Form 17
Coroners Act 2009, Sections 81 & 82

FINDINGS AND RECOMMENDATIONS

COURT DETAILS	
Court	State Coroner's Court of NSW
Case number	1793/08
PROCEEDINGS	
Inquest into the death of	**Michael Vanquelef Capel**
Hearing dates	15 -18 & 21 - 24 June 2010
Date of findings	8 September 2010
Place of findings	Newcastle Court House
Findings of	His Honour Magistrate MacMahon, Deputy State Coroner

FINDINGS

Michael Capel (born 29 June 1965) died on 10 October 2008 at Belmont NSW. The cause of his death was multiple gunshot wounds received during the course of a police operation.

RECOMMENDATIONS

To: The Commissioner of Police

1. That consideration is given to the development of a training module for general duties police officers to assist them in dealing with mentally ill persons.

2. That such training module, when developed, form part of the mandatory training obligations of general duties officers.

To: The Chief Executive, Hunter and New England Area Health Service

1. That where a patient, who is receiving antipsychotic medicine by way of periodic injection, is discharged from the care of a mental health team (the MHT) to the care of a general practitioner the MHT ensure that the general practitioner has in place a system to identify and follow up such patients where they cease presenting themselves to receive the prescribed medication.

REPRESENTATION	
Assisting the coroner	Ms P Dwyer (Counsel Assisting), Instructed by Mr T Hammond
Representing the family	Mr J Fitzgerald
Other parties	Mr R Hood, NSW Commissioner of Police and various Police Officers. Mr B Haverfield, for Senior Constable Jason Battle Mr S Barnes, for Hunter and New England Area Health Service.

REASONS FOR FINDINGS

Introduction

Schizophrenia

Schizophrenia is an illness, a medical condition. It affects the normal functioning of the brain, interfering with a person's ability to think, feel and act. Some recover completely, and with time, most find that their symptoms improve. However, for many, it is a prolonged illness that can involve years of distressing symptoms and disability.

If not receiving treatment, people with schizophrenia experience persistent symptoms of what is called psychosis.

These include:

- Confused thinking. When acutely ill, people with psychotic symptoms experience disordered thinking. The everyday thoughts that let us live our daily lives become confused and don't joint up properly.
- Delusions. A delusion is a false belief held by a person that is not held by others of the same cultural background.
- Hallucinations. A person sees, hears, smells or tastes something that is actually not there. The hallucination is often of disembodied voices that no one else can hear.
- Low motivation and changed feelings.

The causes of schizophrenia are not fully understood. They are likely to be a combination of hereditary and other factors. It is probable that some people are born with a predisposition to develop this kind of illness, and that certain things – for example, stress, the use of drugs such as marijuana, LSD or speed – can trigger the first episode.

About one in a hundred people will develop schizophrenia at some time in their lives. Most of these will be first affected in their late teens or early twenties.

Treatment can do much to reduce and even eliminate the symptoms of schizophrenia. Treatment will generally include a combination of medication and community support. Both are usually essential for the best outcome (Sane Australia Fact sheet, 2010.

Http.sane.org/factsheets/schizoprenia.html).

An understanding of the illness of schizophrenia is an essential starting point for the investigation of the tragic death of Michael Capel on 10 October 2008.

Michael Capel

Michael Capel was born on 29 June 1965. In 2008 he was 43 years of age. He was a single man who resided at the Spinnakers Caravan Park at Belmont NSW. He had resided at the Caravan Park since 1997. He had a close and supportive relationship with his mother, brother and sister and their families. In these findings I will refer to Mr Capel as Michael.

In 1988, at the age of 23, Michael was diagnosed as suffering from schizophrenia. Michael was admitted to the James Fletcher Hospital at Newcastle as an inpatient in 1988 and 1989. James Fletcher Hospital is a specialist psychiatric hospital. Following his discharge Michael began having monthly injections of antipsychotic medicine due to his unreliability in the taking of oral medication.

In 1991 the lake Macquarie Mental Health team referred Michael to Dr Denis Gordon a General Practitioner at Belmont, to receive his injections.

Whilst on medication Michael lived independently.

In May 1992 Michael made the decision to cease receiving his monthly injections. After a period he became ill and as a result was readmitted to the James Fletcher Hospital in November 1992 with a two-week history of *"voices commanding him to kill himself and paranoid delusions that people were against him."*

Following his discharge from hospital Michael recommenced receiving monthly injections of antipsychotic medication. Michael thereafter received 150mg of Haldol administered by

injection each month. This was changed to 100mg in 2000 but later increased to 150mg in January 2002.

In 2004 Michael's doctor decided to gradually reintroduce Michael to oral medication. By this time there had been significant advances in antipsychotic medication and it was hoped that the use of the more modern medication Olanzapine would have less chance of adverse side affects.

By October 2004 Mrs Heath became concerned that Michael was not taking his medication. She approached his doctor and expressed her concern. Michael was seen by either Dr Gordon or another doctor in the practice and was not observed to be exhibiting any psychotic symptoms.

Shortly thereafter however Michael was reported to be hallucinating, saying that people were talking about him, he was not eating and he took his phone off the hook. In January 2005 Michael's brother advised the Lake Macquarie Mental Health Team (the MHT) that Michael had stopped taking his medication. Michael's sister also phoned Dr Gordon and informed him that Michael had ceased taking his medication.

As a result of the actions taken by Michael's family the MHT undertook a home visit on 6 January 2005. Michael was found by the team members to be guarded, he denied that he is mentally unwell and he did not allow the team members to enter his home. Dr Gordon was informed of the outcome of the visit.

Over the next few days Mrs Heath became more concerned. On 14 January 2005 she advised a psychologist attached to the MHT that Michael's concentration was poor, that his home was in a mess and that he was hostile towards her.

On 18 January 2005 two staff from the MHT attend Michael's home in the company of Mrs Heath. Michael was guarded and irritable. He was reported as voicing paranoid ideas and as talking to himself. After discussion Michael agreed to attend his general practitioner and following that Michael resumed the receipt of antipsychotic medication (150mg of Haldol) by way of monthly injection.

From February 2005 to August 2008 Michael's medical history was uneventful. Indeed his schizophrenia appeared to be managed; he maintained regular contact with his mother and other family members and later that year expressed an interest in finding work or becoming involved in activities during the day. He was discharged from the Mental Health Service and returned to the care of Dr Gordon receiving his medication by monthly injection.

On 5 August 2008 Michael received his medication by way of injection. He was due for a further injection on 5 September 2008 however he missed that injection. On 5 October 2008 Ms Heath spoke to Michael and found him to be *"quite pleasant."* They discussed the forthcoming birthday party of her grandson, which they intended to attend together.

On 8 October 2008 Mrs Heath contacted Michael again and thought that he appeared to be *"in an abnormal state."* Ms Heath was concerned so she tried to contact Michael again the next day but was unsuccessful. Mrs Heath suspected that Michael might not have been taking his antipsychotic medication. She phoned Dr Gordon's practice on 10 October 2008 and was able to confirm her suspicions. Mrs Heath decided that she would convince Michael to come in to the practice so that he might receive the injection. She then went to the Caravan Park to see Michael, arriving at about 10am.

The above history shows that although Michael suffered from schizophrenia he was able to live an independent life and support himself so long as he continued his medication. The history shows that when he ceased his medication he began to experience psychotic symptoms. Because he was close to his family and in regular contact with them they were able to identify when those symptoms reoccurred and were then able to ensure that he received appropriate care and treatment.

Of significance is the fact that this history shows that Michael had a very close relationship with his mother and there had been no history of violence by him towards her.

Jurisdiction and function of the Coroner

Section 81(1) of the *Coroners Act 2009* (the Act) sets out the primary function of the Coroner. That section provides, in summary, that at the conclusion of an Inquest the Coroner is required to establish, should sufficient evidence be available, the fact that a person has died,

the identity of that person, the date and place of their death and the cause and manner thereof.

Section 82 of the Act provides that a Coroner conducting an inquest may also make such recommendations, as he or she considers necessary or desirable, in relation to any matter connected with the death with which the inquest is concerned. Making recommendations is discretionary. They relate usually, but not always, to matters of public health, public safety or the conduct of services provided by public instrumentalities. In this way coronial proceedings can be forward looking, aiming to prevent future deaths. It is the role of the coroner to discover, if possible, what happened and why. It is not the function of the coroner to attribute blame.

In addition Section 27 (1) (b) provides that where a person dies *as a result of, or in the course of, a police operation* an inquest is mandatory and that Sections 22 and 23 require that either the State Coroner or a Deputy State Coroner conduct such inquest.

Date Place Cause and Manner of Death.

The evidence establishes that Michael died on 10 October 2008 at the Spinnakers Caravan Park, Belmont. The evidence also establishes that the direct cause of his death was gunshot wounds that he received when shot by a police officer. Michael thus died *as a result of, or in the course of, a police operation.* As such an inquest into the death of Michael is mandatory and the provisions of Section 23 apply.

10 October 2008.

As indicated above Mrs Heath was concerned about Michael and went to the Spinnakers Caravan Park to see him. Her evidence was that she went to his home and entered through the front door. She approached him in order to kiss him as she had done many times before. He stepped back and then struck her with his left arm. He pushed her backwards forcing her to the ground. He then kicked her in the area of her hip. She was of course in shock. She had never seen her son behave like this before. He had never been violent towards her.

About that time Mr Ayaha, an employee of the Caravan Park, came to Mrs Heath's assistance. Mr Capel punched Mr Ahaya whilst he was trying to help Mrs Heath. They were able to leave the area and Mrs Heath then went to the reception area of the caravan park

where she phoned the MHT. Because of the violence Mrs Heath was informed that she should phone the police and that the police could phone the MHT after they arrived if that was appropriate. Mrs Heath phoned the police. This call was recorded as having occurred at 11.17am.

Police did not arrive at the caravan park until shortly before 5pm. The reasons for the delay I will examine later in these findings. The responding officers were Senior Constables Sally Hogg and Jason Battle who had commenced duty at 3pm that day. By that time Greg Capel, Michael's brother, had also arrived at the caravan park.

On arrival at the caravan park Officers Hogg and Battle spoke to Mrs Heath and Greg Capel, received a history of the events of the morning and Michael's general medical history then went to see Michael. What happened next was the subject of close examination during the inquest.

Officer Hogg gave oral evidence at the inquest and a DVD recording of a walkthrough in which she had participated was shown. A similar DVD walk through by Officer Battle was also shown. Civilian witnesses, Sheldon and Ruth Byrne who saw much of the tragedy unfold also gave evidence. Three other persons who also saw part of the events also gave evidence. They were Michael's near neighbours, Darren Fursey, Ron McGregor and Ray Noble. In addition Mrs Heath, Greg Capel and Hosain Ayaha also gave evidence as to the events that preceded Officer Hogg and Battle approaching Michael's home.

On the basis of the evidence available I am satisfied that Officer Hogg approached the front door of Michael's van followed by Officer Battle, knocked on the side of the van, announced that she was a police officer and asked Michael to open the front sliding door. Michael refused.

Officer Hogg then slid the partially open front door to the side and observed that Michael had something behind his back. Officer Hogg then stepped back and asked Michael what he had behind his back. Michael said that; *"he had something"*. Hogg and Battle then began shouting at Michael demanding that he show what he had behind his back.

Very shortly after this Michael began walking towards Officers Hogg and Battle with a large knife. The knife was produced at the inquest. The handle was 10.5 cm in length with a 28cm blade.

Officers Hogg and Battle retreated down the stairs to Michael's door. Officer Hogg tripped at the bottom of the stairs. Officer Hogg gave evidence that she sprayed capsicum spray at Michael three times as she retreated in an attempt to disable him. This was unsuccessful. The first two sprays appear to have reached Michael but landed on his clothes and chest but did not deter him. The third attempt did not reach Michael with the spray blowing back into the face of Officer Hogg temporarily blinding her. Officer Hogg was thereafter unable to assist in what occurred subsequently. Indeed being blinded the danger that she faced in the circumstances was considerable.

After officer Hogg was incapacitated she tried to get water in order to wash out her eyes. Battle continued to walk backwards with Michael advancing towards him. Sheldon Byrne, a neighbour of Michael's who was with his wife, who had just returned to the caravan park, and was parking his car called out to Michael. Michael then appears to have turned towards Mr Byrne.

At about this stage Officer Battle discharged his firearm at Michael a number of times in rapid succession. Michael then fell to the ground. There is a difference of recollection between Mr Byrne and Battle as to what occurred at this time. Mr Byrne's recollection was that Michael was advancing towards him and then turned towards Battle who then discharged his firearm. Battle's evidence was that Michael was advancing towards Mr Byrne at the time he discharged the firearm. Ruth Byrne, who had a more restricted view of the events, gave another slightly different account of Michael's movements. Either way all witnesses agreed that the time involved was very short, indeed a matter of a few seconds. The different perspective of the various witnesses might explain the different recollections. In any event all witnesses' recollections of the events testify to the serious danger the circumstances posed to those involved.

Following Michael being shot officer Battle sought help for him by applying first aid and calling for ambulance assistance. Unfortunately such assistance was not able to save Michael's life.

Why did Michael act as he did on 10 October 2008?

It is hard to understand Michael's actions on 10 October 2008 without understanding his illness. Michael, as I have already mentioned, was 43 years of age, lived independently and had a close relationship with his mother and other family members. He had no history of violence. His assault on his mother, and Mr Ahaya, that morning was completely unexpected and completely out of character. Indeed it must have been a most distressing, if not terrifying,

experience for Ms Heath given the relationship she had with Michael.

The explanation for these events can be found in the schizophrenia that Michael suffered. The inquest was helped by the analysis undertaken, and evidence given, by Dr Yvonne Skinner a consultant psychiatrist. Dr Skinner concluded that:

> *"Michael Capel had a past history of psychotic symptoms with paranoid delusions when he had not been taking medications. He had also expressed suicidal thoughts in the past, with command hallucinations, voices ordering him to kill himself when suffering from psychosis. The descriptions given of his behaviour on 10 October 2008 are consistent with behaviour of a person affected by paranoid delusions. It is probable that he had been affected by delusions, had become increasingly psychotic and on the day had acted on his delusional beliefs by assaulting his mother and another person who came to her assistance, and later by threatening police with a weapon."*

Of importance Dr Skinner noted that:

> *"Persons suffering from mental illness sometimes act on their delusions, are at risk of suicide and sometimes persons affected by severe mental illness severely injure or even kill other persons when acting on their delusional beliefs."*

I accept Dr Skinner's analysis and opinion. I am satisfied that at the time of the incident Michael was suffering from an acute psychotic episode and was more likely than not responding to delusional beliefs or command hallucinations that resulted in him fearing for his safety. The psychosis that he was suffering probably meant that he did not recognise Ms Heath as being his mother but as being a person who posed a threat towards him. Likewise when the police came to his home he probably believed that they were a threat towards him and his actions were, as part of his delusional beliefs, understood by him to be an attempt at self-protection.

The Police.

Michael's death occurred during the course of a police operation and as such it is important that the police response to the situation at an organisational level and the actions of the individual officers involved be reviewed. This is, in part, why an inquest is mandatory in such situations. It is in the interest of the public, the family of the deceased and the officers

involved that such events be examined so that where lessons might be learned from the events that can occur.

The actions of the police can be divided into three time periods, each of which I will examine. Those periods are:

- The response to Mrs Heath's request seeking assistance,
- The actions of the police after Michael had been shot, and
- The actions of Senior Constables Hogg and Battle.

On 10 October 2008 at 11.17am Katrena Cox, an employee of Spinnakers Caravan Park phoned Belmont Police Station on behalf of Mrs Heath and sought police assistance. The job was broadcast on police radio at 11.26am. As previously mentioned officers Hogg and Battle did not arrive at the caravan park until just before 5pm. There was thus a delay in responding of a little over five and a half hours. The questions that must be asked are why it took the police so long to respond and did the delay contribute to Michael's death.

The actions of the police on the day were examined in detail. As indicated the job was broadcast on police radio at 11.26am. The evidence was that the Sen Constables McArthur and Mignanelli who were in LM 23 at 12.05pm accepted the job.

At 12.40pm Mrs Katrena Cox once again called the Belmont Police station to find out how long it would be before police arrived at the caravan park. She was assured that police were expected to arrive shortly. Unfortunately at 12.45pm LM23 responded to another job that was considered to be more urgent than the one at Spinnakers.

The reason the new matter was given greater priority was examined at inquest. It was, in fact, very similar to that involving Michael. It involved a person who also suffered from schizophrenia. The difference was that at the time the call was made to the police in that case the patient was still destroying property and attacking his mother and was thus an ongoing threat. It was considered that it had priority over Michael's case as Mrs Heath was safe and there was no current violence by Michael towards any third party. It was also the case that there were no other vehicles available to assist. I am satisfied that in the circumstances, and having regard to the availability of police resources at the time, the decision made was an appropriate one.

When police had not arrived at Spinnakers after 2pm Katrena Cox once again made a call to Belmont Police Station. This call is recorded as having occurred at 2.25pm. Mrs Cox spoke

to Senior Constable Brady. Officer Brady made telephone contact with Officer McArthur and as a result it was decided that the job should be allocated to officers who commenced duty at 3pm. As a result of this Officer Brady spoke to Officer Hogg shortly before she commenced duty. The matter was to be the first matter that was to be undertaken by Officers Hogg and Battle.

Once again circumstances intervened to delay the officers attending to the matter. Unbeknown to officer Hogg at the time she spoke to Officer Brady, Officer Battle had been directed to serve certain documents on the office of the Director of Public Prosecutions and the solicitor for a party in a forthcoming trial. Officer Hogg was required to do so before the conclusion of the day. This required Officers Hogg and Battle to travel to Newcastle and back. This resulted in them not arriving at Spinnakers until just before 5pm as previously mentioned. In the meantime Ms Heath and Greg Capel had, at about 4.20pm, gone to the trouble of attending the Belmont Police Station in person to inquire as to when police would arrive at the caravan park.

The further delay in attending to a request for assistance that was made at 11.17am was most unfortunate. One would hope that in ordinary circumstances where a person has been assaulted by a loved one suffering from mental illness and seeks help the police would be able to respond to such a request in substantially less than five and a half hours.

At the same time the police on duty have to respond to the demands placed on them within the constraints of the resources provided to them. I accept that it was necessary for Officer Battle to comply with the court direction that required him to travel to Newcastle and that he and Officer Hogg were the appropriate officers to be allocated to respond to Mrs Heath's request for assistance. Indeed, on the evidence available, it is likely that they were the only officers that were available.

The delay in responding to Mrs Heath's request for assistance has been explained. I accept that having regard to the resources available the delay, although disappointing, could not be avoided on the day. The question that I must try and answer, if possible, is whether or not the delay contributed in a material way to the events that were to occur when officers Hogg and Battle arrived at Michael's home. I accept that the best assistance available in answering this question is the opinion of Dr Skinner who thought:

> *" Police officers who attended the caravan park were faced with an emergency situation. At the time it would have been difficult to prevent a dangerous confrontation*

> *with Mr Capel. Even if they had arrived hours earlier, the situation would have been as problematic, as Mr Capel had been violent towards his mother and another person. Prevention of the acute psychotic episode might have been addressed at an earlier stage, weeks or days earlier, when Mr Capel might have been accepting of assistance from the general practitioner or the mental health team."*

Having regard to the evidence available I am satisfied that it is more likely than not that the delay in responding by the police did not aggravate the situation and as such the delay was not a significant contribution factor to the events that led to Michael's death.

Officers Hogg and Battle arrived at the caravan park just before 5pm. After speaking to Mrs Heath and Greg Capel for a short time they drove to Michael's home and parked in a position below his lounge room window. They then went to the front porch of the home and knocked on the door.

As I have already indicated during the inquest what followed was examined in detail. After the initial exchange between Michael and the officers they backed away from him and he followed with the knife in a threatening pose. Capsicum spray was used on three occasions apparently having no effect on Michael but ultimately, due to the wind, disabling Officer Hogg.

As previously mentioned I am satisfied that during the confrontation with the police Michael, as was the case in the confrontation with his mother and Mr Ahaya, was suffering from an acute psychotic event. He was either responding to delusions that Officers Hogg and Battle were threatening him or suffering from hallucinations involving auditory commands requiring him to act to protect himself. I am satisfied that his actions in threatening Officers Hogg and Battle, as well as Mr and Mrs Byrne, were thus a symptom of his illness.

Notwithstanding this the danger posed by Michael to Officers Hogg and Battle and Mr and Mrs Byrne was no less serious. At first glance many questions could be asked, and were, about the response of Officers Hogg and Battle to the situation. Such questions would include matters relating to where the police vehicle was located, how they approached the front door of Michael's home, the decision of Officer Hogg to slide the front door open, the use of capsicum spray by Officer Hogg, the manner in which they backed away from Michael as he advanced towards them, the manner in which they shouted their commands to him and finally the timing of the decision of Officer Battle to use his firearm. The asking of such questions is legitimate. The death of an individual resulting from the actions of a police officer

must be examined in detail.

Having regard to the evidence available I am satisfied that each of the officers acted reasonably in the circumstances and that no criticism of their actions is warranted. I am satisfied that when Senior Constable Battle discharged his firearm he did so in response to a threat to life.

NSW Police guidelines with regard to the use of firearms states that:

> *"You are only justified in discharging your firearm when there is an immediate risk to your life or to the life of someone else, or there is an immediate risk of serious injury to you or someone else and there is no other way of preventing the risk."*

I am satisfied that at the time Officer Battle discharged his firearm he was confronted with Michael who, because of his actions, posed an immediate risk of death or serious injury to either himself or the other people in the vicinity. I am satisfied that Officer Battle acted in accordance with the above guideline.

The actions of Officers Hogg and Battle were reviewed by a number of parties including senior police officers. Each reached a similar conclusion. Of considerable assistance was the review undertaken by Dr Skinner. Dr Skinner reached a similar conclusion to that which I have reached in respect of the actions of the officers.

Of significance, however, Dr Skinner expressed the opinion that Offers Hogg and Battle may have underestimated the threat posed in attending Michael's home. Dr Skinner said:

> *"Police attending the situation appear to have underestimated the possibility of a crisis, they were told that Mr Capel had no record of violence and would be likely to go along with police. They anticipated that they would be able to speak with him, arrange a schedule and transport him to hospital, apparently without considering the possibility of a dangerous situation developing."*

The officers had assisted persons suffering from mental health issues on many occasions before. They no doubt had a good police understanding of how to respond in situations. Unfortunately this expectation was not a valid one in this case. As Dr Skinner pointed out:

> *"The fact that he had assaulted his mother and another person, acts that were out of character, and then remained in his caravan without attempting to check on his*

> *mother were indications that he was in an acutely psychotic state and might have presented a danger to police and others."*

This observation of Dr Skinner, with which I agree, is not made by way of criticism of Officers Hogg and Battle but simply to highlight that dealing with persons suffering from mental health issues is a complex matter and officers doing so need specific training and assistance in order to ensure that they can respond in the best possible way when faced with situations such as that which occurred on 10 October 2008. Indeed Dr Skinner recommends that such training occur. I shall return to this matter later in these findings.

One issue that must be dealt with is the number of wounds that Michael suffered. We were assisted in this matter by the evidence of forensic pathologist, Dr Nadesan, and ballistics expert, Senior Constable Schey.

The evidence, which I accept, is that Michael suffered eleven gunshot wounds. There were at least five identifiable entry wounds. The experts were not able to determine the order in which the wounds were suffered. They were, however, able to identify two wounds that would have been fatal.

Officer Battle's firearm was seized after the event and examined. Eight rounds were found to be missing from the firearm. Two bullet holes were located in a caravan wall and its vicinity. The evidence substantially accounted for all shots fired by Officer Battle.

Those who heard the firing gave slightly different evidence as to the number of shots fired and the manner in which the shots were fired. Those differences can probably be accounted for by the different circumstances of the various witnesses. The one common aspect of the evidence was that the time during which shots were fired was very short.

Police training requires that the use of a firearm should be no more than what is necessary to ensure that the danger is contained. I accept that once Michael fell to the ground no more shots were fired. I accept that shortly after that occurred Mr Byrne approached Michael and removed the knife that he had been carrying.

One might wonder whether the number of wounds suffered by Michael was excessive in the circumstances. The evidence was, however, that not all wounds Michael suffered were disabling. According to Dr Nadesan, two of the shots would have been fatal. Only one of those would have made Michael fall immediately to the ground. That meant that Michael

could have continued to move forward, even after he had been shot several times. I am satisfied, having regard to the evidence considered as a whole; there is no basis to suggest that the number of shots fired by Officer Battle was excessive. I accept the evidence that once Michael fell to the ground Officer Battle ceased firing.

Greg Capel made a statement to the police on 10 October 2008 and then participated in a video walk-through on 20 October 2008. When describing the events of 10 October 2008 during the walk-through Greg Capel suggested that whilst Michael was laying on the ground a police officer:

"Just kicked him over with his boot and that was it, as I stood there_"

Describing the event further Greg Capel said:

"And then they've just gone and shoved him over with the steel-capped boot, whatever they wear."

Greg Capel when further questioned on this topic said that the person, who acted in the way described was standing behind Michael and *"kicked him forward."*

Greg Capel was unable to describe the officer he said acted in that way and was unsure as to precisely when the incident happened.

It would be most inappropriate for a police officer to kick a person in the back that was on the ground having been shot. Such action would need to be the subject of criticism and the officer involved disciplined. I have examined the evidence available on this matter. Officer Battle denies that he acted as suggested. Mr and Mrs Byrne did not see such an event. Other officers who gave evidence denied moving Michael with their feet and stated that they did not see Officer Battle do so. None of the other persons present can assist directly.

The evidence is however that immediately after Michael fell to the ground Officer Battle sought to assist him. Towels were sought and Michael was rolled onto his side. At about the same time Mr Byrne approached Michael and removed the knife. There was a lot of activity going on at the time Greg Capel arrived. Perhaps Greg Capel misinterpreted what was occurring. There is no doubt that it would have been an extremely stressful, distressing and probably confusing time for him. Ultimately the evidence available does not support the suggestion that Michael was kicked. I am satisfied that Greg Capel was mistaken in this matter.

Michael's Medical Treatment Before 10 October 2008.

Michael was at various times under the care of his local general practitioner, Dr Gordon, and the Mental Health Team (the MHT) of the Hunter and New England Area Health Service (the AHS). There is no evidence to suggest that the care that Michael received was inappropriate.

All evidence available confirms that, when Michael was supported by the medication prescribed for him, he was able to live an independent life and was not a threat to either himself or any other person. However when he was not receiving his prescribed medication the symptoms of his illness began to manifest themselves and, as the events of 1992 and 2005 show, a crisis quickly developed.

Michael was receiving his monthly injection from his general practitioner Dr Gordon. He received his last injection on 5 August 2008. He was thus due for a further injection on or about 5 September 2008. He missed that injection. When Ms Heath spoke to him by phone on 8 October 2008 she thought that Michael *"seemed in an abnormal state."*

When Mrs Heath could not make contact with Michael on 9 October 2008 she became concerned. She suspected that he might not have received his medication and, the next day, contacted Dr Gordon's practice where her suspicions were confirmed. Unfortunately when Michael missed his injection on 5 September 2008, and again on 5 October 2008, he had not been followed up by anyone to ensure that he received the medication.

As I have already indicated I am satisfied that at the relevant times Michael was experiencing an acute psychotic event. The evidence would suggest that such events would be unlikely to occur if Michael were to receive his monthly injection of antipsychotic medication. In the circumstances I am satisfied that a contributing factor to Michael's death was the fact that he did not receive his medication when it was due.

At the relevant time Michael was not under any legal obligation to take his medication. He did so voluntarily. It would seem, however, that a symptom of the illness that he suffered could be the delusional belief that he did not suffer from an illness and thus did not need to take medication. That is why the legislation provides for the making of a Community Treatment Order (CTO) in an appropriate case so as to ensure that the individual receives the medication needed to maintain their wellbeing.

In this case Michael had been cooperating in his medication regime for a number of years and the making of a CTO would not have been appropriate. However it is unfortunate that when he did not attend to receive his injection he was not followed up. As Michael was a voluntary patient, Dr Gordon did not have any power to require him to receive his medication. However if Dr Gordon had had a system of following up patients who had not attended to receive the injection Michael might have been contacted at a time when he was willing to comply with the recommendations of his treating doctor.
By saying what I have said above I am not intending to criticise Dr Gordon in any way. He did not have a legal obligation to follow up Michael when he did not attend to receive his prescribed antipsychotic medication. The role of the Coroner is, however, to seek to learn from the circumstances of a death so as to, if possible, develop systems that will avoid such circumstances in the future.

Dr Gordon gave evidence at the inquest. He acknowledged the importance of following up patients such as Michael who have not attended to receive their prescribed medication. He gave evidence that since Michael's death his practice has introduced a system of following up such patients. This is a very positive response to the tragedy that led to Michael's death. I propose to make a recommendation in accordance with Section 82 that hopefully will ensure that all general practitioners who are assisting patients such as Michael have such a follow up system.

As indicated above Michael had also been a patient of the MHT of the Hunter and New England Area Health Service. He had been an in-patient at the James Fletcher Hospital in 1988 and 1992. The MHT had been his primary mental health carer between 1988 and 1991 and had also become involved with his care in 2003 and 2005.

It is not in dispute that Michael's last involvement with the MHT was more that three years prior to the events of October 2008. None the less on 10 October 2008 in her efforts to assist her son Ms Heath phoned the team at Charlestown. She was advised to phone the police. Having regard to Michael's violence towards Ms Heath the advice given was appropriate as police are the lead service provider in such situations.

Although there was no doubt that the advice that Mrs Heath received on this occasion was appropriate a question was raised as to whether or not such advice should have been given to Ms Heath by an employee who was not clinically trained. The evidence was that Mr Gavin Rook, an experienced administrative officer of the MHT, gave the advice to Mrs Heath. The fact that Mr Rook gave the advice did not give rise to any coronial issues in the inquest as

the advice was appropriate and did not contribute to Michael's death.

Nevertheless evidence given at the inquest was that since Michael's death action has been taken by the Area Health Service to ensure that in such situations an employee with clinical qualifications and experience will give such advice. The giving of advice in such situations will on many occasions require the exercise of clinical judgement. It is appropriate that a person who is able to exercise clinical judgement respond to requests. The action of the Area Health Service is to be commended.

The MHT does, however, have a role to play in situations such as that which involved Michael. In a situation where a patient decides to cease taking medication and the treating general practitioner is unable to get him to do so it may be that members of the mental health team will be called upon to assist. Such assistance may involve undertaking an assessment of the patient's mental state and instituting action to ensure appropriate treatment in accordance with the relevant mental health legislation.

In Michael's case because he had been discharged into the care of Dr Gordon his file had been closed. Had the members of the mental health team been required to assist they would not have had easy access to their file information relating to Michael's condition.

One would expect that the officers involved would have sought to obtain up to date information as to Michael's situation at the time they became involved. However it might also be the case that the MHT files could contain useful information.

During the course of the inquest it was suggested that I might make a recommendation in accordance with Section 82 that the files of patients' who have been discharged by the MHT be maintained, that there should be regular reviews of the patient's mental health status and that where an event occurs that requires access to such information the file would then be readily available.

The Area Health Service (the AHS) resisted such a recommendation. It was argued by them that the demand on the MHT was such that once a patient was discharged into the care of a general practitioner the resources available did not allow the conduct of regular reviews. The AHS was also of the view that it was for the general practitioner, who had responsibility for the care of the patient, to determine when, and if, mental health reviews should be undertaken.

Dr Gordon in his evidence agreed that he would have had access to the assistance of the MHT if he had needed it. He also agreed that it would be helpful if there were closer involvement between the general practitioner and the MHT in the care of a patient.

Resource availability for the care of persons with mental health difficulties is a major challenge for Australia. The AHS must, of course, use the resources it has available in the way it considers most appropriate. It is not for this court to make recommendations as to the distribution of funds between competing needs. I do not know what those competing needs are.

In any event the evidence available does not suggest that the lack of availability of the MHT file contributed to the circumstances of Michael's death and, in addition, I could not conclude that regular mental health assessments would have prevented the tragedy that occurred on 10 October 2008. In the circumstances I do not propose to make the suggested recommendation.

As I have already mentioned one of the reasons why coronial investigations are undertaken is to try and learn from the circumstances of a death. Michael's death was a tragedy for both his family and the wider society. Put in stark terms Michael lost his life when he became a danger to others due to an illness that he suffered. From the evidence available when Michael was appropriately medicated he was not a threat to either himself or any one else. This changed when his medication ceased.

The MHT is the default primary carer for persons with mental illness. When diagnosed, and the patient is discharged from a hospital, the MHT will be the carer. I accept that in some, if not many cases, it is also appropriate for the patient to be discharged by the MHT to the care of a general practitioner once the acute stage of the illness has passed. The evidence suggests that the maintenance of regular medication is what is necessary to ensure that the illness will not once again become acute.

As has now occurred in Dr Gordon's practice there, needs to be a system in place so that when a patient ceases attending to receive medication they can be followed up and if necessary the assistance of the MHT can be sought. To ensure that this occurs the MHT should arrange that when a patient is discharged into the care of a general practitioner it ensure that such a system is already in place. I propose to make a recommendation in accordance with Section 82 to this effect.

Mental illness is a complex human condition. Its effect on a patient can be dynamic. Violence can be a characteristic of such illness when in an acute phase. In such situations the police will provide the primary response to the crisis. In this case, even though Officers Hogg and Battle had had previous experience in dealing with persons with mental illness it was Dr Skinner's assessment that they under- estimated the danger that they faced on 10 October 2008.

In dealing with such situations it is necessary to have regard to the wellbeing of not only the person suffering from the mental illness but also the police officers called upon to assist the patient. The officers thus need to be provided with as much training and information as possible concerning mental illness and how best to respond in situations such as occurred on 10 October 2008. Dr Skinner made a recommendation as to the need for such training in her evidence.

Evidence was given to the inquest that the NSW Police Force had responded to such a need by the development of the Mental Health Intervention Team (MHIT) course. The MHIT course was developed because there was a recognition by police that:

> *"Front line police officers are often faced with mental health incidents that have the potential to impact on their own safety, and that of the community."*

As such the MHIT course aims to provide police with:

> *"The knowledge and skills to confidently interact with persons who are affected by mental health issues."*

The goals of the MHIT course are said to be to:

- Reduce the rate of injury to police and mental health consumers in interaction;
- Improve the awareness amongst frontline police of risks involved in mental health incidents;
- Improving collaboration with other government and non-government agencies in response to, and management of mental health crisis incidents; and
- Reducing the time taken by police in the handover of mental health consumers to the health care system.

In December 2009 the Final Evaluation report of the MHIT course, was released by the Charles Sturt University. That evaluation was positive and as a result the NSW Police Force

is now arranging for officers to undertaking the course.

The NSW Police Force is to be commended for the development of the MHIT Course. It is clearly a very positive response to a significant need. The evidence before the inquest was that dealing with mental health incidents was an important, and growing, aspect of general duties policing.

The nature of the MHIT course is, however, resource intensive and costly. Only a small proportion of front line police officers will be able to undertake the MHIT course. No doubt for the officers that have the opportunity of undertaking the MHIT course the benefits will be considerable.

Dr Skinner in her review suggested that:

> *"It would be useful for police officers to have some training in dealing with mentally ill persons. This could be brief instruction of only one or two hours to give some insight into the problems that they might encounter."*

The MHIT course as described in the evidence before the inquest is a more substantial training activity than that suggested by Dr Skinner. The advantage of Dr Skinner's suggestion is that such training could be made available to a greater number of officers than the number it is anticipated will attend the MHIT course.

Balancing the resource demands for training is a difficult challenge for NSW Police management. The significance of the benefits that will flow to the community in general, and front line police officers in particular, by the expansion of availability of the MHIT course would suggest that it should have priority over other training packages.

Notwithstanding this I propose to recommend that the Commissioner give consideration to the development of a training module as suggested by Dr Skinner and that such module form part of general duties officers mandatory annual training as soon as possible.

This proposed training should be in addition to the provision of the MHIT course. The involvement of front line police in incidents involving persons with mental health issues is significant and creates a current need. Basic training of the nature suggested by Dr Skinner would provide officers with training and support in the interim whilst the numbers of officers who are able to attend the MHIT course is expanded.

The Police Investigation

Michael's death occurred as a result of the action taken by police. It was a critical incident. The *Guidelines for the Management and Investigation of Critical Incidents* of the NSW Police Force applied to the subsequent police investigation. That investigation was the subject of review during the course of the inquest. Having regard to the evidence available I am satisfied that the police investigation was conducted in accordance with the Guidelines.

There is, however, one aspect of the investigation that I wish to comment on. In situations where a person dies during or as a result of a police operation there is sometimes a debate as to how the evidence of the involved officers should be taken.

In some instances such evidence is taken by way of electronic recording whilst at other times a statement is taken from the involved officers. It has been suggested that the taking of a statement is more appropriate as it treats the officers involved as witnesses where the taking of their account in an electronic form might be suggestive of wrongdoing or inappropriate action on their part.

In this case the use of the video recorded walkthrough by Officers Hogg and Battle shortly after the events was a very effective way of dealing with this issue. The evidence was taken whilst it was fresh in the minds of the officers concerned and in a manner that was non-threatening. Indeed it was so effective that at inquest none of the parties granted leave to appear required Officer Battle to be available to give oral evidence. The Officer in Charge, Detective Inspector Bryne Ruse, and the various other officers responsible for the police investigation are to be commended for the quality and effectiveness of the police investigation.

Conclusion

Michael's death was a tragedy. Looking at the circumstances of his death in retrospect it is apparent that it could have been prevented. If it had been realised that he had ceased receiving his prescribed antipsychotic medication and he had received assistance prior to him entering an acute psychotic state he may not have become a danger to both himself and others. Once that occurred, however, the situation became dynamic with an uncertain outcome. Hopefully the examination of those circumstances will help to lessen the possibility of a similar event occurring in the future.

SIGNATURE

Signature	
Name	Magistrate P MacMahon
Capacity	Deputy State Coroner
Date	14 June 2011