CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Dion White-Cotterell
Hearing dates:	28 July - 31 July 2025
Date of final submissions by the parties:	6 February 2026
Date of findings:	19 May 2026
Place of findings:	Coroners Court of NSW, Lidcombe
Findings of:	**Deputy State Coroner Carmel Forbes**
Catchwords:	CORONIAL LAW – mental health-homicide-community mental health treatment – mental health policy and practice
File number:	2019/67494
Representation:	Mr C McGorey, Counsel Assisting, instructed by Ms L Shepherd, NSW Crown Solicitor's Office Mrs R and Mr M Stevens, family (unrepresented) Mr R and Mrs K White, family (unrepresented) Mr S Barnes, for Dr L Kondadasula, instructed by Mr P Tsaousidis, Avant Legal Ms K Holcombe, for Western Sydney Local Health District and Ms A Vivekanathan, instructed by Mr J Holohan, Minter Ellison Ms J Walshe, for Homes NSW, instructed by Ms C Bellamy, Department of Communities and Justice

Non-publication order:	Orders for non-publication have been made in this Inquest. The Orders may be found on the Registry file.
Findings:	**Identity** The person who died was Mr Dion White-Cotterell **Date of death** Mr White-Cotterell died on 28 February 2019 **Place of death** Mr White-Cotterell died at 16 Gladstone Street, Parramatta NSW **Cause of death** The cause of Mr White-Cotterell's death was multiple stab wounds **Manner of death** Mr White-Cotterell's death was a result of a knife attack upon him by a known person

Recommendations:	**To the Chief Executive of the Western Sydney Local Health District (WSLHD) NSW** The WSLHD consider introducing a procedure that: (1) Requires the development of a comprehensive care plan for patients being supervised or treated through its community mental health centres, (2) Requires that plan to be reviewed and updated through multidisciplinary reviews that the community mental health centre is expected to carry out for patients, and (3) Ensures that plans have a section directed to key information about the patient's risk of violence when acutely unwell (including reference to key risk assessment reports if any exist) and mandates consideration of that in planning around frequency of contact and responding to a suspected relapse. **To the Chief Executive of Homes NSW and the Chief Executive of the WSLHD** That Homes NSW and WSLHD consider developing a memorandum of understanding as regards the exchange of information between Homes NSW and the WSLHD to facilitate community mental health services

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IN THE STATE CORONERS COURT NSW

LIDCOMBE

SECTION 81 *CORONERS ACT 2009*

REASONS FOR DECISION

INTRODUCTION

1. This is an Inquest into the death of Mr Dion White-Cotterell. At the opening of the inquest Mr White-Cotterell's family requested that I refer to him as Dion. For this reason, throughout these findings, I will refer to him by that name.

2. Dion was 45 years of age when he was stabbed to death on 28 February 2019 by a neighbour, Mr Benjamin Moore, in an unprovoked attack. His neighbour was suffering from an acute relapse of schizophrenia and for no apparent or known reason attacked Dion in the common area of their townhouses.

3. The primary role of a coroner is to make findings as to the identity of the person who died and the place, date, cause and manner of their death. A secondary function of a coroner is to make recommendations, arising from the evidence, in relation to matters that have the capacity to prevent a similar death in the future.

4. Mr Moore was found not guilty by reason of mental illness of Dion's murder. Mr Moore had a long history of mental health issues and violence. The primary issue for this inquest is whether the agencies involved in the care and treatment of Mr Moore's mental health could have done more to prevent the terrible and violent attack on Dion and whether any lessons can be learnt from this tragic event.

DION WHITE-COTTERELL

5. Mr Dion White-Cotterell began living in his NSW Housing townhouse at 1/16 Gladstone Street, North Parramatta in November 2011. His townhouse was one of eight. He had no history for aggressive or violent behavior. Other residents described him to have been friendly and affable. At the time of his death, he was living on his own.

6. Dion had two daughters who were his pride and joy. On the day of his death, he was returning home from a birthday dinner with one of his daughters. The impact of his death upon them has been devastating.

7. Dion's mother has described the enduring pain she suffers from losing her son.

8. Dion's mother, brother, sister-in-law, stepfather and other supportive friends attended each day of this inquest with a clear sense of love, loss and the hope that a horrific incident like this will not happen again to another family.

9. Dion worked for a time with his brother in a security systems company. He suffered a workplace injury and was on the disability pension with ongoing pain and mobility issues relating to his neck and shoulder. While he was off work, he volunteered on the Sydney Tall Ships, and his mother informed this inquest that he had a great passion for sailing and for the peace he experienced while at sea.

10. On behalf of the Coroners Court of NSW, I extend to Dion's family my deepest sympathies for their loss.

THE EVENTS OF 28 FEBRUARY 2019

11. On the evening of 28 February 2019, Dion arrived back at his home at about 8:40pm. He parked his van in an open carparking space across from his townhouse.

12. About 8:47pm, Dion was captured on CCTV walking from his vehicle towards his nearby premises.

13. His neighbour, Mr Moore, was not far behind him. Mr Moore had returned to the complex in his own car minutes beforehand and parked in the garage area. CCTV captured him in the garage area swinging his legs back and forth and jumping up and down before he began walking to his residence.

14. Dion walked off camera with Mr Moore behind him. At this point Mr Moore attacked Dion. As a result, Dion suffered 83 stab wounds to his back, hands, head and neck.[1] He was also punched and kicked while he was on the ground. It was an unprovoked and frenzied attack lasting for 45-60 seconds.

15. Mr Moore entered his house after the stabbing.

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[1] Ex 1 Vol 1 Tab 3

16. Dion was heard by nearby residents calling for help. Police and ambulances were called. Police arrived on the scene followed by paramedics. Dion had no pulse, was not breathing and had suffered significant blood loss. He was declared deceased at the scene by an intensive care paramedic.[2]

17. Police tactical response arrived to arrest Mr Moore who refused to come out of his home. Mr Moore finally exited his unit 5 hours later at about 2:30am after extensive negotiations with police.

18. Police found a black handled folding knife under Mr Moore's bed.

19. Mr Moore was charged with Dion's murder and was remanded in custody. He remains a detained forensic patient.

Criminal proceedings

20. The only issue at the criminal trial was whether Mr Moore was not guilty by reason of mental impairment. Dr A Martin and Dr O Nielssen, consultant psychiatrists, gave expert evidence in relation to Mr Moore's mental state.[3]

21. Dr Martin stated that Mr Moore had reported that he had become increasingly paranoid in the three months before killing Dion. His paranoia worsened over six

[2] Ex 1 Vol 2 Tab 53

[33] Report of Dr Eagle at Ex 1 Vol 9 Tab 116; Report of Dr Ryan at Ex 1 Vol 9 Tab 136

weeks, and he heard voices about two weeks beforehand. On 28 February 2019, he heard a voice telling him to "*stab him before he stabs you*" and he believed Dion would rob and stab him. Mr Moore said he stabbed Dion in a perceived act of self-defence. Dr Martin considered that Mr Moore exhibited persecutory beliefs of a paranoid type and stated that:

> *"[There] is overwhelming evidence of Mr Moore having chronic schizophrenia complicated by substance use disorder [cannabis, amphetamines] going back to Mr Moore's teens, with lengthy hospitalisations as an involuntary patient. The fact that the hospitalisations included lengthy rehabilitation admissions is testament to the severity and chronicity of his illness. His history is characterised by previous unprovoked violence against staff, other patients and his mother, and this was previously attributed to persecutory thinking and auditory hallucinations [hearing voices]. He has previously been catatonic, which is a severe and life-threatening manifestation of schizophrenia..."*[4]

22. Dr Nielssen agreed with Dr Martin and confirmed that in his opinion Mr Moore suffered from schizophrenia and substance use disorder.[5]

23. The court accepted that Mr Moore was suffering from psychotic symptoms at the time of the fatal stabbing and was not guilty of murder as he could not be held to have had the necessary criminal intent due to his mental impairment. Mr Moore remains detained as a forensic patient.

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[4] Ex 1 Vol 9 tab 117

[5] R v Moore [2020] NSWSC 1561; Ex 1 Vol 10 Tab 135.

MR MOORE'S BACKGROUND AND CARE AND TREATMENT

Mr Moore's background

24. I have drawn from submissions by Counsel Assisting in relation to non-contentious factual matters. I am grateful for this assistance.

25. Mr Moore began smoking cannabis at about the age of 13. By 17 years of age, he was smoking daily and had begun using amphetamines and/or methamphetamines. He used different illicit substances throughout his adult life. There was no record of any long-term relationships or employment during his adult life. His primary family contact was with his maternal grandfather and his father who lived on the south coast of NSW.

26. He was diagnosed with schizophrenia at the age of 18, in July 2001, when he was admitted to hospital for psychosis after a period of intravenous methamphetamine use.[6]

27. His psychiatric treatment and reported episodes of aggressive behavior is summarized in the following table.

July 2001	Admitted to Sutherland Hospital for psychosis (first known mental health inpatient admission) after period of intravenous methamphetamine use (during admission became catatonic and required IV rehydration).[7]

6 Ex 1 Vol 9 Tab 116

7 Ex 1 Vol 4 Tab 92

Sep 2001	Discharged into the care of his mother.
Nov 2001	Readmitted after deterioration in context of non-compliance with medication and illicit substance misuse.
Nov 2002	Involuntarily admitted to the Chisholm Ross Centre, Goulburn Hospital.
Jan 2003	Charged with committing assault occasioning actual bodily harm (AOABH) on his mother (committed 8 January 2003). This occurred while he was on leave from Chisholm Ross Centre. Remanded into custody, admitted to Long Bay Prison Hospital (*per Dr Eagle – thereafter Mr Moore had about 18 months of continuous hospitalization for exacerbation of a psychotic illness*[8]). AOABH charge dealt with under s 32 of the MHFP Act (Batemans Bay Local Court 22 December 2003).[9]
2003	Admitted to the Chisholm Ross Centre, Goulburn Hospital.
Mar 2003	Discharged from Chisholm Ross Centre into the care of his grandfather. Subsequently admitted to Manara Clinic (locked unit at Bloomfield).[10]
Feb 2004	Charged with AOABH. Assault on another patient at the Manara Clinic (elderly male) (AOABH charge later dealt with under s 33 of MHFP Act (Central Orange Local Court 12.1.2015[11]). He had reportedly assaulted staff or patients on a number of occasions.[12]
13-15 Mar 2004	Transfer to D Ward of Long Bay Prison Hospital (13.3.2004) and thereafter to the Rozelle Hospital on 15 March 2004 under s 33(1)(a) of the MHFP Act.

8 Ex 1 Vol 9 Tab 116
9 Ex 1 Vol 4 Tab 85
10 Ex 1 Vol 4 Tab 93
11 Ex 1 Vol 4 Tab 85
12 Ex 1 Vol 9 Tab 116

Jul 2004	Discharged from Rozelle Hospital into supported accommodation managed by the Richmond Fellowship (NGO).[13]
Nov 2004	Readmitted to Rozelle Hospital following medication non-compliance.
May 2005	Managed by Camperdown Community Mental Health Service after moving into another supported accommodation facility.
Oct 2005	Admitted to Royal Prince Alfred Hospital (RPA) following deterioration in context of medication non-compliance.
Sep 2009	Discharged from RPA.
Aug 2010	Began leasing a unit through Housing NSW in Batemans Bay region (13/215 Beach Road, Batehaven NSW).[14]
14-22 Oct 2014	Allegedly committed common assault at shopping centre (where previously banned from attending for being abusive). Charged with assault police, armed with intent to commit indictable offence, possess prohibited drug and custody of knife in public place after he confronted police at his unit. Charges dealt with under s 33(1)(b) of the MH Act.
29 Oct 2014	Admitted to the Concord Hospital Intensive Care Unit for catatonia.
12 Jan 2015	Transferred to the Long Bay Prison Hospital under s 33 of the MHFP Act. Before admission he reportedly assaulted another patient who annoyed him with recurring cough.[15]
10 Feb 2015	Transferred to Chisholm Ross Centre, Goulburn Hospital.
9 Mar 2015	At the Chisholm Ross Centre - reportedly entered the bedroom of another patient and kicked him repeatedly in the head (reports that the victim had been making “dirty noises”).

13 Ex 1 Vol 9 Tab 117

14 Ex 1 Vol 2 Tab34

15 Exhibit 1 Vol 7 Tab 111

28 Mar 2015	At the Chisholm Ross Centre - reported assault of another patient by stabbing the victim to the head and neck with a pen (patient resting in the open area of the low dependency unit at the time).[16]
29 Mar 2015	At the Chisholm Ross Centre – reported assault of another patient in the high dependency unit. Began punching the victim in the face who was asleep on the lounge owing to patient's snoring and coughing.
2 Apr 2015	Admitted to Cumberland Hospital. Initially placed in the Yaralla (Intensive Psychiatric Care Unit) owing to risk of aggression.
13 Apr 2015	Transferred to the Hainsworth Unit (admission ward), Cumberland Hospital.
8 May 2015	Transferred to the Waratah (Rehabilitation Cottage), Cumberland Hospital. Complaint with medication but refuses to engage in drug and alcohol interventions.
3 Jun 2015	CFMHS Report completed by Dr Ellis.
3 Dec 2015	Admitted to Westmead Hospital for septicemia suspected to be linked to his injection of illicit drugs in his left arm (drug paraphernalia found in search of his room in Waratah Cottage) (in review on 17.12.2015 admits to injecting 'ice' and using cannabis).[17]
8 Feb 2016	Random drug screens return positive for amphetamines (denies use).
9 Aug 2016	Community Mental Health Report completed for the Mental Health Review Tribunal (**MHRT**).
5 Oct 2016	Reports smoking cannabis each afternoon most days.
21 Nov	Mr Moore signs lease with Housing NSW for 2/16 Gladstone Street,

16 Exhibit 1 Vol 7 Tab 111

17 Exhibit 1 Vol 7 Tab 111

2016	North Parramatta.
9 Dec 2016	MHRT makes a Community Treatment Order (**CTO**) set to end on 8 June 2017. Noted that the MHRT notes include that the tribunal was "*satisfied Mr Moore has a history of noncompliance leading to relapse and there is a serious risk that without a CTO his mental state will deteriorate*".[18] Formally discharged from inpatient care (had increasing periods of leave in the lead up to discharge).
7 Jun 2017	Parramatta Community Mental Health (**CMH**) team home visit.
8 Jun 2017	CTO extended by the MHRT to end 13 December 2017.
12 Dec 2017	CTO extended by the MHRT to end 11 June 2018.
14 Jun 2018	CTO extended by MHRT to end 13 December 2018.
7 Aug 2018	Parramatta CMH team home visit by case manager.[19]
26 Nov 2018	Parramatta CMH team gives MHRT an application to extend the CTO will not be made.[20]
28 Nov 2018	Case manager notes that "*discussed with team*" that Mr Moore's CTO would not be renewed, however, "*if need arises will apply in the community*."[21]
20 Dec 2018	Case manager made last home visit and Mr Moore refused to open door as he was in bed and spoke over the phone.[22]
20 Feb 2019	Mr Moore's last review with the Parramatta CMH team at the Clozapine Clinic (Parramatta Community Mental Health Centre).

18 Ex 1 Vol 7 Tab 113.A

19 Ex 1 Vol 9 Tab 120B.16

20 Ex 1 Vol 7 Tab 114

21 Ex 1 Vol 9 Tab 120B.22

22 Ex 1 Vol 9 Tab 120B.26

Offending in October 2014

28. In October 2014 Mr Moore lived alone in a unit at 13/215 Beach Road, Batehaven, leased through Housing NSW.[23]

29. In October 2014 he was alleged to have committed offences following two sets of events:

    (1) A common assault at a shopping centre when he pushed a manager who directed him to leave as he had been banned from attending owing to abusive behavior.

    (2) When police later went to his unit over the common assault, Mr Moore reportedly exited his unit without a shirt on. He was sweating profusely. He appeared under the influence of substances. He pulled a 20cm steak knife from his pocket and held it level at head height. Police successfully restrained him without major incident.[24] During a search of his unit cannabis was found. For this event he was charged with various offences including assault police and possession of prohibited drug.[25]

30. Housing NSW records refer to Mr Moore abusing another resident in his unit at Batehaven. He was reportedly banging on the resident's door and yelling at him.

[23] Ex 1 Vol 2 Tab 34

[24] Ex 1 Vol 2 Tab 34 Annexure A

[25] Ex 1 Vol 4 Tab 95

Housing NSW noted receiving numerous letters and contacts from residents in the complex reporting their fear of his return there.[26] Housing NSW terminated his lease there on 1 March 2005 at which time he was an inpatient.

Inpatient admission between early 2015 and December 2016

31. Mr Moore was in custody for a time following his apprehension in October 2014. His charges were dealt with pursuant to s.33 (1) (b) *Mental Health Forensic Provisions Act* 1990 (NSW). He was involuntarily detained to a gazetted mental health facility for the provision of treatment under the *Mental Health Act* 2007.

32. In early January 2015 his condition had reportedly improved somewhat. He reported that in the period preceding his arrest he had been engaging in amphetamine and cannabis use (including intravenous amphetamine use).[27]

33. In February 2015 he was transferred to the Chisholm Ross Centre, Goulburn Hospital. At this point there was a potential plan for Mr Moore to return to South Coast region upon his release. [28]

34. While at the Chisholm Ross Centre (February to April 2015), Mr Moore was described to be isolative and to have assaulted other patients on three occasions (9, 28 and 29

[26] Ex 1 Vol 2 Tab 34

[27] Ex 1 Vol 4 Tab 99

[28] Ex 1 Vol 7 Tab 111

March 2015) including one occasion where he stabbed a patient with a pen (28 March 2015). [29]

35. In April 2015, Mr Moore was transferred to the Cumberland Hospital. This was considered the most appropriate place due to his behaviour and his mental health needs. Cumberland Hospital was able to offer more secure units.

36. Mr Moore was involuntarily admitted to the Cumberland Hospital until December 2016. During his admission he progressed to its Rehabilitation Cottage section (Waratah Cottages)[30] and was prescribed oral clozapine (550mg daily) medication.

37. As he progressed, Mr Moore engaged in leave. This was done to assist his gradual transition from an inpatient unit back into the community. It began with supervised leave (with his grandfather or father) and progressed, in later period, to unsupervised leave.

38. During his admission to Cumberland Hospital, it was documented:

(1) There were challenges in securing Mr Moore an appropriate residential release plan as part of discharge planning.

(2) There were occasions when Mr Moore used illicit substances being cannabis and amphetamines (intravenously). That included occasions where drug

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[29] Ex 1 Vol 7 Tab 111 (incidents described by Dr Tan in this report).

[30] Ex 1 Vol 7 Tab 111

paraphernalia was found in his room (Waratah Cottage 3 December 2015[31]), him testing positive for illicit substances (amphetamines on 8 February 2016[32]) and self-reports (e.g. reported smoking cannabis each day on 5 October 2016[33]).

(3) Mr Moore indicated to treating clinicians, who sought to encourage him to engage in Drug and Alcohol therapy and other rehabilitation, that he did want to engage in such interventions.

Cumberland Forensic Mental Health Service (CFMHS) report mid 2015

39. On 3 June 2015 Dr Ellis, forensic psychiatrist with Justice Health & Forensic Mental Health Network, completed a forensic risk management report at the request of Cumberland Hospital. The report was completed to inform treatment and planning regarding Mr Moore's eventual discharge from the forensic hospital. Without being exhaustive, the following views were expressed:

    i. Mr Moore's "*problem behaviour could best be described as reaction aggression, which has led to serious, non-fatal outcomes on multiple occasions*".[34]

    ii. Mr Moore presented with numerous risk factors that predispose him to future episodes of reactive aggression which are historical and relatively unchanging. These include his history of problems with violence and other antisocial

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[31] Ex 1 Vol 7 Tab 111

[32] Ex 1 Vol 7 Tab 111

[33] Ex 1 Vol 9 Tab 116

[34] Ex 1 Vol 9 Tab 124.A

behaviour, major mental disorder, evidence of violent attitudes, substance use and problems with supervision and treatment response.

iii. Regarding dynamic risk factors that could precipitate future episodes of reactive aggression, Mr Moore manifested recent problems with insight evidenced by his significant minimisation of his mental illness and substance abuse, failure to understand the factors that aggravate his illness and minimisation of the interpersonal consequences of his illness and substance use. He also presented with recent problems with violent ideation or intent, manifested by a hostile attributional bias and acting on urges to harm others.

iv. He presented with some risk factors that may perpetuate his risk of reactive aggression. These included the possibility of future problems with professional services and plans and problems with his living situation. He is likely to have problems with personal supports and seemed to be "*profoundly socially isolated, spending most of his time alone in his unit*". He would likely have future problems with treatment and supervision.

v. At the time of assessment, he had limited protective factors that would ameliorate his risk of reactive aggression however that "*is likely to improve with further treatment and comprehensive discharge planning*". His parents were engaged in his treatment and liaised regularly with his treating team.

vi. Overall, **"***Mr Moore falls into a group of individuals that pose a high risk for future episodes of reactive aggression*". Warning signs indicative of an escalation in risk includes sleep disturbance, substance abuse and intoxication, persecutory/paranoid ideation, complaints regarding excessive noise and accusing others of "provoking" him.

vii. Despite his poor insight the development of a relapse management plan should be attempted, and it would be "*helpful to collaborate with Mr Moore's family and previous CMH team, who may have noticed Early Warning Signs prior to acute deterioration*".

viii. An action plan for relapse should be developed and distributed to Mr Moore, his family and his CMH team.

ix. Given his history, in addition to his history of successful management by the Richmond Fellowship (a non-government organisation that provided support accommodation which had assisted Mr Moore in the past), "*it is the opinion of the CFMHS that a supported accommodation facility would be the most appropriate placement for Mr Moore following his release from hospital. His mental state, particularly paranoid ideation about others, will need to be carefully assessed prior to any potential placement.*" Placement geographically to enable him access to his family is important given his long history of social isolation.

x. At the point of discharge, a planning meeting involving the community mental health services should be arranged. The inpatient service "*should ensure this report is provided to community mental health services to assist with the management of Mr Moore*".

Discharge in December 2016

40. In the latter part of 2016, while an in-patient in the Waratah Unit (Rehabilitation Cottage), Cumberland Hospital, Mr Moore's mental health had reportedly stabilized, and he was prepared for discharge into the community.

41. The treatment and planning were conducted under the statutory framework provided by the *Mental Health Act 2007* (NSW).

42. The *Mental Health Act*'s objects are specified in s 3 as follows:

> ***3 Objects of Act***
>
> *The objects of this Act are:*
>
> *(a) to provide for the care and treatment of, and to promote the recovery of, persons who are mentally ill or mentally disordered, and*
>
> *(b) to facilitate the care and treatment of those persons through community care facilities, and*
>
> *(c) to facilitate the provision of hospital care for those persons on a voluntary basis where appropriate and, in a limited number of situations, on an involuntary basis, and*
>
> *(d) while protecting the civil rights of those persons, to give an opportunity for those persons to have access to appropriate care and, where necessary, to provide for treatment for their own protection or the protection of others, and*
>
> *(e) to facilitate the involvement of those persons, and persons caring for them, in decisions involving appropriate care and treatment.*

43. Mr Moore's preparation for discharge included:

    (1) Mr Moore securing the lease for 2/16 Gladstone Street, North Parramatta.

(2) Increasing Mr Moore's leave from the inpatient unit including some time living in his private accommodation.

(3) Engaging Mr Moore with the Parramatta Community Mental Health (**CMH**) for treatment before final discharge.

44. In November 2016, in preparation for discharge, Parramatta CMH whose catchment area Mr Moore would be residing in, completed a treatment plan in support of an application to the MHRT for the making of a Community Treatment Order (**CTO**).

45. A CTO treatment plan was completed by the Parramatta CMH team on 24 November 2016 and was submitted to the MHRT in support of the CTO application.

46. This plan identified the professionals within the team as a treating doctor or psychiatrist and a case manager.

47. The treatment plan proposed CTO conditions which required Mr Moore:[35]

(1) To take medication as prescribed by his doctor (clozapine 550mg orally each evening).

(2) To attend blood testing 24 hours prior to attending the clinic or as directed by the clozapine director.

(3) To attend reviews with his doctor or his delegate at least every month.

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[35] CTO treatment plan 24.11.2016 signed by Jayabalan Sinnathural and Dr Keat Toh; Ex 1 Vol 7 Tab 112.A ; summarised by Dr Eagle at Ex 1 Vol 9 Tab 116.

(4) To meet his case manager or delegate at least monthly at the Parramatta Community Health Centre (at direction of case manager or treating doctor).

(5) To comply with requests to provide a urine sample for urine drug screens no more than once every 2 weeks or as requested by the case manager or treating doctor.

48. The treatment plan also specified that Mr Moore be encouraged to engage with the Centre for Drug Addiction Medicine.

49. On 2 December 2016, a report was completed by Mr Moore's inpatient treating team which noted his illness seemed stable and he remained isolative and he maintained his refusal to engage in rehabilitation programs during his admission.

Discharge on 9 December 2016

50. On 9 December 2016, the MHRT made a 6-month CTO, in terms set out in the treatment plan completed by the Parramatta CMH team and made an order for Mr Moore's release from involuntary detention under the *Mental Health Act 2007* (NSW).

Treatment and supervision between late 2016 and 2018

51. Parramatta CMH was continuously engaged with Mr Moore from his formal discharge in December 2016 until late 2018.

52. Mr Moore attended monthly reviews at the Clozapine Clinic where he received a prescription for a monthly supply of clozapine.

53. Home visits were carried out, or attempted, by case managers on the following dates:[36]

No.	Date
1.	29 Dec 2016
2.	14 February 2017
3.	28 February 2017
4.	7 March 2017
5.	30 March 2017
6.	7 April 2017
7.	18 April 2017
8.	9 May 2017
9.	10 May 2017
10.	6 June 2017
11.	5 July 2017
12.	3 December 2017
13.	3 April 2018
14.	4 June 2018
15.	6 June 2018
16.	7 August 2018

[36] Dr Ghaly statement [42]; Ex 1 Vol 8 Tab 115A

17.	20 December 2018 (***last home visit***)

54. There is no evidence of Mr Moore coming to the attention of police between December 2016 and February 2019. He was not charged with any offence during that period.

55. Mr Moore did not work during that period, his contacts were with Parramatta CMH, his GP and other professionals as necessary for testing (ECG, blood testing).

56. Mr Moore reported to Parramatta CMH clinicians that he had contact with his maternal grandfather and father, who resided outside of Metropolitan Sydney. Based on Parramatta CMH's records, no clinician within the service had direct contact with these persons.

57. In the time Mr Moore resided at Gladstone Street, before 28 February 2019, Homes NSW received several complaints about Mr Moore from another resident (not Dion) about excessive noise. These were on:

    (1) 22 February 2017: complaint about loud music coming from Mr Moore's home and Mr Moore refusing to acknowledge neighbours when they approached. He had also ripped his screen door off and left it in the front yard.[37]

[37] Statement of M Parkinson [16] Ex 1 Vol 2 Tab 24; C Williams' complaint 22.02.2017 Ex 1 Vol 2 Tab 27.A.

(2) 3 August 2017: excessive loud noise (music).[38]

(3) 11 October 2017: excessive loud noise (music).[39]

(4) 9 November 2017: excessive loud noise (music).[40]

58. There is no evidence Homes NSW received a formal complaint alleging violent or aggressive behaviour by Mr Moore, however, following Dion's death, some residents made statements to police describing Mr Moore as presenting with evident mental health difficulties. This included descriptions of strange or intimidating behaviour (e.g. unexpected outbursts[41]) and what appeared to have been unusual, ritualised behaviours by Mr Moore (e.g. bowing to front door when exited, opening and shutting garage door numerous times after parking car).

Expiration of the CTO on 13 December 2018

59. On 26 November 2018, the Director of Community Treatment of Parramatta CMH, gave written notice to the MHRT that no further application was being made to renew Mr Moore's CTO due to end on 13 December 2018.[42]

60. On that same date, the case manager, made a short electronic progress note that stated:[43] *"Discussed with team regarding CT renewal which expires on 13/12/18. - - - Plan: not to renew CTO, however if need arise will apply from the community.*

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[38] Statement of M Parkinson [17] Ex 1 Vol 2 Tab 24

[39] Statement of M Parkinson [18] Ex 1 Vol 2 Tab 24

[40] Statement of M Parkinson [19[Ex 1 Vol 2 Tab 24

[41] Ex 1 Vol 2 Tab 37

[42] Ex 1 Vol 7 Tab 114

[43] Ex 1 Vol 9 Tab 120B.22

Last home visit on 20 December 2018

61. The last home visit to Mr Moore attempted by Parramatta CMH was on 20 December 2018. Mr Moore was at home but declined to answer the door. The case manager spoke to Mr Moore by phone and recorded that Mr Moore reported being in bed, that he did not want to see the case manager that day, that "*he is doing ok, did not go to GP yet for his hypertension…denies thoughts of harming to self or others…*"[44]

Last clinic attendance on 20 February 2019

62. On 20 February 2019, Mr Moore attended Parramatta CMH Centre for the last time. The psychiatrist reported that Mr Moore was polite, cooperative, and did not exhibit delusional thinking, psychotic symptoms or mood disorder.[45]

Homes NSW visit/inspection on 27 February 2019

63. On 27 February 2019, the day before Dion's death, two client service officers with Family and Community Services (now Homes NSW), attended 16 Gladstone Street to inspect the Housing NSW premises.[46] Mr Moore allowed them to enter his unit. They noticed a baseball bat in the corner of the loungeroom. They believed there to be something wrong with Mr Moore as he was sweating considerably and seemed to be agitated, confused and weird. They decided not to inspect the whole house as they were concerned about his behavior and they left.

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44 Ex 1 Vol 9 Tab20B.25

45 Ex 1 Vol 6 Tab 104.V

46 Ex 1 Vol 2 Ex 31; Ex 1 Vol 2 Ex 32

64. The two client service officers did not contact police nor Parramatta CMH. They were not aware of his mental health history.

ISSUES

65. The Court has had the benefit of independent expert reviews of Mr Moore's mental health care and treatment by Dr Kerri Eagle, forensic psychiatrist and Dr Christopher Ryan, consultant liaison psychiatrist. They have both carefully considered Mr Moore's medical records and the brief of evidence for this inquest.

66. An issues list was prepared prior to the inquest commencing to provide structure to the hearing. Following the evidence, some of the issues are no longer of great relevance. I have considered all the submissions made by the parties and I am of the view that the following matters are the relevant issues that require comment.

1. Was the decision to discharge Mr Moore from Cumberland Hospital in December 2016 reasonable?

67. As of December 2016, Mr Moore had been involuntarily detained in mental health facilities for almost 2 years (since early 2015). Those involved in his treatment and planning for discharge were mindful that:

    (1) Mr Moore had a long-term psychotic illness requiring lifelong medication;

    (2) His history pointed to difficulties in pro-social functioning in the community and a lack of pro-social supports;

(3) His risk for relapse and violence would be increased if he was not compliant with medication as prescribed and, potentially, by ongoing illicit substance misuse (principally cannabis); and

(4) At the time of his release his misuse of cannabis was ongoing, and he was resistant to engaging in substance abuse interventions.

68. The undoubted preference of Mr Moore's treatment team was for Mr Moore to willingly engage in substance misuse interventions to achieve abstinence. The difficulty is that meaningful therapy cannot occur without his willingness to do so. Dr Eagle explained to the court that clozapine treatment probably moderated the effect of illicit substance use on his risk of relapse. This would be particularly so with cannabis use; however, the likelihood of relapse would have been greater if he used methamphetamines or amphetamines as well.

69. The treating team also considered the possibility of supported accommodation. An Occupational Therapy functional assessment found he could live independently and Mr Moore indicated his preference to live in his own leased accommodation.[47]

70. The difficulty for the treating clinicians, in terms of recommendations in favour of continuing involuntary detention in the latter part of 2016, unless or until Mr Moore agreed to meaningfully engage in drug therapy interventions and agreed to live in

[47] Ex 1 Vol 9 Tab 116

supported accommodation (assuming such a placement could be arranged), was that:

(1) Mr Moore's psychotic symptoms were relatively stable after a long inpatient admission (nearly two years);

(2) They were aware the MHRT was legislatively mandated to order his discharge unless it was satisfied that he was a "*mentally ill person*" and, additionally, there was "*no other care (other than care in a mental health facility) that was appropriate and reasonably available*" which were the parameters by which their opinions / recommendations had to be made; and

(3) They were aware of the high demand for, and lack of availability of, inpatient beds by other people who required inpatient mental health treatment.

71. Dr Eagle and Dr Ryan were not critical of Mr Moore's release from hospital.

72. I accept Dr Eagle's opinion that the timing of Mr Moore's discharge on 9 December 2016 was reasonable considering; the length of his admission at that point, his mental state reportedly being stable over the preceding months and there having been a staged transition with increasing amounts of leave, including several nights overnight leave.[48]

[48] Ex 1 Vol 9 Tab 116

2. Was the treatment plan implemented at the time of Mr Moore's discharge on 9 December 2016 reasonable?

73. On his release from Cumberland Hospital in December 2016, Mr Moore posed significant challenges from a therapeutic management perspective. Both Dr Eagle and Dr Ryan agreed that Mr Moore was "*very high risk*" in regard to future violence if unwell.[49] Dr Ryan described Mr Moore to be a very concerning person to be looking after either in hospital or in the community.[50] His violent history included the use of weapons. He had used a weapon in 2014 when he brandished a knife at police and in 2015 when he stabbed another patient with a pencil.

74. Mr Moore had a longstanding chronic psychotic illness that required lifelong treatment. Even with full compliance of his medication and abstinence from substances, there was still the risk of a relapse of his psychotic symptoms from time to time. His risk of relapse was increased by his ongoing illicit substance use.[51]

75. Mr Moore had historic deficits with his insight into his illness. There were instances of him impulsively committing unpredictable and violent acts in response to delusional thoughts that other people were acting threateningly or provocatively towards him.

[49] See evidence of Drs Eagle and Ryan, 31.7.2025, T213-216

[50] See evidence of Drs Eagle and Ryan, 31.7.2025, T214:41-43

[51] Ex 1 Vol 9 Tab 116; Ex 1 Vol 11 Tab 136

76. In Dr Eagle's view, upon discharge, Mr Moore required a single comprehensive treatment plan, sometimes called a Mental Health Care Plan, which summarises key matters relevant to ongoing treatment, supervision and risk management. This would include information about:

(1) His history and any prior risk assessments (including identifying key risk assessments completed in the past such as Dr Ellis' report).

(2) The support Mr Moore required given his needs;

(3) The role family would play in his monitoring and support (including seeking their views); and

(4) The plan for responding to a suspected relapse of his psychotic illness or symptoms.

77. Dr Eagle believed the treatment plan that was submitted with the CTO application (see para 47 above) was not appropriate for the purposes of the community mental health service's supervision and treatment of Mr Moore. She explained that the availability of a Mental Health Care Plan that summarises key historic events and directs attention to key matters, ensures clinicians that become involved in the future care are readily made aware of material information.

78. An example of the significance of a single care plan with important documents attached in Mr Moore's case is that the risk assessment prepared by Dr Ellis in June 2015, was never seen by the principal clinicians at Parramatta CMH who were involved in Mr Moore's treatment post discharge. That report was completed to

inform treatment and planning regarding Mr Moore's discharge from the forensic hospital. Dr Ellis specifically stated that at the point of discharge, Cumberland Hospital "*should ensure this report is provided to community mental health services to assist with the management of Mr Moore*".[52]

79. The treating clinicians at the Cumberland Hospital said that Parramatta CMH were invited to photocopy a hard-copy version of that report for its own records however there is no evidence this occurred. A copy of this report was not found in Parramatta CMH's records.

80. The Parramatta CMH records only included the Mental Health Discharge and Transfer Summary completed by the Cumberland Hospital treating team on 9 December 2016. These documents referred to Mr Moore's long-standing schizophrenia, polysubstance dependence and his "7 involuntary admissions to hospital". It also referred to his arrest in October 2014, without mention of his brandishing of a knife at police, it noted that there had been "*3 serious unprovoked attacks on other patients*" in February and March 2015 during his admission to the Chisholm Ross Centre. It seems this was the extent of the information handed over to Parramatta CMH as to Mr Moore's history of violence.

81. The Forensic Risk Management Report prepared by Dr Ellis was fundamental to Mr Moore's discharge. In the report, Dr Ellis recommended the development of a relapse management plan, and that it would be helpful to collaborate with Mr

52 Ex 1 Vol 9 Tab 124.A

Moore's family and the previous CMH team, who may have noticed early warning signs prior to acute deterioration and the development of an action plan for relapse that should be developed and distributed to Mr Moore, his family and his CMH team and also that Mr Moore should be located geographically so as to enable access to his family which is important given his long history of social isolation.

82. The names and contact details for Mr Moore's father and grandfather were listed in a "designated carer form" signed by Mr Moore in December 2016. Mr Moore's family members were not contacted by Parramatta CMH during the two years and seven months it was engaged with him (but for one clinic attendance in June 2017 where Mr Moore was noted to have attended with his grandfather).

83. This was a potentially missed opportunity to involve Mr Moore's family members in the scaffolding of monitoring and supports.[53] Both Dr Eagle and Dr Ryan were critical of the lack of engagement with Mr Moore's family. His family may have helped identify his relapse at an earlier stage.

84. Dr Eagle explained that if there had been a single comprehensive Mental Health Care Plan it would have remained a "live document" to be regularly reviewed in multidisciplinary reviews held by Community Mental Health teams and any other clinicians that become involved in a patient's treatment. It would have attached the Forensic Risk Management Report, summarised key historic events and included

[53] Ex 1 Vol 11 Tab 136

notes on family contact. She says that such a plan is updated considering the patient's progress and any significant developments and can focus a multidisciplinary review on key matters relevant to care and risk management.

85. Dr Eagle was not suggesting that had a comprehensive Mental Health Care Plan been developed, it would have necessarily prevented the events on 28 February 2019. She is of the opinion that it would have been an opportunity for the whole team to see, in one place, Mr Moore's's complex history, his risks to others when unwell and to remind themselves of the plan.

86. Dr Sara Ghaly, a Senior Staff Specialist in Psychiatry and Acting Executive Director of Medical Services for the Western Sydney Local Health District (**WSLHD**) informed the court that the WSLHD is currently engaged in a project that is looking at the introduction of a single care treatment plan as proposed by Dr Eagle. The Clinical Performance Team is performing work in the multidisciplinary team space to develop a single care plan template. I commend that project and recommend to the Acting Chief Executive Officer of the WSLHD the introduction of a procedure that:

I. Requires a single comprehensive care plan for patients being supervised and/or treated through its community mental health centres,

II. Requires that a patient's plan be reviewed and updated through multidisciplinary reviews that the community mental health centre is expected to carry out for patients, and

III. Ensures that the plan has a section directed to key information, including points of contact for support such as family, and or reports/assessments, about the patient's risk of violence when acutely unwell, and expressly mandates consideration of that in planning around frequency of contact and responding to a suspected relapse.

87. Dr Ghaly also stated that now there is an expectation when establishing a treatment plan that an attempt is made to engage a patient in their care planning, along with their carer, and that the reasons why a carer may not be involved is fully documented.

3. Was the mental health treatment and supervision of Mr Moore between 9 December 2016 and 28 February 2019 appropriate?

88. On the one hand, during the period from discharge to February 2019 Mr Moore made little to no meaningful progress in his engagement in prosocial activities; the quality of his day-to-day living; and with his insight into the risks his illness and the continuing substance use posed on his of unpredictable violent behaivour if he became unwell.

89. On the other hand, during that period, Mr Moore went to monthly reviews at the Clozapine Clinic where he received a prescription for a monthly supply of clozapine. He was seen by a doctor and at these appointments his case manager frequently spoke to him. The appointments typically lasted for 30 minutes, where patients were typically asked about symptoms, day-to-day activities, illicit substance use, and medication compliance. The doctor would look for signs of thought disorder and review blood test results.

90. Mr Moore's monthly clinic attendances were his primary contact with Parramatta CMH service. His case manager also had periodic contact through home visits every 1-3 months. He was not aggressive nor threatening to clinicians during this period.

91. Mr Moore's violent history was not considered an uncommon feature of patients being managed through Parramatta CMH and many patients with that profile were living in public housing.[54]

92. During this period, Mr Moore did not come to the attention of police for aggressive or violent behavior and his symptoms were relatively stable.

93. Dr Ryan considered the monthly clozapine reviews in tandem with the frequency of home visits reasonable in Mr Moore's case.

93. Dr Eagle is of the opinion that Mr Moore's monitoring and treatment in the community once he was discharged could have been more robust. She believed that there should have been recognition that the Clozapine Clinic reviews would not provide sufficient oversight given Mr Moore's complex illness and risks. In particular she said: [55]

54 See evidence of Dr Ghaly 30.7.2025, T159 81-23

55 Ex 1 Vol 9 Tab 116

a) The Clozapine Clinic reviews "*appeared brief and superficial*" with the information documented seemingly "*copied over from previous reviews, which may impact on the reliability of the documentation as reflective of that review*" (each documented review seems identical in terms of how it was documented).

b) Mr Moore seemed to have "*limited contact with his care coordinator*".

c) There is no documented record of multidisciplinary team case reviews.

d) Mr Moore's clozapine levels were not reviewed (at least in 2018-2019), this would have provided an easy means of monitoring his clozapine compliance. It could have been done at the same time as routine clozapine monitoring blood tests, with other methods of monitoring, such as inspecting a Webster pack, not being as reliable.

e) Although Mr Moore's grandfather and father were identified at discharge (December 2016) as supports for Mr Moore, they were not involved in his community mental health care.

94. Dr Eagle felt there should have been clinical oversight by a consultant psychiatrist, from the time of discharge in 2016 and ongoing, to determine how Mr Moore should be monitored, his treatment needs, review of his risk and overall management plan.[56]

95. Dr Eagle also believed Mr Moore's treatment and management plan should have been regularly reviewed at multidisciplinary team case reviews that included a consultant

[56] Ex 1 Vol 9 Tab 116

psychiatrist. Such reviews ought to have occurred every three months or in the event of some deterioration or material change in circumstances. Mr Moore should also have had regular face-to-face contact with his case manager and there should have been ongoing engagement with his family.

96. Dr Eagle's above opinions raise the following questions in relation to the adequacy of the care proved to Mr Moore from Parramatta CMH during between 9 December 2016 and 28 February 2019:

    i. Were the monthly clozapine reviews in tandem with the frequency of home visits reasonable in being able to provide adequate oversight to Mr Moore and detect, as far as possible, any deterioration?

    ii. Was the access and communication between Mr Moore and his case worker adequate considering Mr Moore's history, whilst taking into account his supposed stability at the time? Should that communication have extended to include Mr Moore's family contacts?

    iii. Should Mr Moore's clozapine levels been routinely checked during this period?

    iv. Was it inadequate not to have Mr Moore's risk and overall management plan reviewed periodically by a consultant psychiatrist, particularly in relation to decisions pertaining to his CTO, namely in the context of a multidisciplinary meeting?

a. What was the availability of consultant psychiatrists for the Parramatta CMH between 2017 to early 2019?

97. Between January 2017 and June 2018, a staff specialist consultant psychiatrist worked part time at the Parramatta CMH, 3 days a week.[57] It was considered rare to have a consultant psychiatrist working on a full-time basis at the community mental health centre in 2017 and now.

98. Mr Moore was reviewed by a consultant psychiatrist on four occasions between January 2017 and February 2019. [58]

99. The review on 8 March 2017 occurred at the request of the Clozapine Clinic doctor owing to her concerns at the possible relapse of Mr Moore's symptoms and whether physical symptoms (e.g. restlessness, looking side to side, possible agitation) were attributable to the clozapine medication or some other neurological condition (e.g. Parkinson's disease).[59] It was concluded that Mr Moore's psychotic symptoms were stable.

100. The review on 30 May 2018 was close in time to the expiration of Mr Moore's CTO in June 2018. The psychiatrist recommended in favour of the CTO being extended, recording "*The patient needs a renewal of CTO given his long history of a very chronic, severe and enduring illness. CTO has helped to provide support, supervision and consistent care. [Mr Moore] happy with this plan*".[60] Thereafter the

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57 See evidence of Dr Ghaly 30.7.2025, T155-156; see evidence of Dr Bhavanishankar 30.7.2025, T187

58 Ex 1 Vol 104.G.

59 See evidence of Mr Sinnathurai 29.7.2025, T88-89; see evidence of Dr Kondadulsa 29.7.2025, T104-105

60 Ex 1 Vol 104.G

Parramatta CMH applied to the MHRT for a 6-month renewal of the CTO (which was granted).

101. Mr Moore did not receive a consultant psychiatrist review again before his arrest for Dion's death in late February 2019. A consultant psychiatric review did not take place in relation to the decision by the Parramatta CMH in November 2018 nor to apply for an extension of Mr Moore's lapsing CTO.

102. From June 2018 onwards, the staff specialist consultant psychiatrist position at Parramatta CMH was not filled. That remained the case as at the hearing of this inquest in July 2025 (7 years later).[61]

103. Between 2017 and 2019, the clinicians could contact a consultant psychiatrist working in inpatient units to discuss particular patients if the clinician had a concern they wished to discuss.[62] The consultant psychiatrist was available for consultation but did not assume oversight of the treatment or necessarily review the patient themselves. This practice did not require a consultant psychiatrist to be involved in ongoing monitoring or reviews of Mr Moore's case.[63]

b. Were multidisciplinary reviews taking place at Parramatta CHM between 2016 to early 2019?

[61] Ex 1 Vol 8 Tab 115A; see evidence of Dr Ghaly 30.7.2025, T161

[62] Ex 1 Vol 8 Tab 115A; ; see evidence of Dr Ghaly 30.7.2025, T156-157

[63] See evidence of Dr Ghaly 30.7.2025, T157:31-36

104. Although there was a practice of weekly team meetings during which patients' cases were discussed, involving clinicians such as nurses and the career medical officers (**CMOs**) and, if available, a consultant psychiatrist, there was no formal documented procedure for this in 2017.[64] The patients discussed in these meetings were, generally, the "*acute care crisis clients and the case management clients*" however the focus of discussions was typically directed to the crisis clients.[65]

105. On the face of the available records, even accepting Mr Moore's case was occasionally discussed at some weekly meetings, those reviews and discussions were not documented. There is no evidence of a consultant psychiatrist being regularly involved in such meetings when Mr Moore's case was discussed.

c. What were the case manager workloads at the Parramatta CHM between 2016 to early 2019?

106. The case manager's responsibility for their patients includes having contact with the patient at clinic attendances, arranging blood tests and urine screening, phone contact and home visits.

107. Before June 2018, case managers had on average 25 to 30 patients under their care, being a mixture of voluntary patients, Clozapine Clinic patients, patients on CTOs and forensic patients. Staff also provided acute care to patients presenting to Parramatta CMH Centre as walk-ins from the community. [66]

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[64] Ex 1 Vol 8 Tab 115A

[65] See evidence of Dr Kondadsula 29.7.2025, T102

[66] Ex 1 Vol 9 Tab 120B

108. In about May or June 2018, the structure of the team at Parramatta CMH changed. A specific team was created for providing short term acute crisis intervention, called Parramatta Acute Care Team (**PACT**) with a separate team providing long term case management for regular patients in the Parramatta and Dundas areas (Parramatta Clinical Care Coordination Team or **Parramatta CCCT**). [67] Since this reform case managers in the Parramatta CCCT had on average about 40 to 50 patients under their care.[68]

d. What is the current situation at Parramatta CMH?

109. Dr Ghaly gave evidence about changes made at the WSLHD since February 2019. She informed the court that now a permanent multidisciplinary team committee meet weekly at the Parramatta CMH centre. This is chaired by the Parramatta CMH Team Leader. Patients are expected to undergo a multidisciplinary review at least once every 13 weeks. The matters discussed in these reviews are to be documented in the patient's medical records.[69] Parramatta CMH holds a 2-hour multidisciplinary review each week, which follows a discussion plan template, led wherever possible by a psychiatrist from Cumberland Hospital.

110. Dr Ghaly could not confirm the regularity of the psychiatrists' availability. It was beyond the scope of this inquest to examine the reasons and factors for the lack of a permanent consultant psychiatrist at the Parramatta CMH since mid-2017.

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67 Ex 1 Vol 9 Tab 120B

68 Ms Vivekananthan evidence 29.7.2025, T121

69 Ex 1 Vol 8Tab 115A

111. Whatever the underlying reasons for it occurring, it remains of significant concern that the community mental health service, operating in a geographically significant area such as Parramatta, has not had a permanent consultant psychiatrist over this time (8 years).

4. What was the significance of urine drug screening?

112. Drs Eagle and Ryan were not critical of the lack of urine screening undertaken in 2017 and the decision of the Parramatta CMH team not to seek a condition, as part of CTOs made in late 2017 to late 2018, requiring Mr Moore to submit to such screening.

113. Dr Eagle said:[70]

> *"Urine drug screening as part of a CTO plan or mental health care plan is a complicated issue. Community mental health services are often not in a position to facilitate urine drug screening, and the screening may be of limited benefit even as a risk management strategy. Urine drug screening is essentially regulatory in nature, rather than evidence based mental health treatment or intervention. If, for instance, Mr Moore tested positive, unless he appeared mentally unwell, he would not be accepted for inpatient treatment as the least restrictive option. The core intervention of value is the monitoring of his mental state, not the urine drug testing. Mr Moore appeared to openly acknowledge using cannabis, and in those circumstances, it is arguably of limited value to be testing for it, and the regulatory nature of testing can potentially reduce mental*

[70] Ex 1 Vol 9 Tab 116

health engagement."

4. Quality of record keeping / documentation of reviews during the 2017-2019 period by Parramatta CMH

114. Mr Moore clearly suffered an acute relapse sometime before the stabbing of Dion. Dr Eagle gave evidence that she cannot definitively say when Mr Moore became unwell, or whether his deterioration would have been prevented by an ongoing CTO or closer monitoring of his mental state.

115. Dr Eagle explained that it is difficult to form an opinion about his deterioration as there was insufficient engagement, review and documentation with Parramatta CMH.

116. Progress notes were made for each review, however, these frequently involved copying the same details from the previous review with some minor amendments to reflect reports made by Mr Moore and certain events since the last review (e.g. outcome of a particular test since the last review noted).

117. Dr Eagle was critical of the quality of the records made by the clinicians of the contacts and reviews conducted at the Clozapine Clinic.

118. Dr Eagle, in her first report, stated:[71]

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71 Ex 1 Vol 9 Tab 116

"The Clozapine Clinics review… documentation appeared to have been copied over for previous reviews, which may impact on the reliability on the documentation of the documentation as reflective of that review."

119. Dr Ryan agreed in his evidence:[72]

"*…the documentation - well, in some senses was good, but in other senses, copying across your previous - using a template is good because of the nature of the clozapine clinic. Literally copying across and then changing, perhaps not so good*."

120. Dr Ghaly acknowledged there was an issue with the clinical documentation in Mr Moore's case and stated that the clinicians involved had been counselled.[73]

121. The doctor from the clinic informed the inquest that:

"*…a number of my consultation notes in 2018 are similar. This was due to time constraints at the clozapine clinic. Due to the busy workload and staff shortages, after assessing Mr Moore's clinical condition, I would copy and paste the notes from my previous clinical record entry if there was no noticeable change in his clinical condition and use these as a template, making adjustments accordingly. For example, in relation to any recent history; pathology test results; BP; weight and the management plan. If there had been any change in his MSE I would make a different entry reflecting this*."

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72 See evidence of Dr Ryan31.7.2025, T231

73 Ex 1 Vol 8 Tab 115A; see evidence of Dr Ghaly 30.7.2025, T181-182

93. The doctor further informed the court that they have changed their practice since then.

5. Was the lapse of Mr Moore's CTO on 13 December 2018 appropriate?

94. On 26 November 2018 the Director of Community Treatment, at the Parramatta CMH team, gave written notice to the MHRT that no further application was being made to renew Mr Moore's CTO due to end on 13 December 2018.[74]

95. On this same date the case manager made a short electronic progress note that stated:[75]

> *"Discussed with team regarding CT renewal which expires on 13/12/18. - - - Plan: not to renew CTO, however if need arise will apply from the community."*

96. It is not clear from the records how much time was given to this decision, the extent to which his risks were discussed and who had input in those discussions. Nor is there any documentation in the records of the decision not to renew the CTO being discussed with Mr Moore beforehand (to seek his views) or that being the final position taken by Parramatta CMH.

97. The WSLHD did not have a formal procedure governing the decision making around whether to seek, or not to seek, a CTO's renewal. There were no formal requirements

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[74] Ex 1 Vol 9 Tab 120B.24

[75] Ex 1 Vol 6 Tab 104

as to who should have input into this decision and what needed to be documented as regards discussions.

98. There is no evidence that a consultant psychiatrist or doctor was involved in the decision.

99. The rationale for not applying for a renewal of the CTO was:[76]

I. Since his discharge, Parramatta CMH had not had to formally exercise the CTO powers to compel Mr Moore to submit to treatment.

II. The lapsing of the CTO would not mean an end to Parramatta CMH's engagement with Mr Moore. It was envisaged that he would continue to attend the Clozapine Clinic each month.

III. If Mr Moore disengaged, or was non-compliant with his medication, the treating team could reapply for making another CTO.

IV. The lapsing of the CTO made no difference to Parramatta CMH's approach to Mr Moore's treatment and there was no basis for seeking its extension.

100. Dr Eagle and Dr Ryan had differing views as to whether an application to renew Mr Moore's CTO should reasonably have been made.

[76] See evidence of Dr Kondadasula 29.7.2025, T118 (also see evidence of Ms Vivekanathan and Ms McMartin 29.7.2025)

101. In Dr Eagle's view, even though it could not be known if an ongoing CTO would have prevented Mr Moore's relapse, an application should have been made to renew the CTO because of his needs and his risks, and the potential contribution the CTO's existence might have made to his passive compliance. Dr Eagle said:[77]

> *"Mr Moore had a significant history of non-compliance with treatment that had contributed to relapses of psychosis resulting in serious harm to others. He continued to display functional and cognitive deficits associated with his illness. He was routinely noted to display limited insight and impaired judgment. He was noted on review to minimise his symptoms and present as guarded. His historical risk indicators (factors) would suggest that he would always require a mandatory regime to ensure compliance and enable a rapid response to non-compliance in order to prevent relapse with associated harm to others.*
>
> *It is unclear from the available documentation how the decision to allow the CTO to lapse was made, who was consulted in the treating team, and what was considered. A decision not to renew a CTO in relation to a patient with severe mental illness and an identified elevated baseline risk of harm to others that is associated with noncompliance, should in my view only be made with the input of the multidisciplinary team and involving the treating psychiatrist. The decision requires a review of the patient's risk management plan, with consideration as to whether there are adequate safeguards in place to monitor for non-compliance in the absence of a CTO."*

[77] Ex 1 Vol 9 Tab 116

102. As for the importance of a CTO for patients like Mr Moore, Dr Eagle considers that continuing CTOs can assist in ensuring their compliance with treatment, stating in evidence:[78]

> *"…in my experience…we see a lot of lapsed CTOs resulting in…people getting unwell and engaging in harm…I don't think there was a downside in continuing the CTO in a situation like Mr Moore's. I think he was not affected by it, other than coming in to get his medication. He wasn't getting dragged into hospital. He wasn't getting injected with a medication he didn't want…it was a very low… level of restriction on him, other than his perception, I think, that he had to take it and he had turn up, and if he didn't turn up they might do something about that. And actually, as we know now, only in retrospect, but now he's a forensic patient, and he's been in gaol for year, and he'll be a high secure forensic hospital for many, many years, and it's resulted in a much more restricted pathway for him. So if we think about things in terms of least restrictive, and that's often raised, I think the decision to lapse a CTO does need to consider the consequence of lapsing the CTO and how restrictive that might end up being."*

103. In Dr Eagle's view, the decision not to apply for the renewal of the CTO should, at the very least, have involved the input of a consultant psychiatrist having overall responsibility for Mr Moore's management and supervision, with an appropriate risk management plan developed for ongoing monitoring and compliance.[79]

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[78] See evidence of Dr Eagle 31.7.2025, T242

[79] Ex 1 Vol 9 Tab 116

104. Dr Ryan considered the decision not to apply for a renewal of the CTO was reasonable and accorded with the requirements of the statutory framework (e.g. least restrictive care).

105. In his report Dr Ryan opined:[80]

> *"… the decision not to apply for a renewal of Mr Moore's CTO in late 2018 on the apparent basis that it appeared to be achieving little and was needlessly restrictive was reasonable. In my opinion, it is more likely than not that the manner in which this decision was reached – via discussion in a regular multidisciplinary team meeting - was reasonable.*

106. Dr Ryan's evidence included (non-exhaustively):[81]

> "…*I would have thought that - and actually one of the - the time I do in my report have some criticism of the documentation is literally at that time, at the time that it's - there's not really good documentation about why they thought it should lapse. I'm not necessarily critical of it lapsing, actually, but I am critical of the lack of documentation. I would have thought, at that time, then that would involve at least going back and looking at the previous community treatment orders and seeing what that was about, and what had changed now, which I would have thought would probably be enough to keep that in mind. But I mean perhaps it wasn't in this case, I don't know."*

107. The two experts differ on this issue. I note that Dr Ghaly outlined the following changes made to the WSLHD's procedures in relation to CTOs since February 2019.

[80] Ex 1 Vol 11 Tab 136

[81] See evidence of Dr Ryan 31.7.2025, T226

These changes go to addressing the concerns raised by Dr Eagle. In October 2019, the WSLHD published "*Management of Community Treatment Orders"* which set out the following:[82]

(1) A month before a CTO expires, the case is to be reviewed in a care review meeting involving the case manager, Team Leader and, if available, a consultant psychiatrist and or the treating doctor (e.g. CMO).

(2) The case manager will present a report in that meeting which will include setting out the treating doctor's, patient's and family / carer's views.

(3) If the patient is engaged with other support services, the case manager is expected to consult those services when preparing this report.

(4) The case manager is to document the discussions in this review meeting and next steps (whether the CTO is to be renewed).

6. Whether Mr Moore was likely suffering a relapse of his psychotic symptoms at his last attendance at the Clozapine Clinic on 20 February 2019?

108. 20 February 2019 is the date of the last known mental health professional contact Mr Moore had before the events on 28 February 2019.

109. On this date, he attended Parramatta CMH and was seen at the Clozapine Clinic. The progress notes for this review noted:

(a) Mr Moore was polite, cooperative and did not exhibit delusional thinking, psychotic symptoms or mood disorder.[83]

[82] Ex 1 Vol 8Tab 115A

[83] Ex 1 Vol 9 Tab 120

(b) He denied suicidal and homicidal ideation, nor did he exhibit agitation or aggression.

(c) The plan was to continue clozapine and review Mr Moore in 28 days.[84]

110. Much of what was recorded in this progress note is identical to that recorded in prior progress notes.

111. On the face of the progress note the doctor did not observe any overt indicators of psychosis in Mr Moore's presentation or based on his self-reports.

112. Blood samples were not taken on this occasion to test Mr Moore's clozapine levels. The available evidence from the webster packs photographed by police at the time of his arrest and the prescriptions filled at his chemist do not suggest that Mr Moore was no longer taking his medication.

113. When Mr Moore was assessed by Dr Martin consultant psychiatrist, after his arrest, Dr Martin noted Mr Moore's report to him that he had become increasingly paranoid in the three months before 28 February 2019, with his paranoia worsening over the 6-week period prior to the events. He also reported hearing voices about 2 weeks beforehand.

114. Dr Eagle and Dr Ryan could not exclude as a possibility, that:

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[84] Ex 1 Vol 6 Tab 120B.U

(1) Mr Moore was already experiencing a deterioration of his symptoms at the time of the review on 20 February 2019 which he did not disclose and that weren't otherwise obvious; or

(2) Mr Moore might not have been experiencing acute symptoms at that review, with him experiencing rapid and acute deterioration thereafter by 28 February 2019; and that,

(3) Mr Moore's acute relapse occurred even with medication compliance.[85]

115. Dr Eagle further said in her evidence at the hearing:[86]

> *"a person can hold themselves together for ten minutes, but not 30 minutes…a person might answer routine questions that they know easily the answers to, but if you're delving a little bit more they might - then things are going to start to slip out, and that's the whole point of doing an assessment of a person in that situation. I think also we don't really know if there were signs. I mean, the fact that he was not cooperative, even that in of itself seems to be slightly different to previously, when he would be passively cooperating and coming and deemed to be - one of the reasons of the lapsing of the CTO was that he was seen to be very cooperative. So soft signs like that – we don't really know if there were signs of deterioration from what [was] recorded.*
>
> *Things that I would be careful to document, for instance, would be signs of his self-care. Was he malodourous, did he look a little bit more disheveled. You know, those things could have been, again, soft signs that he was deteriorating. But you know, it's very hard to actually identify*

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85 See Dr Ryan's report, Ex 1 Vol 11 Tab 136*: "It is important to stress that if a patient suffers a relapse of their schizophrenia this does not, in and of itself, suggest that the patient has been non-adherent to their antipsychotic medication….[antipsychotic] merely make relapse less likely and / or less frequent than would be the case if the patient were not taking antipsychotic medication…"*

86 See evidence of Dr Eagle 31.7.2025, T239-240

symptoms of auditory hallucinations and delusions in some people, particularly if they're paranoid, because they know that if they say certain things, even if they believe it, you're going to respond in a certain way…"

116. Dr Ryan, in his evidence, said:[87]

> *"we have some evidence from what he told the psychiatrist who saw him that he recalled that he'd been getting unwell for some time, and he also recalled that he didn't want to tell anybody that he was getting unwell because he thought - and this is probably not unjustified - that if he told them, then he might end up on the medication which he didn't think helped, and he really hated having. He also thought that he would lose him home, which perhaps that wasn't unjustified either. So I mean, I think the hope was always going to be that some sort of relationship could be built with him where he would reveal that, and I think that efforts were made to do that, but that's - at least, if we're to believe Mr Moore's - what Mr Moore says after the crime, that's not what happened.*
>
> *Could he have appeared perfectly well… during the review, yes, and actually I think he could have appeared, if he did have a half an hour review, and he could have appeared well if he'd half an hour review with me…I might have wheedled a little something out of him, but I might not have."*

117. I accept the expert evidence that Mr Moore may well have presented without obvious signs of psychosis at his review at the Clozapine Clinic within the Parramatta CMH Centre on 20 February 2019. I accept that there can be no certainty as to when he became acutely unwell and it is not possible to judge what the window of opportunity would reasonably have been to detect his deterioration and intervene before he fatally stabbed Dion on 28 February 2019.

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[87] See evidence of Dr Ryan 31.7.2025, T240

7. Whether staff at Homes NSW should have, or could have, contacted NSW Police and/or Parramatta Community Mental Health Services following the interaction with Mr Moore during their home visit on 28 February 2019, the day before Mr White-Cotterell's death?

118. Homes NSW, as with all public sector agencies, must comply with the *Privacy and Personal Information Protection Act 1998* and the *Health Records and Information Privacy Act 2002*, along with the requirements arising under the *Housing Act 2001.*

119. Pursuant to s 71 of the *Housing Act 2001*, client service officers are prohibited from disclosing information obtained in connection with their administration unless the exceptions in subsection (1)(a) to (e) are enlivened. Section 71 relevantly provides:

> ***71 Disclosure of Information***
>
> *(1) A person must not disclose any information obtained in connection with the administration or execution of this Act (or any other Act conferring or imposing functions on the Corporation) unless that disclosure is made--*
>
> *(a) with the consent of the person from whom the information was obtained, or*
>
> *(b) in connection with the administration or execution of this Act (or any such other Act), or*
>
> *(c) for the purposes of any legal proceedings arising out of this Act (or any such other Act) or of any report of any such proceedings, or*
>
> *(d) in accordance with a requirement imposed under the* Ombudsman Act

> *1974 , or*
>
> *(d1) to a* law enforcement agency *for the purposes of law enforcement (including in connection with the investigation of an offence) or ascertaining the whereabouts of an individual who has been reported to a police officer as a missing person, or*
>
> *(e) with other lawful excuse."*

120. This bears on the lawfulness of a client service officer to contact a community mental health service to report concerns about a client if the client service officer suspects that a service is engaged with the client. Without the consent of the client, such a disclosure would need to fall within the "*other lawful excuse*" exception.

121. Client Service Officers can, lawfully, make a concern for welfare report to the NSW Police Force if they have concerns for the wellbeing of a client.

122. If a police officer attends and holds concerns for a person's mental health, the options potentially enlivened for the police officer include:

(1) Requesting the person accompany police to a gazetted mental health facility for a mental health assessment;

(2) Exercising a statutory power to detain and convey the person to a gazetted mental health facility for assessment if the person is not willing to do so voluntarily and assuming the statutory thresholds are satisfied,[88] and/or

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[88] Section 22 *Mental Health Act 2007* (NSW)

(3) Requesting paramedics with the Ambulance Service NSW attend to assess the person.

123. The NSW Police Force may hold information and have electronic alerts for that person if he or she has had past dealings with police in a mental health context. In Mr Moore's case there had been such dealings with police.

124. A memorandum of understanding also exists between the NSW Police Force and NSW Health to facilitate coordination and sharing of information between police and health providers for mentally ill persons.[89]

125. The client service officer who attended upon Mr Moore on 27 February 2019 informed the court during this inquest that having had this experience, and knowing in hindsight, what happened, she would most likely make a call to the police and inform them of what they had discovered or would possibly look at referral services that would take him in if they were able to get consent.

126. With the benefit of hindsight, Mr Moore's presentation to the client service officers on 27 February 2019 was probably attributable to an acute deterioration in his psychotic symptoms. His sweaty presentation was similar to that described by police when he was arrested in October 2014 after brandishing a knife at police.

[89] https://www.health.nsw.gov.au/mentalhealth/resources/Publications/mou-health-police-2018.pdf

127. It can only be speculated what might have occurred had a concern for welfare report been made to police. The possibility police may have attended that day in response to such a report and required Mr Moore to undergo a mental health assessment at a gazetted mental health facility, cannot be excluded.

128. It is understandable why the client service officers did not contact the police. There were no verbal abuse nor physical threats made to them. However, had the client service officers realised the magnitude of Mr Moore's mental health history, and his risks, they likely would have made a concern for welfare report to police.

129. The reasonableness of their actions must consider what they knew or understood at the time. It appears neither knew Mr Moore's diagnosis nor that he was engaged with Parramatta CMH. Although they were sufficiently concerned to leave his residence without undertaking their inspection, Mr Moore had made no express threats towards them.

130. It would be beneficial for Homes NSW and local health districts such, as WSLHD, to consider instituting a memorandum of understanding as to how information can be shared between these agencies (where lawful). In saying this it is acknowledged that client service officers historically manage a portfolio of approximately 300-400 tenancies and could not be expected to be abreast of each client's mental health background or be expected to check with mental health services before each client service visit.

131. One possibility is for residents, who may be engaged with community mental health services, to be encouraged to consent to Homes NSW sharing information with their community mental health provider in certain circumstances (e.g. if they hold concerns for their wellbeing).

132. Client Service Officers with Homes NSW may become aware, through their contact with a lessee or nearby residents, of information pointing to a person's deterioration which could be shared with the local community mental health service.

133. This is a nuanced issue and would require careful examination. A person's engagement with Homes NSW, and/or their health providers, may be adversely impacted if he or she feels their confidentiality is not being maintained over their treatment and medical history. Making the person's access to public housing conditional on them consenting to the disclosure of information risks may render this exercise as coercive in nature.

134. Homes NSW supports a recommendation to the Chief Executive of Homes NSW and the Chief Executive of WSLHD, that Homes NSW and WSLHD consider the exchange of information between them to facilitate community mental health services in light of Mr Moore's case. It is agreed by Homes NSW that client service officer assessments would benefit from understanding the client more and their physical and mental health needs better.

135. I propose making a recommendation to the Chief Executive of Homes NSW and the Chief Executive of the WSLHD that Homes NSW and WSLHD consider developing a memorandum of understanding as regards the exchange of information between Homes NSW and the WSLHD to facilitate community mental health services.

CONCLUSION

136. Dion's family are concerned to know why a patient with Mr Moore's history was discharged from hospital and living in public housing. They wish to ensure that all reasonable precautions are considered to ensure that an incident like this does not occur again and that another family is not inflicted with the enduring pain that they suffer.

137. The regime for detention of patients such as Mr Moore for mental health treatment under the *Mental Health Act 2007* is directed to ensure humane mental health treatment.

138. The evidence is that many persons suffering a chronic psychotic illness present with a history of violence when unstable and ongoing substance misuse difficulties and will be at heightened risk of committing a future offence of violence when unwell. Although some are at higher risk of violent offending as compared to the general population, not all will commit a future violent offence or one that might cause serious injuries. Accurately predicting who in this cohort will go on to commit violence offences in the future is extremely challenging.

139. It cannot be positively found that the tragic events on 28 February 2019 could have been avoided, however this inquest did highlight the critical state of affairs with resourcing of community health services like Parramatta CMH. Particularly in relation to the level of oversight offered by a psychiatrist for the mental health team.

140. I accept the evidence from the independent experts that Mr Moore would have benefitted from a single mental health care plan, incorporating his risk factors, warning signs, treatment plan and escalation process, developed with the input of Mr Moore, his family and the treating team. That such a plan should be reviewed and updated through regular multidisciplinary meetings. I propose to recommend to the WSLHD that this process be adopted and utilised.

141. The involved agencies have informed this inquest that they are committed to focusing closely on each of the recommendations arising from this inquest.

142. In relation to the issue of Mr Moore living in public housing, I note that in the recent inquest into the fatal stabbings at Bondi Junction Westfield the State Coroner, Teresa O' Sullivan relevantly recommended to the NSW Government that it support the establishment and ongoing evaluation of long-term accommodation for those experiencing mental health issues and homelessness, with on-site or easily accessible long term mental health care, based on the models delivered by Habilis (NSW) and Haven (Victoria). I endorse these recommendations.

CONCLUDING REMARKS

143. I express my sincere condolences to Dion’s family.

144. I thank counsel assisting, Mr Chris McGorey and his instructing solicitor, Ms Lara Shepherd for the work they put into assisting me in this inquest.

145. I would also like to acknowledge the work of Detective Sergeant Adriano Buttigieg who conducted a thorough police investigation in this matter and compiled the initial police brief.

Findings pursuant to *s.81 Coroners Act 2009 (NSW)*

Identity

The person who died was Mr Dion White-Cotterell

Date of death

Mr White-Cotterell died on 28 February 2019

Place of death

Mr White-Cotterell died at 16 Gladstone Street, Parramatta NSW

Cause of death

The cause of Mr White-Cotterell's death was multiple stab wounds

Manner of death

Mr White-Cotterell's death was a result of a knife attack upon him by a known person

Recommendations pursuant to *s.82 Coroners Act 2009 (NSW)*

I am satisfied that the following recommendations arise out of the evidence and are desirable in accordance with s. 82 *Coroners Act 2009*

To the Chief Executive of the Western Sydney Local Health District (WSLHD) NSW

I recommend that:

The WSLHD consider introducing a procedure that:

(1) Requires the development of a comprehensive care plan for patients being supervised or treated through its community mental health centres,

(2) Requires that plan to be reviewed and updated through multidisciplinary reviews that the community mental health centre is expected to carry out for patients, and

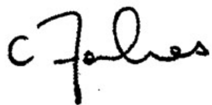
(3) Ensures that plans have a section directed to key information about the patient's risk of violence when acutely unwell (including reference to key risk assessment

reports if any exist) and mandates consideration of that in planning around frequency of contact and responding to a suspected relapse.

To the Chief Executive of Homes NSW and the Chief Executive of the WSLHD

I recommend that:

That Homes NSW and WSLHD consider developing a memorandum of understanding as regards the exchange of information between Homes NSW and the WSLHD to facilitate community mental health services



Magistrate Carmel Forbes
Deputy State Coroner
Coroners Court of NSW, Lidcombe
19 May 2026