involve less restriction of the freedom of choice and movement of the person than would result from the person being an involuntary patient."

112. Thus, the mere making of a PTO does not establish that a person generally has "impaired decision making ability". In the making of a PTO, the focus is upon the mental illness, the patient's insight into the need for mental health treatment and his or her willingness to accept treatment. It is clear, from a reading of the Mental Health Act as a whole, the legislature recognised that the presence of a mental illness does not inevitably result in general "impaired decision making and ability". Indeed, in a number of areas of the Act the clear intention is expressed that the patient who is subject to an order should be encouraged and assisted, as far as possible, to make decisions for himself or herself and to lead a normal life. As an example, ss 26 (g), (h) and (i) provide, inter alia, as follows:

> **"26 What ACAT must take into account**
>
> In making a mental health order in relation to a person, the ACAT must take into account the following:
>
> . . .
>
> (g) that the person's rights should not be interfered with except to the least extent necessary;
>
> (h) that the person should be encouraged to look after himself or herself;
>
> (i) that, as far as possible, the person should live in the general community and join in community activities;
>
> . . ."

113. Clearly there will be cases where a patient does have "impaired decision making ability" by reason of mental illness. In such cases, an Enduring Power of Attorney will come into effect or, if one does not exist, a guardianship order might be made. However, there is no evidence that this was the situation in the deceased's case. It is significant to note there is no evidence that, at any stage, the deceased's sister felt obliged to act pursuant to the Enduring Power of Attorney. This points to her not having formed the view, at any stage, that the deceased had "impaired decision making ability". Indeed, the thrust of other submissions made by the family is that the deceased should have been allowed to be more involved in making decisions about his treatment.

114. As to the submission that the deceased's medication regime was a factor which played a role in rendering him with " impaired decision making ability", there is no evidence that the medication had this effect upon him.

115. It follows that, in the deceased's case, the circumstances did not arise which would have permitted Mental Health ACT to provide information from his health records to his sister, as his attorney, pursuant to s 10 (2) of the Health Records Act.

116. Counsel for the family noted that, even where a patient's health record can be disclosed to a person other than the patient, neither the Health Records Act, nor any other legislation, imposes a positive obligation on a record keeper, such as Mental Health ACT, to actively disclose health records to a guardian or attorney. In his submission, family members play a vital role in supporting people in their use of health care services and should, therefore, be kept informed about a person's treatment and care when they have an "impaired decision making ability". On behalf of the family he submitted that I should recommend that:

> "Positive obligations should be imposed on ACT Mental Health to:
>
> - assess an individual's capacity to make decisions in respect of their treatment, particularly when the individual is subject to a PTO and demonstrates poor insight into his/her illness;
> - refrain from asking an individual to make key decisions rendering his/her treatment, such as involving family members, when it is clear that the individual's ability to understand, retain, use and weigh up information relevant to the decisions is impaired;

- actively determine whether an individual who is subject to a PTO has appointed an attorney to act on his/her behalf pursuant to a power of attorney or an Enduring Power of Attorney; and
- communicate health care information to an individual's appointed attorney and involve the appointed attorney in decision-making in so far as the Power of Attorney or Enduring Power of Attorney allows."

117. Counsel for the ACT informed the Court that Mental Health ACT agrees with the proposition that the family play a valuable role in the provision of treatment to a person with mental illness and it endorses the proposition that, as much as lawfully possible, discussion with the family of a patient take place concerning the provision of treatment. He noted that, in his evidence, Dr Lambeth stated that the staff of Mental Health ACT understands the need for open dialogue to take place with a patient's family, and that it should be given some priority, provided it takes place within the constraints of the law.

118. I am satisfied that in this case the staff of Mental Health ACT acted according to the law, as they were obliged to, once the deceased gave the instruction that they were not to discuss his treatment and care with his family. If they had attempted to act in the way suggested in the recommendations suggested by Counsel for the family, they would have been in breach of the law.

119. I have much sympathy for the frustration felt by the families of adult people suffering mental illness when they are confronted by privacy legislation which prevents them from being kept informed as to developments in their loved one's illness and the treatment being given to, or proposed for, them. In my 25 years as a coroner this has been a frequent complaint made by the families of persons who suffered from mental illness and who have taken their own life. I agree with the submission that family members play a vital role in supporting their relatives in their use of health care services. However, this role can be frustrated by an adult patient who, although considered to be incapable of making reasonable judgements about matters relating to his or her health or safety, or doing anything necessary for his or health or safety (see s 11, Mental Health Act), is considered able to make judgements concerning the communication of information relating to their mental health to members of their family.

120. However, in my view, it would be too great a burden to place the responsibility on the staff of Mental Health ACT to determine, from the day to day, whether an adult patient, who is subject to a PTO, has " impaired decision making ability" for the purpose of deciding whether information can be provided, pursuant to s 45 of the Powers of Attorney Act, to a person holding an Enduring Power of Attorney.

121. In considering what recommendations to make in respect of the ability of relatives to obtain information from Mental Health ACT concerning their relative it is important to bear in mind relevant provisions of ss 25 and 26 of the Mental Health Act which are as follows –

> **"25 Consultation by ACAT etc**
>
> (1) Before making a mental health order in relation to a person, the ACAT must, as far as practicable, consult—

(a) if the person is a child—the people with parental responsibility for the child under the *Children and Young People Act 2008*, division 1.3.2; and

(b) if the person has a guardian under the *Guardianship and Management of Property Act 1991*—the guardian; and

(c) the person most likely to be responsible for providing the treatment, programs and other services proposed to be ordered.

(2) If the person has an attorney appointed under the *Powers of Attorney Act 2006*, the ACAT must also consider consulting the attorney.

. . .

26 What ACAT must take into account

In making a mental health order in relation to a person, the ACAT must take into account the following:

. . .

(c) the views and wishes of the people responsible for the day-to-day care of the person, so far as those views and wishes are made known to the ACAT;

(d) the views of the people appearing at the proceeding;

(e) the views of the people consulted under section 25;

(f) that the person's welfare and interests should be appropriately protected;

(g) that the person's rights should not be interfered with except to the least extent necessary;

. . ."

122. It will be seen that s 25 requires the ACAT, before making a mental health order, to consider consulting a person who is an attorney under a power of attorney and, in making a mental health order, s 26 makes it mandatory for the ACAT to take into account the views and wishes of the people responsible for the day to day care of the person, so far as those views and wishes are made known to the ACAT, and the views of people appearing at the proceeding. In many cases, the persons responsible for the day to day care of the persons are members of his or her family and, in many cases, members of a patient's family appear at the proceeding. The ACAT is also obliged to take into account the views of the people consulted under s 25. Included in this group is a person holding a power of attorney.

123. Upon the making of a mental health order, the Chief Psychiatrist becomes responsible for determining matters relating to the patient's treatment, care or support and the place at which he or she should live (see s 32(1),(2) and (3), Mental Health Act) and it is important to note that, before making such determinations, the Chief Psychiatrist is obliged, if practicable, to consult the patient's guardian and any attorney appointed by the patient under the Powers of Attorney Act (see s 32(4), Mental Health Act). However, it would seem that the Chief Psychiatrist is constrained by s 10 of the Health Records Act from providing information contained in the patient's health record to the guardian or attorney when conducting the consultation. In these circumstances, it is

probable that the value of such a consultation process is diminished when the guardian or attorney cannot be fully informed about the patient's condition and treatment.

124. Given then that members of a patient's family are able, and indeed required, to participate in the ACAT process leading up to the making of a mental health order – be it as an attorney, carer or simply by appearing at a proceeding – and that any guardian or attorney must be consulted by the Chief Psychiatrist before he or she makes a determination as to the patient's treatment, care, support and place of residence, it seems incongruous that, once a mental health order has been made, and thus it has been confirmed that the patient is unable to make reasonable judgements as to his or her health and safety, or do anything necessary for his or her health and safety, the patient's relatives may not be provided with information concerning the patient's health and treatment.

125. If it has been considered necessary, in the patient's best interests, to interfere with his or her human rights to the extent of making a mental health order, it does not seem to me to be a significantly greater interference with those rights, and would appear to be in his or her best interests, to mandate the sharing of the patient's health information with at least his or her attorney, or, in the absence of an attorney, the closest member or members of his or her family who demonstrate a legitimate interest in his or her welfare. If this were done, it would be consistent with the view expressed in Statement 7 of the National Standards for Mental Health Services 2010, published by the Commonwealth Department of Health and Ageing, which states, at p 16, that " the MHS recognises, respects, values and supports the importance of carers to the well-being treatment and recovery of people with mental illness".

Record Keeping

126. The deceased's family raised some concerns about the accuracy of the records relating to him maintained by Mental Health ACT and made assertions as to a number of specific discrepancies relating to his admission to the PSU in 2008. The accuracy of these assertions was not explored in evidence taken during the hearing because the assertions related to an admission some 18 months prior to the deceased's death, and clearly played no role in his death. Accordingly, an investigation into the records would have been beyond the appropriate scope of the inquest.

127. However, I note that Counsel for the ACT agreed with the following propositions submitted by Counsel for the family –

- The responsible health authority should ensure that relevant clinical notes, provided by another health service/provider in hard copy, be scanned into the appropriate ACT Health clinical records so that electronic access can be secured from all electronic access points.
- Record keeping with respect to patient interactions should be as contemporaneous with the patient interaction as is practicable.
- Documents relevant to privacy issues including Enduring Powers of Attorney should be scanned into the electronic health record so as to allow ready access by all health personnel having access to electronic record access points.

128. In light of the foregoing, I make no findings in respect of the accuracy of the deceased's mental health records. However, I will forward to the Director-General, ACT Health

Directorate, and to the Chief Psychiatrist, the family's submissions, and the submissions of Counsel for the ACT, for their information.

Notification to Family as to ACAT Hearings

129. During the hearing, the issue of the adequacy of notification given to members of a patient's family in relation to the date and time of ACAT hearings was raised.

130. The issue was not explored in detail but it was agreed by both Counsel that a patient's family should be made aware of any impending ACAT hearing. It is, of course, important that this be done so that members of the family, and any attorney, can avail themselves of the opportunity to have their views considered by the ACAT pursuant to ss 25 and 26 of the Mental Health Act

131. Accordingly, I propose to make a recommendation concerning the giving of notice of ACAT hearings to family members and attorneys.

Competency Level of English Communication of Mental Health ACT Staff

132. The deceased's mother raised a concern about the competency level of English communication of two particular members of the staff of Mental Health ACT.

133. As with the accuracy of the deceased's mental health record, the complaint related to the deceased's admission to PSU in 2008.The assertions, even if correct, played no part in the deceased's death and was thus too remote an issue for investigation in this inquest.

134. Counsel for the ACT advised the Court that the ACT does not accept that the language skills of the members of staff nominated by the deceased's mother were inadequate. However, he said that the ACT agreed that clinicians employed by it should meet the English language skills required by the Medical Board of Australia.

135. I make no findings on this issue and, again, the submissions of the family and the ACT will be forwarded to the Director-General and the Chief Psychiatrist, for their information.

Pharmaceutical Regime

136. Counsel for the family made a general submission concerning the pharmaceutical regime pursued in respect of patients of Mental Health ACT. He submitted as follows –

> "Patients' wishes with respect to their own clinical assessment of pharmacological suitability should wherever possible be taken into account. Patients transferred from another health service/provider should be considered for continuity of medication rather than commencement on new pharmacology.
>
> "Clients on a PTO, to whom high doses of anti-psychotic medication are compulsorily administered, are under a special duty of care by the Territory. Clopixol is designed to affect mental state. Although Professor Drummer stated that the level of accumulating Clopixol to toxicity over a long time of administration by depot cannot be tested, why is it that can be measured post-

> mortem? There is a lack of safeguards to prevent levels of compulsorily administered depot medication from accumulating to toxic levels.
>
> "The Royal Australian and New Zealand College of Psychiatrists states that 'access to crisis support 24 hours a day' is essential for treatment. Maintaining clients on long-term medication without close review is inconsistent with these guidelines."

137. This submission was not based on any evidence that the deceased's mental health was adversely affected by a change in his medication, that he ever reached a toxic level of Clopixol, that he was not regularly reviewed, nor that there was any lack of safeguards to prevent medication levels reaching toxic levels. It was simply a statement as to best practice generally.

138. Counsel for the ACT stated that Mental Health ACT agreed with the family's submission in this regard, apart from the assertion that there was a lack of safeguards to prevent medication levels reaching toxicity. In this regard, he noted that the deceased was assessed at regular intervals by the same psychiatrist on 14 Septembe,r 2009, 26 October, 2009 and 1 February, 2010.

139. Again, I make no findings concerning the deceased's medication regime and I will forward the submissions to the Director-General and the Chief Psychiatrist.

Stigma Attached to Mental Illness When Perceived as a Justice Issue

140. The family of the deceased accepts that it will never be established to the requisite degree that the prospect of an upcoming ACAT hearing caused him to take his own life. However, it is their view that the holding of ACAT hearings in the Magistrates Court Building may have increased his perception, and that of members of the public, that mental illness is a justice issue. In their view, the involvement, at times, of members of the police by Mental Health ACT may add to this perception.

141. Again, it is not open to me to make any findings or recommendations in respect of this issue. However, I note that Counsel for the ACT informed the court as follows –

> "Mental Health ACT is very aware and cognisant of this issue and in particular the unwarranted and undesirable stigma that may attach to a person suffering a mental illness.
>
> "Police intervention is a last resort.
>
> . . .
>
> "Mental health ACT is very supportive of the position that any application for a PTO should be done in the least confrontational and stressful manner possible avoiding any misperceptions as to the nature of that application by the patient or the public "

142. I also note that, for some time now, ACAT hearings have not been held in the Magistrates Court Building.

Independent Inquiry

143. Counsel for the family submitted that an independent enquiry be conducted in the ACT in relation to suicide deaths. He submitted as follows –

> "The Coroner's Court of Victoria and The University of Melbourne have commenced a study investigating confirmed suicides and other suspected suicide deaths that occurred between 2009 and 2010. The study will identify 'the frequency and nature of any contact these people had with health, housing and other services such as police, ambulance and health professionals before they died. A similar study to this should be conducted in the ACT over a five-year period from 2009 to 2013, which includes the factors laid out in the Victorian study as well as any contact with clinicians, the use of any medications and the incidence of the recycling of PTOs on the authority of a nurse."

144. In my view, there is a substantial impediment to this Court being involved in such a study in the ACT. It is that the Court has no statutory authority to arrange or commence such a study. In any event, this Court does not have the type and level of resources enjoyed by the Coroner's Court of Victoria.

145. Whilst such a study may prove very useful in the development of strategies to reduce the rate of suicide in the ACT, I agree with the submissions of Counsel Assisting that, given the scope and extensive nature of the Victorian study, a recommendation to commence a similar ACT study at this stage is unnecessary. I also agree that, following the completion of the Victorian study, the findings can be assessed by the relevant bodies in the ACT and a decision then made as to whether any further study of ACT cases is necessary and what direction any such study should take.

146. However, I do propose to recommend that the progress of the Victorian study be monitored and that its report be closely considered by the relevant bodies in the ACT to determine whether any recommendations made should be implemented in the ACT and whether a similar study should then be carried out in the ACT.

Formal Findings

147. As required by s 52 of the act I find that :

- the deceased was Mark Rodney Jolliffe, born on 31 October 1972;
- the deceased died at some time between 6.25pm on 14 February, 2010 and 7.15am on 15 February, 2010 on City Hill, Canberra City in the Australian Capital Territory; and
- the deceased died as a result of hanging, which was self-inflicted with the intention of taking his own life.

Findings about Quality of Care, Treatment and Supervision

148. Notwithstanding the number of important issues raised by the deceased's family, there is no evidentiary basis for the making of a finding, under s 74 of the Act, that the quality of care, treatment and supervision provided to the deceased by the ACT contributed to the cause of his death.

Recommendations

149. Pursuant to s 57 of the Act, in the interests of public health and safety, I recommend to the Attorney-General that:

- If Mental Health ACT team meetings are not held before every decision is made to apply for a psychiatric treatment order, or the continuation of such an order, they be held before every such decision is made and that all such team meetings be clearly recorded in the patient notes.

- Consideration be given by the Executive and the Legislative Assembly to the making of all necessary statutory amendments so as to mandate, in the case of a person in respect of whom a mental health order has been made under the *Mental Health (Treatment and Care) Act 1994*, the disclosure of that person's mental health records to a person appointed as the person's attorney under the *Powers of Attorney Act 2006*, or corresponding Act of a State or other Territory, or, if there is no such attorney, to the closest living relative or relatives of the person who demonstrate a legitimate interest in his or her welfare and a wish to be involved in his or her treatment, care and supervision.

- Where the ACT Civil and Administrative Tribunal is conducting proceedings in relation to an application for the making of a mental health order in respect of a person, it be required to notify any known person appointed as the person's attorney under powers of attorney legislation and all known close relatives of the person who are, or are likely to be, concerned and interested in the person's treatment, care and supervision.

- The relevant bodies in the Australian Capital Territory monitor the progress of the study into suicides occurring in Victoria between 2009 and 2010 being conducted by the Coroner's Court of Victoria and the University of Melbourne and that its report be closely considered to determine whether any recommendations made in it should be implemented in the Australian Capital Territory, and whether a similar study should be conducted in the Australia Capital Territory and the direction that it should take.

Condolences

150. I extend my condolences, and deepest sympathy, to Mr Jolliffe's relatives and friends for their tragic loss.

P.G. Dingwall
Coroner