CORONERS COURT OF QUEENSLAND

FINDINGS OF INQUEST

CITATION:	**Inquest into the deaths of Charmaine, Aaleyn, Matilda, Wyatt, and Zaidok McLeod**
TITLE OF COURT:	Coroners Court
JURISDICTION:	BRISBANE
FILE NO(s):	2019/2314, 2019/2307, 2019/2316, 2019/2318, 2019/2319
DELIVERED ON:	21 August 2024
DELIVERED AT:	Brisbane
HEARING DATE(s):	25 November 2022, 4 April 2023, 31 May to 16 June 2023.
FINDINGS OF:	Kerrie O'Callaghan, Brisbane Coroner
CATCHWORDS:	Coroners: *Inquest, Mental Health Services, Department Child Safety, Seniors, Disability Support, Domestic and Family Violence, Queensland Police Service, Family Court, Suicide, Filicide*

Non-publication orders were made by the Court on 31 May 2023, 2 June 2023, 5 June 2023, 13 June 2023, 14 June 2023 and 16 June 2023. This version of the findings has been redacted.

REPRESENTATION:

Counsel Assisting:	Ms Kylie Hillard (assisted by Ms Jennifer Capper)
Commissioner of Queensland Police:	Ms Emily Cooper
Police Officers:	Mr Pat McCafferty KC (instructed by Gilshenan and Luton)
Department of Child Safety, Seniors, and Disability Services:	Ms Karen Carmody (instructed by DCSSDS legal)
Wide Bay Hospital And Health Service:	Ms Melinda Zerner (instructed by Corrs Chambers Westgarth)
Queensland Health Office of Chief Psychiatrist:	Ms Jesika Franco (instructed by Queensland Health legal)
Dr Nkechinyere Ibe:	Ms Donna Callaghan (instructed by Justine Matthews)
Mr Paul and Ms Brooke Harris:	Ms Rebekah Bassano (instructed by Caxton Legal Centre)
Mr James McLeod:	Ms Amelia Hughes (instructed by Townsville Community Law)
Ms Fiona Terrell:	Mr Jeremy Trost

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INTRODUCTION

1. On 27 May 2019, Charmaine McLeod drove her car into the path of an oncoming truck. In doing so she killed herself and her four young children Aaleyn, Matilda, Wyatt and Zaidok who were in the car. This was a devastating tragedy that caused unimaginable grief and trauma to the children's father, Mr McLeod, and to Ms McLeod's family and friends. It no doubt deeply affected the broader members of the community who had known or had contact with Ms McLeod and her children.

2. Naturally, people want to know why this tragedy happened. A Coronial investigation and Inquest can be an opportunity to find answers within the confines of the Coronial Jurisdiction.

3. Ms McLeod had suffered from mental health concerns from an early age. Her diagnosis changed during her life but was ultimately Comorbid Borderline Personality Disorder and Schizophrenia. She was married to Mr James McLeod from 2008 to 2017. She made allegations of domestic and family violence and sexual assault both against her and two of the children by Mr McLeod. She had a lot of interaction with various agencies including the police and child safety. At the time of her death, she was engaged in contested proceedings in the Family Court and was receiving legal advice.

4. A note written by Ms McLeod was found at the crash site. The note revealed a sense of hopelessness in being let down by her lawyer and the legal system, suggesting dissatisfaction with the responses to her complaints of domestic violence and assault.

5. It is apparent that Ms McLeod perceived that she had been let down and was in a desperate situation.

6. My conclusions following the inquest are in line with the submissions made by Counsel Assisting. That is, that no adverse comment should be made against any of the individuals or agencies that Ms McLeod and her children had dealings with. Further, that the murder and filicide was virtually impossible to detect by the agencies.

7. With the benefit of hindsight, it will be seen that with respect to some issues things could have been done differently or with a different focus. Ultimately however, I conclude that even with a different approach to those issues the death of Ms McLeod and her children would not have been prevented.

BACKGROUND AND PRELIMINARY POINT

8. I adopt Counsel Assisting's summary of the events immediately preceding the crash and set them out as follows:

9. Ms McLeod and the four children were in Domestic and Family Violence (DFV) refuge accommodation on the day of the crash. On 25 May 2019, DV Connect arranged for Ms McLeod and the children to be in a hotel, and they confirmed her safe arrival at the emergency motel on that date. On the morning of 27 May 2019, Ms McLeod was told by DV Connect to go to [Not for publication] as there was a place for her at a refuge. She attended an intake meeting at the [Not for publication]. She and the children were then settled in the accommodation. They were last heard by staff or other tenants at about 6.00pm.

10. Ms McLeod had a white Nissan X-Trail bearing registration plates 993XJY. The events on 27 May 2019 that led to the crash include:

a) 8:57am – DV Connect telephone [PZ] from [Not for publication]. [Not for publication];

b) 9.13am – DV Connect telephone Ms McLeod to confirm motel rebooking. She said she really needs to go into a refuge because she is not being supported by her lawyers and current FLCO (Family Law Court Orders). Her lawyer has told her she can't respond to his documents where she is the respondent. She had asked for a transfer from legal aid. She was given instructions about the refuge accommodation;

c) 9.27am - DV Connect document their referral time;

d) 10:45am - Heather Cummings, a friend and counsellor spoke with Ms McLeod on the phone. Ms McLeod had messaged her the day before about being in accommodation with DV Connect in [Not for publication]. When they spoke, she referred to James harassing her. She also said she didn't want to bad mouth James. They spoke about talking again on Wednesday. Heather considered the conversation positive.

e) 11.09am – Ms McLeod called DV Connect requesting an update. She was heightened and anxious about her issues with Legal Aid / her current lawyer and what she needs to do legally for her children in regard to schooling. She was provided contact details for Women's Legal Service.

f) 11.10am – DV Connect send Ms McLeod a text telling her to go to the [Not for publication] and to call DV Connect on arrival. She was advised that the refuge wanted to do the intake at 1.30pm or 2.00pm.

g) 11:20am - Ms McLeod and children check out of motel room.

h) 1:21pm - Ms McLeod was advised by email of the Family Law Court matter being adjourned to 27 August 2019.

i) 2:00pm - [Not for publication]

j) 2:13pm – Ms McLeod's safe arrival at the refuge is confirmed by DV Connect.

k) 3:50pm - Ms McLeod emails Fiona Terrell:

"Hi Fiona,
Due to James behaviour, intimidation & continual threats, the children and I have left Hervey Bay.
We are safe with DV connect.
It really is not safe for us to return for the supervised visit on Saturday, not that we are anywhere near to really do so. Matilda has to be at Queensland Children's hospital next week for specialists.
So what can we do please?"

l) 4:30pm – [Not for publication].

m) 5:21pm - Fiona Terrell replied to Ms McLeod by email:

"Charmaine, Have you reported these threats to the police? If so what actions have the police taken?
Can you please detail (what where when) the allegations for me.
While cancelling the visit next due to the hospital appointment (although the visit would be on a weekend and I doubt your appt would be on the same day) may be understandable the court may not take the same view about you stopping supervised visits where there is little risk to the children.
I have started to view the subpoena material and it is my view that the notes made by Harmony House staff in relation to the issues you have raised, such as allegations that the father has made threats and assaulted the children during visits when 2 staff are in supervision at all times, will not assist you in this matter. From the staff observations it could appear that you are being obstructive in facilitating the father's time with the children when the observations are that the children are happy to see him each visit displaying no fear. The children have also been noted to say that they want to either live with dad again or that they want him to live next door to them. The children have also remarked to staff that 'Mummy won't love us if we like daddy.'
It is my opinion that you need to demonstrate to the Court that you are willing to facilitate a relationship between the children and the father and that supervised visits ensure that the children are safe when they do so. Should you not do so and if your allegations against the father are determined to be unfounded you run a real risk of having the court order that the children should live with the father.
Accordingly I strongly urge you to re-consider whether you should stop supervised visits.
I am also aware that you have indicated to legal aid that you are unsatisfied with my legal advice. If that continues to be the case then it may be appropriate for you to transfer to another solicitors."

n) 5:44pm Ms McLeod replies to Fiona Terrell regarding her dissatisfaction with Harmony House and James' threats to the children and herself:

"Ok, I have an issue with harmony house.
It seems every client does in fact.
Yes I phone harmony house after a visit as Aaleyn came home very upset saying her dad hit her.
They denied it, & said Aaleyn was a liar.
Last visit I spoke them the Thursday prior, where I discussed Matilda's needs. Sue assured me that she would phone James & make sure he brought everything in she would need. Upon arrival he didn't have the Panadol, the main thing she needed. I asked why, all I got was I don't know, & a shoulder and a shrug.
They then demanded I drive home get Panadol & come back. I said no because I couldn't afford the fuel.
I asked why they couldn't call me & let me know James wasn't happy to supply this, so then I could have. Again, I got…don't know & a shoulder shrug. I said this is disgraceful.
As for Wyatt and only Wyatt at times making comments about living with dad, yes I've heard it too…
But do you know why? Do you know why? James threatened them too before we left him, before I got the DVO, when Aaleyn only came with me,

they were all told, Daddy will die if you don't live with him, daddy will be lonely all by himself…
He made comments about comments about hurting & killing mummy.
Maybe someone needs to ask the children especially the girls how much money I give them every harmony house day & where I take them straight after…so it's nice & peaceful, to get in the car & go into harmony house.
I feel like your sort of saying now, I've pretty much lost my children????"

o) 6:00pm - Witness (worker at [Not for publication]) hears Ms McLeod and children still inside the house;

p) 6:04pm - Ms McLeod sends further email to Fiona Terrell in relation to threats made by James and not reporting to police:

"No I haven't reported it to police…
Honestly it's a waste of time, effort.
Police never do anything anyway.
It's almost daily… he manages to drive beside me, behind me etc… I've done what police told me to do, pull over & get my camera but he takes off so it's too late…
He uses his fingers as a gun, and slides fingers/hand across his neck… after pointing at me…
I would love for the children to have a relationship with their father… I would love for it to be more than just harmony house.
But don't I deserve to feel safe too…
I emailed you about videos that I have, where the children don't want to go with him…
Maybe they feel safe at harmony house, because there are others there watching, because James isn't drinking beer & so engrossed on the play station. They know they have dad 100% because let's face it, dads being watched."

q) 6:51pm – Ms McLeod's vehicle (Nissan X-Trail) is seen on CCTV [Not for publication]. She had also left the lights on in the accommodation.

r) 6:52pm - Ms McLeod's Nissan X-Trail is seen passing [Not for publication].

s) 6:62pm – Ms McLeod's Nissan X-Trail is sighted passing [Not for publication]. There is no evidence she was speeding or driving erratically at any time.

t) 7:15pm – A vehicle believed to be Ms McLeod's vehicle sighted passing a service station and heading towards Dalby.

u) About 7:30pm - The crash occurs. After passing the service station the vehicle is sighted travelling on the Bunya Highway at Kumbia. Officer McKindley states that the crash was reported to have occurred at 7.18pm. O'Leary says the crash occurred at 7.30pm. The precise time of the collision was not in issue at the inquest.

11. Prior to the crash, Ms McLeod was driving along an open stretch of the road between Kumbia and Bell described as "Bunya Highway Mannuem Qld 4610 (Via Kumbia)" on the forensic map.

12. Ms McLeod was following another semi-trailer truck driven by Mark Orreal. She completed the overtaking manoeuvre and her car returned to the correct side of the road. There was a truck in the distance, which was easily visible having all its lights on. Orreal saw the collision some distance ahead of him.

13. The section of the road where the overtaking manoeuvre was made had a slight incline, which is clearly able to be seen in the photos of the scene taken in the daylight. These also show the markings on the road.

14. The truck that collided with Ms McLeod's vehicle was travelling in the opposite direction driven by Scott Trace (bearing registration plates 964WFF on the truck and YQ48K on the trailer). Mr Trace said that Ms McLeod's vehicle swerved suddenly into his truck. He stated that he believed that Ms McLeod's car had passed him, and that the car appeared suddenly leaving him with no time to react or brake.

15. As to where the crash occurred, the stretch of the road of the collision was documented by the police on the below map:

Image 1: Scene location (Google Maps Satellite Image) showing location of crash site located as Bunya Hwy, alignment of 7582 Bunya Highway, Kumbia QLD.

16. Given the visibility of the truck driven by Mr Trace, it seems impossible for Ms McLeod not to have seen the oncoming truck on what was a straight section of the road.

17. After the collision, the truck driven by Mr Trace capsized and veered off to the left hand side of the road in its direction of travel, where it came to rest on its side. Ms McLeod's vehicle veered off the right hand side of the road and came to rest on the grassed area at the side of the road. Both vehicles caught on fire.

18. The truck driver, Mr Trace, wasn't wearing his seatbelt and experienced burns as a result of the crash. He was seen on the scene by police, and was described as appearing dazed.

19. Mr Orreal, the man in the truck who had been overtaken earlier, stopped to render assistance to both the truck driver and to Ms McLeod and the children. He went to Ms

McLeod’s vehicle to check for the pulse of the people in the car. He checked two and felt no pulse. He said that the others were clearly deceased.

20. Another motorist arrived shortly thereafter to also render assistance.

21. There were some grass fires that occurred from the fire of the vehicles that needed to be put out. Mr Orreal and the other motorist attended to this. At some point, Mr Orreal moved his truck to cast light on the side of the road and, in doing this, drove through the debris path between the truck and Ms McLeod’s car.

22. The oldest child, Aaleyn, was found on the ground having been thrown from the car after the impact. The Autopsy Report notes information that she was located 20 metres from Ms McLeod’s vehicle. Some footage was provided by Mark Orreal from inside his truck when he drove through the debris field. He appears to travel over the top of the body of Aaleyn which was laying right side down on the road. The footage clearly shows no impact of the under carriage of the truck with her and passes over the top of her. Mr Orreal clearly had no idea she was there at the time, and even on Counsel Assisting viewing the footage repeatedly, it is very difficult to discern that there is a body on the road at all with any level of certainty. A comparison to the photos at the scene show that in that section of the road, there is no other debris, which suggests that Aaleyn may have been on the road. On attendance by the Queensland Ambulance Service she was located on the side of the road on the edge of the bitumen. She was unresponsive with blood in the airways. Aaleyn was then taken to the Kingaroy Hospital and air lifted to the Children’s Hospital Queensland with further arrests. She had to be resuscitated on route but died shortly thereafter.

23. The other children were located in the vehicle; two in the back, one in the front passenger seat, and Ms McLeod in the driver’s seat. The evidence showed that it was apparent to those who rendered assistance that the people in Ms McLeod’s car were deceased, and that their bodies were later consumed by flames. That is, the car was heavily compressed in the front such that the driver and front passenger would not have survived, and biological debris was observed in the compressed space. The children in the back of the car were checked for signs of life – there were none.

24. Detective Sergeant Scott Prendergast and Senior Constable James Dixon were the first police officers on the scene. Officer Prendergast saw a small child lying on side of the road on the edge of the bitumen. He spoke to the motorist, Graham Newson who indicated that there was a child. Dixon attended to the child. Officer Prendergast approached an ambulance and walked with the ambulance officer to the child. The fire from the car made it difficult to access the child. The ambulance officer had to shield the child from the heat. The child was assessed and quickly taken by ambulance to Kingaroy Hospital. Officer Dixon left with them. Officer Prendergast remained and took control of the scene.

25. The evidence showed that the point of contact between the two vehicles was on the side of the road that the truck was travelling in. Evidence showed that speed was not a factor and that, while there were limits on the extent to which examination of the brakes and electrical systems of the car could be undertaken, there was no identified mechanical cause for the crash in either the car, truck, or trailer.

26. Police officers attending the scene found Ms McLeod's purse amongst the debris. In it they found a handwritten note consisting of a number of pages apparently written by Ms McLeod in these words: -

“*To emergency I'm sorry. Yes intentional.*
I couldn't cope with custody shit any longer. Legal aid and solicitor won't help me.

Currently staying at Women's Refuge.
My solicitors said blah blah blah wasn't happy. I don't understand. Do I have to be dead before any take my domestic violence seriously?
Family courts considering handing my kids over coz I finally had the courage to stand up and report my abusive husband? I'm being seen as withholding yet I was raped and abused. My children abused and 2 of them molested.
How much more? Far out. This is what pushes one to the brink of murder/suicide. From Charmaine
Blame the courts.
Not enough help for DV victims and kids"

27. Ms McLeod had a lengthy history of complex mental health issues and had engaged with a variety of mental health providers. She also had many interactions with other government agencies, including QPS, Child Safety, the Family Court and domestic and family violence service providers.

28. Against the background of these interactions and the context of the note found by police, the issues for the inquest into Ms McLeod and her children's deaths were identified.

29. A pre-inquest conference was held on the 25 November 2022 and the parties were invited to make submissions about the identified issues. No submissions were made.

30. A further pre-inquest conference was held on 4 April 2023 and no submissions were made about the identified issues. The issues for the inquest were:

    1) the findings required by section 45 (2) of the Coroners Act 2003, namely the identity of the deceased persons, when where and how they died and the cause of their deaths.

    2) the appropriateness and adequacy of the police responses to the complaints of domestic and family violence and allegations of abuse made by Ms Charmaine McLeod against her and her children.

    3) the appropriateness and adequacy of the mental health responses by Queensland Health, associated entities and service providers responsible for Ms Charmaine McLeod's care, treatment and monitoring, as well as their responses to her domestic and family violence complaints and child abuse complaints.

    4) the appropriateness and adequacy of responses by relevant agencies to the protection, safety and welfare of the children, including the Department of Children, Youth Justice, and Multicultural Affairs ('Child Safety'), the Queensland Police Service ('QPS') and Queensland Health.

    5) the appropriateness of training, support and guidelines available to legal practitioners for clients experiencing crisis with complex mental health, domestic and family violence and child protection needs.

31. The inquest was held over 13 days (Wednesday 31 May 2023 to 16 June 2023). Voluminous written material was provided. Oral evidence was heard from civilian witnesses, police officers, Child Safety personnel, health professionals and legal witnesses.

32. Counsel Assisting delivered her written submissions on the 9 October 2023. Other parties' submissions were in the most part delivered in late November 2023. Some parties (Brook and Paul Harris (The McLeod family), Queensland Health the Office of

the Chief Psychiatrist (QHOCP), QPS Commissioner and the Queensland Police officers delivered submissions in reply in December 2023. In January 2024 Counsel Assisting helpfully provided a document which collated the parties' responses to submissions.

Preliminary point

33. Counsel Assisting in her written submissions submitted that -

    1) Factual findings need not be made, nor should any be made, as to whether Mr McLeod did any of the sexual complaints he is alleged to have perpetrated against Ms McLeod, [Not for publication] or [Not for publication] nor whether there was domestic and family violence committed by him or anyone.

34. Counsel Assisting did suggest that I make recommendations but said that the making of the recommendations did not turn on the truth of the allegations and the factual findings of the truth or otherwise of any allegation.

    2) No adverse comment needed to be made, nor should any be made against any individual.

35. It was submitted that whilst I could find there were missed opportunities for intervention by QPS, Queensland Health and Wide Bay Health Service and Child Safety, no adverse comment should be made against any agency, because the deaths were virtually impossible to detect when those agencies operated alone. Any recommendations suggested were intended to aid in improving gaps in services to prevent similar deaths from occurring in the future.

36. Some parties submitted in reply that in light of these submissions it was unnecessary and indeed inappropriate for me to consider issues two and four:

    - the appropriateness and adequacy of the police responses to the complaints of domestic and family violence and allegations of abuse made by Ms Charmaine McLeod against her and her children.

    And

    - the appropriateness and adequacy of responses by relevant agencies to the protection, safety and welfare of the children, including the Department of Children, Youth Justice, and Multicultural Affairs ('Child Safety'), the Queensland Police Service ('QPS') and Queensland Health.

37. Submissions on behalf of Mr McLeod in this regard were that in circumstances where it is accepted that no factual findings against Mr McLeod be made the issue concerning the allegations against him (issues 2 and 4) should not be further considered. It was submitted that it is not appropriate to deal with these issues, as to do so would involve setting out the substance of the allegations when the allegations have not been properly tested. However, if I was to consider issues 2 and 4, I should make findings that there is insufficient evidence to establish the findings against Mr McLeod.

38. The police officers given leave to appear submitted that in view of Counsel Assisting's submissions (which they agreed with) the court should not engage with or make any comment or recommendations on any matter traversed by Counsel Assisting as regards issue 2 and issue 4 because these issues invite comment on the actions of QPS.

39. It is submitted that the only basis the court could engage with these matters is the power conferred by section 46 of the Coroner's Act and it is not appropriate to do so in light of Counsel Assisting's submissions. Further, there is no proper basis on which the court can be satisfied that the matters contended by Counsel Assisting, the subject of comment and recommendations, are connected with Ms McLeod's death.

40. In relation to findings required by section 45 the police officers submit that the findings under section 45 (2) (a) (c) (d) (e) - ie. the identity of deceased persons, when, where and what caused them to die is uncontroversial.

41. In relation to section 45 (b) that is 'how they died' it is submitted that I should accept the conclusion of the forensic crash unit investigators and Detective Senior Constable O'Leary who provided the coronial police investigation report. That conclusion being in essence that Ms McLeod's actions were wilful and calculated to take her own life and that of her four children and that her actions were premeditated in retaliation against Mr McLeod.

42. Concerns are raised that Counsel Assisting's position outlined in her submissions (that is, that Ms McLeod's actions were virtually impossible to detect when the agencies operated alone and that no adverse findings should be made against individuals) was only made known to the parties upon receipt of Counsel's submissions, and that those submissions were "*far removed from the tenor and tone of examination of witnesses which at various stages, involved police witnesses and others being criticised*".

43. It is said that in submitting that acting alone Ms McLeod's actions were virtually impossible to detect this necessarily means 'no agency operating alone could have prevented the tragedy'. As such, these two propositions must have the consequence that issues 2 and 4 should no longer be considered or commented on by the court.

44. I will be considering the issues 2 and 4 in these findings. I reject the submissions of Mr McLeod and the police officers that those issues should not be considered in light of Counsel Assisting's submissions that: -

    - No findings of fact need be made whether Mr McLeod committed the acts of sexual abuse or domestic violence.
    - No adverse findings been made against individuals or individual agencies.
    - That Ms McLeod's actions could not have been detected by individual agencies acting alone.

45. These submissions are made by Counsel Assisting following her consideration of all of the evidence oral and written adduced during the two-and-a-half-week inquest and of voluminous written material. The issues were identified prior to the holding of two pre-inquest conferences and the hearing.

46. No concerns were raised by any party in relation to the issues identified. The parties now complain that Counsel Assisting's submission is at odds with 'how Counsel Assisting conducted her examination of witnesses at the hearing'. Minimal objection was taken to any cross-examination at the hearing. The parties had the same opportunity to examine and cross-examine and they did.

47. It is a matter for me, having regard to the evidence elicited through examination and cross-examination of witnesses and the submissions made by the parties, to make findings.

48. Mr McLeod objects to the consideration of issues because it will involve setting out allegations against Mr McLeod and that would be inappropriate if no adverse findings are to be made.

49. The allegations against Mr McLeod were always going to be considered at the inquest.

50. The note written by Ms McLeod raised the issues of domestic violence, assault and police responses. That was the reasoning behind the identification of police responses to her allegations as an issue to be considered. It was never intended (and indeed, it is prohibited under The Coroners Act 2003) for this court to make findings about whether Mr McLeod did in fact commit the acts complained of. The issue was whether the police response (in coming to the conclusions that they did) was appropriate or inadequate.

51. The Police Commissioner is critical of Counsel Assisting and submits that the inquest was conducted by Counsel Assisting on the basis that Ms McLeod was a victim survivor and because she was not the 'ideal victim' the investigation into her complaints was inadequate. The inference being, it is submitted, that the complaints should have had a different outcome. It is said that it is at odds now with Counsel Assisting's submissions.

52. I disagree. The evidence about police response to Ms McLeod's complaints was heard and submissions made. It is a matter for me to consider whether police response to her complaint was adequate. It does not follow that if I was to find any inadequacies, I must consider that there should have been a different outcome to the investigation/response.

53. I accept this consideration of the police response must be done in the context that the complaints were made in 2017 to 2019 and to have regard to the training, policing and resources available to police in relation to allegations of domestic violence at that time.

54. I disagree with the police officers' submission that the only basis that the court could engage in the matters raised in issues 2 and 4 is via section 46.

55. Section 45 (b) requires the coroner to make findings about 'how the person died'.

56. As stated in 8.3 of the Coroner's Guidelines: -
"*How the person died is the equivalent to the manner of death or mechanism and the context in which it occurred*.

It should not be given the unduly restrictive meaning of 'by what means' but should be understood to refer to 'by what means and in what circumstances the death occurred', It is broader than the medical cause of death which is referred to in section 45 (2) (e). When recording the manner of death, the coroner should strive to indicate whether the death was accidental or intentional".

57. In the decision of *Hurley v Clements and Ors* [2009] QCA 167 the Queensland Court of Appeal acknowledged that when making a finding of how a person died, a coroner will often have to resolve other factual issues that led to or underpin the finding.

58. The note found at the crash site refers to domestic violence, custody issues, abusive husband, rape and abuse of children.

59. These references bring those allegations into the realm of the investigation of the circumstances of the deaths of Ms McLeod and her children. That is what were the circumstances that led to her decision to drive into the path of the oncoming truck. Issues in 2 and 4 were identified to be covered at the inquest and evidence was given on these issues in this context.

60. I have considered all of that evidence and with the benefit of all parties (including Counsel Assisting's) submissions I can and will make findings on issues 2 and 4.

61. I will then consider whether in light of the findings I can and should make any comments or recommendation pursuant to section 46.

FORENSIC AND CORONIAL POLICE INVESTIGATION

The Forensic investigation into the crash

62. The forensic investigation was conducted by Senior Constable Christopher McKindley who attended the scene of the crash at about 8.15pm. By the time he arrived, Aaleyn had been removed from the scene by the Queensland Ambulance Service.

63. Officer McKindley liaised with other officers and had regard to other documents and reports in relation to the investigation prior to giving his evidence. Counsel Assisting has summarised his evidence and I adopt this summary as follows: -

64. The Nissan X-Trail driven by Ms McLeod was extensively damaged and had been consumed by fire. It was located on the edge of the road, on the grassed area on the shoulder of the road.

65. Concerning the truck and trailer that collided with the Nissan X-Trail, the undercarriage and cabin were impacted by fire damage. It was located on the edge of the road, partially on the shoulder of the road.

66. The evidence showed grooves and indents on the bitumen surface of the road, which confirmed that the point of contact between the two vehicles was on the side of the road that the truck and trailer was traveling in. The force of the impact was such that the registration plate of the Nissan was transferred to the front metal of the truck.

67. The truck came to rest 86.3 metres from the point of collision and the car came to rest 35.0 metres from the point of collision.

68. In relation to both vehicles, while each vehicle travelled some distance following the collision, speed was determined not to be a factor for either vehicle. While there were limits on the extent to which examination of the brakes and electrical systems of the car could be undertaken because of impact damage and/or fire damage, there was no identified mechanical cause for the crash in either Ms McLeod's vehicle, the truck, or the trailer towed by the truck.

69. The road had a gentle grade, no side railings and grass flats on either side, with two lanes - one direction of travel each way, and an unbroken centre line.

70. There was no apparent driver error or mechanical failure with either vehicle. Nor was there any issue with the road conditions which could have contributed to or caused the collision.

71. Senior Constable McKindley concluded that from the evidence located and observed at the scene of the crash, it was apparent the truck was travelling easterly towards Kumbia. The Nissan was travelling westerly in the direction of Dalby. The Nissan crossed onto the incorrect side of the road impacting in a head on type collision with the Truck.

The Coronial Police Report

72. Detective Senior Constable Lisa O'Leary provided a report to the State Coroner detailing the QPS investigations into the deaths. Extensive investigations were undertaken. Material was obtained from agencies Ms McLeod had contact with including mental health agencies, police, child safety and various support agencies and numerous statements of evidence taken.

73. DSC O'Leary concluded: -

"The deceased had considerable calls for service with both the Queensland Mental Health and Queensland Police Service, with often the two agencies being required to administer services due to her diagnosed mental health illness. The deceased was first diagnosed with Mental Health illness at the age of 16 years. This diagnosis changed over the years; however, Schizophrenia and Borderline Personality Disorder were the most common of the mental illnesses that the deceased was diagnosed as suffering from.

Scrutiny of these documents between these agencies indicate a strong reliant on their services, however a reluctance to continue with services, when questioned or challenged around the validity of claims or requirements. There is a clear pattern of the deceased moving from one support agency to another "shopping around for services".

Statements provided by employees at Harmony House strongly indicates that the deceased would make vexatious complaints against Witness 23 when he had his supervised visits with his children. However, these complaints were always unsubstantiated by Harmony House Staff members as Witness 23 was always supervised when visiting the children and was never observed harming the children.

Queensland Police Service documents reveal that the deceased would make private applications against family members which were all later withdrawn. Deceased Ms McLeod also put a Domestic Violence Order on Witness 23. Over the past 19 years, the deceased showed a tendency to make serious vexatious complaints that were sexual in nature. QPS records show that these complaints were either withdrawn by the deceased or unfounded by Police due to insufficient evidence. The deceased, in 2018/2019, also made complaints that [not for publication]*. This, however, was also unfounded by Police due to no disclosures being made by any of the children at the time. The complaints that the deceased made against Witness 23 were always uncorroborated claims and there were never any witnesses to support her claims of Domestic Violence and physical/sexual abuse.*

Upon the relationship failing, witness 23 recorded a number of conversations, disproving her vexatious complaints to service providers. Further supporting these claims are addressed by Pastor FORD, whereby the Church challenged her, and she then proceeded to unjustly criticise the Church via Social Media.

The Department of Child Safety are an agency that have also had extensive dealings with the McLeod family dating back to 2016. During these dealings' matters have been unsubstantiated or unfounded. There is no evidence available to the Department of Child Safety leading up to the incident, to suggest that the deceased was suicidal or would harm her children. As a result of this, the Department of Child Safety had no justification to remove the children from the deceased's care. The last recorded suicide attempt made by the deceased was in January 2018 and no recorded attempts made between then and the time of the incident.

DV Connect and Domestic Violence Service providers have acted in accordance with their

charters and provided a level of service that appears fair and considerate. On the 27th of May 2019, all services provided were of a required standard and within their guidelines.

The last known identified service provider to interact with the victim is the email conversation between the deceased and her Family Law Solicitor Fiona TERRELL on the 27th May 2019, regarding family law matters.

There is a plausible correlation between conversations with her Family Law Solicitor, the formation of the suicide note including the contents of this note and the traffic incident on the Bunya Highway. The deceased makes reference in her note of her dissatisfaction with solicitors and the court system and also highlights her feeling of being ignored as a Domestic Violence victim. This correlation can be drawn due to the timeline between final email with the Family Law Solicitor, the contents of the note containing information from this email and the subsequent traffic incident.

The actions of the deceased are violent and tragic, nevertheless, service agencies have attempted to engage, provide support and assist the deceased for a number of years. The deceased then becoming unengaged when agencies failed to meet her own expectations or challenging of her allegations.
It is the belief of the investigative team that her interpretation of the information provided by the Family Law Court was the causation of the traffic incident due to her misconceived view that she may lose her children through the Family Law Courts.

From this Police Investigation, Police are unable to identify any agencies that have not provided the deceased and her family a high level of service. On the contrary, as mentioned previously, the deceased would select agencies and then move on to others if she felt like she was not getting her way.

When taking all these factors into light, it appears evident that the deceased had premediated the murder/suicide in retaliation against Witness 23` and the Family Law Courts. The deceased appeared determined that if she could not have full custody of her four children, no one else could and this is a consistent theme noticed by Police throughout this investigation."

AUTOPSIES AND MEDICAL CAUSE OF DEATHS

Medical causes of deaths

Ms McLeod

74. I adopt the summary of Counsel Assisting in regard to the medical cause of deaths.

75. The Toxicology Report for Ms McLeod showed Fluvoxamine (an antidepressant) at 0.75 mg/kg which was reported in the Autopsy Report as being a toxic level of the antidepressant. All other items detected were unremarkable or nontoxic. In relation to Ms McLeod's stomach contents, the lumen contained cream fluid in which no drug residues could be recognised.

76. No parties at the inquest suggested that Ms McLeod was driving erratically as a result of having taken an overdose. There was no evidence that Ms McLeod was speeding or that she was driving erratically, having executed a normal over taking manoeuvre moments before the crash. The autopsy report does not suggest that Ms McLeod was compromised in any way.

77. Later review processes determined that the level of Fluvoxamine was likely an effect of the post-mortem process.

78. The expert consultant opinion of Doctor Heffernan (who also held the position of Director of Forensic Mental Health Services for Queensland Health) was Ms McLeod showed no decompensation or evidence of any acute mental health issue on 27 May 2019. It was not suggested to him by anyone that an overdose may have been a factor.

79. Although Ms McLeod's body was consumed by fire at the scene, the Autopsy Report showed no evidence of soot in her lungs or smoke inhalation indicating that she was already deceased prior to the car catching fire and the fire consuming her body. CT scans revealed extensive and severe antemortem craniofacial, thoracic, spinal, and pelvic injuries. Her head injuries were so severe that they distorted her head shape and features. She had extensive internal injuries including a traumatic disruption of the right coronary artery.

80. Consistent with the evidence, the Autopsy Certificate notes the cause of death was due to multiple injuries from a motor vehicle collision as the driver.

Aaleyn Faith McLeod

81. The Toxicology Report for Aaleyn showed unremarkable items detected or nontoxic items detected.

82. As set out above, while documented as having been located 20 metres from the car, there is no evidence of Aaleyn's body being photographed in situ at the scene of the crash. On attendance by the Queensland Ambulance Service, she was unresponsive with blood in the airways. She was taken to the Kingaroy Hospital and experienced cardiorespiratory arrest enroute. She was air lifted to the Children's Hospital Queensland with further arrests. At 11.18pm she had complete heart block and pacing was ceased. She was asystole and resuscitation efforts were ceased. She was declared like extinct by hospital staff at 11.41pm.

83. Although Aaleyn's body was located outside of the Nissan on the ground and appears to have been on the road when the carriage of Mr Orreal's truck passed over top of her in the bid to assist at the scene, it is apparent from the Autopsy Report and Addendum Autopsy Report that Aaleyn had extensive injuries consistent with a high velocity motor vehicle crash and did not die as a result of anything connected to Mr Orreal. The Autopsy Report states that the CT scan shows intracranial subarachnoid haemorrhage with possible cerebral oedema and swelling, displaced right temporoparietal bone fracture, extensive pulmonary parenchymal changes, intraperitoneal haemorrhage and right humerus and right tibia long bone fractures. She had extensive blunt force injuries to the face, torso, and extremities most prominent over the anterior right side of the body. She had extensive internal injuries. She died from multiple injuries due to, or as a consequence of, a motor vehicle collision.

84. In an addendum report asking that the truck footage be addressed, along with specific questions, about whether this contributed to the cause of death, the cause of death remained unchanged. The external injuries were most predominantly on the right side of her body consistent with impacting the road when thrown from the vehicle. The internal injuries were not isolated to one side of the body. There were no injuries identified consistent with being impacted by the undercarriage of the truck, and no pattern injury consistent with tyre marks. The brain injury was a significant deceleration

injury consistent with a 100km/hr collision, which would have resulted from the collision and resulted in death even in the absence of any other injuries.

85. Consistent with the evidence, the Autopsy Certificate notes the cause of death due to multiple injuries from a motor vehicle collision as a passenger.

Matilda Azaria McLeod

86. The Toxicology Report for Matilda showed unremarkable items detected or nontoxic items detected.

87. Although Matilda's body was consumed by fire at the scene, and the CT scans did not enable clear identification of antemortem injury or fractures, there was no objective evidence to indicate that she was alive at the onset of the fire. There was recent traumatic injury to the upper cervical spinal cord and right chest cavity consistent with traumatic injuries sustained in a high velocity motor collision.

88. Consistent with the evidence, the Autopsy Certificate notes the cause of death due to multiple injuries from a motor vehicle collision as a passenger.

Wyatt James McLeod

89. The Toxicology Report for Wyatt showed unremarkable items detected or nontoxic items detected.

90. Although Wyatt's body was consumed by fire at the scene, and the CT scans did not enable clear identification of antemortem injuries, a posterior dislocation of the right hip was considered compatible with traumatic injury. An acute brain injury was confirmed and considered evidence of a traumatic brain injury. There was no evidence of soot within the upper or lower airways to indicate that he was alive at the onset of the fire.

91. Consistent with the evidence, the Autopsy Certificate notes the cause of death was due to multiple injuries from a motor vehicle collision as a passenger.

Zaidok John Sampson McLeod

92. The Toxicology Report for Zaidok showed unremarkable items detected or nontoxic items detected.

93. Although Zaidok's body was consumed by fire at the scene, and the CT scans did not enable clear identification of antemortem injuries, a possible sacral ala fracture adjacent to the sacroiliac joint was identified. There was evidence of recent traumatic intra-abdominal injury including extensive laceration of the liver and spleen with collections of blood within the abdominal cavity, consistent with traumatic injury prior to death. There was no evidence of soot within the upper or lower airways to indicate that he was alive at the onset of the fire.

94. Consistent with the evidence, the Autopsy Certificate notes the cause of death due to multiple injuries from a motor vehicle collision as a passenger.

EVIDENCE ON THE ISSUES

Ms McLeod's Mental Health

95. Ms McLeod had a complex and longstanding mental health history. Her contact with Queensland Mental Health Services was extensive and commenced when she was 15 years old.

96. It is necessary to detail Ms McLeod's mental history to obtain a full picture of the complex nature of her mental health issues.

97. In setting out details of Ms McLeod's mental health history I have relied on the summaries of the evidence as contained in the submissions of Counsel Assisting, Wide Bay Hospital and Health Service (WBHHS), and West Moreton Hospital and Health Service (WMHHS), and of Queensland Health Office of the Chief Psychiatrist. (QHOCP) A combination of these submissions, in my view, accurately sets out the evidence concerning Ms McLeod's mental health history interactions and diagnosis.

98. Dr Mohammed Sabry, Clinical Director of Wide Bay Mental Health and Specialised Services, provided a report detailing the clinical history diagnosis and treatment provided to Ms McLeod by the WBHHS.

99. Dr Sabry explained in his statement that he did not know Ms McLeod personally and was not her treating clinician but had reviewed her or consulted about her treatment on the odd occasion. Dr Sabry said that he had reviewed the complete copy of Ms McLeod's voluminous clinical records held by WBHHS which dated back to January 1999.

100. He details Ms McLeod's history as follows:

Wide Bay Mental Health Service – January 1999 to April 2007

101. Ms McLeod was first admitted to WBMHS Inpatient Unit in or around January 1999. This was in the context of a medication overdose.

102. On 15 April 2001 Ms McLeod presented to Hervey Bay Hospital's Emergency Department and was diagnosed with adjustment disorder with depressed mood, bulimia nervosa/anorexia, and Borderline Personality Disorder (BPD) traits.

103. Between 2001 and 2007 Ms McLeod frequently presented to the WBMHS with episodes of emotional dysregulation, associated with self-harming behaviours and suicidal ideation and intent. Depending upon the severity of Ms McLeod's presenting symptoms, her diagnosis included:
    (a) Adjustment disorder
    (b) Eating disorder
    (c) Anorexia nervosa
    (d) Anhedonia
    (e) Depression
    (f) Major depressive episode
    (g) Chronic suicidal ideation
    (h) Cluster B personality
    (i) Axis II traits
    (j) BPD traits: and
    (k) BPD

104. On 27 September 2006 Ms McLeod appeared to have first reported auditory hallucinations. During this and subsequent presentations, Ms McLeod reported she was hearing the voices of animals, males, demons, God and the devil encouraging her to harm or kill herself. Ms McLeod was discharged from WBMHS on 10 April 2007.

Mercy Ministries Sunshine Coast – April 2007 to July 2008

105. Sometime between April 2007 and July 2008 Ms McLeod was in the care of Mercy Ministries.

Wide Bay Mental Health Service – July 2008 to November 2009

106. On 18 July 2008 Ms McLeod's primary diagnosis of Borderline Personality Disorder appears to have first been questioned, with investigations commenced into the possibility of a bipolar disorder diagnosis on a history of hyperactivity, and auditory and visual hallucinations. She was admitted to the WBMHS Inpatient Unit under an ITO. During this and subsequent presentations, Ms McLeod reported suffering from visual hallucinations, including seeing people standing against the wall, a giraffe in her car, and aliens landing in a tree.

107. From 20 July 2008 to 24 July 2008, Ms McLeod was readmitted to the WBMHS Inpatient Unit under an ITO with an ongoing queried diagnosis of bipolar disorder. Investigations into an alternative diagnosis of bipolar disorder continued throughout Ms McLeod's presentations to the WBMHS in August, September, and October 2008. On 15 October 2008 Ms McLeod presented to the Hervey Bay Hospital ED with a principal diagnosis of depression and suicidal ideation, and an additional diagnosis of cluster B personality disorder. A psychotic illness was also queried. She remained overnight in the ED and was for further review on 18 October 2008.

108. On review Ms McLeod was admitted to the WBMHS Inpatient Unit in the context of a depressive episode, associated with suicidal ideation, interrupted sleep, poor appetite, agitated behaviour, and self-reports of reading the minds of animals which were telling her to kill herself. Having been admitted under an ITO, an additional diagnosis of schizo-affective disorder was investigated.

109. During her hospitalisation Ms McLeod suffered emotional dysregulation associated with self-harm and required admissions to the High Dependency Unit (HDU), resulting in multiple changes to her medication dosages. The treating doctor was of the impression Ms McLeod was experiencing a depressive phase of her illness with psychotic features and did not believe that her axis II personality was playing a major part in her symptoms, acknowledging though, it may have been a minor contributor.

110. Ms McLeod absconded on 28 October 2008 and on 31 October 2008. On each occasion she was returned under Warrant by Queensland Police Service and Queensland Ambulance Service. At the time of discharge on 3 November 2008 Ms McLeod's ITO was revoked and she was to receive follow-up care in the community.

111. During November 2008, Ms McLeod continued to report suffering auditory hallucinations. On 13 November 2008, Ms McLeod was in a crisis situation with suicidal intent, and an ITO was invoked with QPS in attendance. Her principal diagnosis during this admission was bipolar disorder, with consideration given to a schizo-affective disorder, cluster B personality and Borderline Personality Disorder.

112. Ms McLeod was reviewed in the HDU after having escaped from hospital. She was having command hallucinations telling her to kill herself. It was thought she may have had a psychosis which was not responding to antipsychotic treatment.

113. A second opinion was obtained on 5 December 2008. The working diagnosis was mood disorder, bipolar spectrum, and axis II-cluster B traits. Ms McLeod's medication was adjusted.

114. On 11 December 2008 Ms McLeod reported her condition had improved significantly. After family meetings in December 2008, it was determined her husband Mr McLeod was to take responsibility for Ms McLeod's medications on discharge to improve her compliance.

115. Following her discharge in December through to February 2009 Ms McLeod reported a reduction in her auditory hallucinations. Most of Ms McLeod's care was facilitated in the community, with occasional Hervey Bay Hospital ED admissions in the context of suicidal ideation and medication overdose. Ms McLeod's working diagnosis at that point were Borderline Personality Disorder, bipolar disorder-spectrum, mood disorder, axis II-cluster B traits, and schizophrenia disorder.

116. In March 2009 Ms McLeod reported some suicidal and homicidal ideation associated with increased auditory hallucinations, resulting in multiple Hervey Bay Hospital ED presentations. Her primary diagnosis during these admissions was Borderline Personality Disorder.

117. In April 2009 Ms McLeod experienced a crisis situation for which she received care in the community. Her mental health care throughout May 2009 was facilitated within the community.

118. In June 2009, Ms McLeod began to query whether her medications were working effectively. She reported having separated from her husband and was associated with suicidal ideation and a resultant presentation to the Hervey Bay Hospital ED in the context of a medication overdose.

119. On 6 July 2009, Ms McLeod signed a management plan. It notes she and Mr McLeod were separated at the time but that she wanted to develop a level of stability in her life to start a family with Mr McLeod. While her clinical condition was under control, she found it difficult to manage increased levels of stress with adaptive coping strategies. She frequently presented to the ED with stress-related suicidal thoughts, overdoses or under the influence of substances. The management plan was to try and help Ms McLeod manage her own mental health. The plan set out treatment, coping strategies, crisis strategies and a crisis response.

120. In August 2009 Ms McLeod reported she was applying for an annulment from her husband. This was due to having lacked the necessary mental capacity to make an informed decision when she consented to their marriage.

121. Ms McLeod experienced suicidal ideation and was admitted to WBMHS Inpatient Unit for a 24-hour respite, on a diagnosis of schizo-affective disorder as an axis I diagnosis. She was admitted to the Bundaberg Mental Health Unit and discharged on 28 August 2009.

122. In September 2009 Ms McLeod identified her main psychosocial stresses contributing to her recent crisis was conflict with her stepfather and frequent fights with Mr McLeod and a possible divorce. She also reported concerns regarding a perceived breach of her confidentiality by WBMHS.

123. Ms McLeod decided as the result she didn't want to receive any care through WBMHS. Ms McLeod admitted to missing two doses of her medication, which she refused to recommence despite stating she was hearing voices and experiencing suicidal ideation. She was brought in via QAS in the context of voiced suicidal intent, hyperactivity and auditory hallucinations, and was voluntarily admitted to WMBHS Inpatient Unit. She was admitted under an ITO to the unit in the context of an attempted hanging in response to domestic problems and having acted on the "voice of God". - [Not for publication]. Her ITO was revoked on 21 September 2009. She was discharged into the community to follow up with a mental health case manager.

124. On 8 October 2009 Ms McLeod was admitted to Hervey Bay Hospital's Intensive Care Unit in the context of an overdose reportedly following an argument with her husband. On admission, her previous medical history of bipolar disorder and Borderline Personality Disorder was noted. She absconded on 9 October 2009 and was returned by QPS to the ICU.

125. Ms McLeod's care was transferred back to the community where she continued to report her relationship with her family and husband were ongoing stresses.

126. On 13 October 2009, Ms McLeod presented to the Hervey Bay Hospital ED in the context of self-harm as a result of having been notified of her aunt's or friend's death which triggered memories of her childhood sexual assault. It was determined that Ms McLeod's actions did not fulfil the criteria for an actual suicide attempt and her ongoing risk was low, acknowledging her chronic self-harm risk. The principal diagnosis was of situational crisis, with bipolar disorder and Borderline Personality Disorder noted as her additional diagnosis. She was discharged back into the care of her sister, with ongoing case manager support.

127. On 20 October 2009 Ms McLeod presented to Hervey Bay Hospital's ED in the context of an overdose. She reported a telephone conversation with her mother caused the impulsive act. Her principal diagnosis of situational crisis was noted, with bipolar disorder and Borderline Personality Disorder an additional diagnosis. She was discharged on 21 October 2009 for case manager support.

128. Ms McLeod continued to receive care in the community receiving daily dispensing of her medications.

129. On 27 October 2009 Ms McLeod telephoned her case manager to advise she had overdosed. She self-presented to Hervey Bay Hospital. She absconded once medically cleared and notified her case manager of the same, who notified the ED.

130. On 29 October 2009 Ms McLeod presented to Hervey Bay Hospital's ED in the context of another overdose. She was medically cleared and discharged into her case manager's care.

131. Ms McLeod continued to receive care in the community with one occurrence of having been brought in by QPS due to a text message she sent to her husband. She then moved to Ipswich.

132. On 18 November 2009 Ms McLeod was discharged from WBMHS. Her principal diagnosis was bipolar spectrum disorder, with Borderline Personality Disorder as her additional diagnosis.

West Moreton Mental Health Service – 23 November 2009 to 20 June 2012

133. Ms McLeod attempted suicide on 23 November 2009 which resulted in her engagement with WMHHS.

134. Dr Alan Drummond, a Consultant Psychiatrist with West Moreton Hospital and Health Services, provided a statement setting out Ms McLeod's interactions with that health service. He explained that Ms McLeod first engaged with that health service in February 1999 when she was 15 years of age. At that time, she presented with low self-esteem issues and anxiety symptoms. She subsequently disclosed sexual assault by her mother's partners. She also disclosed suicidal ideations.

135. At that time the diagnosis was adjustment disorder with mixed emotions, post-traumatic stress disorder, phobia. The treatment plan included to continue sessions occupational therapy and referral for self-esteem in liaison with her school. Ms McLeod's next interaction with WMHHS was in 2009 when she moved to Ipswich.

136. WBMHS provided WMHHS with a copy of Ms McLeod's management plan. The management plan indicated her diagnosis was bipolar spectrum disorder and Borderline Personality Disorder with weekly appointments with her case manager, six weekly appointments with a psychiatrist, and regular appointments with her psychologist, and weekly to fortnightly appointments with a centre care support worker. She was only to use her GP for matters that were unrelated to mental health. The plan indicated Ms McLeod had the ability to utilise 24- to 48-hour admissions to mental health unit if needed. It advised her discharge medication.

137. On the 23 November 2009 Ms McLeod attempted suicide by an intentional overdose of medication. She was admitted to the Ipswich General Hospital Intensive Care Unit and subsequently transferred to the general ward. On 24 November 2009 she self-discharged against medical advice prior to being seen by a medical team.

138. Between the 26 November 2009 and 27 January 2010, the following occurred:-

- Involuntary admission to High Dependency Unit
  - (a) Ms McLeod had told her GP that she had had an argument with Mr McLeod and that she intended to suicide by hanging. The GP called QAS, who attended and transported her to the emergency department under an EAA. She was admitted to the mental health unit, initially to the high dependency unit. Whilst admitted to the HDU she advised that she was hearing commands and seeing hallucinations from animals telling her to kill herself. She was initially treated by Consultant Psychiatrist Dr Scott. Dr Scott's opinion was that Ms McLeod suffered from Borderline Personality Disorder but also suffered from schizophrenia as she reported auditory hallucinations of voices outside her head which she believed were from animals talking to her. He noted that Ms McLeod would have a lot of secondary gain in reporting these symptoms as it helped her to elicit care, but he was of the opinion it was more likely that she was genuinely suffering from these symptoms. He discussed a treatment plan with her of commencing Clozapine, a medication used for treating resistant schizophrenia. Dr Drummond, who took over Ms McLeod's care, agreed with this opinion and continued this treatment plan.
  - (b) On the 22 December 2009 Ms McLeod was found with a plastic bag over her head. She said she intended to suicide. She was given medication.
  - (c) 23 December 2009 Ms McLeod was again found with a plastic bag over her head attempting to suffocate. She was then under constant observation.

- On 27 January 2010 Ms McLeod was discharged from the mental health unit. Her diagnosis was schizophrenia disorder and a Borderline Personality Disorder. She was discharged on Clozapine with weekly follow-up reviews. Because she was on the drug Clozapine, she was required to attend a Clozapine Clinic.

139. As per her management plan she engaged with Goodna Community Mental Health, who discussed with her how they would support her by doing home visits and follow-up calls. During February 2010 there were nil concerns. Ms McLeod attended her Clozapine Clinic appointments and engaged with home services.

140. On the 17 March 2010 Ms McLeod presented to emergency department with Mr McLeod after he contacted the Crisis Line due to Ms McLeod's increased suicidal ideation. She said that she was having ongoing conflict with Mr McLeod which meant she had difficulty coping. She was having auditory hallucinations, and she was being told to kill herself. She was given medication, Olanzapine.

141. Ms McLeod indicated that she was feeling better, the voices were now muffled, and she was happy to go home.

142. On 18 March a follow-up home visit was completed by her case manager, no concerns were noted.

143. During March 2010 the same pattern continued with no concerns being noted. The same pattern continued during April and May 2010, where home visits were completed without concerns.

144. On the 8 June 2010 Ms McLeod attended her weekly session advising that she intended to overdose on Clozapine. She was admitted to IGHMHU. Upon release on 10 June 2010 Ms McLeod's supply of Clozapine was restricted to one week's supply.

145. On 18 June Ms McLeod's case manager reported that Ms McLeod said the auditory hallucinations were greatly diminished and were not troubling her at the time. She had good insight into her illness early warning signs and strategies needed to cope under stress. Ms McLeod continued with no incidents.

146. On 2 November 2010 Ms McLeod contacted her case manager advising that she was having auditory hallucinations, being told to overdose on her medication. She said she thought she was able to manage and stay safe.

147. On 11 November Mr McLeod called Ms McLeod's case manager concerned about Ms McLeod's suicidal ideations. He was told to call an ambulance or take her to the ED if he had further concerned. Daily phone calls were made by her case manager after this, where Ms McLeod reported decreasing anxiety and denied self-harm thoughts.

148. During November Ms McLeod reported feeling more depressed, had a slight increase in auditory hallucinations, but denied any suicidal or homicidal ideations. Her antidepressant dose was increased.

149. On 1 December 2010 Ms McLeod collapsed on the floor of the chemist. She was transported to the emergency department where she was examined. She told staff she was seeing bats in the room. She was given Olanzapine and appeared to calm.

150. On 2 December Dr Drummond saw her. Her mental state had improved. Her husband was happy for her to be discharged into his care.

151. On 9 February 2011 Mr McLeod called the hospital to advise that Ms McLeod was upset as a friend had suicided, and she had suicidal thoughts again. The next day a home visit was conducted with her. Ms McLeod denied suicidal ideation and said she was able to distract herself from auditory voices.

152. Dr Drummond reviewed her on 15 February 2011. She had experienced increased suicidal thoughts and auditory hallucinations in the context of the stresses of her grandfather's death and the unexpected suicide of a friend. She was receiving counselling. Her mood improved during the session, and she was confident of managing her distress with support from Mr McLeod. She was receiving daily dispensation of medicines. In March her condition continued to be of nil concern, and she was permitted again to change to weekly dispensation of medications.

153. In June 2011 it was noted in mental health records that she was engaging well with case management and treatment and reported medication compliance. The risks were recorded as low.

154. In January 2012 it was noted again that Ms McLeod was engaging well with case management and treatment and medication compliance. It was also noted Ms McLeod a had found out that she was pregnant and that she and Mr McLeod were happy about that.

155. In February 2012 Ms McLeod presented to the Goodna Clinic advising that she was suffering auditory hallucinations of animal voices telling her to kill herself. She was voluntarily admitted at this stage to IGHMHU. A diagnosis was Paranoid schizophrenia and Borderline Personality Disorder. Upon her discharge her medication was amended to Clozapine 100 milligrams in the morning and 300 milligrams at night.

156. In June 2012 Ms McLeod was relocating back to the Fraser Coast and an AMHS referral was forwarded to Fraser Coast IMH.

Wide Bay Mental Health Service – 21 June 2012 to 27 August 2014

157. Dr Sabry explained that Ms McLeod's mental healthcare was voluntarily transferred back to WBMHS upon her return to Hervey Bay. The intention was that she was to follow up with the Clozapine Clinic on a monthly basis.

158. On 21 June 2012 Ms McLeod was seen in the Clozapine Clinic. Her diagnosis was noted as schizophrenia and Borderline Personality Disorder. She was four months pregnant. She reported she had a good improvement in her mental health since commencing Clozapine. She said this included a decrease in suicidal ideation, decrease in anxiety, improved mood, decrease in oral hallucinations, and a decrease in thought disorder. Mr McLeod and Ms McLeod were both aware of the risk of continuing Clozapine during her pregnancy but decided the risk versus the benefit ratio outweighed ceasing it.

159. On 19 July 2012 Ms McLeod was reviewed by the consultant psychiatrist. She said she believed Borderline Personality Disorder was a misdiagnosis. She continued to be seen monthly in the Clozapine Clinic.

160. On 5 October 2012 Ms McLeod and Mr McLeod and their five-week-old baby presented to WBMHS. Ms McLeod reported having visual hallucinations of animals along with some paranoia.

161. On 12 October 2012 Ms McLeod was reviewed by a psychiatrist. She continued to report hearing voices, and that they were saying that bad things would happen. It was

thought she was having breakthrough auditory hallucinations and low mood with identified risk. A medication was added.

162. On 18 October 2012 Ms McLeod was still reporting hearing derogatory auditory hallucinations telling her to hurt herself or others, but they were kept under control if she kept busy. She was to continue her current treatment and put down for further review.

163. On 13 December 2012 during a consultation in the Clozapine Clinic, Ms McLeod disclosed she was pregnant. The pros and cons of staying on Clozapine were again discussed. It was agreed to continue her current treatment.

164. On 18 May 2013 Ms McLeod was admitted to the Maryborough Mental Health Unit with worsening auditory hallucinations in the context of ongoing stress at home with Mr McLeod. She said Mr McLeod had agreed to stop drinking, and she no longer wanted to harm herself. A safety plan was put in place, and she was discharged on 19 May 2013.

165. On 6 September 2013 Ms McLeod was admitted to the Maryborough Mental Health Unit as a voluntary patient. She reported increased anxiety, tearfulness, and a lack of energy and motivation. She was hearing negative voices. She was having strong suicidal thoughts. She was discharged on 12 September 2013. Ms McLeod continued to be reviewed regularly in the community and in the Clozapine Clinic. She had some improvement in her mood and in coping with the stresses at home.

166. In November 2013 Dr Gilbert, who had been regularly reviewing Ms McLeod, was questioning her diagnosis of schizophrenia because Ms McLeod had only reported voices following conflict with Mr McLeod and when in situational crisis.

167. On 5 December 2013 Ms McLeod presented to the ED after an unintended overdose of medication. She reported relationship issues and family stress.

168. On 23 December 2013 Ms McLeod confirmed she was three weeks pregnant (her third pregnancy since February 2012). She was advised to have a medication review.

169. On 3 January 2014 she was reviewed by a psychiatrist. Her antidepressants were withdrawn after discovering she was pregnant. She remained on 400 milligrams of Clozapine. She continued to report visual hallucinations of animals.

170. On 31 January 2014 Ms McLeod was seen by her case manager. She said that she was back with Mr McLeod on the basis he stopped using Cannabis. She was given options of couples counselling and to see a psychologist.

171. On 28 February 2014 Ms McLeod was seen by her case manager. A reduction in Clozapine was discussed given her level of wellness. Ms McLeod was considering the long-term effects of metabolic syndrome and cardiac conditions (potential consequence of Clozapine use). She was willing to slowly reduce Clozapine during her pregnancy and discuss alternative medications. She acknowledged stability in recent years.

172. On 11 April 2014 Ms McLeod reported to her case manager her mood was stable, and she was coping. Her and Mr McLeod were attending marriage counselling and she had reduced her contact with her case manager as she was feeling well.

173. On 20 May 2014 a review team led by Dr Gilbert noted that Ms McLeod remained attached to a diagnosis of schizophrenia when there was little in the way of evidence. Dr Gilbert recorded moving towards considering alternatives to schizophrenia and to review after the birth of her third child.

174. In or around August 2014 Ms McLeod and Mr McLeod had decided to move to Bribie Island. Her case manager did the transfer on Clozapine Patient Monitoring System and a referral to the local team was to be made through the acute care team. Her third child was born on 19 August 2014.

175. On 1 September 2014 the case manager noted that Ms McLeod was stable and symptom free. She was to contact her local MHS on arrival to Bribie Island.

176. In December 2014 Ms McLeod was admitted to hospital with an increase in voices after a fallout with her parents and siblings.

177. In October 2015 Ms McLeod returned to Hervey Bay and her mental health care was voluntarily transferred back to WBMHS. She was immediately linked to a case manager and a Clozapine Clinic nurse through Wide Bay's Hervey Bay Continuing Care Team (CCT). She was utilising self-helping techniques including distraction and cognitive behavioural techniques during times of distress.

178. She attended regular appointments with her case manager to work through and problem solve mental health challenges whilst attending monthly appointments in the Clozapine Clinic.

179. On 4 January 2016 Ms McLeod was admitted to the Inpatient Unit under an ITO in the context of an impulsive Diazepam overdose in response to command auditory hallucinations and distressing psychotic symptoms. It was noted she was experiencing financial issues and was feeling overwhelmed with the care of the children. She continued to complain of voices and required a stay in the HDU after punching a wall and injuring her hand.

180. On 19 January 2016 Ms McLeod reported the voices had lessened, her mood had improved, and she was feeling motivated. Graduated leave was arranged with a longer-term plan for Ms McLeod to commence dialectical behaviour therapy through her General Practitioner under a mental health assistant plan. She was discharged on 22 January 2016.

181. On that date an approval was given for an amendment to her ITO Category 2 "Community" in the context of her being assessed as stable and willing to continue her treatment and therapy in the community. Ms McLeod recovered well from the admission and continued to access community supports with some episodes of emotional dysregulation, associated with an increase in her reported hallucinations, managed successfully with no major disruption or further admission to the inpatient unit.

182. On 3 February 2016 her ITO was revoked. She was assessed as being compliant with her medication, aware of how to seek help, insightful into the need to receive help, and was assessed at being of no immediate risk.

183. On 26 February 2016 Ms McLeod was contacted by a registered nurse. She said she was four weeks pregnant and that her relationship was going well, with her husband being more supportive. There was a plan made to reduce her Clozapine and a case manager was allocated to support her.

184. On 24 March 2016 Ms McLeod attended her monthly appointment at the Clozapine Clinic. She reported hearing occasional voices but was not distressed. She reported experiencing palpitations. It is reported she self-reduced Clozapine, but she had been instructed to do this by a nurse. She was to continue the reduced dose of Clozapine and other adjustments were made to her medications.

185. On 31 March 2016 Ms McLeod was reviewed. An ECG showed her QTCs (interval between the Q wave and the end of the T wave) was 46, and she had had no further palpitations or other side-effects. She was to continue on prescribed medication.

186. In May 2016 Ms McLeod self-reduced her Clozapine from 400 milligrams down to 300 milligrams as she was concerned of the effects of the medication on her baby.

187. On 21 May 2016 to mitigate her risk to self, Ms McLeod was admitted to the WBMHS Inpatient under an ITO in the context of intense emotional dysregulation and an increase in the intensity of the animal voices telling her to kill herself.

188. Ms McLeod's Clozapine dosage was adjusted back to 500 milligrams during the admission.

189. On 24 May 2016 an assessment of Ms McLeod was requested in response to her demands for discharge. She was still reporting commanding auditory hallucinations telling her to kill herself. She was continuing to exhibit a lack of insight into her safety and wellbeing. She was 17 weeks pregnant.

190. On 25 May 2016 Ms McLeod's ITO was revoked and she was discharged on 7 June 2016.

191. On 29 June and 17 July 2016 Ms McLeod had overnight stays in the ED with reported increase in voices. She was discharged on each occasion.

192. On 24 October 2016 Ms McLeod gave birth to her fourth child, who needed medical attention in Brisbane. Ms McLeod's family was split between Hervey Bay and Brisbane.

193. On 17 November 2016 Ms McLeod was noted to be stable on her medications with no side-effects. She was to continue Clozapine 400 milligrams. Ms McLeod advised she wished to reduce the dose; the plan was to transfer her to the Maryborough Mental Health Unit.

194. On 20 November 2016, due to Ms McLeod's reports of commanding auditory and visual hallucinations and threats of committing suicide, she was admitted to WBMHS Inpatient Unit.

195. On 22 November 2016 an ITO was authorised to mitigate her risk of serious physical and mental deterioration. An ECG showed a concerning QTC result, and Ms McLeod's Clozapine was reduced to 300 milligrams per day.

196. On 1 December 2016 it was noted Ms McLeod's ECG showed a QTC of 528. The treating team consulted a pharmacist, and it was decided to further reduce her Clozapine by 100 milligrams.

197. On 2 December 2016 Ms McLeod's ITO was revoked by Dr Amish Jagad, as she had capacity and insight and had agreed to comply with treatment for her mental illness. She was discharged and was to have the ECHO as an outpatient.

198. On 3 December 2016 Ms McLeod presented to the Hervey Bay Hospital ED in the context of her inability to cope and reports of ongoing animal voices telling her to kill herself and resultant suicidal ideation.

199. She was readmitted to the WBMHS Inpatient Unit under an ITO on 3 December 2016.

200. On 6 December 2016 the ITO was revoked as she had gained insight and capacity. Her Clozapine was ceased.

201. The reason for ceasing Ms McLeod's Clozapine on 6 December 2016 is outlined in detail by Dr Padhi in his statement. He also gave oral evidence at the Inquest. His evidence was that there were several investigations, including consultation with the cardiologist and discussions with Ms McLeod and Mr McLeod.

202. He said following the outpatient appointment on the 17 November 2016, Ms McLeod presented to the ED on 20 November 2016 threatening to take Clozapine overdose. She was admitted to Maryborough Hospital on the same day and that during this admission several ECGs were done and it was noted that her QTC interval was progressively increasing. He said prolonged QTC interval can cause fast, chaotic heartbeats, and an increased duration of above 500 is associated with life threatening arrhythmia. He said Ms McLeod was on two antipsychotics and two antidepressants, which in his view was contributing to her prolonged QTC interval. He also had concerns about low white blood cell count. He said Ms McLeod also complained of chest pain during the period and various investigations were done.

203. He said that due to the abnormal ECG and blood results, the findings were discussed with Ms McLeod, and her Clozapine was gradually tapered initially from 400 milligrams to 300 milligrams, and thereafter to 200 milligrams. He said Ms McLeod and Mr McLeod were at all times informed of the investigations being done and the rationale for reducing Clozapine during the admission. During the admission the dose of other antipsychotic medication was ceased and reduced to optimise her medications and to prevent further physical complications.

204. He said Ms McLeod's care and medication changes were also discussed in the ward round on 23 November 2016 with the pharmacist and inpatient nurse unit manager and team leader for the mental health service.

205. He said at the point of discharge she was on Clozapine 200 milligrams, Fluoxetine 400 milligrams, and Mirtazapine 30 milligrams. The discharge summary of the admission between 20 November 2016 and 2nd December 2016 was sent to her referring GP, Dr Abdel-Malek.

206. Ms McLeod was admitted to the High Dependency Unit at Maryborough Hospital on 3 December 2016 with worsening mental health and suicidal thoughts.

207. Dr Padhi said he reviewed Ms McLeod on 6 December 2016 and she reported that she could hear voices, but failed to elaborate, and was vague and inconsistent in her description. She was informed of her blood results and discussion was had regarding the risk of being on Clozapine.

208. Dr Padhi said that before seeing Ms McLeod he had discussions with the Clinical Director, Dr Ramsden. He said he requested Dr Ramsden to offer a second opinion.

209. Dr Ramsden met with Ms McLeod and Mr McLeod on the 6 December 2016. Dr Ramsden, he said, did not find any evidence of delusional beliefs, disordered thoughts or any other psychotic features, and concluded that Ms McLeod's reported hallucinations were mood related. He said Dr Ramsden's opinion was that Ms McLeod had major depression, moderate recurrent dysthymia and Borderline Personality Disorder. Dr Ramsden suggested that an antidepressant would be the medication of choice with a small dose of antipsychotic to address the ego-dystonic hallucinations which presented upon stresses.

210. Dr Padhi said he ceased Ms McLeod's Clozapine medication on the 6 December 2016, but she was maintained on a small dose of antipsychotic Olanzapine.

211. In oral evidence, Dr Ramsden maintained that it was Dr Padhi's decision and responsibility to determine Ms McLeod's diagnosis and treatment. As the treating consultant it was his diagnosis to make. Dr Padhi determined a diagnosis of mixed anxiety and depression with Borderline Personality Disorder.

212. Dr Padhi said he reviewed Ms McLeod on 13 December 2016 after her return to hospital from leave. Ms McLeod reported worsening of voices, but also admitted to using Cannabis whilst on leave. She said she wanted to be on Risperidone instead of Olanzapine as she felt the voices were getting worse. He agreed to switch the antipsychotic and she was put on a small regular dose of Risperidone.

213. He said by 16 December 2016 Ms McLeod had settled and her antipsychotic had been regularised. She was also prescribed Olanzapine to be taken in crisis only. Dr Padhi said Ms McLeod's past threats of self-harm, her specific threat of taking an overdose of Clozapine, her presenting symptoms and psychopathology, the second opinion from Dr Ramsden, along with Ms McLeod's abnormal investigation results, were taken into consideration during the reduction and cessation of her medications.

214. He said her medication on discharge on 16 December 2016 was Fluoxetine, Risperidone and Olanzapine.

215. Ms McLeod was brought to the emergency department by Police on 19 December 2016 after she had absconded from her house having made threats to harm herself. Dr Padhi reviewed her on 20 December 2016 and noted there were no psychotic features, and she was settled. Her care was discussed at the ward round on December 2016, which was also attended by Dr Ramsden, the pharmacist, and also a registered nurse, and the leader of the HBCMH to facilitate Ms McLeod's safe discharge into the community. She was on day leave and returned on 23 December 2016 with Mr McLeod. They both reported that the leave had gone well, and they were happy for Ms McLeod to be discharged back into community care. The recommendation at the point of discharge was for the Acute Care Team to follow up and a case manager to be allocated from HBCMH.

216. Ms McLeod was referred to the ACT (Acute Care Team) at Hervey Bay. She was followed up by clinicians on 28 December 2016, 4 January 2017, and 27 January 2017. Though the records indicate at those times she was relatively stable other than some difficulties in sleep and energy levels. There were no acute symptoms suggestive of psychosis.

217. Dr Padhi reviewed Ms McLeod on 1 February 2017. During his review Ms McLeod was stable in her mental health. Her relationship difficulties, which in the past had been a trigger to her presentations, had improved. Ms McLeod had, through the pastoral service, been referred to marriage counselling. She was futuristic and informed Dr Padhi that she intended to complete her childcare course and wanted a supporting letter. In terms of mental state, she was well kept with no evidence of psychomotor retardation-agitation. Her speech was spontaneous, goal directed and logical. She did not have clinical symptoms of depression. There was no active or passive suicidal or self-harm thoughts, intent or plans. There were no thoughts of harming others. She stated that "*the voices are all gone*", and there was no evidence of any psychotic features. She did not complain of any side-effects from the medications.

218. He suggested she be transferred from the ACT and should be allocated a case manager. The plan was to transfer her care eventually to the continuing care team, and

gradually transition her care to the GP. He reiterated to her the crisis contacts that were available to her in the community in the event of crisis and made a follow-up appointment.

219. Dr Padhi said that Ms McLeod approached her case manager in Hervey Bay Mental Health Service on 24 February 2017 stating she felt under-serviced by HBMHS. She inquired about case manager allocation and expressed her desire to be followed up by the Maryborough Mental Health Service.

220. She remained certain that she would not like to be followed up by HBMHS. She was accepting of a transition to GP care following the transfer of her care to MBMHS. She said she was happy with her current medications.

221. MBMHS were subsequently informed that Ms McLeod's care could not be transferred to MBMHS.

222. A Mental Health Case review was held on 24 March 2017 to discuss Ms McLeod's future care. Dr Padhi said that was a multidisciplinary case review attended by case managers, junior doctors and the team leaders. He attended this review and was informed of the discussion around her transfer of care and that her care could not be transferred to MBMHS and noted Ms McLeod's reluctance to continue with HBMHS. During the case review discussion, it was mentioned that Ms McLeod and her husband were happy to have minimal contact with the services unless the situation deteriorated. He was informed that Ms MacLeod was aware of her crisis plan and contact details. During that case review a decision was made to discharge Ms McLeod to the care of her GP.

223. Dr Padhi said there were limited options, given that Ms McLeod's care could not be transferred to MBMHS, and she was reluctant to continue with HBMHS. He said the decision to discharge was made on the considerations that Ms McLeod was a voluntary patient and did not meet the criteria for involuntary treatment order. She was relatively stable since her discharge from hospital on 23 December 2016, and her husband was supporting her with the children. In her last review she had responded well to the medication and was happy with it. She was on two regular medications and no longer on a complex polypharmacy regime. She did not report any side-effects from the medication. She had not reported any recent thoughts of self-harm or harm to others.

Wide Bay Mental Health Service – 16 May 2017 to 30 June 2017

224. During the period of May 2017 to 30 June 2017 Ms McLeod had interactions with Wide Bay Mental Health Services.

225. On 24 April 2017 Ms McLeod’s GP referred her to WBMHS for a review of her antipsychotic medications, during this period, she had a very unsettled.

226. On 16 May 2017 she was reviewed by a psychotic registrar from the Community Mental Health which records, quote, “*Ms McLeod reported that she has been doing reasonale (sic) well. Said that she feels good most of the times and is well supported by her husband. Told me that mental health wise her mood was pretty, has been pretty stable. Does not feel anxious most of the time. Denied hearing any voices and said that she has been off drugs since a few months now*.”

227. During the mental state examination, Ms McLeod was noted to have no perceptual disturbances. A plan was developed to gradually adjust her medications due to the side effects of Risperidone. She was to commence a different antipsychotic medication,

Aripiprazole. She had some concerns about the medication as it had not assisted her symptoms in the past. She was encouraged to call if she felt unwell.

228. On 20 May 2017 Ms McLeod presented to Hervey Bay Hospital's ED reporting suicidal thoughts and auditory and visual hallucinations. She was discharged home. She phoned later that evening reporting she was still unsettled, and she agreed to present. The plan was for Ms McLeod to be admitted to WBMHS acute inpatient unit in crisis. During the episode of care Ms McLeod was diagnosed with emotionally unstable personality disorder, borderline type and obsessive-compulsive disorder. Her prescription of Risperidone was ceased due to the side-effects and her dose of Aripiprazole was increased and her antidepressant increased.

229. Ms McLeod was permitted day leave with her husband on 26, 27 May. Family arguments on the second day caused Ms McLeod's mental health to deteriorate. She was adamant she wanted to be discharged.

230. On 29 May 2017 Dr Zhang assessed her mental state as being stable and her risk to self and others as low. She met the criteria for overnight leave. Ms McLeod reported the overnight leave was going well. Her mental state stabilised. She was discharged on 30 May 2017. That afternoon she telephoned her case manager, reporting ongoing auditory hallucinations, feeling anxious and agitated.

231. Later that evening Mr McLeod called the QAS to collect Ms McLeod for inpatient admission. Ms McLeod attended Marlborough Hospital ED with QAS but left after six minutes.

232. On the 31 May 2017 Ms McLeod and Mr McLeod attended a face-to-face appointment. She reported she was not at her best and the animals were annoying her, she had recurrent suicidal thoughts. A mental state examination was conducted, it was noted cluster B personality traits with no objective evidence of psychosis or pervasive disorder of mood. Taking into account current presentation, recent admission, and past history of trauma and underlying personality structure, readmission to hospital is unlikely to be beneficial for Ms McLeod. Least restrictive option of care would be for her to be followed up in the community, although there exists a chronic risk of self-harm.

233. On 1 June 2017 Ms McLeod was brought to Hervey Bay Hospital's ED after a confrontation at a pharmacy when attempting to purchase 100 tablets of Paracetamol. Ms McLeod had said she wanted to kill herself. She met the criteria for assessment under the Mental Health Act and a further mental state examination was conducted on the 2 June. She was reviewed, she said she was feeling safe and able to be discharged home. She was not making any threats of suicide and denied current suicidal ideation and no intent to harm herself or anyone else.

234. Mr McLeod was contacted, he declined to take responsibility for Ms McLeod and voiced significant concern regarding her suicidal ideation. She was further assessed with a multidisciplinary plan team and a plan was developed on 2 June. The family was to place all medications at the local pharmacy, except those required over the weekend. Ms McLeod was adamant she would be able to use positive coping skills and would use support phone numbers if required.

235. On 2 June 2017 Ms McLeod's stepfather Rodney telephoned Mental Health Services concerned that Ms McLeod was driving around in the car with the children when she was not well. On 4 June 2017 Rodney telephoned Maryborough's Inpatient Unit reporting Ms McLeod was unwell again, but she was refusing to go to Maryborough ED.

236. On 4 June 2017 Ms McLeod telephoned AODS Inpatient Unit in crisis. This was in the context of auditory hallucinations and suicidal ideation on the background of feeling overwhelmed by her family situation. She said she wanted help, but she didn't want to come back to the unit.

237. Ms McLeod then presented to Maryborough Hospital's ED with a family member after taking a number of tablets and expressing suicide thoughts. She said if she was released, she would take more. She was given involuntary admission to the inpatient unit. Ms McLeod absconded. QPS were called to collect and return her. Ms McLeod was then admitted to WBMHS Inpatient Unit under a treatment authority.

238. Ms McLeod's diagnosis was Borderline Personality Disorder, and a plan was formulated, including admission to the High Dependency Unit under the TA and a following team review.

239. Dr Zhang and the registered nurse reviewed Ms McLeod the following morning, the notes include, "impression Borderline Personality Disorder in crisis". The plan was to remain in HDU under a TA.

240. She was reviewed again on 7 June 2017 where it was noted she was stable in her mental health state and the risk of harm self to others or suicide was low but unpredictable when she faces stress or being overwhelmed.

241. At a family meeting it was agreed that Ms McLeod would be discharged into Mr McLeod's care, she was to attend a case manager in the community for ongoing help and to engage with psychotherapy and DBT via a psychologist. Her TA was revoked, and she was discharged on 7 June 2017. She was discharged for ongoing follow-up with her Hervey Bay CCT case manager and was advised to commence DBT to treat her Borderline Personality Disorder with her private psychologist on a weekly basis.

242. She was seeing Counsellor Julie Jorgensen from 31 May 2017 up to 26 February 2019.

243. At a mental health inpatient follow-up appointment on 9 June 2017 Ms McLeod was assessed as being stable and the plan was for continuing her current Webster-pack medications, psychotherapy with DBT via her private psychologist, and ongoing follow-up by her case manager and GP.

244. On 12 June 2017 Ms McLeod telephoned mental health services seeking support for auditory hallucinations and suicidal ideation. She was reminded to call an ambulance if required.

245. On 12 June 2017 her GP, Dr Ibe, referred Ms McLeod to Hervey Bay Hospital's ED for an opinion and management of Borderline Personality Disorder, auditory hallucinations and suicidal ideation and intent.

246. Later that day Ms McLeod presented to Hervey Bay Hospital's ED in the context of having expressed suicidal ideation to her GP to get away from the voices. Assessment by WBMHS deemed Ms McLeod to be of low risk to self and others and she was discharged. That evening she telephoned the Maryborough Inpatient Unit and reported she wasn't doing well but mental health was not listening to her and the medication she was given was not helping her. She wanted Risperidone.

247. Late on 12 June 2017 Ms McLeod overdosed on her medications. She attended Hervey Bay Hospital ED with QPS and QAS and her sister Catherine. Recommendation for assessment and emergency examination authority was completed in the ED.

248. The psychiatric registrar assessed Ms McLeod to be a high suicide risk and a treatment authority was completed to admit her to WBMHS.

249. While an inpatient in HDU Ms McLeod received support of psychotherapy and psychoeducation and expressed remorse for her impulsive overdose and willingness to be discharged home. Dr Ramsden and Dr Winthwaite and Nurse Buckley performed a mental state examination on 14 June, the impression noted was Borderline Personality Disorder. The plan was to remain on the TA at present.

250. A child protection notification was made. Child Services advised there would be an investigation of the McLeods, but staff had not been allocated. Child Services representative advised that a child abuse neglect report was not necessary. Ms McLeod's children remained with Mr McLeod, who is the primary caregiver.

251. Having been diagnosed with Borderline Personality Disorder her discharge plan was discussed with Mr McLeod prior to her discharge on 15 June 2017.

252. Ms McLeod's case manager telephoned her on 16 and 19 June where Ms McLeod reported she'd made the decision to attend drug and alcohol rehab and was assessed as low risk.

253. On 20 June 2017 Ms McLeod attended an appointment with her case manager and disclosed her ongoing use of Cannabis, Valium, Panadeine Forte, Morphine and Endone. The case manager recalled Ms McLeod acknowledged that her drug use was affecting the effectiveness of her prescribed medication. A crisis plan was put in place and Ms McLeod talked about addressing her drug abuse issues. Ms McLeod was followed-up by the case manager on 22, 23, 27 and 28 June 2017. Ms McLeod said she had not used any drugs and was settled.

254. On around 24 June 2017 Ms McLeod admitted herself to Bayside Transformations. She discharged herself on around 27 June as she did not like the environment and felt lonely.

255. Late on 29 June 2017 Ms McLeod presented to Hervey Bay Hospital's Emergency Department with a friend reporting lack of sleep and not eating. She said she was having thoughts of hitting the car into a tree tonight, and reports driving at 140 kilometres per hour without noticing it. Reports by MHS registrar reveal Ms McLeod was experiencing pseudo hallucinations with some irritability and resolving suicidal ideation. The registrar was not convinced Ms McLeod was truly manic at the time of her presentation and found her symptoms to be in keeping with emotional dysregulation as a result of her Borderline Personality Disorder diagnosis. Ms McLeod was able to take her medication, settle her mental state, and engage in a safety plan. She was discharged into the care of her friend on advice not to drive and was to be followed-up by her case manager.

256. On 30 June 2017 during a consultation with Ms McLeod her GP telephoned Mental Health Services reporting she was unsure what to do with Ms McLeod. The case manager spoke with Ms McLeod, Ms McLeod reported she had had an argument with Mr McLeod and began to experience hallucinations after that. Ms McLeod's case manager spoke to her regarding the consequences of erratic driving, having assessed her to be mentally stable the case manager records, "spoke with GP again and informed

her to call police if after her own assessment she felt Ms McLeod was not rational and unfit to drive vehicle”.

257. Later that morning Ms McLeod presented to WBMHS CMH with her husband complaining that WBMHS was hopeless and querying why they can't fix her. Ms McLeod’s diagnosis and possible illicit drug withdrawal symptoms were explained by her case manager. Ms McLeod refused to participate in the discussion and left the building. The case manager records Mr McLeod was unaware of Ms McLeod's use of Marijuana and feels he's also being lied to and manipulated by Ms McLeod. Support and reassurance were offered around keeping the children safe and boundary setting with Ms McLeod. Ms McLeod did not return.

258. That afternoon Ms McLeod telephoned her case manager and presented to CMH. The records note that Ms McLeod said she was going to go down south. She was told to call police if she was to drive in an impulsive manner.

259. That evening, on 30 June Ms McLeod presented to Bundaberg Hospital’s ED reporting having mental health issues. She intended to drive her car off the road and end her life if she does not get help with her symptoms. She was seeking a second opinion from a psychiatrist because her treating team does not believe she hears voices. Ms McLeod was diagnosed with schizophrenia and given Olanzapine and the plan was for ACT review. She self- discharged before Mr McLeod could collect her.

260. Bundaberg Hospital’s ED telephoned Maryborough Hospital’s ED. The clinician recorded quote, “Ms McLeod presented to them saying she was hearing voices and was wanting a second opinion as to her current treatment… has been seen four times in the last two days… believes the treating team don't believe she hears voices. She is annoyed she isn't able to have Clozapine due to side-effects of heart issues and the same with Risperidone”.

West Moreton Mental Health Service (WMMHS) 2 July to 8 July 2017

261. In July 2017 Ms McLeod was brought into IGH Mental Health Unit Emergency Department by QAS with chest pain and suicidal thoughts. She advised she had driven from Wide Bay area the previous day as she felt her life was in danger at home. She stated that whilst driving she experienced thoughts to drive into something to end her life. She said she was still hearing voices at the time.

262. Ms McLeod advised that she'd been compliant with her medication but hadn't gone to her psychology sessions because she didn't want to, and she didn't like the case manager.

263. She made disclosures about alleged sexual abuse by her stepfather.

264. She advised she was frustrated with WBMHS as she said they told her she had a Borderline Personality Disorder, which meant she was “faking it for attention”. She advised she had not made a complaint as “they all stick together”. She said she found the diagnosis of emotionally unstable personality disorder, borderline type offensive and felt that she was suffering from schizophrenia as had been previously diagnosed.

265. Ms McLeod was admitted to the mental health unit as she was currently in crisis and for containment of risks. Upon assessment by a psychiatrist and registrar the management plan was that inquiries need to be made with her GP regarding her medication.

266. Ms McLeod was discharged later that morning. She advised that she intended to return to the Wide Bay area and transfer of care was completed and forwarded to Wide Bay Mental Health Service.

267. On 4 February Ms McLeod was contacted. She said she was anxious, and she wasn't sure whether she would stay in the Wide Bay area or return to Ipswich. On 5July 2017 Ms McLeod phoned WMACT where she said she was struggling. She had thoughts of self-harm but had not made any plans. She said if she felt that she would harm herself, she would drive to acute care at Ipswich. The acute care RN told her that as she was in Hervey Bay it would not be the best option to drive to Ipswich.

268. On 6 July Ms McLeod phoned WMACT distressed, stating she wanted to see someone from Ipswich Mental Health, and she was feeling suicidal after a fight with her husband. She said she was going to leave her husband, and the children could stay with him, but she couldn't live without her children, so she may as well kill herself. She said she was hearing voices and felt completely overwhelmed. She was encouraged to present to services closer to Hervey Bay, rather than drive four to five hours to Ipswich.

269. On 7 July Ms McLeod contacted WMHACT and advising that she was staying with a friend at Raceview in the WMH region and that she had separated from her husband. She said she'd recently been admitted to Maryborough Hospital and that while she was there the psychiatrist had sided with her husband and would ensure she didn't get custody of the children.

270. She said she wanted to kill herself but didn't have a plan. She said she was homeless. Ms McLeod was given options, and she said if she needed to go to the emergency department, she would get her friend to drop her off. She had a scheduled appointment for 11 July 2017, but she said she couldn't wait that long.

271. She was given details of Floresco. Floresco is a consortium of services designed to deliver non-clinical community based mental health services. She would call them and if necessary, contact WMACT.

272. Later that morning Ms McLeod presented to IGHED where she was reviewed by the psych registrar. She advised that she'd absconded from Gympie hospital and had been brought back on an EAA and then later released. She advised that she was going to make a statement to police about her stepfather. It was noted she was emotionally dysregulated during the interview. She was offered a voluntary admission but declined. She was placed under recommendation for assessment and admitted.

273. On 8 July 2017 she was reviewed by the consultant psychiatrist, who noted that she was sleeping and more settled. She had spoken with her husband and was more settled and positive. She denied any ongoing suicidal thoughts or intent and believed she would be able to resolve her marriage issues.

274. She was diagnosed at this time as having Borderline Personality Disorder with chronic suicidal ideation.

275. The management plan was for her to be discharged home that day with her stepmother, continue with her current medications, and have WMACT follow up to monitor her risk level and mental state.

276. On 8 July 2017 a mental health child protection notification was completed for Ms McLeod's four children.

277. On 9 July 2017 WMACT called Ms McLeod, who advised she was returning to Burrum Heads, that her sister had moved in with her husband and he was in love with her sister. That same afternoon Ms McLeod phoned WMACT very distressed, advising that she was having thoughts of self-harm. It was suggested she seek help at Hervey Bay ED.

278. Her appointment with WMACT was on 11 July and on 10 July she confirmed that she would attend the appointment.

279. Ms McLeod rang later on 10 July, advising that she'd returned to Hervey Bay, and was requesting that all relevant documents be forwarded to the local services there for ongoing follow-up and support.

280. She was advised she would need to contact local emergency services if she was in acute distress now that she was living in their catchment area. The Wide Bay ACT team were contacted and told of her current situation. Ms McLeod did not attend her face-to-face appointment at Ipswich.

Wide Bay Mental Health Service – July 2017 to 29 August 2017

281. On 12 July 2017 Ms McLeod returned to Hervey Bay and stayed with a friend, having moved between Gympie, Ipswich and Hervey Bay for the previous few weeks. Mr McLeod was caring for the children and intended to apply for custody. Ms McLeod attended a meeting with her case manager to initiate a plan for her re-engagement with WBMHS and to establish a crisis management plan for all parties. It was noted that Ms McLeod had committed to face-to-face meetings once a week, had committed to DBT group through CMH and committed to not using any drugs. She was to continue to engage with her counsellor, Julie Jorgensen. She understood that she was a voluntary client and that she was wanting to seek help.

282. On 13 July in 2017 Ms McLeod's case manager completed a child protection form, noting that there were appropriate arrangements in place for the care of the children with their father.

283. On 17 July 2017 Ms McLeod attended a scheduled appointment with her case manager. She reported a supportive relationship with Mr McLeod who was allowing her to visit the children. She denied delusions or perceptual disturbances.

284. On 25 July 2017 Ms McLeod telephoned WBMHS reporting she felt alone and had no one to support her regarding issues with her estranged husband and children. She denied suicidal intent or plans. Later that morning Ms McLeod again telephoned WBMHS and reported plans to attempt to overdose last evening, before she stopped herself. She had feelings of great sadness being isolated from her children.

285. On 31 July 2017 Ms McLeod telephoned her case manager requesting an in-person appointment. The case manager recorded, "Ms McLeod demonstrated strong Borderline Personality Disorder traits".

286. During this period Ms McLeod was also seeing other practitioners and support persons. She sought the assistance from an additional General Practitioner, Dr Shanmugam. He referred Ms McLeod to a private consulting psychiatrist, Dr Nandam. Dr Nandam's assessment of Ms McLeod on 31 July 2017 was that she had both schizophrenia and Borderline Personality Disorder. Dr Nandam reported Ms McLeod had rejected the community mental health team, something Dr Nandam considered was driven by her Borderline Personality Disorder. Dr Nandam also noted Ms McLeod was in Cannabis withdrawal. His management plan included the increase of Seroquel from 100

milligrams to 300 milligrams and the continuation of Fluvoxamine at 300 milligrams as a daily pickup. Dr Nandam noted in his letter to Dr Shanmugam that the main danger with Ms McLeod is her Borderline Personality Disorder dynamics, "such as her trying to recruit you as an ally against the mental health service".

287. On 2 August 2017 Ms McLeod advised her case manager that she was seeing a private psychologist and wished to disengage from case management appointments but continue with the DBT group at WBMHS. A mental health assessment deemed Ms McLeod to be of low risk to self and others with no major concerns or current crisis.

288. On 7 August 2017 Ms McLeod advised her case manager she was doing really well mentally and was caring for her children every other weekend. She reported her private psychiatrist had increased her prescription of Quetiapine to 300 milligrams as well as her antidepressant. Ms McLeod agreed to be heavily engaged with her private psychologist, follow up with a PIR and be discharged from WBMHS with the DBT handbooks.

289. Ms McLeod's case manager completed the transfer of care document on 8 August 2017.

290. At this point Ms McLeod was receiving support from: -

- We Care 2
- Counsellor Julie Jorgensen
- PIR
- Flourish (women's group for 12 weeks)
- GP Dr Ibe
- GP Dr Shanmugam

291. On 17 August 2017 Ms McLeod presented to Hervey Bay Hospital's ED reporting an impulsive overdose in the context of relationship difficulties. She was regretful of her impulsive act and denied any further suicidal ideas and reported that she would immediately get help if she had suicidal thoughts. She reported using Cannabis that day. There was no evidence of psychosis.

292. On 24 August 2017 at her request Ms McLeod was formally discharged from WBMHS into the care of other services.

293. Later on 24 August 2017 Ms McLeod presented to Hervey Bay Hospital's ED reporting an impulsive overdose "due to emotional crisis feeling lonely and isolated and rejected by family and friends and poor coping strategies… Ms McLeod reports her children are a protective factor and stated she is motivated to continue with seeing her therapist to develop better coping strategies. Objectively she presented as euthymic in mood.. she denied experienced voices and there was no FTD".

294. Post discharge Ms McLeod presented to Hervey Bay Hospital's ED on a number of occasions, reporting family disputes and feeling lonely, isolated, and as though she was coping poorly with life stresses. On each occasion Ms McLeod's mental health was assessed by WBMHS's ACT and she was deemed to be of low risk to self and others with no psychosis identified. She presented well, remorseful, and engaged when discussing safety plans for discharge, was able to settle her mental state in the ED and was discharged with prompt follow-up from WBMHS's ACT from 24 August 2017 to 29 August 2017.

295. Ms McLeod's mental health was managed in the community by services other than WBMHS from 30 August 2017 to January 2018.

296. On 2 January 2018 Ms McLeod had an appointment with her Counsellor Julie Jorgensen. She reported domestic violence with Mr McLeod and that he tried to throw her down the stairs, and child abuse of her [Not for publication]. Ms McLeod advised she was living in protection housing and child safety were involved. Ms McLeod said she was planning on going into a refuge tomorrow and required a DVO. Julie Jorgensen attempted to follow up Ms McLeod on 5 January and left a message. On 4 January 2018, following her report of the allegations, Ms McLeod overdosed in her car. She had dropped her children to associates first. She went to the Hervey Bay Emergency Department. On assessment Ms McLeod had no formal thought disorder, no delusions, no suicidal or homicidal ideation, no auditory hallucinations and denied any features of psychosis. Ms McLeod felt regretful of the overdose.

297. On 5 January 2018 Ms McLeod was brought into Hervey Bay Hospital ED by QAS, QPS and the department in an agitated state reporting having overdosed. She was assessed by a mental health doctor once settled and admitted to having taken her children to a women's shelter in Maryborough for fear of losing custody of them to Mr McLeod who had applied for full custody.

298. Ms McLeod denied any ongoing suicidal or homicidal ideation with no evidence of psychosis or mood symptoms observed. Ms McLeod expressed remorse for having overdosed and determination to obtain custody of the children. Ms McLeod reported taking Fluvoxamine 300 milligrams and Quetiapine 100 milligrams as prescribed by her private psychiatrist. She was assessed as being low risk of self-harm and subsequently discharged into the care of the women's shelter. The department had arranged for the children to be returned to the care of Mr McLeod.

299. On 8 January Ms McLeod was followed up by Community Mental Health. She advised she had no thoughts of harming herself. She listed her supports as Dr Shanmugam, a private skype psychiatrist in Brisbane and a private social worker. She was happy to be discharged back to those supports. Clinical records indicate she continued to engage with counsellors Julie Jorgensen and Carol Yates (We Care 2).

300. On 5 March 2018 Mr McLeod telephoned WBMHS's ACT to refer Ms McLeod back to their care. He called to say he was worried about Ms McLeod's mental health and her ability to care for the children. He had custody of the children, however, Ms McLeod picked the kids up from school yesterday and refused to return them. He states she was shouting at him that she would get a protection order against him and was emotionally abusive in front of her children. A call was made to Ms McLeod, where she sounded bright and reactive, settled and organised. She said she was happy to engage and that she had a protection order against Mr McLeod on advice she took from Child Safety and the police. It was noted that there were nil acute mental health concerns identified. Ms McLeod said she felt supported by her sister, her church, her psychologist and her GP. Ms McLeod offered to come in and be assessed and the registered nurse informed her she would discuss with the multi-disciplinary team if that was necessary. It was decided that was not necessary.

301. On 14 May 2018 Ms McLeod presented in "*requesting information on how to manage her acute anxiety*". She reported a DVO against Mr McLeod and he breaches it often which is causing her anxiety. She said her GP would not engage with discussion about medication or management of her anxiety without input from mental health. Ms McLeod was noted to be well aware of crisis management and her crisis management plan.

302. In May 2018 WBMHS CCT attempted telephone contact with Ms McLeod to encourage DV supports and check mental state and risk due to stresses regarding the DVO

application. Ms McLeod returned the call and said the order was granted on 23 May. She denied anxiety, any mental health complaint or thought, plan or intent of harm to self or others. She reported compliance with prescribed medication and a plan to return to her previous GP for a referral to counselling, she reported being motivated and confident. She declined the need for further follow-up for mental health and any ongoing referral. She was motivated to do it herself.

303. Ms McLeod engaged with counsellor Carol Yates at 'We Care 2' on 17 July, 14 August and 28 August 2018. During the consult of 13 April 2018, she said she was confused about her thoughts regarding the domestic violence order. The trial date and what was likely to happen was discussed.

304. During her consultation with Carol Yates on 17 July 2018 Ms McLeod referred to her new partner Chris, and the lack of support she got at church, resulting in her immediately leaving and never wanting to go back. Ms McLeod disclosed one of her children was displaying sexualised tendencies. This was explored and Ms McLeod confirmed she had reported it to Child Safety. Carol states, "C is feeling very unsupported at this time. She is struggling with the pressure of dealing with four children as a single parent".

305. During the consult with Carol Yates on 14 August 2018 Ms McLeod reported she was still in a relationship with Chris, that she was less angry about the church, and she was supported by Act For Kids, that her medications had decreased, and she was doing quite well. She had started going back to church and was attending a lady's group on Friday mornings.

306. During the consultation with Ms Yates on 28 August 2018 Ms McLeod said she was unable to do the Circle of Security parenting course through an outside agency. She was wanting to address her issues with anger.

307. On 18 July 2018 Ms McLeod self-referred to Community Mental Health advising that she couldn't cope, she was struggling to deal with her feelings and thoughts due to her social circumstances including the DVO and relationship breakdown. Ms McLeod was encouraged to contact her community supports through her GP and psychologist and to link in with DV Connect and other domestic violence services. Ms McLeod was reminded of her crisis management plan and offered a face-to-face appointment on 23 July 2018 to discuss her concerns with the view to link her in with non-government organisations and check if she required mental health support.

308. On 23 July 2018 a mental health services triage and rapid assessment was completed.

309. On 24 July 2018 Ms McLeod was contacted and reported she was doing alright. She was happy to be contacted again in a couple of days and advised her GP was sending a referral.

310. Intake review on 30 July 2018 resulted in a plan for WBMHS's ACT to liaise with Ms McLeod's GP in relation to a possible referral.

311. Intake reviews on 7 August 2018 determined a plan for WBMHS's ACT to fax the intake form and triage assessment to Ms McLeod's GP Dr Ibe and close her to WBMHS.

312. On 14 December 2018 Ms McLeod telephoned WBMHS's ACT reporting that her ex-partner had contacted Department of Child Safety stating she is unfit mother increased anxiety over this and requesting mental health review. Ms McLeod was recommended to contact her GP for a report referral for a private psychiatrist for review of her mental health.

313. Shortly after on 14 December 2018 WBMHS received a referral from Dr Ibe "for an opinion and management" in relation to an ongoing custody court case and Ms McLeod needs an urgent psychiatrist review for legal purposes. Her current medication was noted as including Fluvoxamine 100 milligrams and Seroquel 25 milligrams. WBMHS booked Ms McLeod a face-to-face appointment on 21 December 2018.

314. On 21 December 2018 Ms McLeod attended Community Mental Health for her scheduled appointment. A Mental Health Services general assessment was undertaken. Ms McLeod reported anxiety relating to the divorce and court proceedings scheduled to take place in February 2019. Her mental state was observed to be stable, with no evidence of mood or psychotic symptoms. She was assessed as being of low risk to self and others, having denied any suicidal or homicidal ideation intent or plan. She reported she was undertaking a Diploma of Community Services and planned to start work after completing her diploma. She was taking Quetiapine 25 milligrams (which her GP had reduced from 300 milligrams) and Fluvoxamine 100 milligrams. Ms McLeod reported she would attend her GP for a mental health care plan to engage with her psychologist.

315. According to the assessment Ms McLeod had normal speech (volume, rate and tone and was easy to engage) had an okay mood of five out of 10 with effect reactive: had no auditory or visual disturbances and was appropriate and congruent. Ms McLeod expressed her worries about custody court, also upset that the police didn't support her towards her husband. Her protective factors were that she was living with her four children and her younger sister.

316. Ms McLeod was subsequently advised by telephone that CMH would not send information to external parties such as Child Support Services or her lawyer unless requested by a third party. The nurse records, "*let her know that ACT won't send any report or information to Child Support Services, writer explained if Child Support Services need any information, they will contact ACT. Patient then asked to give her a report that she can give to her lawyer, writer repeated her the same: that the lawyer should contact us, and we release the information. Patient agreed with same.*"

317. It was decided on 2 January 2019 no follow-up was required as Ms McLeod did not have any acute mental health concerns at that time and had contacted the service wanting collateral from mental health for the purposes of child safety. Ms McLeod had no further engagement with WBMHS after the review on 2 January 2019.

318. On 30 March 2019, as per Ms McLeod's reduction plan, at that time she was fully ceased on Seroquel. Dr Ibe saw Ms McLeod twice in May. On 3rd of May 2019, she confirmed she was off Seroquel and doing well, and on 17 May 2019 she was otherwise doing well. That was the last time Dr Ibe saw Ms McLeod.

Reviews conducted of Ms McLeod's interactions with Mental Health Services

- **The Chief Psychiatrist investigation and Report**

319. Following Ms McLeod's death, the Chief Psychiatrist, Dr John Riley, determined that an investigation under the Mental Health Act should be undertaken into the mental health assessment, treatment and care of Ms McLeod. It was noted that at the time of her death Ms McLeod was not a patient of AMHS despite the fact that she had had frequent interaction with Wide Bay authorised mental health service and admissions at both the Sunshine Coast and West Moreton Adult Mental Health Service.

320. The intent of the investigation was to examine the individual circumstances and to understand the processes and decisions that applied with a view to identifying any

lessons and potential systemic issues and improvements. Both Dr Riley and Dr Isabel Wesdorp, who was one of the inspectors appointed to investigate matters gave evidence at the inquest.

321. Ms McLeod's mental health history was detailed in the report. QHOCP refers in submissions to a helpful summary of Ms McLeod's care as follows-:

"*Miss McLeod's longitudinal presentation was characterised by effective dysregulation, manifest as dysfunctional coping with situational crisis and relationship stressors. Often these crises resulted in emergency medical and psychiatric attention due to suicidal action (primarily, attempted hanging and overdoses). Assessments by emergency and acute care team staff at these times frequently elicited reports of perceptual and thought disturbance involving animals, God, and the devil talking to her, reading her mind and commanding her to harm herself. Another long-standing recurring theme to Miss McLeod's crisis presentations involved disordered eating, including severely restricting her food intake in order to lose weight and excessive consumption of energy drinks.*

Over the years she attracted multiple diagnosis, including anorexia, schizoaffective disorder, post-traumatic stress disorder, schizophrenia, and BPD. Her most recent treating teams however differed in their understanding of her primary pathology; being either based in her borderline personality structure, or a more chronic psychotic disorder like schizophrenia. Miss McLeod was offered various pharmacological and psychosocial interventions, both in inpatient and community settings.

In December 2016, when Miss McLeod was 33 years of age her diagnosis was changed from schizophrenia to BPD, and her Clozapine was ceased. Prior to then she had seven crisis presentations and admissions altogether, but subsequently had about 20 presentations to emergency departments resulting in several hospital admissions in the 11 months from May 2017 to April 2018. During this period, there had been also a number of changes to her treatment including the choice of antipsychotic agents. Her relationship with Mr McLeod had deteriorated, eventually leading to their separation. At the time of her death in May 2019, Miss McLeod was not engaged in public mental health services, but had been seeing her GP and various private mental health practitioners in the preceding months. From the available information, it is understood that Miss McLeod was living in Hervey Bay with her four children and was dealing with issues of custody of them in the context of a family law case".

322. The Chief Psychiatrist Investigation Team unanimously held the view that Ms McLeod's mental health condition was complex. It was noted that the view held by the mental health services was that Ms McLeod presented with complex needs throughout her history with them. What differed was how the health services approached that complexity. The investigation team reported that the teams differed in their understanding and opinion of Ms McLeod's presenting symptoms and therefore offered treatments in keeping with their respective formulations, whether conceptualised as a primary psychotic disorder, Borderline Personality Disorder, or comorbid psychotic disorder and Borderline Personality Disorder.

323. The Chief Psychiatrist investigation team were of the view that whilst there was evidence for both schizophrenia and emotionally unstable personality disorder, the conditions can be comorbid and are not mutually exclusive. The investigators remained neutral on diagnosis and rather focused on the processes embedded within mental health services that enables clinicians to recognise and manage complexity.

324. The investigators made a total of 15 recommendations. By the time of the Inquest these recommendations had either all been implemented or were in the stages of being finalised for implementation.

325. One recommendation was directed towards Mental Health Alcohol and Other Drugs Board (MHAODB) to develop a statewide strategy that supports mental health services in their provision of evidence-based treatment for people with Borderline Personality Disorder. This strategy would also apply to those patients whose diagnosis are of a primary psychotic illness, but those presentations are complicated by borderline personality features.

326. The report detailed the reasoning behind the recommendation.
It was noted:

- For patients with symptom profiles similar to Ms McLeod's, their personality disorders can essentially function as an illness. For some, experience of psychotic symptoms can represent the manifestation of a breakdown in defences in the context of severe stress.
- For those with comorbid primary psychotic illnesses and personality disorder, their personality structure can render them more vulnerable to severe deterioration in mental state. Accordingly, there are important implications for public mental health services in the provision of treatment and care to patients across the spectrum, in both inpatient and outpatient settings.

327. In determining an appropriate strategy to provide treatment for Borderline Personality Disorder the report referred to academic literature which included references to Project Air as a suggestion for inclusion in such a strategy. It was seen as an example of a well-developed system-based approach in the management of Borderline Personality Disorder.

328. Project Air was developed by University of Wollongong in partnership with Health Services in New South Wales. In recognition of the significant treatment challenge that Borderline Personality Disorder presents to mental health services, the Project Air strategy outlines approaches to clinical leadership and service redesign, targeted training, the provision of brief and longer term treatments, rapid access to psychological assistance, support for families and carers, and better accesses to information and clinical resources to provide more hopeful and integrated treatment. Along with severity of symptoms and high prevalence, the particular nature of the disorder can challenge capacity of teams to maintain compassion towards patients, given the particular features that can induce negative countertransference responses. The Project Air strategy takes an integrated, step down, whole of service approach that focuses on both the intrapsychic difficulties of the patient and the broader interpersonal conflicts that can challenge families and treating teams.

329. Project Air Strategy Queensland has now been funded to support health services to deliver effective evidence-based treatment and care for people with personality disorder. University of Wollongong Project Air Team were engaged by Queensland Health to work in partnership with Health Services to provide expert training, guidance and support for implementation evaluation and suitability of the strategy, with a number of health services to recruit project leads to support and coordinate implementation efforts.

330. The strategy commenced in 2023 for an initial period of three years. It is codesigned with health and hospital services and rolled out statewide in a stage process, with a small number of hospital and health services commencing each year.

331. Metro South HHS, Wide Bay HHS and Central Queensland HHS were selected as the first group of services to commence working with the MHAODB and the University of Wollongong team to start implementation. Metro South HHS commenced in May 2023 with the Wide Bay and Central Queensland HHS expected to commence in mid to late 2023. The Gold Coast and West Moreton HHS have both incorporated the Project Air

model into their services and plan to strengthen and grow their service approach through the Project Air Strategy Queensland.

332. QHOCP pointed out that HHS's will be supported to implement evidence based local initiatives that enhance service system capability and capacity to provide effective care for people with personality disorder. The strategy was not in place at the time of Ms McLeod’s death.

333. The investigation report also recommended consideration be given to develop a standardised approach towards risk assessment of driving and to include the risk of driving and a risk screening tool to document consideration of same.

334. The Chief Psychiatrist also gave evidence of other steps taken since the deaths to address shortcomings in MHAOD including gaps in service responses to domestic and family violence.

335. These include the Comprehensive Care Initiative. This initiative was initiated in 2020 by the former MHAOD branch within Clinical Excellence Queensland. The focus was on streamlining, standardising and enhancing clinical processes to better support MHAOD services to provide high quality clinical care at all stages of the consumer care journey by streamlining both the care process and their documentation. The comprehensive care documentation (CCD) framework aims to improve clinical care through incorporation of significant and longitudinal information into formulation and care planning. There is a CCD Guide and Comprehensive Care resource packages for different points of a consumer's journey, which were developed in collaboration with staff across various HHS's and with the MHAODB. Training is provided to practitioners on the revised tools.

336. Clinical risk screening is another development. It is an ongoing and dynamic process of identifying the potential for risk across a range of risk domains including suicide, self-harm, violence, DFV, treatment, non-adherence, risk of harm to children and vulnerabilities.

337. It is noted clinical risk screening forms part of routine mental health assessment, and where necessary, leads to further assessment and response by the treating teams to risks identified through risk management plans and treatment.

338. Changes have been made in that where any risk factors have been identified with the consumer a risk screen within the consumer integrated mental health and addiction application (CIMHA) must now be completed as soon as feasible. Further there have been added features to the risk screen which include a large and greater range of historical and current factors which impact on the risk.

339. Dr Riley stated that a new addition to the risk screen included a trigger for the clinicians to contact child protection liaison officers to discuss child protection notification processes where there are risks to children identified in the risk screening process.

340. Dr Riley gave evidence as to the use of the longitudinal summary which should incorporate key information obtained from the overall assessment of risk. A key intention of the Comprehensive Care Initiative is to support a longitudinal perspective to assessment, accurate diagnosis, comprehensive and collaborative care planning and review, and treatment to address the consumer's comprehensive care needs. The longitudinal summary is the primary repository for collating and documenting a detailed account of key issues which have been central to the consumers presenting difficulties and trajectory of their condition over time and was created with the intention of providing a comprehensive and up-to-date account for others to access without a comprehensive

search of previous clinical notes. The longitudinal summary is part of the suite of clinical documents in CIMHA and the most recent version of the template is automatically visible in the viewer. A longitudinal summary should be commenced by the principal service provider within two days of the start of the service episode. The intention is that the longitudinal summary should be updated following the care review to reflect any updated content discussed and agreed upon during the care review and care planning process. The intention is that the longitudinal information is to be contained in the discharge documents and transfer of care documentation.

341. One of the areas canvassed by the Chief Psychiatrist Report was Ms McLeod's transition of care which was documented to have occurred from case management on 8 August 2017, but not thereafter. The transfer of care in MHAOD services incorporates transitions that are inclusive of consumers moving between services, consumers being discharged from inpatient care and or consumers exiting the service to be cared for by a primary care, private or interstate healthcare providers. Transfer of care decision making and planning is an ongoing process that commences at the beginning of a care episode, and it is expected that the transitions are informed by a current risk screen, care plan, substance use assessment where this is clinically significant, case review and longitudinal summary.

342. Handover of clinical care using the transfer of care template is an essential element of communicating for safety across all stakeholders within the consumers "care team" and ensures that the consumer's transition needs, including any need for ongoing support, avenues to reengage and information required for the continued provision of comprehensive care are available to the next care provider. The transfer of care document is one of the range of CCD forms that captures risk factors and management strategies.

343. The Chief Psychiatrist gave evidence concerning the issues of domestic and family violence, higher risk patients and risk to children.

344. Clinicians working in MHAOD services screen for DVF as part of routine clinical risk screening and assessment. They are guided by the QH developed DFV Toolkit of Resources for Health Workers, which provides links to a range of training packages, guidelines and fact sheets aimed at building capability of staff across the state to identify signs of DVF, use sensitive inquiry techniques and refer appropriately. This includes the Queensland Health Domestic and Family Violence – referral to a specialist support service model, which outlines the process for referring a person to a specialist DFV services once that risk has been identified.

345. Dr Riley outlined that where routine clinical assessment identifies that a consumer poses a risk of violence towards others, clinicians have a responsibility to engage with the family, carer or support person to ensure they are given appropriate information and support to maintain their safety. A safety plan can be provided to families, carers and identified others for completion whilst discussing risk to their safety. The safety plan would be entered into CIMHA. The Queensland Health Violence Risk Assessment and Management Framework was developed in response to a 2016 report, "when mental health care meets risk: a Queensland Sentinel events review into homicide and public sector mental health". This framework provides clinicians with a systematic approach for the identification, assessment and management of consumers who may pose a risk of violence towards others, including family members and children. The framework supports comprehensive assessment of violence risk by examining previous episodes of violence, past, current and future risk factors, protective factors and interventions for each risk factor. Where routine risk assessment identifies a heightened risk to others, a

more intensive risk assessment and management process is triggered which includes expert input, and oversight through local government processes.

346. In 2020 the Chief Psychiatrist Forensic Order identified higher risk patients policy was revised to strengthen risk management. The term “high risk patient” was changed to “other patients identified as higher risk towards others or to property”. An Assessment Risk and Management Committee (ARMC) review is to occur when there is an increase in risk, where there are significant material changes in circumstances or any time the clinical director, administrator of the Adult Mental Health Service (AMHS) or chief psychiatrist determines that that review is required. The patient does not need to be a forensic patient or on a treatment authority to be captured as higher risk.

347. Evidence was also heard about other specialist roles within Queensland Health. Queensland Health is part of the integrated DFV High Risk Teams (HRT) implemented by Department of Justice and Attorney General. HRT are coordinated multi-agency teams that collaborate to provide integrated holistic, culturally appropriate safety responses for victims and their children who are at high risk of serious harm or lethality. Queensland Health is represented at the multi-agency meetings by specialist DFV clinicians employed by HHS. HRT clinicians are responsible for undertaking detailed risk assessment and safety planning where DFV risk has been identified.

348. In 2021 Queensland Health also established the DFV specialist positions in HHS across Queensland under the DFV Specialist Health Workforce Program. Those programs develop and deliver locally tailored face to face training to all Queensland Health clinical staff to build capability in recognizing, responding to and referring suspicions and disclosures of DFV.

349. Queensland Health also has Forensic Liaison Officers, who are specialised clinicians with knowledge and expertise in the management of forensic and or higher risk patients. Clinicians working in MHAOD (Mental Health And Other Drugs) services can seek assistance from forensic liaison officers.

350. Further MHAOD service clinicians are stakeholders in relevant Suspected Child Abuse and Neglect (SCAN) team meetings where a parent's mental illness and or substance use disorder contributes to a significant risk to a child.

Dr Heffernan’s Report

351. Dr Edward Heffernan, Director of Forensic Mental Health Services for Queensland Health, was engaged by the coroner's office to provide an expert report. He considered the Chief Psychiatrist report and made further observations about opportunities to improve. Dr Heffernan also gave oral evidence at the inquest.

352. In his report Dr Heffernan noted that his task was to review clinical records only and that the clinical records did not include any detailed records of contact with clinicians or services Ms McLeod had outside of the public mental health system. He also noted it may not have included all the information held within the various electronic record systems of the three relevant hospital and health services (HHS) that is Wide Bay, West Moreton and Metro North.

353. Dr Heffernan considered the issue of Ms McLeod's diagnosis.

354. He noted that the two disorders that Ms McLeod was most likely and consistently diagnosed with were Borderline Personality Disorder and schizophrenia.

355. As to Borderline Personality Disorder, he said that the key features are instability of interpersonal relationships, identity disturbance, affect (observable emotion), instability, and impulsivity. In clinical practice he said people with Borderline Personality Disorder often exhibit relationships that are tense and unstable, fear of abandonment, intense, often short lived, emotions such as anger or very low mood, impulsivity, particularly in ways that can be harmful, such as self-harming or suicidality, substance use, treatment non-adherence, reckless behaviour including driving, and a poor sense of self that impacts on the way a person thinks and feels about themselves and others, usually from a negative perspective.

356. From a review of Ms McLeod's clinical records from her earliest contact with public mental health services to when she was 23, there was a consistent conclusions reached by various clinicians and services with respect to the diagnosis of Borderline Personality Disorder. He says Ms McLeod's clinical record up to the time of her death includes information that consistently supports the diagnosis of Borderline Personality Disorder.

357. In relation to a diagnosis of schizophrenia, Dr Heffernan said schizophrenia is a type of psychotic disorder and characterised by five key features.

(1) Delusions
(2) Hallucinations
(3) Disorganised thinking
(4) Grossly disorganised or abnormal motor behaviour.
(5) Negative symptoms

358. He said certain criteria must be met for a diagnosis of schizophrenia to be made. Firstly, two or more of the five features must be present for a significant portion of time during a one month period.

359. He said Ms McLeod was diagnosed with a number of different disorders that can present with psychotic features, bipolar disorder with psychotic features, schizo-affective disorder, and schizophrenia during the course of her contact with mental health services. He said the predominant psychotic disorder diagnosis between 2009 and 2016 was schizophrenia. He said in 2016 the diagnosis was reconsidered and excluded in favour of conceptualising her mental health problems as primarily arising from Borderline Personality Disorder.

360. Dr Heffernan noted that Ms McLeod commenced taking clozapine on 9 December 2009 and remained an inpatient until February 2010, and that during this day the dosage of clozapine was gradually increased. It was noted that she responded well.

361. Dr Heffernan said in general terms the reviews of her treating psychiatrist and the treating psychiatry registrar indicate that throughout 2010 Ms McLeod responded well to the management plan of regular mental health service contact and treatment with clozapine. The primary diagnosis was changed to schizophrenia with a secondary diagnosis of Borderline Personality Disorder.

362. Dr Heffernan said that based on the available clinical records the weight of evidence supported that Ms McLeod fulfilled the criteria for DSM five criteria for schizophrenia, noting that she experienced: -

(a) Hallucinations and delusions that were extensively reported from 2009 on.
(b) She had a significant disturbance in her level of function.
(c) She demonstrated disorganised behaviours.

(d) There were signs of disturbance for a protracted period certainly greater than the six months required to meet criteria.

363. Dr Heffernan also commented on his view of the appropriateness of treatment and medication.

364. He said Ms McLeod had a very complex mental health problem. She experienced the interplay of trauma, personality disorder, psychotic symptoms and substance abuse. Her mental health problems were present and active during the years she had four children in a relatively short space of time. While this is an extremely positive time for her family, it is also a very challenging time, particularly for someone with significant mental health treatment needs. The challenges were compounded, particularly in the last five years of her life by relationship problems, separations, allegations of domestic violence, and sexual abuse and child custody concerns. It was appropriate that Ms McLeod have extensive mental health service support and in general there was significant consideration, care and support provided through public mental health services, Ms McLeod's mental health needs were at the most challenging end of the spectrum for mental health services in terms of complexity and risk.

365. He said that there were a variety of reasons why Ms McLeod's case was closed to mental health services at various times including due to her own desire to have care in the private sector. Her care needs, however in his view, would have been best addressed if she had remained a patient of public mental health services.

366. He said the benefit of public mental health services relative to other agencies is the capacity to ensure continuity of care between inpatient and outpatient settings, availability of a multi-disciplinary team and crisis services, expertise in monitoring of medication and medication side effects, and capacity for multi-disciplinary coordination from multiple agencies involved in the care of an individual and their families.

367. He said the services would have been particularly helpful between 2017 and 2019 when Ms McLeod's care needs were complicated by a relapse of substance use, and a resurgence of a variety of symptoms in the context of changes to treatment, and significant stressors related to allegations of family violence and abuse, separation and child custody matters.

368. He said the treatment of Borderline Personality Disorder can be difficult within the public health system. Treatment requires structured psychological therapies that are specifically tailored to the condition and ideally provided by a trained and supervised health professionals. While mental health services recognised, diagnosed, developed management plans, and provided crisis admission for Ms McLeod, he thought it would be widely accepted that they could not meet all the care requirements for someone with such severe and complex needs related to Borderline Personality Disorder. Resourcing and training are key limitations for public mental health services in providing high quality and continuous interventions and appropriate therapy for people with Borderline Personality Disorder. Nevertheless, this is a common condition that presents to mental health services either as a sole diagnosis or, as was the case for Ms McLeod, co-morbid with other disorders. He said it is therefore appropriate to expect a higher level of skill and expertise in the diagnosis and management of this condition in acute and subacute settings.

369. In relation to the treatment of schizophrenia he said that requires a focus not just on symptoms but on function, and therefore requires a variety of approaches to management including psychological interventions, recovery, and support services in addition to pharmacotherapy therapy. He said Ms McLeod's management for schizophrenia between 2009 and 2016 was in general terms of an appropriate standard

within the context of her illness. She had access to inpatient services when required, clozapine clinics in the community, case management, and for supports within the broader mental health sector.

370. Dr Heffernan noted Ms McLeod ceased taking clozapine. He said it was unclear if the treating team ceased clozapine because of the concerns with side effects or because the diagnosis was reviewed.

371. Dr Heffernan commented on the medication Ms McLeod was taking at the time of her death. He noted she was prescribed antipsychotic medication quetiapine and the antidepressant medication fluvoxamine. The dosage of quetiapine in his view was very low and would not be an effective dose to treat schizophrenia or other psychotic disorders.

372. Dr Heffernan also commented that in addition to medication decisions, another area of significance in clinical management was the transfer of care between healthcare providers. He said that requires good communication and documentation. He said whilst there were transfer of care documents in Ms McLeod's clinical records, the timelines and comprehensiveness of information communicated to healthcare providers on the occasions when Ms McLeod's case was closed to public mental health services was unclear from the clinical record. He said she moved locations a number of times over the last decade of her life, and she moved between public and private health care systems. He said given the complexity of her mental health problems; continuity of care was critical.

373. He identified opportunities to strengthen clinical practice as follows:

(1) Documentation at key points in care planning or changes to care should be clear and comprehensive, which would include the need for clinical records to articulate.
   - The reasoning for significant treatment changes, such as a change in a long-standing diagnosis and treatment.
   - Why a person has been closed to a service, what information has been provided and what subsequent care plans have been put in place to support continuity of care.

374. He noted that the MHAOD was developing a capability within CIMHA to provide a long attitudinal clinical summary which will support that matter.

(2) Ms McLeod had complex mental health and psychosocial problems, and it was evident she presented a risk to herself and others. He said as such key decisions in treatment and care planning and risk management should have been supported by a comprehensive multi-disciplinary review process. He said it was likely that a formal, complex case review process would benefit decision making. He said that can happen a number of ways that are currently standard practice in HHSs such as complex case review meetings or acute risk management committee meetings.

(3) In Ms McLeod's case there were potential significant risks related to her mental health, and there were multiple stakeholders involved in her and her family's care. Communication between agencies greatly enhances risk management. He said the level of communication between key stakeholders was unclear to him from the review of the clinical records. He said communication between agencies, for example, health services, police, ambulance, child safety, and domestic and family violence services can occur with consent and without consent when supported by, for example, memorandums of understanding or legislation.

375. He said he believes there is a role for multi-agency stakeholder meetings to share appropriate limited information for complex high-risk cases where there are multiple

agencies involved. He said the purpose would be for planning and problem solving for the benefit of the individual, their family and the community. He said currently from a mental health perspective there are examples where this can occur on an ad hoc basis, supported by existing policies and procedures. He said the barrier to such a process happening routinely for specific high-risk matters relate to identifying a lead agency, the coordination of agencies involvement and identifying the appropriate information sharing mechanism.

376. He said the management of Borderline Personality Disorder, including when it is co-morbid with other conditions is complex. In public mental health services, management often varies, depending on the experience and training of clinicians within the service, and the resources of relevant HHS. Enhanced training and ensuring consistency of practice between HHSs would improve the capacity to manage individuals with Borderline Personality Disorder.

377. He said the available records indicate Ms McLeod, particularly in 2018, was driving at times when she may have been experiencing significant mental health problems and had been prescribed sedating psychotropic medications. He said given the nature of the deaths, fitness to drive is an important consideration. The assessment of driving is a challenge for mental health services. There are good resources available to guide this process, however, he was unaware of the standardised process across Queensland mental health services for the assessment of fitness to drive particularly as it applies to risk individuals.

378. He said there were presentations in 2018 and 2019 to mental health services in which family violence was a central issue. He said it was unclear how this was considered in terms of care for Ms McLeod and her family. He said that that was a critical issue for mental health services and one that required well-developed training standards of practice.

379. In oral evidence Dr Heffernan confirmed at the time of her death there was no evidence of psychosis. He found that Ms McLeod was at the point of her death likely to have a mental state where interpretation of sensitive information could be challenging and a state that was particularly vulnerable to emotional distress.

Allegations of domestic violence and sexual assault

Allegations in relation to Ms McLeod

380. Ms McLeod and Mr McLeod met in 2002.

381. They married in 2008 and were in a relationship for approximately 15 years. Between 2012 and 2016 they had their four children, Aaleyn, Matilda, Wyatt and Zaidok.

382. They separated in December 2017.

383. Ms McLeod reported to various people and services throughout their relationship, and after they separated, incidents of what would be regarded as domestic violence and sexual assault. Counsel Assisting outlines evidence given by witnesses who had interactions with Ms McLeod and Mr McLeod about behaviour which could amount to acts of domestic violence by Mr McLeod. She rightly notes that some of the information was as told to these people by Ms McLeod. The evidence for example was: -

- Ms McLeod's sister [ZR] gave some evidence that Mr McLeod would 'choose where Ms McLeod could or couldn't go'.

- Miss Davis, a church Pastor who had known Ms McLeod since she was about 17 gave evidence that Ms McLeod told her that Mr McLeod wanted to know where she'd been and who she was with, and he was jealous. She said this was what Ms McLeod had told her. She did not herself see that behaviour.
- There was evidence that Mr McLeod made derogatory comments about Ms McLeod's weight.
- Mr McLeod told Ms McLeod he wanted a second wife and that he wanted that wife to be Ms McLeod's sister [NR].

384. Ms McLeod made a number of complaints to people from early in the relationship about rape and being forced to have sex by Mr McLeod.

385. No complaints were made to police until 30 December 2017.

386. On 28 December 2017, Ms McLeod told DV Connect of wanting to leave and that Mr McLeod had raped her. She said she was worried about the children being left with him. Police assisted her to leave the home in December 2017, and she went to emergency accommodation in 2018.

387. On 29 December 2017, Ms McLeod attended the police station with [Not for publication]. and made a complaint that Mr McLeod had [Not for publication]. A Section 93A statement was taken from [Not for publication].

388. On 30 December 2017 Ms McLeod made a complaint to police that she had been raped by Mr McLeod between August and December 2017.

389. Ms McLeod was admitted to hospital in January 2018 following an overdose. The officer in charge of the rape allegation was aware of this. Ms McLeod was contacted by police after she was released from hospital. She withdrew her rape allegation, saying "*if I don't lose my kids*".

390. Ms McLeod had applied for a domestic violence order against Mr McLeod in the Magistrates Court in Hervey Bay. [Not for publication].

391. A Protection Order was made after a contested hearing in May 2018. Ms McLeod was legally represented in those proceedings. Mr McLeod was not.

392. Ms McLeod filed affidavits in family law proceedings containing allegations of domestic violence.

393. In 2018 and early 2019, Ms McLeod made further complaints alleging acts of domestic violence and sexual assault against Mr McLeod.

394. She was in a short-term relationship with Mr [KO] between December 2018 and February 2019. She told him that Mr McLeod had raped her and one of the children was conceived by rape.

395. In December 2018, she posted on Facebook that she had been raped and two of her children were from rape.

396. On 15 January 2019, she spoke to a counsellor at Wide Bay sexual assault counselling service. She told the counsellor that she was frustrated with the Department of Child Safety. She thought she was being punished for leaving an abusive relationship.

397. On 18 January 2019, she made a complaint to police of sexual assault by Mr McLeod. She gave a statement in which she alleged she was sexually assaulted by Mr McLeod in November 2012, February 2016 and 2017.

398. Detective Senior Constable Maurice Cottrell investigated Ms McLeod's complaint. He was aware of the complaint made in 2017, and of her domestic and family violence complaints to police. Officer Cottrell took a statement from Ms McLeod in March 2019 in which she said: -

- Mr McLeod raped her a lot during the relationship.
- On the 8 November 2012 about two months after giving birth to Aaleyn, Mr McLeod forced her to have sex against her will. She became pregnant again as a result.
- During 2015 to February 2016, when [AM] was living with them Mr McLeod raped her on a number of occasions. She recalled one incident Mr McLeod had run a bubble bath for her and told her to get into the bath. She didn't want to, but she did, and he had sex with her against her.
- In July 2017 to September 2017, Mr McLeod forced her to have sex. He said if she didn't, she would lose the kids.

399. Officer Cottrell spoke to [AM]. He said [AM] told him Ms McLeod had never told her about a rape (it is noted [AM] herself gave evidence that Ms McLeod had told her about a rape). She also told him that Ms McLeod was known to lie.

400. A pretext recording was conducted with Mr McLeod, during which he said: -

- He never publicly fat shamed her.
- He denied forcing her to have sex.
- He accused her of lying.
- He asked if he was being recorded.

401. Officer Cottrell interviewed Mr McLeod in April 2019. Mr McLeod denied the allegations and provided alternative accounts of the allegations.

402. Officer Cottrell made a notation in the occurrence log on 8 April 2019:
"*Please independently verify all information provided by this person. She is known to make false allegations against police and ex-partners. Please exercise caution when dealing with this person*".

403. Officer Cottrell obtained Ms McLeod's medical records from the Hervey Bay Hospital. He made entries in relation to the records noting that: -

- Ms McLeod made no allegation of rape to hospital or medical staff.
- She had not made any indecent dealing allegations concerning the children.
- She had pseudo-hallucinations in the context of anxiety and stress.
- On 4 October 2017 she 'complained she had no peripheral vision whatsoever'. Staff observed and noted that she was able to react to things she could only see in her peripheral vision.
- Ms McLeod had presented for treatment on 16 occasions in 2017/2018 and none were for DFV.
- The hospital notes identified that Ms McLeod was determined to get custody of the children.
- Ms McLeod presented a number of times to the hospital and did not wait to be assessed. The consistent feature of the vast majority of Ms McLeod's interactions with hospital staff is that soon after Ms McLeod received analgesic medication, she'd often calm down and was subsequently discharged'.

404. On 22 April 2019 Officer Cottrell spoke to Ms McLeod's sister [NR]. [NR] said that Mr McLeod had spoken about her being his second wife. [NR] was asked her opinion of whether Mr McLeod raped Ms McLeod over the years. She said she didn't think so but did say Mr McLeod was manipulative and harassed [NR] to sleep with him.

405. On 23 April 2019, Officer Cottrell determined to recommend that the matter be unfounded. His entry noted:-
- [NR] had memory issues and could not answer specific questions.
- In Ms McLeod's domestic violence application of 6 March 2018 she [Not for publication]. This was not in her statement to police.
- Ms McLeod had been obfuscatory about information that she has provided to police. In contrast, Mr McLeod made admissions against his own interests in relation to the use of cannabis and amphetamines.
- A doctor's file note summed up her condition and medications. This explanation neatly sums up what weight police can place on Ms McLeod's recollections from this period. Police consider that Ms McLeod is not a credible witness.
- Police anticipate that if the end result of investigation is not to Ms McLeod's own satisfaction, it will be reincarnated at a time convenient to her, in the same way that this current complaint is a reincarnation of a previous complaint….Police strongly believe that this complaint is motivated by child custody matters currently in the Family Court, which is highlighted as a footnote to the vast majority of the allegations that Ms McLeod has caused police to investigate over a number of years.
- The evidence suggested it was unsubstantiated and recommended to be deemed as unfounded.

406. The officer in charge approved the unfounded entry and on 28 May 2019 the complaint was finalised. Ms McLeod was not informed of this outcome prior to her death.

407. Officer Cottrell said in oral evidence he had received face to face training in the past 12 to 18 months about rape and the law of consent, and coercion to have sex. He said he has a better understanding of the dynamics of domestic and family violence relationships now compared to 2019. He agreed he had a better appreciation of misconceptions around how a rape victim is expected to behave.

408. He agreed that in 2023, he had a better understanding of victims, not making complaints until they were free of a relationship. He also agreed he had a better understanding of myths and misconceptions about separation and using complaints as leverage. He maintained however that if presented with the same situation today the outcome would not be any different in that considering the sufficiency of evidence test there was insufficient evidence to lay charges against Mr McLeod.

Allegations of sexual abuse against [Not for publication]

409. On 28 December 2017 police were called to a domestic violence incident at Mr McLeod and Ms McLeod's house. Police were told Ms McLeod was being held against her will. Ms McLeod told police that wasn't the case. She said she was wanting to leave and wanted help to retrieve her youngest child who was still in the house. Mr McLeod told police there was a fight about dinner, Ms McLeod intended on leaving and wanted 50/50 custody. Police helped Ms McLeod leave the house. Ms McLeod contacted DV Connect that night and motel accommodation was arranged.

410. On 28 December Ms McLeod had taken [Not for publication] to the Doctor with lower abdominal pain. A urine test was done, and Ms McLeod was given the results on 30 December showing no urinary tract infection.

411. On 29 December 2017 DV Connect contacted Ms McLeod at 10:38 am to check on her well-being. She said she needed to recover her youngest child Zaidok who had been left at the house with Mr McLeod.

412. On 29 December at 5:25 pm, Ms McLeod attended the police station with [Not for publication] to make a complaint of sexual abuse of [Not for publication] by Mr McLeod. The incident was alleged to have occurred between 10 December 2017 and 29 December 2017. The complaint recorded: -
    - The victim child and [Not for publication] mother attended the front counter to report offence. The victim child has made disclosures about the abuse on 29 December 2017 in the morning. The mother has then brought the victim child to the police station to make a report.
    - Medical treatment unknown.
    - [Not for publication]
    - [Not for publication]

413. The complaint was investigated by Detective Senior Sergeant Meagan Johnson. Officer Johnson conducted a 93A interview with [Not for publication] commencing that evening. The 93A interview was played during the inquest.

414. Officer Johnson recorded the 93A in the occurrence log as follows: "*the case officer, then obtained a 93A statement from the complainant child* [Not for publication]."

415. Officer Johnson obtained a medical consent form for the medical appointment that [Not for publication] had had at the Burrum Head's Medical Centre. Officer Johnson did not obtain the medical records.

416. Officer Johnson made an entry in the occurrence log as follows "*further information to consider. The informant reported a DV incident to Howard police on 28 December 2017, this indecent treatment occurrence at Maryborough Police station on 29 December 2017, a rape allegation against the suspect at Maryborough Police station for which she is the victim on 30 December 2017, followed by another DV report to Hervey Bay police on 30 December 2017. It is curious that the informant made no mention of the rape allegations when speaking at length with Case Officer Johnson on 29 December 2017. During interactions with Howard police and the case officer there was significant focus by the informant on how to get her youngest child back into her custody. Whilst this is understandable, this may need to be considered a cause for the informant's multiple police reports over consecutive days.*"

417. Officer Johnson sought to obtain a pretext call. She told Ms McLeod this on 1 January 2018. Ms McLeod told her that she was now in Brisbane with the four children at DV accommodation. Officer Johnson advised Ms McLeod that a task would be sent to the nearest police station for an officer to contact her to arrange a suitable time for her to attend the station for the pretext call.

418. Officer Johnson had contact with Ms McLeod about the pretext call on 2 January. Ms McLeod had already attended Fortitude Valley Police Station to do the call. The police station wasn't aware as the task had not been assigned. The task was assigned on 3 January 2018 but by that stage Ms McLeod had returned to Hervey Bay.

419. Officer Johnson spoke to Ms McLeod on 4 January 2018.

420. Ms McLeod told her she had tried to do the pretext, but she'd returned to Hervey Bay because she had no support in Brisbane. Mr McLeod arrived at the home whilst Officer Johnson was talking to Ms McLeod on the phone. Officer Johnson asked Ms McLeod if

the suspect was listening to the phone conversation to which Ms McLeod said yes. Officer Johnson asked Ms McLeod what terms she was on with Mr McLeod for him to currently be at her accommodation talking with her and playing with the children. Ms McLeod became defensive saying words to the effect of "*do you think I've made it all up*". Johnson explained the need to understand the relationship dynamics prior to proceeding with the investigation. Ms McLeod ended the conversation by saying "*fuck ya's all*" then hung up.

421. Officer Johnson obtained a search warrant at Mr McLeod's house on 4 January 2018 and his version of events was obtained.

422. Officer Johnson ultimately made a recommendation to unfound the report on 4 January 2018.

423. In doing so she:-
- referred to the search and Mr McLeod's denials.
- Mr McLeod explained that the informant suffers with bipolar and has not been taking her medication of late. He explained they had separated, and she resides on the ground level of the two-story residence and he resides upstairs with the children whom he has primary care of due to the informant's poor mental health. The informant had not mentioned the separation during dealings with the case officer.
- the suspect stated that the informant had called him the previous day (3rd January 2018) and stated that she needed to move back into the family home and that a support service agency told her that she couldn't move back there until the suspect had moved out. The suspect does not believe it is appropriate for the children to be in informant's care unsupervised due to her poor mental health.
- when questioned regarding whether the victim child had ever had [Not for publication]
- [Not for publication].
- [Not for publication].
- the suspect denied the allegations, he showed the officer personal notes he had made in relation to the events over the past week that corroborated his version. He is currently in the process of completing a private DV application listing the informant as the respondent. Whilst he seeks custody of the children, he does not wish to restrict contact between the informant and the children.
- the victim child's disclosures were limited and not sufficiently particularised. There is no medical or forensic evidence to support the victim child's disclosure. There are no witnesses. The suspect made no admissions to the allegations. The informant has fabricated information throughout this investigation in an attempt to gain full custody of the children and coerce the suspect to move out of the family dwelling. After agreeing to participate in a pretext call, the informant failed to cooperate with the investigative process and even took action that interfered with the investigation. As such evidence indicates the offence did not occur. A task has been sent OIC CPIU Maryborough requesting approval to unfound.

424. Detective Sergeant Adam Spinks approved the unfounded request on 5 January 2018. The police file was closed on 8 January 2018.

Allegations of sexual abuse of [Not for publication]

425. On 11 July 2018 Ms McLeod made a notification to Child Safety that [Not for publication].

426. On 12 July 2018 Child Safety approved an investigation. It was documented as requiring further assessment noting amongst other things the mother's capacity to protect the children on an ongoing basis and the possibility of Ms McLeod's fixation on sexual issues and sexual deviance things in the past noting [Not for publication]'s complaints in December 2017.

427. On 12 July 2018 Child Safety made a request to police for a joint investigation. Later that morning Officer Cheeseman, (a SCAN representative) responded advising that no investigation would be undertaken. She stated "*the family involved in this referral has been the subject of numerous police occurrences predominantly at the instigation of the mother Ms McLeod Harris/McLeod. The parents have been embroiled in a lengthy custody dispute which led to Harris making a number of vexatious and proven false reports against Mr McLeod of domestic violence and sexual abuse of herself and the children. One such report of domestic violence contained allegations of threats to kill by McLeod whilst on an access visit with the children. McLeod was able to produce a tape recording of his entire visit with the children and Harris which proved the allegations to be false. Harris has also made sexual abuse allegations about two other persons in the past which have also proven to be false. McLeod is known to have mental health issues and is well known to sexual assault and mental health services who are aware of her false complaints. Unless some independent information is presented to substantiate the alleged disclosures by the child, police are unwilling to subject a* [Not for publication] *child to a police interview especially given the limited disclosure provided and the credibility of the information ie. paternal grandfather has no criminal history for sexual offences and has never been investigated for this, the allegations of sexual abuse* [Not for publication] *were found to be unfounded and vexatious and there is no records of the father selling himself to gay men*".

428. On 8 May 2019 Ms McLeod went to the Hervey Bay Police Station and made a complaint that [Not for publication] had been to a counsellor and had made disclosures of a sexual nature against [Not for publication] father. The complaint was investigated by Officer Price. Officer Price spoke to Ms McLeod on 12 May 2019.

429. Ms McLeod told Officer Price that in mid-2018 [Not for publication]was playing outside in the dirt when he had to go to the toilet, [Not for publication]. Ms McLeod said that she had notified Child Safety about the disclosure. Ms McLeod said that she did not report the disclosures to the police because she had no faith in the police after a previous investigation where allegations of sexual abuse were made in relation to the same suspect and Ms McLeod's [Not for publication]. She said [Not for publication] had made disclosures to his counsellor on 8 May 2019.

430. Officer Price spoke to the counsellor (Sharon Kirkman).

431. Ms Kirkman told Officer Price that [Not for publication] had attended with her for counselling. She said [Not for publication] had never made any particularisation or disclosure of being the victim of sexual offences. She said that at times [Not for publication]'s mother Ms McLeod had been present and had asked [Not for publication] direct and leading questions suggesting that [Not for publication] had offended against [Not for publication]. She said she was unsure whether [Not for publication] had been subject to sexual abuse. [Not for publication] did display sexualized behaviours such as pulling [Not for publication] pants down at the neighbour's house. She said at best [Not for publication] would have been [Not for publication] years old and if offending did occur there were no injuries and no medical evidence to support this.

432. Officer Price considered that [Not for publication] allegedly made disclosures to Ms McLeod in mid-2018 but was not reported to police until May 2019. She noted the Counsellors view that [Not for publication] would not recall a memory as a [Not for publication]-year-old and would be unlikely to speak to police as there was no rapport building. She said she considered the DPP guidelines on children under 5 giving evidence. She considered it would be detrimental to [Not for publication] to conduct a S93A interview. She concluded that the occurrence was unable to be solved in any way and it was filed pending further investigation.

Reviews of police investigation into allegations of domestic and family violence and sexual assault of and the children.

Review by Inspector Melissa Dwyer

433. The police investigations into Ms McLeod's allegations of domestic violence and sexual assault against her were reviewed by Inspector Melissa Dwyer. Inspector Dwyer is an inspector attached to the Domestic and Family Violence and Vulnerable Persons Unit.

434. Inspector Dwyer noted that Ms McLeod had a history of reported domestic violence incidents involving Mr McLeod and other family members. In her review, she gave a precis of 33 reported incidents of domestic and family violence, mental health occurrences and other reported offences commencing in 2017. She set out police responses to each incident.

435. Inspector Dwyer gave her professional opinion on the adequacy of the investigations and finalisation of those incidents.

436. She pointed out that the approach adopted by police in their investigations at that time was an incident focused approach that is, a response that is dependent upon the nature for which the police had been called. She explained that police have since then moved away from incident focused policing to a holistic approach. That is police officers understand the particular incident in the context of a relationship, and a requirement to consider many other factors that are recorded that may impact upon the outcome that the police officer takes. She said holistic understanding is a complete shift in the way in which police respond, going to a job and how they now respond when they're out on the job. She said that it was not an understanding that the officers involved in the incidents that she reviewed had at the time.

437. Inspector Dwyer in general found that the actions of police in their investigations and finalisation of the reported incidents of domestic violence was appropriate and in accordance with policing policy and procedure as it stood at the time. She did observe that the broad allegations of domestic violence made by Ms McLeod in the context of the complaint regarding [Not for publication] could have warranted further investigation by Officer Johnson to understand the context and any risk to Ms McLeod and the children.

438. In relation to Ms McLeod’s allegations of rape, inspector Dwyer said that based on the matters identified by Officer Cottrell and detailed in QPrime reports, she believed a prosecution of a rape offence(s) was problematic to meet the relevant criminal standard due to the credibility of Ms McLeod.

439. Inspector Dwyer said generally in relation to the report of sexual abuse against [Not for publication], given the specialised nature of the child abuse investigations, she could not comment as to the adequacy of the police response insofar as it was a child protection

matter. She did comment, however, that using her investigative and prosecutorial skills, she was sufficiently satisfied that the finalisation of the matter was appropriate in the circumstances and that any charge brought upon the evidence obtained was insufficient to establish a prima facie case or prove guilt beyond reasonable doubt.

440. Dr Silke Meyer (Leneen Forde Chair of Child and Family Research and Professor of Social Work at Griffith University) provided a report and gave oral evidence on a number of issues. Dr Meyer has over 15 years of research experience in the area of domestic violence.

441. Dr Silke Meyer said that it appeared police were quick to form opinions that Ms McLeod was vexatious. Inspector Dwyer did not agree. She said on reviewing all of the material she considered police conducted the investigations in such a way that they did not arrive at their decisions quickly and in fact, some investigations took many months.

442. It is noted that Dr Meyer in cross examination accepted, with the benefit of further information provided to her, that the complaints were not rushed through by police.

443. In cross-examination, Inspector Dwyer agreed that the occurrences that she reviewed showed the complexities that are faced by police in determining the truthfulness and/or the impact of mental health when dealing with allegations. She said that the police arriving at decisions may not have been truly or acutely aware of certain belief being properly or truly held by Ms McLeod. She said it did appear that Ms McLeod's mental health was considered in the way that it might have had some influence on their decision making, but that in any event, police resolved the complaints and came to the view that the complaints were vexatious complaints because of other evidence that supported that outcome. She said that the impact of mental health on how police investigate complaints is also now something that is looked at differently in the context of a holistic response to DFV. Ultimately Inspector Dwyer was of the opinion that even if police had considered the entirety of Ms McLeod's mental health in investigating her complaints, this would not have made any real difference to the approach that was taken in each instance.

Review by Detective Acting Superintendent Blanchfield.

444. Detective Acting Superintendent '(DAS)' Blanchfield of the Child Abuse and Sexual Crime Group of Crime and Intelligence Command undertook a review of the police investigation of the child sexual abuse allegations. DAS Blanchfield was of the view that the categorisation of the [Not for publication] complaint as an outcome 'unfounded' was incorrect. He said in accordance with the Police Procedure Manual (OPM) to categorise the matter as 'unfounded', evidence was required which indicated the offence did not occur. He said that he was unable to clearly identify evidence that would lead an investigator to suspect that the offence did not occur. He said that there was evidence that Ms McLeod was at times erratic and unhelpful in terms of investigative strategies, particularly around a proposed 'pretext phone call' and her attendance at Mr McLeod's address while investigations were ongoing could be seen as undesirable.

445. He said those aspects, however, did not detract from the relatively clear disclosure made by [Not for publication] in [Not for publication] 93A interview. He said rather than characterising the matter as unfounded, it could have more accurately remained as unsolved and 'filed pending further information' as a means of finalising the matter. It could also have been finalised by categorising it as 'juvenile victim - offences cannot be particularised'. He said that the officer in charge at the time reviewed the matter and approved the categorisation as unfounded. That was also an incorrect decision in his view.

446. DAS Blanchfield concluded that although in his view the investigation was incorrectly categorised as 'unfounded', he did not believe that the investigation was inadequate and, based on the information that he had access to the matter would not have progressed to a prosecution.

447. In relation to the allegations of sexual assault against [Not for publication], DAS Blanchfield noted that on the 12 July 2018, QPS received a child protection notification which contained allegations of sexual abuse of [Not for publication] and a joint investigation was requested. He explained, in some instances, QPS and Child Safety Officers conduct a joint investigation which ensures immediate access to information for each agency to fulfil its individual roles and responsibilities to minimise retraumatising a child.

448. He said in line with the policies under Chapter seven of the OPM, the notification was reviewed by the local SCAN representative Officer Cheeseman. He explained officers in charge of CPIU and SCAN representatives are selected due to their knowledge and experience in investigating child protection matters, but also due to their experience working with all sectors of the child protection system. He said these officers are asked to assess referrals from agencies and apply their professional judgement in determining the appropriate police response. Officer Cheeseman determined that no action was needed by the QPS in relation to the allegations and provided some rationale for that. He said in his opinion a key aspect to that decision was the age of [Not for publication] at the time in terms of conducting an interview. He said although not mentioned by the reviewing officer in their rationale, on his review of the notification [Not for publication] was not going to have unsupervised contact with Mr McLeod.

449. He said that there may have been a missed opportunity to conduct a joint investigation. He said that opinion was based on hindsight and without any knowledge of the resource availability or immediate workload of the unit at the time. He said that may have been something that could have been factored in their decision.

450. Overall, he said he believed that Officer Cheeseman applied the policies and procedures appropriately in relation to child harm referrals and prompts for child harm referrals to be considered by officers when matters are finalised in a manner that results in no charges being laid. He also considered that where there was a parent willing and able, a referral may not be required.

451. In relation to incorrect categorisation of matters DAS Blanchfield noted that the Queensland Audit Office in 2016/17 published a report 'criminal justice system - reliability and integration of data'. They found that QPS had an unacceptable amount of crime data that was incomplete, inaccurate or wrongly classified and that that was contributed officer's poor understanding of the use of data classification rules. The report made seven recommendations, including that QPS ensures that there are appropriate guidelines, policy and training for reporting, classifying and managing crime statistics. He said he understood that the recommendations relevant to the issue had been fully implemented.

452. He said in March 2018 the QPS OPM was amended to include a new section providing information about the categorisation of actions to be taken. The section 'evidence indicates offence did not occur' explains that this is to be used when the investigating officer has determined and documented in the occurrence that the offence is unfounded, as there is sufficient evidence to reasonably suspect the offence did not occur.

453. He said the definition as now appears in the OPM was the required standard in December 2017 when the matter was categorised, but at the time, was not well understood or applied by the police.

Involvement of Child Safety

454. Ms McLeod herself had a history with Child Safety as a child and was known to the Department in relation to parental neglect and being exposed to sexual abuse and physical abuse.

455. Ms McLeod and Mr McLeod first came to the attention of Queensland Child Safety Services as parents in June 2016 in relation to concerns regarding Ms McLeod's mental health. Ms McLeod had been hospitalised for suicidal ideation and it was reported that Mr McLeod was struggling to care for the children due to his alcohol use.

456. Between April 2017 and May 2018, a year prior to their death, service delivery to the family consisted of one intake enquiry, seven child concern reports (CCR), and one notification and corresponding investigation and assessment (I&A) which was finalised as unsubstantiated.

457. The child protection concerns related to Ms McLeod's mental health admissions which resulted in Mr McLeod caring for the children. Allegations were also made that Ms McLeod had attempted suicide by overdose in front of the children.

458. There were also general neglect concerns identified while the children were in Mr McLeod's care, including: -
    - Reports that he had engaged in alcohol and Cannabis use,
    - Reports of domestic and family and sexual violence perpetrated by Mr McLeod towards Ms McLeod, as well as allegations made by Mr McLeod of physical violence perpetrated by Ms McLeod towards him.
    - Allegations of child sexual abuse perpetrated by Mr McLeod towards [Not for publication] in December 2017.

459. In July 2018, Ms McLeod contacted Child Safety Services and raised multiple concerns regarding allegations of sexual assault of [Not for publication] and [Not for publication], previous violence by Mr McLeod, and concerns that he would secure full custody of the children in the family court.

460. Child Safety Services undertook extensive information gathering during the investigation and assessment phase of intervention, which included speaking with Mr McLeod, and Ms McLeod's stepfather.

461. CSO Blackwell conducted the investigation in relation to the allegations of sexual assault against the children.

462. On 12 July 2018 Child Safety approved an investigation that required further assessment, noting among other things the mother's capacity to protect the children on an ongoing basis and the possibility of Ms McLeod's fixation on sexual issues and sexual deviance themes in the past documenting the [Not for publication] complaints in December 2017.

463. On 12 July 2018 Child Safety requested to police for a joint investigation that was declined by Officer Cheeseman. She gave reasons for that decision as referred to earlier in these findings.

464. On 16 August 2018 a Child Youth Mental Health Service report notification was received by Child Safety.

465. On 10 September 2018 Mr McLeod notified Child Safety that among other things Ms McLeod had stolen the children, that she had previously overdosed when the police didn't do anything, and that she had Schizophrenia and Borderline Personality Disorder.

466. During the period 3 July 2018 and 13 October 2018 Ms McLeod was engaged with the Intensive Family Support Service in response to an earlier CCR. This support was focused on supporting Ms McLeod to parent four children on her own and manage the stressors in her life.

467. On 6 November 2018 Ms McLeod contacted the support agency Act For Kids and spoke with the specialist domestic and family violence practitioner attached to IFSS. She disclosed that everything was 'ok', but Mr McLeod was scaring her, and she was terrified he would take the children.

468. On 4 December 2018 CSO Blackwell and CSO Milzewski spoke to Ms McLeod. She confirmed the disclosures that [Not for publication] and [Not for publication] had made, that she had contacted DFV providers, and her diagnosis of anxiety, depression and Borderline Personality Disorder.

469. On 4 December 2018 CSO Blackwell assessed Ms McLeod's home as safe.

470. On 5 December 2018, a request was sent out by CSO Blackwell for information from health, education facilities and police. Police provided the summary of the occurrence report for [Not for publication], it did not contain the full details of [Not for publication]'s disclosures and referred to other complaints made by Ms McLeod that were found to be false. It did contain the words "[Not for publication]."

471. On 7 December 2018 CSO Blackwell spoke to Mr McLeod, who referred to Ms McLeod having Schizophrenia and Borderline Personality Disorder and was not currently treated. Mr McLeod told CSO Blackwell and CSO Milzewski on 10 December 2018 that Ms McLeod had overdosed at least ten occasions.

472. On 12 December 2018 CSO Blackwell and CSO Milzewski spoke to Aaleyn. She appeared happy, healthy and well nourished. Among other things she said that Mr McLeod had never done anything to her, and no one has ever touched her privates. She had not seen anyone touch her siblings' privates.

473. On 12 December 2018 CSO Blackwell and CSO Milzewski spoke to Matilda, she appeared happy, healthy, well-nourished and clean. Amongst other things she said Mr McLeod did not touch her on the private parts.

474. On 12 December 2018 CSO Blackwell and CSO Milzewski spoke to Wyatt. He appeared happy, healthy and well-nourished and clean. There was nothing he didn't like doing with Mr McLeod, and he said nothing negative about Ms McLeod.

475. On 14 December 2018 Ms McLeod emailed CSO Blackwell and CSO Milzewski saying among other things that she wasn't allowed to deny hearing voices, but that in 2016 mental health concluded that she wasn't hearing voices, but that they were intrusive thoughts. She referred to arranging a mental health review.

476. On 6 February 2019 CSO Blackwell completed her investigation. While the investigation initially related only to [Not for publication], she assessed all the children. For each she documented that the outcome was 'unsubstantiated – child not in need of protection' and documented that [Not for publication] and [Not for publication] had not been harmed.

477. In the year leading up to the deaths in May 2019, service delivery to the family consisted of one notification and corresponding I&A, three additional notification concerns. At the time of the deaths there was no departmental intervention with the family.

478. On 25 May 2019, two days prior to the deaths, Child Safety Services recorded another CCR. Child Safety Officer (CSO) Leanne McManus received a call from Ms McLeod with respect to her ongoing concerns about the safety of the children and the possible court outcome with respect to whom the children would be living. Ms McManus noted Ms McLeod disclosed that she was stressed because of the ongoing custody issues, and that her lawyer was not accepting her affidavits. She was feeling as though she wanted to give up and just give the children to the father as she believed that it was a battle she couldn't win. She said that father was making threatening gestures towards her, but the police were no longer taking her complaints.

479. Ms McManus advised Ms McLeod that she should continue to communicate with her solicitor, and if threatened she should continue to report to police, and that she could contact DV hotline or Lifeline.

480. Ms McManus assessed the notification as "information indicates the mother as overwhelmed and stressed due to ongoing family law court proceedings and is fearful the father will get custody of the children, even though it is alleged he has harmed the children in the past."

481. She noted that although the current custody arrangements and the relationship between the mother and the father will be having an impact on the children, there is insufficient evidence provided to identify an impact that is significant, detrimental and observable in nature. She noted there were no concerns regarding the children's interactions with the father reported by Harmony House who were supervising the visits. The notification was recorded as a CCR.

Reviews of child safety interactions with the family

482. After the deaths of Ms McLeod and her children Departmental decision-making in relation to Ms McLeod and her family was reviewed through the child death review process in place at the relevant time.

483. The investigation by CSO Blackwell was reviewed by operation of statute because the deaths of the children came within the prescribed period of having some involvement with Child Safety in preceding months.

484. A Child Safety review was conducted, and a "Systems and Practice Review Report" was prepared on 30 October 2019. Among other things, the high value learnings that were identified were:

4.3 Summary of High Value Learnings

The following High Value Learnings have been identified during the review:

- A cautious approach needs to be taken when considering if notified concerns are vexatious. The validity of all worries raised by parents should be considered independently and corroborating information sought from external partners. In circumstances where it has been determined that specific worries raised by a parent may be vexatious, it is important to not assume that all worries raised by the parent lack validity. In this case, while there was evidence to suggest Mother had made vexatious complaints to police in relation to Father, this did not mean that all of Mother's worries in relation to Father were vexatious.
- It is important during an Investigation and Assessment, to hold multiple hypotheses to explain the worries within the family and continue to test these as new information is gathered. In this case there were several explanations for the notified concerns and worries associated with the family. It was important to consider the worries in the context of Mother's mental health, allegations of domestic and family violence perpetrated by Father and the impact of Family Court proceedings.
- Exploration of culture with family members is an important aspect of developing an understanding of a family. In this case, further exploration of Father's culture and family was required following advice that he identified as Aboriginal.

485. There was a Queensland Child Death Case Review Panel report, Panel 85, from January 2020 that noted "The Panel observed a concerning lack of connection and communication between the services and systems intended to support children and young people in contact with the department".

486. The Panel questioned the decision to finalise the I&A on 6 February 2019 with an outcome of 'unsubstantiated – child not in need of protection' recorded for all four children.

487. As part of the rationale for this assessment it was noted that police had advised the Department that Ms McLeod "has continued to make vexatious allegations against Mr McLeod in an effort to retain custody of the children". Child Safety had assessed that Ms McLeod and Mr McLeod were both willing and able to provide care and protection needs for the children. There was some risk that the children would "unnecessarily" be exposed to police and Child Safety further if Ms McLeod continued to make vexatious claims against Mr McLeod prior to family court proceedings being finalised.

488. The Panel noted that although police had determined there was insufficient evidence to pursue criminal charges against Mr McLeod, this did not preclude Child Safety Services from taking action to intervene and provide support to the family as the threshold for Child Safety intervention is significantly different to that of police investigating criminal complaints.

489. It was also noted there were multiple risk factors present for the family, including child sexual abuse allegations, domestic and family violence, parental mental health issues and problematic substance use. The Panel also noted the "risk of assuming all complaints reported by Ms McLeod including those about domestic and family violence were not valid, based on previous interactions between her and the police".

490. In relation to contact made by Ms McLeod with Child Safety on the 25 May 2019 the Panel questioned what training service centre staff have to ensure they have adequate communication skills to check whether a parent or child is suicidal or at an immediate risk of causing harm to others. The Panel agreed that whilst it was not possible for Departmental officers to be mental health experts, it is essential that staff have sufficient expertise to respond to and support a child or a parent who is expressing thoughts of suicide.

491. The Panel did not make any recommendations to address the issues that they identified.

492. An independent review was also undertaken by the [Not for publication]. The [Not for publication] was asked to conduct a whole-of-government Systems review. The [Not for publication] was asked to: -

- [Not for publication]
- [Not for publication].

493. The [Not for publication] identified that: -
[Not for publication][Not for publication]

494. The [Not for publication] made three recommendations: -
[Not for publication][Not for publication][Not for publication]

495. Dr Meegan Crawford, the Chief Practitioner Child Safety Services, provided a response to [Not for publication]'s recommendations. [Not for publication].

496. [Not for publication].

Family Law and Court Process Matters

497. Ms Fiona Terrell of Carswell & Company was the solicitor funded by Legal Aid to act for Ms McLeod in her protection order application and family law matters. Ms Terrell was not a party in the proceedings but provided to the court parts of her file. She also gave a statement and gave oral evidence and was cross-examined.

498. As already noted, Ms McLeod had an email exchange with Ms Terrell in the hours preceding the crash. Ms McLeod's note indicates she felt her lawyer and the legal system had let her down. There was evidence provided to the Inquest that Ms McLeod had often expressed either in person or in writing that she was unhappy with her lawyer, and unhappy with Legal Aid. She was worried about Mr McLeod getting full parental custody of the children.

499. Counsel Assisting summarised extracts of documents which indicate Ms McLeod was concerned about her representation. They included:

a) on 11 May 2019 Ms McLeod spoke to the wife of the Church Pastor, Naomi Oksanen. Ms McLeod expresses concerns about her lawyer and said she will kill herself if Mr McLeod gets the kids.

b) on about 20 May 2019 Ms McLeod spoke to [AM] about concerns of Mr McLeod getting the children.

c) Ms McLeod messaged Patrick Taylor on about 24 May 2019 that her lawyer is a real "*so and so*" She said Legal Aid won't let her change lawyers; and

d) the day before the crash, on 26 May 2019, she told DV Connect that she had requested a change of lawyers, though Legal Aid.

500. Emails and documents provided by Ms Terrell include: -

a) Ms McLeod providing a handwritten document setting out a variety of matters including, among other things, that her overdoses were all a direct result of DFV, she provides an account of the events of 30 December 2017 where she refers to taking an overdose, calling Child Safety and asking them to care for the children.

b) communications between November 2018 and January 2019 about Child Safety conducting an investigation. The emails also referred to various steps that the Independent Children's Lawyer was undertaking.

c) on 21 January 2019, Ms McLeod advised that between 2009 and 2016 she saw a psychiatrist monthly, had to have blood tests, and that the diagnosis of Schizophrenia was not believed to be her mental illness.

d) in February 2019, there are a variety of exchanges that refer to Ms McLeod seeking a new lawyer from Legal Aid, Ms Terrell receiving subpoenas issued by the ICL, Ms McLeod wanting to provide information, and doing so to the ICL instead of the report writer. Ms Terrell strongly advised against stopping the visits at Harmony House unless they determined to do that. Ms McLeod was told that if she stopped the children attending, it may seem she was unwilling to facilitate a relationship with Mr McLeod.

e) on 2 April 2019, Ms McLeod told Ms Terrell that there was an investigation underway for Mr McLeod' rapes. She referred to Child Safety, advising her that Mr McLeod' allegations of her mental health were unsubstantiated.

f) on 3 April 2019 Ms McLeod said she needed help understanding the letter forwarded from the ICL about the report interviews.

g) on 1 May 2019 Ms McLeod requested an appointment with Ms Terrell; and

h) on 2 May 2019 Ms McLeod said she wanted to respond to Mr McLeod' affidavit, that Mr McLeod had lied and that she could prove it, she had videos of the fear the children showed towards Mr McLeod, and that she felt no one was explaining things to her.

501. Ms Terrell referred in her statement to the assistance she provided to Ms McLeod in seeking a protection order, attending for family dispute resolution mediation and responding to material filed in the family law proceedings. In oral evidence she referred to preparing Ms McLeod's various affidavits for the domestic violence application. She also spoke to Ms McLeod in person at court and mediations. She had been in court on 27 of May on an unrelated matter and emailed Ms McLeod responding to her email when she came out of court.

502. In her statement Ms Terrell referred to only becoming aware that Ms McLeod was not in Hervey Bay when she received Ms McLeod's email saying amongst other things that "*we are safe with DV Connect*". She said her advice to Ms McLeod was full and frank, and at that time there was no relationship breakdown between her as the solicitor and Ms McLeod as the client. She said it was more that Ms McLeod did not like the advice she was being provided. She was asked at the Inquest whether her advice not to withhold contact would have been any different if she had known that Ms McLeod was telling people she was afraid of Mr McLeod and that [Not for publication] had disclosed [Not for publication]. She stated that it would not necessarily have changed her advice.

503. In relation to Ms McLeod's mental health, Ms Terrell said Ms McLeod had said she was medication compliant, that she was seeing mental health practitioners, and that she had childhood trauma as well as numerous admissions to hospital due to mental health

issues. She referred to Ms McLeod's affidavit where Ms McLeod had said she had been coerced into exaggerating her mental health symptoms and a medical certificate that Ms McLeod had provided to her dated 5 November 2018 that showed Ms McLeod had been doing well for three months. She said mental health material had been subpoenaed at the request of the Independent Children's Lawyer, but she had not had an opportunity prior to the crash to all of those volumes of material.

504. Ms Terrell said she was aware of the DFV best practice guidelines but was not aware of any risk assessment tools available to solicitors. She described that in essence that she was otherwise self-directed as to her knowledge of DFV and mental health matters for clients.

505. She said that she had never had any specific training around assisting clients with mental health issues, or in identifying clients with mental health issues. She said she did not have any concerns about Ms McLeod's mental health. She did not have any knowledge of Borderline Personality Disorder specifically, other than that it could be treated with behavioural therapy. She agreed that it would have been helpful to have training, and she would support training for practitioners to identify a client with Borderline Personality Disorder.

506. Mr Ralph Moses, Chief Executive Officer from the Queensland Law Society, provided a statement that attached a variety of CPD activities and presentations that the Law Society have undertaken. He said there was a DFV portal that was available to support solicitors dealing with domestic and family violence, personally and professionally. He referred to DFV best practice guidelines.

507. He also gave evidence of the development of competency models in consultation with other organisations to develop training resources for legal practitioners who were exposed to DFV. Ms Sandra Pepper, General Manager of the education team with the Queensland Law Society, said that where clients are in crisis there was no specific training or support to solicitors to assist with this.

508. Ms Nicola Davies, the Chief Executive from Legal Aid Queensland, gave a statement and set out the resources and training that Legal Aid provide, including the best practice guidelines for people working with clients experiencing DFV, as well as mental health reviews. Both in-house lawyers and preferred suppliers were required to comply with case management standards in family law. There were resources available to in-house LAQ staff that were not available to preferred suppliers that included psychological wellness training for staff. It was the expectation of preferred suppliers to maintain their professional development in the area of law they are funded to provided services for.

509. Legal Aid and Queensland Law Society have been proactive in training and gave evidence that they were receptive to improving services for clients and solicitors.

510. Evidence was also heard as to how training system may assist legal practitioners placed in the same situation as Ms Terrell in the future.

511. Dr Silke Meyer gave evidence about the coercive nature of family proceedings and the fear of mothers losing their children because they are blamed for not protecting them, or the fear of DFV or sexual abuse occurring. She said there was benefit to providing training through Legal Aid Queensland or the Queensland Law Society about that and identifying risks. She considered a dedicated specialist practitioner at the Law Society would be useful because not all solicitors can have an understanding of DFV and other issues.

512. Dr Heffernan in his report referred to training he had previously been involved with for Legal Aid Queensland about mental health matters.

513. Amanda Shipway, Director of Integrated Service Responses, Office for Women and Violence Protection, said that they were also, as part of their work, engaging with Queensland Law Society.

FINDINGS ON THE ISSUES

1) - Findings required by s. 45

Identity of the deceased

514. The Inquest concerned the death of five people. The identity of the five deceased persons was not in issue.

    a) Ms Charmaine Louise McLeod (born on 18 November 1983 aged 35).
    b) Aaleyn Faith McLeod (born on 30 August 2012 aged six).
    c) Matilda Azaria McLeod (born on 5 July 2013 aged five).
    d) Wyatt Mr McLeod (born on 19 August 2014 aged four).
    e) Zaidok John Sampson McLeod (born on 24 October 2016 age two).

Place of death

515. Ms McLeod, Matilda, Wyatt, and Zaidok McLeod died at the scene of the crash on the Bunya Highway, Kumbia, Queensland. Aaleyn McLeod died in transit the Children's Hospital Queensland.

Medical Cause of Deaths

<u>Charmaine Louise McLeod</u>

516. The Toxicology Report for Ms McLeod showed Fluvoxamine (an antidepressant) at 0.75 mg/kg which was reported in the Autopsy Report as being a toxic level of the antidepressant. All other items detected were unremarkable or nontoxic. In relation to Ms McLeod's stomach contents, the lumen contained cream fluid in which no drug residues could be recognised.

517. No parties at the inquest suggested that Ms McLeod was driving erratically as a result of having taken an overdose. There was no evidence that Ms McLeod was speeding or that Ms McLeod was driving erratically, having executed a normal over taking manoeuvre moments before the crash. The autopsy report does not suggest that Ms McLeod was compromised in any way.

518. Later review processes determined that the level of Fluvoxamine was likely an effect of the post-mortem process.

519. The expert consultant opinion of Doctor Heffernan (who also held the position of Director of Forensic Mental Health Services for Queensland Health) was Ms McLeod showed no decompensation or evidence of any acute mental health issue on 27 May 2019. It was not suggested to him by anyone that an overdose may have been a factor.

520. Although Ms McLeod's body was consumed by fire at the scene, the Autopsy Report showed no evidence of soot in her lungs or smoke inhalation indicating that she was already deceased prior to the car catching fire and the fire consuming her body. CT scans revealed extensive and severe antemortem craniofacial, thoracic, spinal, and pelvic injuries. Her head injuries were so severe that they distorted her head shape and features. She had extensive internal injuries including a traumatic disruption of the right coronary artery.

521. Consistent with the evidence, the Autopsy Certificate notes the cause of death was due to multiple injuries from a motor vehicle collision as the driver.

<u>Aaleyn Faith McLeod</u>

522. The Toxicology Report for Aaleyn showed unremarkable items detected or nontoxic items detected.

523. As set out above, while documented as having been located 20 metres from the car, there is no evidence of Aaleyn's body being photographed in situ at the scene of the crash. On attendance by the Queensland Ambulance Service, she was unresponsive with blood in the airways. She was taken to the Kingaroy Hospital and experienced cardiorespiratory arrest enroute. She was air lifted to the Children's Hospital Queensland with further arrests. At 11.18pm she had complete heart block and pacing was ceased. She was asystole and resuscitation efforts were ceased. She was declared like extinct by hospital staff at 11.41pm.

524. Although Aaleyn's body was located outside of the Nissan on the ground and appears to have been on the road when the carriage of Mr Orreal's truck passed over top of her in the bid to assist at the scene, it is apparent from the Autopsy Report and Addendum Autopsy Report that Aaleyn had extensive injuries consistent with a high velocity motor vehicle crash and did not die as a result of anything connected to Mr Orreal. The Autopsy Report states that the CT scan shows intracranial subarachnoid haemorrhage with possible cerebral oedema and swelling, displaced right temporoparietal bone fracture, extensive pulmonary parenchymal changes, intraperitoneal haemorrhage and right humerus and right tibia long bone fractures. She had extensive blunt force injuries to the face, torso, and extremities most prominent over the anterior right side of the body. She had extensive internal injuries. She died from multiple injuries due to, or as a consequence of, a motor vehicle collision.

525. In an addendum report asking that the truck footage be addressed, along with specific questions, about whether this contributed to the cause of death, the cause of death remained unchanged. The external injuries were most predominantly on the right side of her body consistent with impacting the road when thrown from the vehicle. The internal injuries were not isolated to one side of the body. There were no injuries identified consistent with being impacted by the undercarriage of the truck, and no pattern injury consistent with tyre marks. The brain injury was a significant deceleration injury consistent with a 100km/hr collision, which would have resulted from the collision and resulted in death even in the absence of any other injuries.

526. Consistent with the evidence, the Autopsy Certificate notes the cause of death due to multiple injuries from a motor vehicle collision as a passenger.

<u>Matilda Azaria McLeod</u>

527. The Toxicology Report for Matilda showed unremarkable items detected or nontoxic items detected.

528. Although Matilda's body was consumed by fire at the scene, and the CT scans did not enable clear identification of antemortem injury or fractures, there was no objective evidence to indicate that she was alive at the onset of the fire. There was recent traumatic injury to the upper cervical spinal cord and right chest cavity consistent with traumatic injuries sustained in a high velocity motor collision.

529. Consistent with the evidence, the Autopsy Certificate notes the cause of death due to multiple injuries from a motor vehicle collision as a passenger.

Wyatt James McLeod

530. The Toxicology Report for Wyatt showed unremarkable items detected or nontoxic items detected.

531. Although Wyatt's body was consumed by fire at the scene, and the CT scans did not enable clear identification of antemortem injuries, a posterior dislocation of the right hip was considered compatible with traumatic injury. An acute brain injury was confirmed and considered evidence of a traumatic brain injury. There was no evidence of soot within the upper or lower airways to indicate that she was alive at the onset of the fire.

532. Consistent with the evidence, the Autopsy Certificate notes the cause of death was due to multiple injuries from a motor vehicle collision as a passenger.

Zaidok John Sampson McLeod

533. The Toxicology Report for Zaidok showed unremarkable items detected or nontoxic items detected.

534. Although Zaidok's body was consumed by fire at the scene, and the CT scans did not enable clear identification of antemortem injuries, a possible sacral ala fracture adjacent to the sacroiliac joint was identified. There was evidence of recent traumatic intra-abdominal injury including extensive laceration of the liver and spleen with collections of blood within the abdominal cavity, consistent with traumatic injury prior to death. There was no evidence of soot within the upper or lower airways to indicate that he was alive at the onset of the fire.

535. Consistent with the evidence, the Autopsy Certificate notes the cause of death due to multiple injuries from a motor vehicle collision as a passenger.

How Ms McLeod, Matilda, Aaleyn, Zaidok, and Wyatt died

536. As previously noted in these findings, the question of how Ms McLeod, Matilda, Aaleyn, Wyatt, and Zaidok died is wide enough to incorporate an investigation of the circumstances leading to their deaths.

537. It is apparent the cause of all the deaths was the crash. There is no evidence they were alive inside the car at the time that the car was engulfed in flames. There was nothing anyone present at the scene or thereafter could have done to prevent the deaths.

538. I find Ms McLeod committed suicide by intentionally driving into the truck and committed filicide of her four children.

539. A decision by Ms McLeod to do this, as Counsel Assisting observed, "was not an objectively rational decision that other members of the public would make".

540. Different views as to possible factors behind Ms McLeod's decision have been put forward in evidence and in submissions from some of the parties at the Inquest.

541. The Forensic Crash Unit investigator, Senior Constable McKinlay's opinion after the investigation was that Ms McLeod had willfully driven into the front of the truck in order to take her own life, and that of four children.

542. Detective Senior Constable Lisa O'Leary was the author of the QPS Coronial Investigation Report into the deaths of Ms McLeod and her children.

543. She concluded in her report that "*it appears evident that the deceased had premeditated the murder/suicide against Mr McLeod and the Family Law Court. The deceased appeared determined that if she could not have full custody of her children, no one else could, and this is a consistent theme noticed by police throughout this investigation*".

544. Counsel Assisting and Ms McLeod's family submit it would be reasonable to find that Ms McLeod committed suicide by intentionally driving into the truck and committed filicide of her four children to protect them from harm that she perceived to exist, noting that the factual truth of that alleged harm is not being determined at the Inquest.

545. Counsel Assisting submitted there is evidence that Ms McLeod was genuinely concerned about her children's safety in the hands of Mr McLeod.

546. It is submitted there was no evidence that her actions were premeditated.

547. At the time of intake at the refuge there were no suicidal concerns seen by the DV workers. There was no evidence the note was prepared prior to 27 May.

548. I accept that it is a reasonable conclusion that the note was written on the evening of 27 May, after Ms McLeod's exchanges with Ms Terrell at around 6pm.

549. I accept that in the days leading up to the incident Ms McLeod has spoken to a number of people in a forward-thinking manner, for example she'd spoken to her friend, [AM], about catching up in Brisbane the following week and she spoke about forward planning with the DV workers at the refuge.

550. On 26 and 27 May Ms McLeod had contact with another friend, Heather Cummings, via text message and on the phone.

551. Ms Cummings said, "*there was no indication from her, that she was-you know, feeling … the whole conversation was very positive. There was no – and, I've spoken to her when she's been really in it, you know?, struggling… and that was not – that was not the way our conversation went. It was very – we're going to be safe – we're getting away from it. And looking forward to see me next- this Wednesday and looking forward to my call on Wednesday*".

552. I accept that it is open on the evidence that there was no premeditated plan prior to the evening of 27 May. There is however evidence which I accept, that Ms McLeod had on previous occasions (in 2016) disclosed to her friend, Anita Gaze, that she had thoughts of killing herself and her children in a car crash.

553. Police interviewed Ms Gaze with whom Ms McLeod had lived for some time and had had intermittent contact with up until June 2018. Ms Gaze told police that in 2016 Ms

McLeod told her that "*it took all of her willpower, when she was in the car with the children, not to drive into a tree and kill them all so that Mr McLeod could not have them*".

554. Ms Gaze reported to Child Safety that she was concerned for the children's safety (but didn't specify precisely what Ms McLeod had said).

555. Further, Ms McLeod had told people that she had dreams or thoughts about being killed in a car crash with her children. Ms Julie Jorgenson (the counsellor Ms McLeod saw from 2017) gave evidence that Ms McLeod had dreams of having a car accident and feared her children dying in the car accident.

556. Ms McLeod's complex mental health is of course relevant when considering what led to her decision.

557. As indicated in the evidence, Ms McLeod's diagnosis changed during the period of her interaction with Mental Health Services.

558. I accept it is unnecessary, as indicated earlier, to attempt to make findings about what the correct diagnosis was.

559. At the time of her death Ms McLeod's preliminary diagnosis was Borderline Personality Disorder.

560. In January 2019 Ms McLeod had told her GP that she had had less hospital admissions and was feeling better. She wanted to go off her antipsychotic medication.

561. Her Seroquel was gradually reduced, and by March 2019 she was completely off that medication.

562. Dr Ibe had two appointments with Ms McLeod in May 2019 (the month of the accident). Ms McLeod confirmed she was doing well off Seroquel. On 17 May Dr Ibe provided her with a prescription for antacid: antidepressants and migraine medication. Dr Ibe said at that time she seemed "well and stable".

563. There had been a decrease in Ms McLeod's presentations for serious crisis and hospital admissions as this point.

564. The evidence showed that Ms McLeod – despite telling Dr Ibe that she was doing well off her medication – had been experiencing some mental health symptoms in the months leading up to her death.

565. Ms McLeod had had a brief relationship with Mr [KO] from December 2018 to February 2019. [KO] gave evidence that when he was living at her place there were times when she would just sit there and go absolutely blank, just like someone turning out a light. He said she would, for no reason, just burst out laughing, and that he couldn't work out her behaviour. He said he had urged her to go back on her medication.

566. Submissions were made by the Police Commissioner and by Mr McLeod that certain traits associated with Ms McLeod's Borderline Personality Disorder impacted on her decision to kill herself and her children.

567. Reference was made to the evidence of Dr Sabry who had indicated that if the symptoms displayed to [KO] were evidence of a psychotic symptom, he would expect the psychosis to progress in the following weeks and months. He did not think if a person was psychotic, that they would be able to mask that psychosis in the following

months. He considered if a person, as Ms McLeod did, presented as doing well to her GP and engaged positively and forward planned, that would be inconsistent with psychosis.

568. He was asked what could happen to a person with Borderline Personality Disorder if their attention is taken away to have a particular focus, for example as with Ms McLeod, a focus of the legal case and custody. He said that usually if they have a goal and a focus, it distracts them from their stresses, and they become more organised and able to focus and get the job done. The problem happens when they are frustrated by something or the process itself fails. If the process itself they have been fighting for or focusing on does not go as they planned, the features of borderline personality, like impulsivity, anger outbursts, and mood swings would be exacerbated.

569. He was asked whether in a situation where there was some bad news or it wasn't going to plan, what that could trigger. He said if the news was very, very bad and very frustrating it could push the person to do very significant actions.

570. Dr Chris Lilley, Clinical Director, Mental Health and Specialised Services of the Sunshine Coast Hospital and Health Service said, "… *in Borderline Personality Disorder, it would not surprise me that somebody, if you like, is having a good day and may well manifest no problems at all, and then, later that day, experience some stress – distress or crisis, and everything unravels*".

571. Dr Heffernan in his addendum report responded to the question "assuming that Ms McLeod's primary diagnosis of Borderline Personality Disorder is correct, would the email communication from her lawyer about having to return the children and/or stop resisting contact have a triggering effect to cause psychosis, or some other impairment of her thinking.

572. Dr Heffernan said, "… *it was important to consider the context of Ms McLeod's state of mind prior to receiving the email communication*."

573. Firstly, this can be interpreted from her actions: fleeing from Hervey Bay to the Women's Refuge in [Not for publication] and reporting that she had grave fears for her safety and the safety of her children. She believed that the father of the children had made death threats to her, and she believed, and reported, that he had been mistreating the children in ways that put them at significant risk, including the type of harm that Ms McLeod reported having experienced in her own childhood. It follows that any communication about issues to do with contact with the perceived persecutor and child custody would have been particularly emotive for Ms McLeod.

574. Secondly, Ms McLeod suffered from mental health conditions, Borderline Personality Disorder and schizophrenia, that were probably not adequately treated at the time. Meaning that she was likely to have a mental state where interpretation of sensitive information could be challenging and a state that was particularly vulnerable to emotional distress.

575. Thirdly, Ms McLeod had longstanding negative connotations about herself and the world arising from her own childhood experiences. These perceptions, characteristic of those who experience childhood trauma, would have coloured her perception of her own and her children's vulnerability and her capacity for trust.

576. These three factors collectively could predispose Ms McLeod to challenges interpreting and managing emotional responses to any communications relevant to her, her children, and her relationship and contact with the alleged persecutor.

577. In this context, it is more likely than not, that the email communications were received and interpreted in a particularly distressing light, and this is evident in the responses by Ms McLeod. She highlights this herself in her own question, "*I've pretty much lost my children*". It seems a reasonable assumption that her interpretation was that this is yet another, in a long line of perceived injustices, that ultimately meant that her and her children could not be safe, and this contributed to a sense of fear, helplessness and hopelessness.

578. In relation to a diagnosis of schizophrenia (which he supported) and whether the exchange with the lawyer could have caused psychosis, he said it is unlikely psychosis, if it were not already present, could have developed over the course of one hour.

579. He did not consider that the suicide note reflected any thought disorder or bizarre delusional material that might be consistent with psychosis.

580. Dr Silke Meyer gave evidence in relation to homicide, murder/suicide and murder/filicide. Her impression, having regard to the email exchange between Ms McLeod and her lawyer on 27 May, was that Ms McLeod displayed a high level of emotional distress, which was compounded by the mental health factors and previous suicide attempts. She gave oral evidence regarding studies that showed it was rare for suicide to connect to filicide for a parent of either gender. Fathers who killed their children are more likely to have criminal histories for violent offending and substance abuse. Fathers are more likely than mothers to kill for revenge to the other parent. Mothers were more likely to have a mental illness and more likely to have a history of victimisation of childhood physical and/or sexual abuse.

581. I accept the evidence shows Ms McLeod was very concerned she was going to lose custody of the children. This issue had been a stressor for her over preceding months. She was stressed by the family law proceedings underway. She had made complaints of alleged domestic violence and sexual assault against Mr McLeod. She complained to various people that the police were not keeping her safe and the legal system was letting her down, She told her friend [AM] that she was not happy with her lawyer and the ongoing custody battle. She contacted Child Safety on 25 May telling CSO McManus she was stressed about the ongoing custody battles and was feeling as though she wanted to give up and just give the children to their father as at was a battle she couldn't win.

582. The email exchange on the evening of 27 May led her to believe she was going to lose the battle and Mr McLeod would get custody of their children. In keeping with her untreated mental health conditions, particularly Borderline Personality Disorder, this belief triggered a dramatic response namely the killing of herself and her children. I am unable to determine whether this was solely an act of revenge against Mr McLeod or a result of a genuine perceived fear for the safety of herself and her children. It is difficult to conclude however that Ms McLeod acted "protectively" in killing her children.

583. I find Ms McLeod, Aaleyn, Matilda, Wyatt, and Zaidok died because Ms McLeod intentionally drove her car into the truck.

Date of death

584. Ms McLeod, Aaleyn, Matilda, Wyatt and Zaidok died on 27 May 2019.

2) - the appropriateness and adequacy of the police responses to the complaints of domestic and family violence and allegations of abuse made by Ms Charmaine McLeod against her and her children.

585. Counsel Assisting, Ms McLeod's family, Mr McLeod, the Commissioner of Police and the named police officers made submissions on this issue.

Submissions by Counsel Assisting

586. Counsel Assisting, whilst maintaining that no adverse comment should be made against QPS, submits that there were missed opportunities officers in the police responses to the allegations of domestic and family violence and sexual abuse allegations made by Ms McLeod and the complaints concerning [Not for publication] and [Not for publication].

587. Counsel Assisting firstly made submissions concerning QPS action in categorising [Not for publication]'s complaint of a sexual assault as 'unfounded'.

588. It was submitted that changes should be made to the police OPM in relation to categorisation of matters as 'unfounded'.

589. Evidence was given and submissions made about police use of the category "unfounded" to finalise charges.

590. The police OPM was amended in 2018 following a Queensland Audit Office Report in 2017 which found that QPS had an unacceptable amount of crime data that was incomplete, inaccurate and wrongly classified.

591. The 2018 amendment included a new Section 1.11.11 to provide information about the categorisation of actions to be taken. The Section 'evidence indicates offence did not occur' explains this was to be used when the investigating officer had determined and documented in the occurrence that the offence was unfounded as there was sufficient evidence to reasonably suspect the offence did not occur.

592. DAS Blanchfield, who reviewed the police investigation into the [Not for publication] allegations, concluded that the use of the category "unfounded" with respect to the [Not for publication] allegation was incorrect.

593. He said to categorise a matter as unfounded there had to have been evidence which indicated the outcome did not occur. In his opinion, on review, there was no evidence that the offence did not occur. He nonetheless was of the view that the investigation and the outcome was appropriate and adequate.

594. Counsel Assisting raised concerns regarding the continued use of the categorisation of 'unfounded'. This included concerns about its inaccurate use and the impact on "the sufficiency of evidence test for prosecution; concerns about the impact on reported crimes statistics, and the false connotation that the use of the term 'unfounded'" may have on other agencies.

595. In relation to the adequacy of police investigation into Ms McLeod's complaints of domestic and family violence, Counsel Assisting referred to the Commission of Inquiry into QPS responses to domestic and family violence. The report from the Commission of Inquiry was completed in November 2022.

596. Reference was made to the Recommendations in the Report in particular recommendation 28 which provided within 12 months, the QPS improve its training in relation to domestic and family violence by ensuring all relevant programmes contain clear messaging that: -

- Dispels myths that women frequently make up allegations of sexual assaults and domestic and family violence.
- Dispels myths that domestic and family violence is not a gendered issue.
- Dispels myths that an ideal victim exists.
- Explains the dynamics of power and control in relationships characterised by domestic and family violence.
- Reinforces the need to investigate domestic and family violence as a pattern of behaviour over time.

597. Counsel Assisting submitted the evidence showed that the issues identified in the Commission of Inquiry were apparent in the police responses to Ms McLeod's complaints.

598. It was submitted that the evidence illustrated many of the misconceptions and views police held about women making complaints of sexual abuse and domestic violence in the context of custody proceedings.

599. For example, it was noted that Ms McLeod was viewed negatively for making complaints during or post-separation, for not telling police of her own rape complaint when she was supporting [Not for publication]'s complaint, and for perceived differences in accounts despite only a front counter complaint being made. Ms McLeod was labelled as a person who made false complaints.

600. It was noted that QPS are in the process of delivering on the recommendations made by the Commission of Inquiry into QPS responses to domestic and family violence.

601. It was submitted that the Vulnerable Persons Unit was not in existence in the Wide Bay area until 2019 and that it was likely that Ms McLeod had not come to the attention of that unit given the status of her domestic and family violence complaints.

602. In relation to the police response to Ms McLeod's rape allegations, Counsel Assisting again emphasised that a finding of fact should not be made about Ms McLeod's allegations. Further, that no adverse criticism should be made against Officer Cottrell concerning his investigations or the views he formed. This is in light of the Commission of Inquiry revealing systemic and cultural QPS issues which are now being addressed as a result of the recommendations.

603. Counsel Assisting concluded in submitting that it could not be said that Officer Cottrell did not investigate the matter. Despite expressing concerns about Ms McLeod, he continued to investigate her complaint. Counsel Assisting submitted that although police response at the time was adequate, going forward it is important to ensure, having regard to systemic issues, that the gaps identified in retrospect are addressed. It is important to ensure that the domestic and family rollout from the Commission of Inquiry addresses adult rape investigations as well.

604. Counsel Assisting noted that a holistic training programme is being rolled out by QPS as part of the Inquiry and other recommendation.

605. In relation to mental health, Counsel Assisting submitted it is important that QPS have better access to mental health experts. It was noted that Officer Cottrell did not have access to Ms McLeod's full medical records, and it is possible that in his references to attention seeking, Officer Cottrell wrongly construed Ms McLeod's history as being attention seeking without understanding that attention seeking was a component of perceived rejection common in patients with Borderline Personality Disorder. This may have been relevant in his construction of her history in a negative way, which may have reflected upon her adversely.

606. Counsel Assisting said that training and understanding of police is deficient when dealing with victims who have mental health issues.

607. The head of the Domestic and Family Violence and Vulnerable Persons Command, Acting Assistant Commissioner Virginia Nelson gave evidence. She said that use is made of the 2017 Memorandum of Understanding between police and Queensland Health. There is also the availability of a Police Advice and Intervention Plan (PAIPS) which is a plan devised by mental health clinicians that provides information and strategies about a consumer to assist QPS to resolve a mental health incident. Further mental health liaison officers are available to assist. Acting Assistant Commissioner Nelson did not consider that separate training was required to address mental health issues, rather there should be avoidance of siloing training and that mental health should be part of best practice responding.

608. Counsel Assisting noted there are now measures put in place for persons with mental health illnesses and domestic family violence matters in the current rollout of the commission recommendations. It was also noted that PoliceLink and mental health liaison officers are now more readily accessible to police. It was submitted however that a multiagency team for persons with complex mental health and trauma background may have been able to meet other unmet needs of Ms McLeod and her family.

609. Evidence was given by various persons about the value of multiagency teams.

610. Dr Silke Meyer said that multiagency teams were effective, but there needed to be a lead agency. Information sharing platforms were important, but it still needed collaboration of agencies, rather than people just accessing information. It was about keeping everyone in view and to consider the family support needs.

611. Inspector Melissa Dwyer said that Ms McLeod would not have met the threshold for the high-risk team.

612. Both Inspector Dwyer and Acting Assistant Commissioner Nelson were supportive of improved delivery of services for victims whose primary need was mental health focus, and both were supportive of a multiagency team linking with Mental Health.

613. Dr Heffernan agreed that a multiagency response was required to meet Ms McLeod's needs and to fill the gaps in the service delivery.

Counsel Assisting's submissions in relation to police response to [Not for publication] allegations

614. Counsel Assisting submits that police officers involved (Officer Johnson and Officer Cheeseman) could not be singled out as the Commission of Inquiry revealed systematic and cultural QPS responses at the time and that they should not be the subject of adverse inference or criticism.

615. She submits that police did not fully understand what was available or admissible as supportive or corroborative evidence, nor the other reasons for seeking medical documents about the examination undertaken of [Not for publication] the day before the complaint was made.

616. She says the views and opinions expressed by police of Ms McLeod were reflective of identified QPS systematic issues revelated in the Commission of Inquiry.

617. She noted in particular that Inspector Dwyer identified a missed opportunity for intervention by Officer Johnson when she didn't enquire into domestic and family violence when she was having contact with Ms McLeod at the time of the complaint. Counsel Assisting submits had enquiries been made by Officer Johnson about Ms McLeod's situation, and with DV Connect, then Officer Johnson may have come to different view of Ms McLeod's situation and perhaps would have better understood that Ms McLeod may not necessarily have been leveraging [Not for publication] for custody.

618. It was noted that it is expected that these matters will be addressed as part of the holistic training for police as the QPS rollout of the Commission of Inquiry recommendations.

619. It is also noted by Counsel Assisting the question must be asked why at least a child harm referral from police to Child Safety did not take place from either Officer Johnson or Cheeseman considering the disclosures made by the children. It is noted that the flow-on effect of the views formed by these officers about Ms McLeod, influenced a potential child harm referral decision, and it is further noted that the basis for these views was a systematic QPS issue which is being addressed.

620. Counsel Assisting made submissions that in her view the evidence revealed at the Inquest that the police did not understand what types of evidence could be admitted in sex cases, which may have an impact on the assessment of sufficiency of evidence.

621. Counsel Assisting also made submissions about collaboration between departments and multiagency teams in reference to [Not for publication]'s 93A statement containing important information that Child Safety needed to know.

622. Child Safety Officer Blackwell gave evidence at the Inquest that the disclosures made by [Not for publication] in the 93A interview could have been material to her investigation, possibly changing the outcome, possibly making the complaint substantiated, or at least change the steps she would have undertaken to clarify matters.

623. Counsel Assisting submitted that reliance on other departments to know to seek information or views that it was the responsibility of another department doing their own jobs to know what they ought to ask, does not satisfactorily protect the interests of children into the future. Some witnesses at the Inquest, including Professor Meyer and Luke Twyford, (Principal Commissioner of the Queensland Family and Child Commission) were supportive of a multiagency team to assist in communication of relevant information.

Counsel Assisting's submissions in relation to police responses to [Not for publication] allegations

624. In relation to Police responses to the complaints concerning [Not for publication], Counsel Assisting noted DAS Blanchfield considered that 12 July 2018 request for a joint investigation (which was rejected by Officer Cheeseman) was potentially a missed opportunity.

625. It was further noted that he considered the investigation of [Not for publication]'s complaint by Officer Price of Ms McLeod's complaint on 12 May 2019 to be adequate.

Submissions by Ms McLeod's Family

626. Ms McLeod's family submit that I should find that the response of QPS to the allegations of domestic violence and sexual assault was inappropriate and inadequate.

627. It is submitted that it is open to make adverse comment about the inactions of police officers involved with the family, even though, they accept that it was impossible to predict that the deaths would occur in the way that they did.

628. It was submitted that the cultural issues embedded in the QPS which were examined in the Commission of Inquiry led to an inadequate response to the complaints of rape and indecent treatment of the children and domestic violence made by Ms McLeod to the QPS.

629. It is submitted adverse comments should be made against the investigation by Senior Constable Cottrell, Senior Sergeant Megan Johnson, and former Detective Sergeant Leanne Cheeseman.

630. It was noted that Senior Constable Cottrell indicated in evidence that he was likely to take the same action if presented with the same circumstances today. It was submitted that as such, I could find that the holistic training programme implemented by QPS since the Commission has not met the objective of ensuring that police take a victim centric and trauma informed approach.

631. It is submitted that in relation to Detective Senior Sergeant Megan Johnson's investigation into the [Not for publication] complaint, it could be found that in failing to notify Child Safety about the 93A interview she failed to provide relevant information to another agency, which was influenced by her views.

632. In relation to former Detective Sergeant Leanne Cheeseman, it is submitted that it could be found that Officer Cheeseman's responses to the referrals received concerning [Not for publication] and [Not for publication] were inappropriate and she failed to properly assess the risk of harm to those children. Sergeant Cheeseman's belief that people commonly make false complaints to gain custody infected her views about the complaints made by [Not for publication] and [Not for publication], and led to her view that Ms McLeod was unreliable and vexatious. Further, it is submitted that it is open to find that Detective Sergeant Cheeseman's responses to the referrals concerning [Not for publication] and [Not for publication] were inappropriate and failed to properly assess the risk to the children.

633. It is further submitted that the Coronial investigation conducted by Detective Senior Constable Lisa O'Leary raises concerns.

634. It was submitted that she was not properly trained to undergo the investigation and provide the report, and that recommendations should be made accordingly.

Submissions of the Commissioner of Police

635. It is submitted it is a matter of critical importance that the events in question, having taken place in 2017 to 2019, are analysed on the basis of the level of training and resources regarding domestic and family violence that were in place at that time. It is submitted it would be unfair to critique the actions of those involved through a lens of what is now known about domestic and family violence, particularly around:

- Being appropriately trained to analyse the presentation of an alleged aggrieved and the factors lying beneath a situation where there are credibility issues correlating to known mental health diagnosis; and
- Being trained to investigate DFV allegations with a holistic lens and investigating the entirety of the relationship and relevant factors, including any mental health

diagnosis, as opposed to the traditional method of police investigation being instant focused.

636. It was submitted that I should accept the evidence of Inspector Dwyer and DAS Blanchfield that the investigations were adequate and appropriate in that context.

637. In relation to the impact of Ms McLeod's mental health, the evidence of Inspector Dwyer was that a person's mental health is something which is now looked at in the context of holistic responses to domestic and family violence.

638. In relation to the [Not for publication] allegations, it is submitted I would accept the evidence of DAS Blanchfield that the investigation was appropriate and adequate.

639. It is also submitted that I would accept DAS Blanchfield's opinion that the investigation by Officer Cheeseman in relation to [Not for publication] was appropriate, and that the relevant policies and procedures were applied.

640. It is submitted that there is no evidence to support the conclusion by Counsel Assisting that Ms McLeod did not come to the attention of the Vulnerable Persons Unit because of a likely police perception that she had made false or vexatious complaints. The evidence is that the VPU in the Wide Bay region did not exist until 5 January 2019, at which time it would have been in its infancy for some months.

641. In relation to criticisms of the failure of police to share the contents of [Not for publication]'s Section 93A statement, it is said that that submission fails to understand or at least acknowledge that information sharing between agencies cannot occur in a legislative vacuum. It was pointed out that there are many pieces of legislation that restrict the sharing of information and certain types of documents, one being a 93A statement. It is said that there are legal complexities surrounding information sharing.

642. In relation to mental health, the Police Commissioner says that Counsel Assisting's submission that the training and understanding of police is deficient in dealing with the victims who have mental health issues fails to provide any acknowledgement to the specific evidence relied upon to make that statement.

643. It is submitted that Counsel Assisting infers an inappropriate expectation on police officers regarding detection of mental health triggers. It is said that submission is inconsistent with the evidence of Assistant Commissioner Nelson, which demonstrated that police should be in a position to deescalate a crisis situation and then apply appropriate supports, rather than be expected to be trained mental health professionals.

644. It was pointed out that in terms of co-responder models, mental health intervention coordinators (MHIC), were rolled out in each district as a result of Coronial findings handed down by the State Coroner in 2018.

645. The role of the MHIC was explained in evidence as being a QPS and QH clinician co-response. It enables the police officer and the clinician to go to jobs and deescalate situations with the intent to avoid subsequent presentation at an emergency department.

646. MHICs liaise with the relevant mental health liaison officer at a hospital about particular persons and share information in relation to repeat calls for service or jobs that are occurring. The MHIC sits within the VPU, so information is also able to be shared surrounding DFV occurrences at the same time.

647. It was pointed out also that the Mental Health Liaison Service exists and is embedded within the Police Communications Centre. It consists of mental health clinicians who can provide timely advice to police officers during mental health incidents.

648. Acting Commissioner Nelson also explained that mental health scenarios were regarded as critical for police and will, in addition to the current mental health training provided, be incorporated into the current rollout of DFV training given the intersection between DFV and mental health.

649. Assistant Commissioner Nelson gave evidence of other training provided to police as part of the mandatory yearly training (operational skills and tactics training) for police.

650. In relation to the submissions by Counsel Assisting and recommendations in relation to 'unfounded' and other categories, it was submitted by the Commissioner that the submissions, and the proposed recommendations, be rejected.

651. The written submissions provide detail as to QPS responses to the Queensland Audit Office Report.

652. It was pointed out that in respect of the [Not for publication] allegations, notwithstanding the evidence of DAS Blanchfield that the matter was incorrectly categorised as unfounded, he remained of the view that the level of investigation was appropriate and adequate in the circumstances.

653. Further, having regard to the requirement to commence proceedings, his opinion was that the matter was appropriately finalised and would not have progressed to prosecution.

654. Submissions were made as to the practical reasons why the proposed recommendations around the use of unfounded were, inappropriate and ill-conceived.

655. Further, relevantly it was pointed out that the practical impact on Ms McLeod regarding the outcome of the [Not for publication] investigation would have been the same, regardless of how the investigation outcome was categorised on QPRIME. The outcome was that Mr McLeod would not be charged with any offence arising out of the allegations. It was submitted that it is that outcome which was of concern to Ms McLeod. It was that dissatisfaction which appeared to be reflected in the suicide note left by Ms McLeod.

656. Further, in relation to the impact of the categorisation on other agencies, it was pointed out that the circumstances of the disclosures made by [Not for publication] were in fact provided to DCYJMA. Information was provided that the disclosures made by [Not for publication] were limited and not sufficiently particularised, which was why the investigation did not progress any further.

657. It was pointed out that Ms Blackwell gave evidence that she could have asked for access to the 93A interview to explore the disclosures further.

658. It is submitted that the categorisation of the investigation by the police did not impact negatively on the capacity of the department to properly undertake its own investigation and assessment, a matter for which it was incumbent on those officers to do.

659. In response to the submissions by the family for Ms McLeod that adverse findings be made against Officers Cottrell, Johnson, and O'Leary, it is submitted that that submission ought to be rejected.

660. In relation to Officer Cottrell and the suggestion that his evidence indicates the training has not met the objective of ensuring that police take a victim centric and trauma informed approach, it is pointed out that Officer Cottrell explained that officers are bound to apply the OPM in determining whether there is sufficient evidence to commence a prosecution. His evidence was to the effect that given the evidentiary issues that existed in this investigation, if presented with the same circumstances today it would likely result in the same outcome. It is submitted that that was an entirely separate consideration to whether the investigation was conducted in a victim centric and trauma informed way.

661. In relation to submissions concerning Officer Johnson's failure to provide information about [Not for publication]'s disclosures to the Department of Child Safety, it was reiterated that Child Safety officers themselves could have pursued access to the 93A interview.

662. In relation to the submission that there should be adverse findings against Constable Lisa O'Leary with respect to her Coronial Investigation Report, it was submitted that should be rejected, noting that the adequacy of the police coronial investigation was not an issue to be examined at the Inquest.

Submissions by the QPS officers given leave to appear at the Inquest.

663. The primary position was that issue 2 should not be pursued. The alternative position was that if it was considered any submission which adopted any criticism against the police witnesses should be rejected.

664. It was submitted that any criticism of police officers was infected with the perception that police should simply charge persons without giving any attention to ascertaining whether a person should be charged by reference to the evidence available.

665. It was pointed out the police officer's obligations under the OPM in relation to the sufficiency of evidence.

666. Reference again was made to the evidence of DAS Blanchfield and Inspector Melissa Dwyer, who both found that the investigations of police were appropriate and adequate.

667. It was submitted that the comment of DAS Blanchfield that it was correct to categorise the [Not for publication] allegation as 'unfounded' was incorrect. It was noted that during the Inquest the details of the classification, including the changes that were made to it, did become apparent.

668. The details for some classifications substantially changed after the relevant investigation was conducted. It is submitted, in any event DAS Blanchfield clarified his statement in oral evidence. Importantly he accepted that at the relevant time and based upon the OPM in force at that time, it was open to the relevant officer to categorise the matter as unfounded. Necessarily therefore there is no basis to offer any criticism of the police investigation of these complaints.

669. It was pointed out that in her statement Inspector Dwyer identified that there were some missed opportunities. However, nothing was identified as a departure from policy and procedure in force at the time of the alleged occurrences. There have been changes to policing since that time. It would be inappropriate for the Court to view events of several years ago through the prism of current practices.

670. It was submitted that it should be found that the relevant officers involved in the investigation of Ms McLeod's complaints performed their duties in an exemplary manner.

671. The Police Officers said the submissions by Ms McLeod's family that adverse findings should be made against DSS Cottrell should be rejected. It was submitted that the suggestion he formed a negative view of Ms McLeod which impacted his ability to impartially investigate the complaints of rape was not supported by the evidence. Further, it was contrary to the opinion expressed by Inspector Dwyer who reviewed the investigation. It was also pointed out that DSS Cottrell was investigating an allegation of rape and he was bound to apply the OPM in relation to the sufficiency of evidence test.

672. In relation to the criticisms of DSC O'Leary, the submission was made that the investigation of Ms McLeod's death was not an issue for the Court to determine and was not the subject of evidence at the inquest.

673. In relation to the criticisms of DSS Johnson and her failure to provide information about [Not for publication]'s disclosure to the Department of Child Safety, it was pointed out that the submission is ignorant of various legislation which prohibits or restricts the sharing of information, notably the prohibition against supplying or offering to supply a Section 93A criminal statement. Further, the department was entitled, if they saw fit, to obtain access of the Section 93A interview.

674. In relation to the criticisms of DS Cheeseman, that her beliefs infected her views about the complaints made by [Not for publication] and [Not for publication], it is submitted that this should be rejected. It is submitted there is no evidentiary basis to make any adverse comment against DS Cheeseman. The basis of support was an abstract academic view expressed by Dr Meyer. It is submitted that Dr Meyer in the Inquest recanted on much of her evidence which was purported to criticise the police involved in the investigation.

Findings

675. I find that the police investigation of the complaints of domestic and family violence and sexual assault by Ms McLeod and of the children was adequate and appropriate.

676. In making this finding I adopt the submissions of Counsel Assisting that no adverse comment should be made about the individual officers. In that regard I reject the submissions made by Ms McLeod's family. The basis of the finding is firstly, that at the relevant time any misstatements or misinterpretation of the police and their investigation based on Ms McLeod's presentation was consistent with QPS practices, policies and systems in place at that time.

677. These issues have subsequently been addressed by recommendations from the Commission into police responses to domestic and family violence.

678. I find that regardless of any misconceived views held by police the complaints were nonetheless fully investigated.

679. I accept the evidence of Inspector Dwyer and DAS Blanchfield, that having reviewed the investigations, they were adequate.

680. In relation to the submissions made by the family of Ms McLeod, I reject the submission that it's appropriate that I should make adverse comments about the investigation of Officers Johnson, Cottrell and Cheeseman.

681. In relation to Officer Cottrell, I accept the submission of the police officers that Officer Cottrell's evidence that he would take the same action in relation to the investigation of the rape complaint as it occurred today, was in relation to the sufficiency of evidence test: that is, if he had the same circumstances and the same evidence today, it would not meet the test. I accept that is a different consideration to whether the investigation was conducted in a victim centric and trauma informed way.

682. In relation to the submissions regarding adverse findings against DSS Johnson's failure to provide the information to the department, I accept the submission of the Police Commissioner and the police officers, that the submission ignores legislation which prohibits the sharing of information in certain circumstances. I also accept the submission that the officers of the department were entitled to and could have asked for access to the 93A interview.

683. I also reject the submission that adverse findings should be made against Detective Senior Constable O'Leary. That Coronial investigation was not an issue considered at the Inquest.

684. The potential misdescription or possible mis-categorisation of the [Not for publication] complaint as unfounded in my view had no impact on the decision not to prosecute Mr McLeod.

685. Critically, my role is to investigate the causes these five deaths.

686. I find there is insufficient connection between the categorisation of the complaint and Ms McLeod's decision to commit murder and filicide.

687. For that reason, I will not be considering that issue further or the suggestion that recommendations be made in that regard.

3) - the appropriateness and adequacy of the mental health responses by Queensland Health, associated entities and service providers responsible for Ms Charmaine McLeod's care, treatment and monitoring, as well as their responses to her domestic and family violence complaints and child abuse complaints.

688. Submissions were made on this issue by Counsel Assisting, the McLeod family, Wide Bay Hospital and Health Service and West Moreton Hospital and Health Service and Queensland Health Office of the Chief Psychiatrist.

Submissions of Counsel Assisting

689. Counsel Assisting submits that no individual ought to be the subject of any adverse comment or finding as it relates to Ms McLeod's mental health matters. As noted, her condition was complex, and suicide is not predictable. If a health care professional cannot predict it, it is unreasonable for a general practitioner (or anyone else) to predict it, more so filicide could not have been contemplated by anyone.

690. Counsel Assisting submits that no finding needs to be made of what the correct diagnosis for Ms McLeod was.

691. It is submitted it was apparent that Ms McLeod responded well and positively to the Clozapine Clinic which involved medication, but also regular ongoing contact.

692. It is submitted that had Ms McLeod been part of a multiagency team at the time of her death, the pieces could have been connected, but this was impossible without such a team being in place.

693. Counsel Assisting's submissions dealt with whether a multiagency approach was warranted, and secondly, whether existing frameworks were adequate.

694. During the inquest, contact points between police and Ms McLeod in 2019 were identified and explored as being of possible clinical significance to her mental health. These included Ms McLeod's reports in February 2019 of seeing Mr McLeod with a gun shape with his hand towards her, seeing cable ties and footprints outside her home and noises outside her window.

695. Dr Heffernan said that the contact points were a source of stress to Ms McLeod and had there been a multiagency team at that time the different information could have been beneficially brought together.

696. Counsel Assisting submits no criticism should be directed at the police to suggest that they ought to have known that the contacts with the police may have been significant and may have triggered mental health intervention. Likewise, Child Safety could not be expected to know that when Ms McLeod was expressing stress about matters, she required different responses than other clients of that service.

697. It is submitted that the evidence supports intervention points and missed opportunities at which a multiagency team would have been able to detect the re-emergence of Ms McLeod's symptoms and trigger appropriate interventions to prevent these deaths from occurring if a mechanism was properly available for that to happen.

698. It was submitted that the existing mechanisms are not sufficient as they do not have agency interaction, nor a focus on the entire family. The existing mechanisms focus on one primary need, rather than complex overlapping issues.

699. It was submitted preventative healthcare is cheaper overall, and when one considers the lives of this family and the evidence, there is a strong case for a multiagency team trial.

700. It is submitted that the current options available are insufficient.

- Project Air
  The evidence was that people with Borderline Personality Disorder repeated at emergency department and they found that intervention with support was positive and reduced contact and frequency presentations. It did not, however, have police involvement.
  Dr Heffernan said that Project Air, though multidisciplinary in that it had levels of health professionals, it was not multiagency to manage complex patients.
- Continuing care team. These are multidisciplinary teams (with levels of health professionals) but do not involve multiagency departments like police or Child Safety.
- At-risk Management Committee.
  As per the evidence of the Chief Psychiatrist, the at-risk management committees relate to forensic patients only and do not have the necessary other stakeholder involvement required for the children.

- PAIPs are for crisis attendance. It is submitted that police should not be expected to have to identify mental health needs in a crisis presentation and should not take full responsibility when complex needs people are involved in

needing their assistance. Dr Heffernan observed that PAIPS are a good way to communicate information, but need to be translated in ways that are useful. He said if the police do not know or understand what's contained in the PAIP, matters will be missed. They are also for crisis or acute responses, not longer-term matters, and risk longitudinal information being missed.

701. Counsel Assisting submitted a recommendation be made that the Queensland Government provide funding to trial a specialist multiagency mental health programme for patients with Borderline Personality Disorder as a single or comorbid condition with complex vulnerabilities, and that trial be for a period of 18 months (preferably in the Brisbane district where the lead agencies are presently based), and that at least includes the following: -

   a) individual case management for patients where the patients receive case management reviews with frequency, not any longer than three months between reviews.
   b) regular reporting to the lead agency.
   c) an employee from Queensland Health, preferably a psychiatrist.
   d) an employee from Queensland Police Service.
   e) an employee from the Department of Children, Youth Justice, and Multicultural Affairs.
   f) an employee from the Public Guardian; and
   g) a specialist trauma DVF experienced counsellor or social worker.

Submissions of Wide Bay Hospital and Health Service and West Moreton Hospital and Health Service

702. It is submitted that Counsel Assisting's submission should be accepted that no individual ought to be subject to any adverse comment or finding as it relates to Ms McLeod's health matters.

703. It is agreed that Ms McLeod's presentations after her separation from Mr McLeod, after the acute crisis period in June/July 2017 settled considerably. It is noted that the evidence also suggests that at that time, Ms McLeod was able to get her substance abuse under control and engage with a variety of therapeutic and supportive community services.

704. It is pointed out Ms McLeod had capacity and did not require an involuntary treatment order when she made the decision to seek mental health assistance in the community outside of the Community Mental Health Team in late June, July 2017. Ms McLeod made the decision that she did not want ongoing monitoring or care by the Community Mental Health Team. This could not be forced upon her. Ms McLeod had the capacity and insight to know when she needed to seek mental health support and she did so on many occasions.

705. Ms McLeod had a crisis management plan in place which she and her treating team had agreed to. Ms McLeod did not report any psychotic symptoms or demonstrate to any clinician any feature of psychosis in at least 18 months before her death. Dr Heffernan confirmed the symptoms she was experiencing were consistent with her Borderline Personality Disorder.

706. It is submitted that if Ms McLeod's interactions with the police and the possibility that she was hearing voices during this period were investigated, it is nothing more than speculative to say what further enquiry or assessment would have revealed. This is

particularly so in the context of Ms McLeod otherwise not demonstrating any psychotic symptoms in the immediate period leading up to her death.

707. It was agreed that there need be no finding as to what Ms McLeod's correct diagnosis was. A diagnosis can change over time which will result in interventions and treatment being adjusted accordingly. The issue is whether Ms McLeod was psychotic and required some sort of mental health intervention in the immediate period leading up to her death. There was no evidence of psychosis.

708. It is submitted that it is simplistic and unreasonable to suggest that Ms McLeod responded well and positively to the Clozapine Clinic. Prior to commencing Clozapine Ms McLeod had in any event been seeing a case manager on a weekly basis.

709. In relation to whether a multiagency team at the time of her death could have made a difference, it was submitted that that was a difficult proposition to consider. Ms McLeod was not mentally unwell in the immediate period leading up to her death. She was facing several significant stresses and challenges, but she had been engaging with her general practitioner, community supports and her friends, and she was future focused.

710. It is submitted that a multiagency team may have resulted in better and more comprehensive communication sharing between the agencies supporting Ms McLeod, but it can be no more than speculation to suggest that such a multiagency team would have avoided her death. It is submitted that the challenge this case presented (and would in the future if a patient elected to take this path) is the collation of all the material from the various stakeholders Ms McLeod had contact with, the connection of all the stakeholders with each other, many of who did not relate to Ms McLeod's mental health per se, and how this would have informed how Ms McLeod could have been better supported during her separation and allegations of domestic violence.

711. In relation to Counsel Assisting's submission that the re-emergence of Ms McLeod's symptoms could have potentially triggered appropriate interventions to prevent the deaths from occurring, it is noted that there is no convincing evidence that in fact there was a re-emergence of Ms McLeod's symptoms. She was not psychotic in the months leading up to her death, and there was no evidence she was psychiatrically unwell in the immediate period prior to her death.

712. It was acknowledged that persons like Ms McLeod with Borderline Personality Disorder need additional support when facing stresses and life challenges. They have complex needs which require a multipronged approach.

713. However, how a multiagency team would be set up and how it would be useful in this type of case requires careful consideration. WBHHS and WMHHS consider better communication between agencies through some sort of multiagency team would be beneficial in a regional service, but such a service would require appropriate funding and resources to make it a viable programme.

Submissions of Queensland Health Office of the Chief Psychiatrist

714. QHOCP submits that there is no single factor, that, if corrected, would have directly prevented the incident that resulted in the deaths of Ms McLeod and her children.

715. Upon consideration of the totality of evidence and with the benefit of hindsight QHOCP accepts that there were missed opportunities from a broader Queensland Health perspective.

716. It is submitted that since the deaths steps have been taken by Queensland Health to address the shortcomings and areas of improvement identified by the Office of the Chief Psychiatrist report and by Dr Heffernan. Further, there have been sufficient steps taken by Queensland Health in response to recommendations arising from the 2021 Women's Safety and Justice Taskforce Report, "Hear Her Voice Report 1 – Addressing Coercive Control and Domestic and Family Violence in Queensland", which identified gaps in MHAOD service system responses to domestic and family violence.

717. In relation to Counsel Assisting's recommendation that a specialist multiagency mental health programme for patients with Borderline Personality Disorder be considered, Queensland Health supported the intention of the proposed recommendation. It accepts that a multiagency response connecting agencies and allowing for collaboration on strategies does enhance outcomes for individuals suffering a mental health illness. QHOCP, however, pointed out that there are challenges in supporting the recommendation. Queensland Health assumed it would be the lead agency, given the focus was on mental health, a mental health programme for people with a mental illness.

718. The submissions referred to Dr Reilly's evidence in which he pointed out concerns in relation to the proposal, where he said, "*I think something like that, I think, does work, but the challenges with that is it didn't require a multiagency focus particularly. What it requires with Borderline Personality Disorder from my perspective, is clear assessment, okay? A clear understanding of how we will support that person in crisis and then when needed, some specific psychotherapy, both individual and group, which will go on, and that's what most of the evidence suggests. That's, again not – not something new. The challenge is, then, actually implementing that and funding that. Our approach over recent years has been Project Air, right? But as I said, that's not new teams and it's not – so services still have to set that framework up behind that. Many of the larger ones have, but some of the smaller ones perhaps haven't done that yet. I guess where I'm struggling is, though, when you say then, say that, then say that it's got to be multiagency, I'm not kind of fully understanding what the – where all the multiagency comes from because from my perspective, the problem is that we, in health, still are not doing well as we perhaps could still with picking up on personality disorder, but that's what we're trying to do now with Project Air*."

719. It is submitted that the first issue relates to clear assessment. Borderline Personality Disorder is a contentious personality subtype. The diagnosis presents a difficulty which is highlighted by the inconsistency between the diagnostic criteria provided by the DSM5 and the ICD-11. The ICD-11 classification abolishes all categories of personality disorder, except for a general description of personality disorder, which can be further specified as "mild, moderate or severe".

720. It is submitted that evidence suggests that 5% of the population over a lifetime will have Borderline Personality Disorder. There is a challenge in classifying consumers with Borderline Personality Disorder and those with Borderline Personality Disorder and "complex vulnerabilities". The assessment challenge is specific and accurate diagnosis, of both the personality disorder itself and of other disorders or comorbidities. These need to be linked, along with the person's social situation, vulnerabilities and strengths, in a formulation which outlines how the person's disorder is causing distress and affecting their function and considering in particular how it might affect the person in crisis. This process ideally requires careful consideration by appropriately skilled and experienced mental health clinicians.

721. It is submitted there may be confusion of governance where agencies who aren't able to provide case management of a consumer with a mental illness, are expected to do so each three months.

722. QHOCP reiterated the work undertaken to develop a state-wide strategy that supports MHAOD services in their provision of evidence-based treatment for people with Borderline Personality Disorder, specifically the Project Air Strategy, Queensland.

723. QHOCP also responded to submissions made by the family for Ms McLeod that domestic violence risk screening tools had not been fully completed by Queensland Health. It was proposed by the family that a recommendation be made that Queensland Health provide further training and support to workers completing risk assessments to ensure that there was better compliance to collect the information gathering required to complete the risk assessment. It was also submitted that when health practitioners become aware of the presence of allegations of domestic violence between a patient and a person who is named as the next of kin, or where prior consent has been given to release information to that person, information should cease to be released to the alleged perpetrator of violence. It was submitted by Ms McLeod's family that a recommendation be made that Queensland Health give consideration to implementing a standardised process to ensure that collateral is not sought, or health information released to the alleged perpetrator of domestic violence.

724. QHOCP pointed out that the risk screen in its current form was part of the comprehensive care documentation rolled out in 2020.

725. In relation to training on the revised tools, it is noted there is comprehensive care case history, library fact sheets and webinar series to guide practitioners in their use. Further, there is a range of other resources and mechanisms now in place that are relevant to assist in identifying the risk of domestic and family violence which clinicians can use to inform and guide their risk screening.

726. In relation to submissions regarding the obtaining or releasing of health information where there are allegations of domestic violence, QHOCP submits that clinicians are expected to use their clinical judgement in identifying and responding to potential impacts of seeking collateral from a consumer's family/carer if there is a history or risk of domestic and family violence. The decision to seek or not to seek collateral from a family member suspected of being a person using violence would be expected to be discussed and agreed with the multidisciplinary team and recorded in the care review in CIMHA.

727. QHOCP rejects as appropriate the proposed recommendation that Queensland Health give consideration to implementing a standardised process to ensure collateral is not sought or health information not released to an alleged perpetrator of domestic violence. The concern being that the use of the term "ensure" appears to mandate that no information can be shared regardless of circumstance. Whilst recognising the intent, it is clear that any such guidance requires flexibility to apply clinical judgement to the specific scenario. The decision to obtain collateral or share information should be made on a case-by-case basis with the support of the multidisciplinary team, with regard to safety, privacy and confidentiality obligations.

Findings

728. I accept that no individual ought to be the subject of any adverse comment or finding as it relates to Ms McLeod's mental health matters. Ms McLeod's condition was very complex, and no one could have predicted her suicide or filicide of her children. I find the mental health responses by Queensland Health and associated entities and support providers were adequate.

729. I also accept that no finding should be made about what Ms McLeod's correct diagnosis was.

730. I find that there was no evidence that Ms McLeod was psychotic and required any mental health intervention in the immediate period leading up to her death.

731. I accept the submissions of HHS that it was Ms McLeod's decision to seek mental health assistance in the community outside of the Mental Health Team as she had capacity to do so. As such, Ms McLeod did not require an involuntary treatment order.

732. I find that Queensland Health have taken steps following the Chief Psychiatrists Investigation Report to address areas requiring improvement since the deaths of Ms McLeod and her children.

733. The question is whether a multiagency approach should be considered in an attempt to better meet the needs of someone like Ms McLeod with complex vulnerabilities and mental health concerns, particularly Borderline Personality Disorder.

734. I accept that a multiagency team may have resulted in better communication and information sharing between the agencies supporting Ms McLeod, but it is unknown whether such a team would have avoided the deaths. There was no real evidence that there was a re-emergence of Ms McLeod's significant mental health symptoms prior to the deaths. She had not presented in crisis to any HHSs as she had done regularly in the past.

735. As I have found, Ms McLeod's diagnosis of Borderline Personality Disorder combined with the stresses and challenges she faced at the relevant time contributed to her decision on 27 May. I find that persons with Borderline Personality Disorders do need additional support when facing stresses and life challenges.

736. Whilst the general concept of a multiagency team to support persons with Borderline Personality Disorder and complex vulnerabilities is accepted, parties that would be involved in such a team made the following submissions about the challenges in establishing and operating such a team.

737. WBHHS and WMHHS say it is a difficult proposition to consider how a multiagency team would have made a difference to Ms McLeod at the time of her death. How a team would be set up and how it could be useful in a case such as Ms McLeod's requires careful consideration, appropriate funding and resources.

738. QHOCP says that there are significant challenges in supporting the recommendation for the establishment of the multiagency team. The first challenge relates to a clear assessment of persons with Borderline Personality Disorder. There would be significant challenge in classifying consumers with Borderline Personality Disorder and those with Borderline Personality Disorder and "complex vulnerabilities". The assessment challenges are specific and accurate diagnosis of both personality disorder itself and of other disorders or comorbidities.

739. It is submitted there would be confusion of governance where agencies weren't able to provide case management of a consumer with a mental illness and are then expected to do so each three months.

740. QHOCP reiterated their focus should be on the work undertaken to develop the Project Air Strategy that supports MHAOD services in their provision of evidence-based treatment for people with Borderline Personality Disorder.

741. The Queensland Police Commissioner also had concerns around QPS' involvement in a multiagency team.

742. It was submitted that Counsel Assisting has not indicated the purpose of the multiagency team. It was difficult to understand what use the team would be in circumstances where other multidisciplinary models are already in existence, e.g. SCAN, MHLS and MHIC.

743. It was submitted that the intersection of such a proposal with high-risk teams is a feature to consider and hasn't been adequately addressed in the evidence. Implementation of any such proposal would largely depend on the specifics of the model and its intersection with existing models to provide support to persons with mental illness.

744. It was submitted by the Police Commissioner that Coroners should be cautious about making broadscale recommendations based on single cases when they have insufficient information to appreciate the full implications and possible unintended consequences such recommendations. It was submitted that this proposed recommendation falls into that category and is therefore inappropriate.

745. I agree with this submission. Whilst at face value the concept of a multiagency team enabling agencies involved with a person with complex needs such as Ms McLeod to share information is attractive, I do not consider it appropriate to make the recommendation as suggested.

746. Whilst people with Borderline Personality Disorder need additional support when facing challengers and stressors, there is insufficient evidence to find that the existence of such a team in Ms McLeod's case would have prevented the deaths of herself or her children. I accept the submissions of the Chief Psychiatrist in relation to the challenges in identifying persons who would be a participant in such a multiagency mental health programme. I accept the submission by the Police Commissioner that a Coroner must be cautious about making broadscale recommendation based on single cases. I consider this is a matter where I have insufficient information to appreciate the full implications and unintended consequence of the recommendation.

747. I consider that projects already underway, such as Project Air, to assist persons with Borderline Personality Disorder through the provision of evidence-based treatment and other steps taken by Queensland Health following the investigation and report of The Office of the Chief Psychiatrist, should be focused upon and continue to be funded.

748. In relation to the submissions by Ms McLeod's family that recommendations be made around improving risk assessment, I accept the submission from Queensland Health that steps have been taken since the deaths of the family to address appropriate and recording of risk assessment and that risk screening and completion of risk assessment forms have improved since the deaths of Ms McLeod and her children. There is no need to make recommendations as suggested.

749. Further, in relation to the recommendation regarding the obtaining or releasing of health information where there are allegations of domestic violence, I accept the submission of Queensland Health that it would be inappropriate to make the recommendation as suggested. Decisions regarding obtaining collateral or sharing health information should be made on a case-by-case basis.

4) - the appropriateness and adequacy of responses by relevant agencies to the protection, safety and welfare of the children, including the Department of

Children, Youth Justice, and Multicultural Affairs ('Child Safety'), the Queensland Police Service ('QPS') and Queensland Health.

Submissions by Counsel Assisting

750. Counsel Assisting submits there were missed opportunities by QPS and Child Safety for intervention in relation to the protection, safety and welfare of the children as it relates to [Not for publication] and [Not for publication]'s allegations.

751. In relation to the police investigation of the complaint of sexual assault of [Not for publication], Counsel Assisting notes that no child harm referral was made by Officer Johnson or Officer Cheeseman, and Child Safety were not advised of the referral outcome, or the statements made by [Not for publication] in her 93A statement.

752. It is submitted that no adverse inference, criticism or comment ought to be drawn against Officer Johnson or Officer Cheeseman, nor CSO Blackwell.

753. It is submitted that on one view it is difficult to reconcile why the actions and perceived motives of Ms McLeod resulted in [Not for publication] being disbelieved and her disclosures not being provided to Child Safety in January 2018 when it was open to view the statements by [Not for publication] as disclosures, notwithstanding the views Officer Johnson expressed as to the quality of those disclosures. It is submitted, however, that when it is properly understood that the flow-on effect of the views formed by these officers about Ms McLeod influenced the child harm referral decision, criticism ought not be made of Officer Johnson nor Officer Cheeseman as it was a systemic QPS issue which is currently being addressed.

754. It was submitted, however, that reliance on another department to know to seek information (in this case Child Safety) or views that it was the responsibility of another department doing their own jobs to know that they ought to ask does not satisfactorily protect the interests of children in the future.

755. Counsel Assisting submits that a recommendation be made that consideration be given to amending the OPM by adding a prompt for police officers to consider making a child harm referral where a child sexual abuse offence is considered to have insufficient evidence, but where disclosures were made by the complainant.

756. It is further submitted that would have been important information for Child Safety to know about the contents of [Not for publication]'s 93A statement and better mechanisms were needed to be in place to ensure correct and full information is provided to Child Safety in a timely manner.

757. It was submitted that a multiagency team would be beneficial in these circumstances.

Submissions by the Police Commissioner

758. In relation to provision of information to Child Safety, it was submitted that the circumstances of the disclosures made by [Not for publication] were provided to Child Safety and that CSOs could have requested access to the 93A interview to explore the disclosures further.

759. In relation to the fact that DSS Johnson did not make any contact with Child Safety following the [Not for publication] disclosure this was because she had no reason to believe that Ms McLeod was not acting protectively towards the children. As such any referral would have had no utility in those circumstances.

760. DAS Blanchfield's evidence supported the view that whilst there is a parent who is willing and apparently able and acting protectively, it may not be a matter that is referred to Child Safety. There was no evidence that police viewed Ms McLeod as not being willing and able to act protectively towards her children.

761. DAS Blanchfield considered in relation to child harm referrals that it was a matter for the SCAN officer or investigating officer to make a child harm referral or refer a matter in to SCAN where a 93A could be shared. In relation to prompts for child harm referrals being considered when matters are finalised in a manner that results in no charges being laid, he considered that the police training was sufficient for that to be considered in any event. He considered that where there was a parent willing and able, then a referral may not be required.

762. In relation to the response by Child Safety to the protection, safety and welfare of the children, Counsel Assisting again submits that no adverse findings should be made against Child Safety officers. That is accepted.

763. In light of the failure by Child Safety to obtain all of the details of the disclosures by [Not for publication], it is suggested that a recommendation be made that the Department of Child Safety when requesting information from police include a prompt on their request form for Child Safety staff to consider requesting whether police have conducted a 93A interview and to consider asking for the interview. It is further submitted that Child Safety implement a mechanism for following up 'advice only' referrals to the police to ascertain if disclosures have been made by a child subject of that referral.

764. Child Safety in its submissions, noted that the two recommendations are along the lines of work already being undertaken by the department.

765. The existing departmental documents already either contain or attempt to reflect the intention expressed in those recommendations.

766. In relation to the [Not for publication] allegations, the department submits that to the extent that any records of an investigation into an allegation that impacts upon the safety of a child are relied upon by the department, it is important that all of the details are provided.

767. It is submitted that in this case the specifics of the disclosures made by [Not for publication] were not provided to CSO Blackwell when she requested information from police. It was noted that her evidence at the Inquest was that her findings with respect to the investigation would have more likely been that the allegation against Mr McLeod was substantiated. It was submitted that if there had been a finding of substantiated, the entire case may well have taken a different turn.

768. I do not agree with that submission. I accept as stated by the Police Commissioner that the decision that Ms McLeod was acting protectively towards the children would more than likely have been the outcome, even if the allegation against Mr McLeod was substantiated.

769. It is my view that the failure to provide the full 93A disclosures to Child Safety is not sufficiently connected to the deaths of Ms McLeod and her children for it to be appropriate to make recommendations in that regard.

770. Further, I note that Child Safety in its submissions, say that the recommendations suggested by Counsel Assisting are along the lines of work already being undertaken by Child Safety.

771. It is submitted in relation to the actions of the CSO, Officer Leanne McManus on 29 May 2019 when Ms McLeod called Child Safety, that there was nothing about the presentation of Ms McLeod during the course of that telephone conversation which should have alerted Ms McManus to the fact that the children were at risk in Ms McLeod's care.

772. I accept the submission and that no adverse comment should be made against Ms McManus.

Findings

773. I find that the responses by the relevant agencies, namely QPS and Child Safety, to the protection, safety and welfare of the children were adequate and appropriate in the circumstances.

774. The investigation by QPS into the allegations of sexual abuse of [Not for publication] and [Not for publication] were adequate for the reasons already set out in these findings. There can be no criticism against Officer Johnson for not referring the disclosures made by [Not for publication] to Child Safety in circumstances where she was of the view that Ms McLeod was acting protectively. The same comment can be made in relation to the investigations with respect to the allegations regarding [Not for publication].

775. The provision of the full disclosures made in the Section 93A to Child Safety may have resulted in a different outcome as far as whether or not allegations against Mr McLeod were substantiated. Ultimately however this would have on the evidence played no role in preventing the deaths of Ms McLeod and her children.

776. I accept the submissions that no adverse comment should be made against particular officers, either police or Child Safety.

777. Counsel Assisting has submitted that a multiagency team would have been a benefit or could be a benefit in the future in sharing of information between agencies. I note the evidence of Dr Meegan Crawford that there have been improvements and developments in information sharing with QPS.

778. For the reasons set out above I do not propose to make recommendations in relation to the establishment of a multiagency team.

5) - the appropriateness of training, support and guidelines available to legal practitioners for clients experiencing crisis with complex mental health, domestic and family violence and child protection needs.

779. Counsel Assisting submits that no adverse comment should be directed towards Ms Terrell, but that there is an opportunity to improve services for lawyers through the appointment of a mental health consultant at the Queensland Law Society.

780. It is submitted that there is evidence of Ms McLeod telling others that she was unhappy with her lawyer, unhappy with Legal Aid Queensland, and that she was worried about Mr McLeod getting custody of the children.

781. I have accepted that the email exchanges between Ms McLeod and her lawyer on the day of the crash triggered a response in Ms McLeod which had a role to play in her decision to take her and her children's lives. This is not by way of criticism of the

solicitor involved but is as a consequence of her diagnosis of Borderline Personality Disorder.

782. It was submitted that at the Inquest evidence suggested that training provided to solicitors could be improved.

783. The evidence showed that while Legal Aid Queensland had available psychological support for their in-house solicitors, and the Queensland Law Society provided assistance for members, neither provided the opportunity for solicitors to have a mental health consultant they could speak to for advice with dealing with clients with complex mental health issues.

784. Counsel Assisting submitted that recommendations be made that the Queensland Law Society consider providing a mental health specialist consultant service to solicitors to enable solicitors to seek mental health advice to assist vulnerable clients and those with complex mental health, trauma and/or DFV needs.

785. It was also submitted that the Queensland Law Society and Legal Aid Queensland consider providing continuing professional development opportunities for solicitors that addresses the coercive impact of family law proceedings on clients, with particular emphasis on those with mental health conditions, including Borderline Personality Disorder, how to identify when those clients are experiencing crisis, and how to engage with those clients.

786. The McLeod family submitted that on the evidence Ms Terrell appeared to lack the understanding of dealing with a vulnerable person who had complex mental health issues, domestic and family violence concerns, as well as concerns for her and the children's safety.

787. It is submitted that a finding should be made that Ms Terrell did not act in the best interests of Ms McLeod in terms of her client management and communication or her advice in the email received by Ms McLeod prior to her death. This was particularly in the circumstances of Ms McLeod's complex mental health, and where Ms Terrell was aware of the ongoing domestic violence concerns Ms McLeod had for herself and her children.

788. It was submitted that in engaging with Ms McLeod it would have been helpful for Ms Terrell to have been provided with some assistance in understanding of engagement requirements for a person with such complex issues, both legally, as well as from a mental health perspective, and the importance of meetings, at times, being conducted face to face.

789. The family also referred to evidence from Legal Aid representatives to the effect that there was no specific training in relation to risk assessments provided to Legal Aid preferred suppliers.

790. Submissions were also made concerning grants of aid by Legal Aid for family law matters and also Legal Aid practitioners being offered training regarding warm and cold referrals for support services.

791. Ms Terrell was not a party to the proceedings but was given the opportunity to put submissions in response if required.

792. Ms Terrell did provide submissions in reply to the submissions made by the McLeod family.

793. Issue was taken with the statement that Ms Terrell misunderstood the expectation of Legal Aid funding in terms of meeting with the client based on her response during cross-examination.

794. I accept Ms Terrell's submissions that there was no evidence to support the assertion that she misunderstood the expectation of Legal Aid funding. I accept the evidence was that she responded in general terms as to prioritisation of work in matters. I accept her comments about prioritising work do not support the assertion that she considered that she could not apply the funding to meeting with clients in person.

795. In relation to the submission that a finding should be made that Ms Terrell did not act in the best interests of Ms McLeod in the way she communicated her email advice, it is pointed that Ms Terrell was aware that Ms McLeod had access to numerous mental health professionals and readily accessed them.

796. It is submitted that as Ms Terrel was in Court all day on 27 May it was entirely appropriate and in Ms McLeod's interest for Ms McLeod to receive timely legal advice shortly after business hours on 27 May regarding potential legal consequences of her actions in keeping the children away from Mr McLeod's access visits.

797. It is submitted that in retrospect it may be accepted that a different approach by Ms Terrell may have been beneficial for Ms McLeod's mental health on the evening of 27 May 2019, but prospectively Ms Terrell's advice and the timing and manner of the communication was appropriate.

798. It is submitted that Ms McLeod was aware of the Family Court Orders and had communicated to Ms Terrell an intention to potentially contravene them. This intention necessitated clear and prompt advice. Ms Terrell had been Ms McLeod's solicitor for over a year and regularly assisted her and represented her in Court.

799. It was submitted that it is artificial to consider one email on 27 May 2019 and limited face to face meetings as being acts that were not in Ms McLeod's best interest.

800. It is submitted that the apparent history of successful communication between Ms Terrell and Ms McLeod was not considered in detail at the Inquest.

801. It is submitted that a finding that Ms Terrell did not act in Ms McLeod's best interest should be rejected. Any collection of acts by a solicitor could arguably be better in terms of timing, clarity, brevity (or completeness) or other approach, and "better" in respect of a client's legal interest, mental health interests or various other aspects of life. This is particularly so when viewed in hindsight and with knowledge of grave subsequent events. However, an approach by a solicitor that dulls the gravity of the legal risk because the solicitor is concerned about the possible feelings a client may experience could potentially result in deficient or even negligent advice. The suggested finding needlessly directs criticism at a practitioner who delivered appropriate and timely advice in the normal course of a good professional relationship between solicitor and client and should be rejected.

802. Ms Terrell supports the submission that solicitors ought to be equipped with tools and training to sensitively manage vulnerable clients.

Findings

803. I find that no adverse findings should be made against Ms Terrell. I accept the submissions in this regard. Whilst in hindsight, noting the acts of Ms McLeod

subsequent to receiving that advice, a different communication approach may have been taken, it was not inappropriate at the time.

804. It was appropriate to advise Ms McLeod of the potential risks of contravening a family court order.

805. I find that there is room to provide additional training and support for legal practitioners when dealing with clients experiencing crisis or with complex mental health needs.

806. I will make recommendations accordingly.

RECOMMENDATIONS

807. Pursuant to s46 of the Act, a coroner may:

> Whenever appropriate, comment on anything connected with a death investigated at an inquest that relates to –
>
> (a) public health or safety; or
>
> (b) the administration of justice; or
>
> (c) ways to prevent deaths from happening in similar circumstances in the future.

808. As set out in these findings Counsel Assisting and the family of Ms McLeod have made submissions as to what they consider appropriate recommendations that should be made. Other parties have made submissions either in support or in opposition. I have, for the reasons indicated, found that the suggested recommendations in the most part are not appropriate and/ or are insufficiently connected to the deaths of Ms McLeod and the children.

809. I do consider it appropriate to make the following recommendations in this matter:

    1. That the Queensland Law Society consider providing a mental health specialist consultant service to solicitors to enable solicitors to seek mental health advice to assist vulnerable clients and those with complex, trauma and/or DFV needs.

    2. That the Queensland Law Society and Legal Aid Queensland consider providing continuing professional development opportunities for solicitors that addresses the coercive impact of family law proceedings on clients, with particular emphasis on those with mental health conditions including Borderline Personality Disorder, how to identify when those clients are experiencing crisis and how to engage with those clients.

CONCLUDING REMARKS

810. I acknowledge Mr McLeod and Ms McLeod's family. I extend my deep condolences to them and their unimaginable loss.

811. I also wish to acknowledge and express my appreciation to the assistance given by Counsel Assisting, and all counsel who appeared at the Inquest.

812. I close the inquest.

Kerrie O'Callaghan
Brisbane Coroner
BRISBANE
21 August 2024