OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Steven David BEAUMONT**
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Brisbane
FILE NO(s):	COR 426/05(9)
DELIVERED ON:	29 September 2008
DELIVERED AT:	Brisbane
HEARING DATE(s):	3 March 2008 & 8 April 2008
FINDINGS OF:	Mr Michael Barnes, State Coroner
CATCHWORDS:	CORONERS: Inquest – death in custody, provision of emergency care to the mentally ill.

REPRESENTATION:

Ms Julie Wilson	–	appearing to assist the Coroner
Ms Nicky Keeling	-	Dr William Parke (instructed by Avant)

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The *Coroners Act 2003* provides in s45 that when an inquest is held, the coroner's written findings must be given to the family of the person who died, each of the persons or organisations granted leave to appear at the inquest and to various specified officials with responsibility for the justice system or other agencies with responsibility for the areas of administration referred to in any comments or recommendations. These are my findings in relation to the death of Steven David Beaumont. They will be distributed in accordance with the requirements of the Act and posted on the web site of the Office of the State Coroner.

Introduction

On 25 February 2005, while suffering from severe depression and under the influence of intoxicants, Steven David Beaumont, inflicted severe knife wounds upon himself. He would not allow ambulance officers to treat him and so police, who also attended, handcuffed Mr Beaumont so that be could be attended to. He was then loaded into an ambulance. He died on the way to hospital.

These findings seek to explain how the death occurred and consider whether the mental health treatment he received in the days preceding his death was reasonable and whether the actions of the ambulance officers and police officers who attended on the evening of Mr Beaumont's death was appropriate.

The Coroner's jurisdiction

Before turning to the evidence, I will say something about the nature of the coronial jurisdiction.

The basis of the jurisdiction

Because Mr Beaumont's death was sudden and unnatural it was reported to the Ipswich coroner in accordance with the requirements of s7(2)(a) and (3)(b) of the Act. When it became apparent that at the time of his death Mr Beaumont was detained by police, it was determined that his death was a death in custody within the terms of s10 of the Act and so responsibility for the matter was transferred to me. I was required by sections 11 and 27 to convene an inquest into the death.

The scope of a Coroner's inquiry and findings

A coroner has jurisdiction to inquire into the cause and the circumstances of a reportable death. If possible he/she is required to find:-

- whether a death in fact happened
- the identity of the deceased;
- when, where and how the death occurred; and
- what caused the person to die.

There has been considerable litigation concerning the extent of a coroner's jurisdiction to inquire into the circumstances of a death. The authorities clearly establish that the scope of an inquest goes beyond merely establishing the medical cause of death but as that issue was not contentious in this case I need not seek to examine those authorities here. I will say something about the general nature of inquests however.

An inquest is not a trial between opposing parties but an inquiry into the death. In a leading English case it was described in this way:-

> *It is an inquisitorial process, a process of investigation quite unlike a criminal trial where the prosecutor accuses and the accused defends… The function of an inquest is to seek out and record as many of the facts concerning the death as the public interest requires.* [1]

The focus is on discovering what happened, not on ascribing guilt, attributing blame or apportioning liability. The purpose is to inform the family and the public of how the death occurred with a view to reducing the likelihood of similar deaths. As a result, the Act authorises a coroner to make preventive recommendations concerning public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in future.[2]

A coroner must not include in the findings or any comments or recommendations statements that a person is or may be guilty of an offence or civilly liable for something.[3] However, if, as a result of considering the information gathered during an inquest, a coroner reasonably suspects that a person may be guilty of a criminal offence; the coroner must refer the information to the appropriate prosecuting authority.[4]

The admissibility of evidence and the standard of proof

Proceedings in a coroner's court are not bound by the rules of evidence because s37 of the Act provides that the court "*may inform itself in any way it considers appropriate."* That doesn't mean that any and every piece of information however unreliable will be admitted into evidence and acted upon. However, it does give a coroner greater scope to receive information that may not be admissible in other proceedings and to have regard to its provenance when determining what weight should be given to the information.

This flexibility has been explained as a consequence of an inquest being a fact-finding exercise rather than a means of apportioning guilt: an inquiry rather than a trial.[5]

A coroner should apply the civil standard of proof, namely the balance of probabilities, but the approach referred to as the *Briginshaw* sliding scale is

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[1] *R v South London Coroner; ex parte Thompson* (1982) 126 S.J. 625
[2] s46
[3] s45(5) and 46(3)
[4] s48
[5] *R v South London Coroner; ex parte Thompson* per Lord Lane CJ, (1982) 126 S.J. 625

applicable.[6] This means that the more significant the issue to be determined, the more serious an allegation or the more inherently unlikely an occurrence, the clearer and more persuasive the evidence needed for the trier of fact to be sufficiently satisfied that it has been proven to the civil standard.[7]

It is also clear that a coroner is obliged to comply with the rules of natural justice and to act judicially.[8] This means that no findings adverse to the interest of any party may be made without that party first being given a right to be heard in opposition to that finding. As *Annetts v McCann*[9] makes clear, that includes being given an opportunity to make submissions against findings that might be damaging to the reputation of any individual or organisation.

The investigation

Soon after the ambulance carrying Mr Beaumont left the scene Detective Senior Constable Terry Linford of the Ipswich Criminal Investigation Branch attended and assumed control of the investigation of the incident.

The scene was secured and cordoned off and guarded overnight.

Brief details were obtained from two of the officers who had attended the incident and from Mr Beaumont's partner Ms Walsh. A neighbour who had been involved in the events also gave a brief initial account. A door knock of the locality was undertaken but no witnesses were located. While the initial investigation was being undertaken, advice was received that Mr Beaumont had died on the way to hospital. His mother and partner were advised.

Scenes of crimes officers and scientific officers examined the scene and the ambulance in which Mr Beaumont had travelled and all relevant areas were photographed.

The officers involved in the incident were not interviewed but were directed to provide statements. Enquiries were made with the Gold Coast Integrated Mental Health Unit and the West Moreton Mental Health Unit and statements obtained from doctors who had treated Mr Beaumont.

I am of the view that the investigation was extremely thorough. Detective Senior Constable Linford is to be commended on his industry and application.

The inquest

A pre inquest conference was convened on 3 March 2008. Ms Julie Wilson of the Office of the State Coroner was appointed counsel assisting. Leave to

[6] *Anderson v Blashki* [1993] 2 VR 89 at 96 per Gobbo J
[7] Briginshaw v Briginshaw (1938) 60 CLR 336 at 361 per Sir Owen Dixon J
[8] *Harmsworth v State Coroner* [1989] VR 989 at 994 and see a useful discussion of the issue in Freckelton I., "Inquest Law" in *The inquest handbook*, Selby H., Federation Press, 1998 at 13
[9] (1990) 65 ALJR 167 at 168

appear was granted to solicitors acting on behalf of Dr Parke, Mr Beaumont's treating doctor.

Ms Wilson submitted that a statement was needed from Dr Parke's practice partner, a medical practitioner who Mr Beaumont had visited the day before his death. The matter was adjourned to enable that to happen.

The matter came before the court again on 8 April. On that occasion Ms Wilson submitted that nothing would be gained by calling oral evidence. She had provided a copy of the investigation report to Mr Beaumont's mother; regrettably his partner Ms Walsh is now also deceased. Mr Beaumont's mother agreed that no purpose would be served by calling oral evidence at the inquest. Therefore, on 8 April, all of the material was tendered and Ms Wilson made submissions as to the cause and circumstances of the death. As a result of considering Ms Wilson's submissions I concurred that no oral evidence was needed to allow me to make these findings.

The evidence

I turn now to the evidence. Of course I can not even summarise all of the information contained in the exhibits but I consider it appropriate to record in these reasons the evidence I believe is necessary to understand the findings I have made.

Family background

Steven Beaumont was born in Melbourne on 5 March 1970. He was the son of Carol and Stephen Beaumont. He had one sibling, a younger brother. Steven and his family moved to Queensland when he was six.

Steven's schooling was normal: he didn't do particularly well but engaged in the usual social activities and played competitive sport.

Mr and Mrs Beaumont had an unhappy marriage and separated soon after the boys left school. They and their mother moved back to Melbourne.

When he was 22, Steven married the mother of his twin sons. Four years later he and his wife had a baby girl. Mr Beaumont separated from his wife in 1997 and returned to Queensland to try and re-establish contact with his father.

Just before he did this, he was admitted for the first time to a mental health institution. The diagnosis is not clear but he received in-patient treatment for several days.

Mr Beaumont only stayed a few days in Queensland before returning to Melbourne where he continued trying to sort out his marital problems and establish a routine for having access with his three children.

He was unsuccessful in both endeavours.

Mr Beaumont moves back to Qld

Mr Beaumont continued to have psychotic episodes. He was diagnosed as suffering from paranoid delusional schizophrenia. He was non complaint with his medication and abused marihuana. He formed a relationship with a Natalie Walsh who also had drug abuse problems.

In 2004, they both moved to Queensland and took up residence at Gailes where Mr Beaumont lived until his death, although his relationship with Ms Walsh was not stable and he moved about with some frequency. He spent some time on the Gold Coast where his father lived and was treated by the community mental health service there.

In August 2004, when he had resumed cohabiting with Ms Walsh, Mr Beaumont attended a medical centre at Riverview near Gailes and was seen by Dr Parke. He gave the doctor a brief clinical history of his mental illness and was able to tell him the medication he usually took was Clopixol Depot - 300mg IM. Dr Parke considered it appropriate to continue the medication and arranged for Mr Beaumont to see the West Moreton Integrated Mental Health team. They indicated that they would make a home visit to Mr Beaumont but when he attended on Dr Parke again 2 days later this had not happened. The doctor again contacted the mental health service. He was assured Mr Beaumont would be contacted.

Mr Beaumont attended on Dr Parke on a further three occasions over the next couple of months until he retuned to Victoria for a short time in December 2004. When he returned to Gailes in January 2005, he again saw Dr Parke and told him he had seen his previous case manager in Melbourne. She telephone Dr Parke a couple of days later and faxed some case notes but this did not result in any change of treatment.

He missed the next couple of dates he was due his depot injection and indeed was not seen by Dr Parke again.

Circumstances surrounding the death

In the days leading to his death Ms Walsh noticed that Steven was suffering from what she described as *'severe depression'*. On 24 February 2005 he told Ms Walsh that he was going to commit suicide and stated that he was going to stab himself. He had made similar threats before. Nonetheless, Ms Walsh was very concerned for her partner and contacted his mother.

Later that day, Ms Walsh took Steven to the medical centre at Riverview. Dr Parke was on holidays, so his partner, Dr Ratnam saw him. Steven's mother had telephoned Dr Ratnam and asked that he give her son his usual depot injection. The doctor agreed and administered the drug but he did not undertake any assessment of Mr Beaumont's mental state as he had not previously had dealings with him. He considered that his only role was to give the routine medication. Dr Ratnam was unable to give any evidence concerning Mr Beaumont's condition on that day.

The next day Steven appeared to be worse according to Ms Walsh. When he went with her to the hospital where she sought treatment for an ailment, he was constantly breaking down and manifesting symptoms of severe depression.

They went home late in the afternoon after purchasing some beer and cannabis. Mr Beaumont smoked some of the cannabis and drank some beer before dinner. He did not eat much. The couple then retired to bed. Mr Beaumont was still exhibiting signs of distress and depression.

At about 10.00pm Steven received a phone call from his father. According to Ms Walsh, Steven's father verbally abused him over the phone. After that phone call, Steven smoked approximately 10 cones of cannabis. He was clearly very upset.

Mr Beaumont left the bedroom and went to the kitchen. Ms Walsh could see him sitting at the kitchen table smoking a cigarette and drinking coffee. She lost sight of him and so went to check what he was doing. She found him standing near the fridge, cutting his throat with a carving knife. She rushed back to the bedroom and called an ambulance.

When she returned to the kitchen she found Mr Beaumont stabbing himself repeatedly in the upper chest. Ms Walsh sought the assistance of a neighbour, Jamie-Lea Muntelwit, who on hearing what was happening, also called an ambulance.

Ms Muntelwit, who did not know Mr Beaumont or Ms Walsh, bravely attended the house. She saw Steven lying face down in a pool of blood on the kitchen floor. She obtained a blanket and spread it over him. He was conscious and nodded his head when she asked him if he had inflicted the injuries and intended to kill himself. She removed a large carving knife from under Mr Beaumont's leg and placed it on the kitchen bench.

A QAS unit arrived at the scene but after being told that Steven had a knife and was mentally ill, the officers would not attend to him. QPS officers arrived soon after. At that stage Steven was seen flailing his arms about and craning his neck. That exacerbated the injury to his throat. More police officers and more ambulance officers arrived. The QAS officers were still unwilling to attend to Mr Beaumont for fear he might attack them.

The police officers decided to handcuff Steven to enable the paramedics to attend to him. I consider this was appropriate and reasonable in the circumstances. His hands were cuffed behind his back and when he tried to kick out at police his ankles were also secured in the same manner.

Blankets had been spread on the floor to reduce the chance of the police and paramedics slipping. Mr Beaumont was scooped up with some blankets and carried out of the house and placed on a stretcher. He was at that stage noticed to be unconscious and unresponsive. He was placed in an ambulance

and the handcuffs were removed. An ECG was conducted and Mr Beaumont was found to have an extremely low cardiac rhythm.

The ambulance departed for the Princess Alexandra Hospital, with lights and sirens activated and under police escort. En route basic first aid was attempted without success. Mr Beaumont was confirmed dead when he arrived at the hospital.

Medical evidence concerning cause of death

On 26 February an autopsy was undertaken by an experienced forensic pathologist, Dr Beng Ong. He found an incised wound that severed the trachea allowing blood from various severed blood vessels to pass into the lungs. In Dr Ong's opinion aspects of the wound were consistent with it having been self inflicted by a left handed person.

Eighteen stab wounds were found on Mr Beaumont's chest.

Dr Ong considered the wounds were also consistent with having been inflicted by the carving knife taken from the Gailes premises.

Findings required by s45

I am required to find, as far as possible, who the deceased was, when and where he died, what caused the death and how he came by his death. I have already dealt with this last aspect of the matter, the manner or circumstances of the death. As a result of considering all of the material contained in the exhibits and the evidence given by the witnesses I am able to make the following findings in relation to the other aspects of the matter.

Identity of the deceased – The deceased person was Steven David Beaumont

Place of death – He died in an ambulance en route between Gailes and the Princess Alexandra Hospital at Buranda in Queensland.

Date of death – Mr Beaumont died on 25 February 2005

Cause of death – He died from the aspiration of blood as a result of self inflicted neck wounds while suffering from severe depression that led to a decision to end his life.

Concerns, comments and recommendations

Section 46, in so far as it is relevant to this matter, provides that a coroner may comment on anything connected with a death that relates to public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in the future.

There is no doubt that Mr Beaumont intended to take his own life. He had a long history of schizophrenia and depression but at the time of his death he was not the subject of an involuntary treatment order. In the months before his death he made reasonable efforts to manage his mental illness with some success. However, towards the end of 2004 and in January 2005 Mr Beaumont ceased taking his medication and suffered severe depression as a result. The depot injection he had the day before his death would not have been sufficient to restore his mental equilibrium. His mental state undoubtedly deteriorated further as a result of his consuming large amounts of cannabis on the day of his death.

When he attended on Dr Parke in the second half of 2004, Mr Beaumont seemed to have some insight into his illness. While he did not always attend punctually to receive his deport medication, he seemed to be aware of the need to continue to seek treatment.

I am of the view that there was insufficient evidence to warrant Dr Ratnam, seeking to have Mr Beaumont made subject of an involuntary treatment order. Further, having regard to my experience with applications for such orders, I consider it highly unlikely an order would have been made had Dr Ratnam sought it.

In the circumstances, there was probably nothing Dr Ratnam or Dr Parke could have done to have prevented the death.

The medical evidence indicates that Mr Beaumont could only have been saved if he received expert medical attention within a few minutes of the severing of his trachea. The delay in his receiving such treatment was solely due to his resisting the ambulance officers and police. I do not consider the paramedics or police officers could reasonably have been expected to have handled the situation differently.

I am therefore unable to make any recommendations that would reduce the likelihood of similar deaths occurring in future.

Michael Barnes
State Coroner
Brisbane
29 September 2009