CORONERS ACT, 1975 AS AMENDED

SOUTH  *AUSTRALIA*

FINDING OF INQUEST

An Inquest taken on behalf of our Sovereign Lady the Queen at Adelaide in the State of South Australia, on the 19th, 20th and 21st days of May and the 16th day of July 2004, before Wayne Cromwell Chivell, a Coroner for the said State, concerning the deaths of Cheree Ann Dinsdale and Peter James Klingner.

I, the said Coroner, find that Cheree Ann Dinsdale aged 20 years, late of 3 Barrett Street, Smithfield Plains, South Australia died at West boundary Road, Palmer, South Australia on the 29th day of May 2001 as a result of traumatic brain damage complicating a gunshot wound to the head.

I, the said Coroner, find that Peter James Klingner aged 20 years, late of 44 Rosewarne Crescent, Davoren Park, South Australia died at the Flinders Medical Centre, Bedford Park, South Australia on the 30th day of May 2001 as a result of traumatic brain damage complicating a gunshot wound to the head.

1. Introduction

1.1. At about 3:40pm on Tuesday 29 May 2001, Ms Janet Brock was driving a school bus on West Boundary Road at Palmer, South Australia when she saw a white Commodore on the side of the road. She said that she saw a male person standing outside the vehicle and as the bus approached he turned around and faced her. He then walked back to the driver's side door of the car and sat inside. Ms Brock said that he leaned forward and waved (Exhibit CK7c).

1.2. Ms Brock did not see any other person in or about the car.

1.3. A short time later, Mr Christopher Kraft was driving his vehicle along West Boundary Road at Palmer, South Australia when he saw a white Holden Commodore sedan parked on the eastern side of the road with its bonnet up. As he came closer, he saw a male person lying on his back at the rear of the car. He could see a sawn-off rifle under the man's left arm. He did not stop as he did not wish to frighten his two young children. He quickly drove to the Palmer store and notified the police (see Exhibit CK7b).

1.4. The male person was later identified as Peter James Klingner.

1.5. Senior Constable Sara-Lee Chester-Frahn received a telephone call from Mr Kraft at about 3:55pm. She attended at the location with Constable Dawe and found Mr Klingner in the position described by Mr Kraft. She noted a large circular gunshot wound to the right side of his head. He was holding a sawn-off .22 bolt action rifle cupped in his bent left arm. The fingers of his left had were cupped around the outside of the trigger guard.

1.6. The police officers also found the body of a female person in the front passenger seat of the vehicle, slumped over to her left with her hands in her lap and her head touching the inside of the front passenger door. There was a small gunshot wound to the right temple.

1.7. The female person was later identified as Cheree Ann Dinsdale.

1.8. Senior Constable Chester-Frahn heard Mr Klingner groan and immediately attended to him, noting that he was still breathing. She had already called an ambulance.

1.9. At 4:45pm Dr Peter Joiner attended the scene and at 4:45pm, after having examined the body of Ms Dinsdale, pronounced her life extinct (see Exhibit CD2a).

1.10. An ambulance attended and a helicopter was called. The helicopter arrived at the scene at about 5:15pm. Mr Klingner was transferred to the Flinders Medical Centre where he was admitted to the Critical Care Unit (CCU).

1.11. Mr Klingner's head injury was examined by Dr Evan Everest, a Senior Consultant, who deemed the injury inoperable. Supportive treatment was provided until brain death was noted at about 11am on 30 May 2001. After discussion with family

members, ventilation was discontinued at about 1:05pm and Dr Everest pronounced Mr Klingner's life extinct at about 1:10pm on 30 May 2001 (see Exhibit CK3a).

2. Cause of death

2.1. A post-mortem examination of the body of Cheree Ann Dinsdale was performed by Professor R W Byard, Specialist Forensic Pathologist, on 30 May 2001.

2.2. Professor Byard noted a gunshot wound to the right side of the head with an area of black smudging on the anterior and lower margin of the wound, and an area of tattooing also mainly anterior to the wound. Beneath the entrance wound there were fractures of various bones of the skull, haematomas and disruption of the brain tissue. A large fragment of the projectile was located in the left posterior parietal region.

2.3. Professor Byard concluded that Ms Dinsdale's death was caused by the .22 gunshot wound to her head. He commented:

> '1. Death was due to cerebral laceration and contusion from a .22 calibre gunshot wound to the right temple. The projectile passed horizontally and slightly posteriorly through the skull resulting in fractures, and then into the brain substance. The deceased would have been incapacitated immediately by the wound and death would occurred rapidly (within minutes). The injuries would not have been amenable to medical treatment.
>
> 2. The projectile wound was in keeping with close range, given the amount of tattooing of the skin surrounding the wound. No exit wound was present.
>
> 3. Given the possibility of the assailant standing beside or sitting in the drivers seat of the car with the deceased sitting in the passenger seat a likely scenario would be that:
>
>   1. The deceased was shot in a semi crouching/sitting position and slumped forward against the door of the car.
>
> 4. There were no significant injuries elsewhere with no evidence of defence type wounds of the hands. The minor bruises and abrasions may have occurred at some time before the fatal episode.
>
> 5. A precise time of death was not possible given that temperatures were not taken at the scene by attending personnel. The condition of the body with rigor mortis and lividity would not be inconsistent with death 20 hours prior to the autopsy.
>
> 6. No underlying organic illnesses were present which could have caused or contributed to death.
>
> 7. Toxicological analyses of blood did not reveal alcohol, amphetamines, benzodiazepines, cannabinoids, methadone, opiates or tricyclic anti-depressants.'
>
> (Exhibit CD3a, pp3-4)

2.4. A post-mortem examination of the body of Peter James Klingner was performed by Dr R A James, Chief Forensic Pathologist, on 31 May 2001.

2.5. Dr James noted the presence of a gunshot entry wound on the right side of his head, 8cm above the root of the right ear. He noted that beneath the wound there were radiating fractures of various bones of the skull and the projectile entered the right parietal lobe of the brain causing disruption of brain tissue and subarachnoid haemorrhage. A deformed .22 calibre lead projectile was recovered from the inner aspect of the left calvarium.

2.6. Dr James concluded that Mr Klingner's death was caused by the .22 calibre gunshot wound to his head. He commented:

> 'The background information suggests the deceased died at Flinders Medical Central with a .22 calibre gunshot wound to the head. Review of Lyell McEwin Case Notes and SAMHS Case Notes – see inclusion.
>
> The gunshot wound entry site is a little posterior than normally seen for self inflicted gunshot wounds but the characteristics are consistent with self infliction.
>
> The toxicology results are not available at the time of this report.
>
> The brain has been submitted for formal neuropathological examination in view of the psychopathology and the gunshot wound.
>
> Stigmata of chronic drug abuse: No physical features. Clinical history of intravenous amphetamine abuse.
>
> Infectious status: Not tested.'
>
> (Exhibit CK4a, p4)

2.7. A neuropathological examination of Mr Klingner's brain was performed by Professor P C Blumbergs of the Institute of Medical and Veterinary Science, and Professor Blumbergs examination confirmed Dr James' conclusions (see Exhibit CK5a).

2.8. A toxicological analysis of Mr Klingner's blood taken on admission to Flinders Medical Centre was performed by Mr D M Sims, Senior Forensic Scientist, of Forensic Science SA. His conclusions were:

> '1. The hospital admission blood contained:
>
> (1) 0.02 mg morphine per L. (therapeutic)
>
> (2) 0.03 mg venlafaxine per L. (subtherapeutic)
>
> (3) approximately 0.1 mg o-desmethylvenlafaxine per L. (metabolite, subtherapeutic)

(4) lignocaine and midazolam

2. None of the drugs alcohol, amphetamines, cannabinoids, methadone, tricyclic antidepressants, sertraline, Risperidone, citalopram, Olanzapine or other common basic drugs were detected in the hospital admission blood.

Note: The limit of determination for Risperidone in the blood was estimated to be 0.04 mg/L which is mid way within the therapeutic range.'

(Exhibit CK6a)

2.9. The ballistic evidence was examined by Sergeant N R Maiden of South Australia Police. His conclusions were as follows:

> 'The physical evidence at the scene and subsequent examinations, indicate that Cheree Ann Dinsdale was shot in the right side of her head at close range while she was seated in the front passenger seat of Holden sedan VEU-257, with her seat belt fastened. While the fatal bullet could not be conclusively identified to the Mossberg rifle, serial number 7428, a spent cartridge case (exhibit E) located at the scene was identified as having been fired from this firearm. The condition in which the firearm was found and its relative position to where Peter James Klingner was found, is consistent with him having shot Dinsdale, ejected the spent case (exhibit E) and re-loaded the firearm before shooting himself. There is no evidence to suggest a third party was involved.'
>
> (Exhibit CK11a, pp9-10)

2.10. Conclusion

I accept the evidence of Professor Byard and Dr James, supported as it is by the evidence of Professor Blumbergs, Mr Sims and Sergeant Maiden, and find that both Cheree Ann Dinsdale and Peter James Klingner died from traumatic brain damage complicating a gunshot wound to the head.

2.11. I find that Mr Klingner shot Ms Dinsdale in the head, thereby causing her death, and that he then shot himself, causing his own death.

3. Background - mental health issues

3.1. History of treatment

Mr Klingner first came to the attention of the mental health system in September 1999 when he presented himself to the Caboolture Hospital in Queensland. He described symptoms of impaired memory and reasoning ability, persecutory ideas, delusions of thought control and thought withdrawal. He said that he had been using significant amounts of marijuana and had recently been abusing intravenous amphetamines as well.

3.2. The clinicians noted evidence of psychotic thought disorder with persecutory delusions. He had poor insight into his condition. He absconded on a number of occasions.

3.3. Mr Klingner had a number of further admissions to Caboolture Hospital from September until December of 1999. Several of these admissions were as a detained patient. He was noted to be agitated, paranoid and delusional with features consistent with schizophrenia including feelings of thought control and persecutory ideas. He continued abusing drugs throughout this period and had little insight into his psychiatric condition, attributing his mental state to drug use.

3.4. Over this period of time, a diagnosis of paranoid schizophrenia was made.

3.5. On 3 October 2000, Mr Klingner was seen by Dr Craig Raeside, Consultant Forensic Psychiatrist, at the request of the Elizabeth Magistrates Court. At the time, Mr Klingner was a prisoner at the Adelaide Remand Centre. Dr Raeside found him to be psychotic, with auditory hallucinations, possible paranoid delusional ideas about threats in custody, with associated mild psychotic thought disorder (see Exhibit CK30, p4).

3.6. Dr Raeside prescribed Olanzapine and referred Mr Klingner to the North Western Adelaide Mental Health Service ('NWAMHS') upon release from custody. On 12 December 2000 Mr Klingner was seen by Community Mental Health Nurses from NWAMHS at his mother's home and was found to be psychotic with marked paranoia and psychotic thought disorder.

3.7. Dr Yong, also from NWAMHS, saw Mr Klingner on 14 December 2000. Mr Klingner's mother and sister reported that he had threatened self-harm, saying:

> 'bang … I should just end it all.'
> (Exhibit CK30, p5)

Dr Yong formed a diagnosis of paranoid schizophrenia and arranged appropriate community management including a follow-up by the Assessment and Crisis Intervention Service ('ACIS'), Olanzapine, psycho-education and consideration of an inpatient admission if Mr Klingner was non-compliant with medication.

3.8. Dr Yong saw Mr Klingner again on 27 December 2000 when he found that he was still psychotic and with signs of depression. He was complaining that he was sedated by the Olanzapine so Dr Yong substituted Risperidone.

3.9. Dr Yong gave notification to the Registrar of Firearms pursuant to Section 20a of the Firearms Act, 1977, because Mr Klingner told her that he hated life and would like to get a gun to shoot himself (Exhibit CK30, p5).

3.10. Dr Yong noted similar symptoms on 3 January 2001. Mr Klingner told her that he had been thinking about shooting his girlfriend and himself, but denied that he had any current ideas. Dr Yong noted that he 'will not do it, guaranteeing safety'.

3.11. On 12 January 2001 Mr Klingner was seen by Dr Maria Naso, the Senior Psychiatric Registrar at the North Western Adelaide Health Service based in Salisbury. Dr Naso assessed that he was suffering from paranoid schizophrenia, depression with possible cognitive deficits, polysubstance abuse and an antisocial personality disorder. Her plan was to commence him on Zoloft and Risperidone and refer him to the Continuing Community Care and Consultancy Team ('4C Team').

3.12. Dr Naso completed a referral form on 18 January 2001 in which she described his provisional diagnosis as '1st episode psychosis' with previous amphetamine usage.

3.13. Dr Naso acknowledged that this was not a first episode psychosis. Even on her referral form she stated:

> 'Currently remains psychotic (it appears he has been psychotic since his admission in 1999).'
>
> (Exhibit CK27a)

She said that the 4C Team had a waiting list of between 30 and 50 patients, and in the ordinary course a patient might wait four or five months to be seen. However, cases of first episode psychosis were given priority, and so, after discussion with her Team Leader, she described the diagnosis in that way so that he would be seen earlier (T106).

3.14. On 2 February 2001, Dr Naso saw Mr Klingner again. He told her that he did not take the Zoloft as prescribed. She noted that his mother was distressed and was not coping with his condition even though she was supportive of him. She noted that his

mental state was unchanged. She counselled him to commence taking Zoloft and arranged for Mrs Klingner to be referred to an early psychosis support group.

3.15. As a result of the referral, Mr Klingner was seen by Ms Natasha Miliotis, a Social Worker attached to the 4C Team at Salisbury. Ms Miliotis is an experienced case worker dealing with patients with psycho-social issues.

3.16. Ms Miliotis received a referral on 13 February 2001. She contacted Mr Klingner on 15 February and saw him on 2 March 2001 in a home visit. She proposed that he receive 4C Team case management for a number of issues including medication non-compliance, and suicide risk. In relation to his alcohol/drug history, she noted:

> 'History of +++ speed use IV (STD tests = ¯ve)
> and THC and alcohol use (Peter associates paranoia onset with IV speed use)
> Currently not using THC or other illicit drugs …'
> (Exhibit CK27a)

3.17. The association between amphetamine use and psychosis in Mr Klingner's case is a significant one which I will discuss later in these findings.

3.18. Ms Miliotis conducted a number of home visits and spoke to Mr Klingner a number of times on the telephone until the next time he saw Dr Naso on 23 March 2001. Dr Naso noted on that occasion that he was particularly distressed about information that he and Ms Dinsdale had seen on the internet about schizophrenia, and in particular, that 10% of people diagnosed with that condition commit suicide. Both Dr Naso and Ms Miliotis attempted to reassure them that the position was not hopeless.

3.19. Mr Klingner told Dr Naso that he had a noose in the shed at home, and that he was thinking about suicide, although he did not have any plans to act upon these thoughts. She noted that Ms Dinsdale undertook to remove the noose from the shed so no further action was taken.

3.20. Dr Naso changed his medication from Risperidone back to Olanzapine, as he had been complaining of impotence. She continued the prescription of Zoloft, although he told her that he had not been taking that either.

3.21. On 29 March 2001, Ms Dinsdale telephoned Ms Miliotis and expressed concerns held by both her and Mr Klingner's mother that he was becoming increasingly suicidal, with reference to 'gun seeking behaviour and attempts to find a rope for a noose'. Ms

Miliotis, after discussion with Dr Naso, referred Mr Klingner to the ACIS and noted on the referral form:

> 'Peter aware that ACIS staff will be attending tonight, likely to present as guarded and masking suicidality. May need a detained admission.'
>
> (Exhibit CK27a)

3.22. On the evening of 29 March 2001, Mr Klingner was seen by Dr Yong. He denied that he had any plans to suicide stating that he was depressed. Dr Yong noted:

> 'Able to guarantee safety overnight. Stated he would contact ACIS if under stress/unsafe.'
>
> (Exhibit CK27a)

3.23. Dr Yong decided, after discussion with Dr Janina Gipslis, the Consultant Psychiatrist on-call, that Mr Klingner was not detainable at that stage and arranged for him to see Dr Naso the following morning.

3.24. On 30 March 2001, Dr Naso saw Mr Klingner at a home visit with Mr Peter O'Connell from Northern ACIS and Ms Miliotis. Dr Naso discussed the case with Dr Yong and Dr Gipslis. She made a detailed entry in the clinical record. Her assessment was that he was suffering from a major depressive disorder with suicidal ideation in addition to his first episode psychosis. She noted that there was a 'risk of an impulsive attempt', although there was minimal sign of psychosis. Dr Naso decided that Mr Klingner was not detainable at that time. She noted:

> 'He denies any current suicidal thought or intent.
>
> He denies any current plans to end his life.
>
> He also denies any homicidal ideation towards his girlfriend.
>
> He does describe being very "jealous", and feeling that she would be unfaithful to him if he was not around.
>
> He denies any paranoia'
>
> (Exhibit CK27a)

3.25. The home visit was concluded with a prescription for Effexor. Mr O'Connell retrieved the noose from the shed. Ms Dinsdale had apparently failed to dispose of this previously.

3.26. Mr O'Connell saw Mr Klingner the following day on 31 March 2001 as part of the Northern ACIS follow-up to Dr Naso's visit. His impression was that although Mr

Klingner had improved somewhat, he remained at risk of impulsive behaviour. A follow-up telephone call on 1 April 2001 also noted some improvement.

3.27. Dr Naso spoke to Mr Klingner on the telephone on 2 April 2001 and also noted some improvement.

3.28. On 5 April 2001 Dr Naso conducted a home visit. Mrs Klingner stated that although Mr Klingner seemed less depressed, he was still not taking his medication and that he had taken out an advertisement in the 'Ad-Mag' seeking a hand gun. He told Dr Naso that he had been feeling suicidal when he had placed the advertisement a week earlier, but that he no longer felt that way. It is interesting to note that the advertisement must have been placed at around the time of the 30 March 2001 home visit, at which time Mr Klingner was denying that he was suicidal. This inconsistency in his history suggests that some of these denials lack credibility.

3.29. Dr Naso arranged to review Mr Klingner in a weeks' time. On 9 April 2001, Mrs Klingner telephoned Mr O'Connell at Northern ACIS and expressed concerns that he had gone into the city to either buy a gun, or to buy amphetamines. He was subsequently located by his parents in the city and he told them that he was going to buy 'speed'.

3.30. Dr Naso and Ms Miliotis decided that there was little further action available to them in relation to Mr Klingner's drug seeking behaviour.

3.31. On 12 April 2001, Mrs Klingner told Ms Miliotis that Mr Klingner continued to be non-compliant with his antidepressant medication, and that she was 'at breaking point' in relation to his behaviour. She wondered whether there was a need for him to obtain separate accommodation.

3.32. On 24 April 2001, Ms Miliotis conducted a home visit. Mrs Klingner told her that Mr Klingner had become more verbally abusive and threatening to his parents, that he had physically assaulted Ms Dinsdale, that he had purchased a motor vehicle and was driving without a license, that he had obtained a double-barrelled shotgun which his parents had since found and hidden, and that she had seen 'track marks' in his arms and believed he had been using amphetamines again.

3.33. Detention

Ms Miliotis advised the Northern ACIS team. As a result of receiving this information, the police were notified with a request to visit in order to remove the gun, and to convey Mr Klingner to hospital for a mental state examination. The police attended and detained Mr Klingner pursuant to Section 23(1) of the Mental Health Act 1993 ('the Act').

3.34. Mrs Klingner later expressed anger that Mr Klingner had been arrested as a result of the information she had imparted (Exhibit CK27a).

3.35. After having been detained by the police, Mr Klingner was taken to the Lyell McEwin Hospital where he was examined by Dr Maghazaji who detained him pursuant to Section 12(1) of the Act. He noted:

> 'Peter presents with psychotic symptoms and depressed mood. Expressed suicidal and homicidal ideation with poor insight and judgment. Unwilling to stay in hospital voluntarily → needs admission for further assessment and treatment.'
>
> (Exhibit CK28b)

3.36. Mr Klingner was admitted to Ward 1G at Lyell McEwin Hospital with a provisional diagnosis of paranoid psychosis aggravated by drug abuse and depressive symptoms. Dr Maghazaji directed that he receive close observation re suicidal thoughts and minor risk of absconding. He noted:

> 'Patient reported that he suspected that his girlfriend is cheating on him. He noticed that her 'genitalia is larger than usual'. Also reported paranoid persecutory delusions, ideas of reference (radio and TV shows are about him) and thought insertion and delusion of external control. Denied perceptive disturbance … patient reported using IV speed yesterday.'
>
> (Exhibit CK28b)

3.37. Mr Klingner was reviewed by Dr Daven Kurl on 25 April 2001 who made an order pursuant to Section 12(4) of the Act confirming the order made the previous day. This had the effect of detaining Mr Klingner for a further three days.

3.38. Mr Klingner was reviewed by Dr Naso on 26 April 2001. He continued to assert that Ms Dinsdale had been having an affair and threatened to kill her, her 'boyfriend' and then himself if his suspicions were correct. She noted 'no other psychotic symptoms are present'.

3.39. Dr Naso concluded that Mr Klingner had developed delusional jealousy, and that he constituted a risk to himself and others. She noted that Ms Dinsdale should be informed of the risk to herself posed by Mr Klingner. She also decided to seek a Community Treatment Order from the Guardianship Board.

3.40. On 27 April 2001, Dr Naso noted that Ms Dinsdale was aware that Mr Klingner had plans to kill her and her alleged boyfriend. She added:

> 'Today he denies any plans to harm himself or Cheree - however there was obvious guarding and evasiveness evident.
>
> *On the board in the patient area Peter has written - Cheree dead*'
>
> (Exhibit CK28b)

3.41. Mr Klingner was seen by Dr Jöerg Strobel, Consultant Psychiatrist, on 27 April 2001 at 12:30pm. He made an order pursuant to Section 12(5) of the Act further detaining Mr Klingner for 21 days. He noted:

> 'Patient presents guarded, presenting a jaundiced version of events, stating that he made threats only in anger but did not mean to. States his mother wants him home. No insight, impaired judgment. Remains a risk to others +/- self.'
>
> (Exhibit CK28b)

3.42. Dr Strobel said that Mr Klingner required ongoing inpatient treatment, a Community Treatment Order, and depot medication.

3.43. Not long after Dr Strobel's examination, Mr Klingner absconded from the ward. He was last seen at around 1:10pm. The police were informed, as was Ms Dinsdale. Mr Klingner returned to the ward on 28 April 2001 stating that he had been staying in a motel. Although urine specimens were taken, there was no record of the results, in particular whether they indicated that he had been taking amphetamines.

3.44. Mr Klingner resisted depot (intramuscular) medication until he was seen by Dr Strobel on 30 April 2001 when he agreed to a 50mg 'test dose' of Zuclopenthixol.

3.45. In a nursing note on 29 April 2001 at 0600 hours, it is recorded:

> 'Added that he was not psychotic and that there was nothing wrong with his mind. Should he be forced to have an injection "I have a gun at a friend's house and I will come back and shoot whoever gives an injection to me, whilst I am here".'
>
> (Exhibit CK28b)

3.46. Dr Naso saw Mr Klingner on 30 April 2001 and noted:

> 'Remains insightless and paranoid.'
> (Exhibit CK28b)

She said that he seemed guarded and evasive and that he remained, in her view, at risk.

3.47. On 1 May 2001, Dr Naso also noted made a note to the same effect.

3.48. On 3 May 2001, Dr Naso noted that Mr Klingner continued to have thoughts that Ms Dinsdale might have been having an affair, although these thoughts seemed less delusional than before. He was still psychotic, but Dr Naso thought that his condition had improved somewhat, to the extent that she allowed him to have leave with his mother that afternoon. Further leave was granted on 4 May 2001 and over the ensuing weekend.

3.49. The nursing notes from 3 May 2001 onwards indicated that Mr Klingner was 'settled on the ward', he was cooperative with staff and was receiving frequent visits from Ms Dinsdale.

3.50. On 7 May 2001, Dr Naso saw Mr Klingner and noted some further improvement in his condition, although her assessment remains:

> 'Psychotic illness – high risk issues'
> (Exhibit CK28b)

3.51. <u>Decision to discharge</u>

The decision to discharge Mr Klingner was made by Dr Naso in consultation with Dr Strobel. He explained that Mr Klingner had consistently denied suicidal or homicidal ideation after 3 May 2001, his mood had improved, he had complied with leave requirements and that, in his opinion, he no longer had psychotic symptoms. He pointed out that if Mr Klingner was further detained, he was likely to abscond, that such an order would be unlikely to stand up on appeal, and that it was unlikely that it would be renewed. Further, he felt that the continuation of the order might destroy the therapeutic relationship developed between the therapists and Mr Klingner.

3.52. Ms Dinsdale expressed concern at the plan to discharge Mr Klingner from hospital. She told Ms Miliotis in a telephone call on 4 May 2001 that he had told her that,

following discharge from hospital, he would 'probably go straight home and hang myself'. Ms Miliotis noted:

> 'Peter no longer threatening Cheree's life but stating it wouldn't be fair not to let her live her life. However, Cheree does not believe him fully stating that he is very sly in what he says and whom he says it to.'
>
> (Exhibit CK27a)

3.53. Mr Klingner's mother also opposed his discharge, in a telephone call to Dr Naso on 7 May 2001. Dr Naso noted:

> 'I made it very clear that if Peter describes any more suicidal thoughts or thoughts of killing someone that they need to contact the police and obtain restraining orders. She stated that Cheree is in fear of her life - again I reiterated that they need to contact the police and NACIS if there are any threats. Cheree also aware to obtain a restraining order. She feels that Peter needs to stay in hospital 'long term' because 'I can't cope with him'. However she does not want him to leave home either.
>
> She was very angry at me and also quite verbally abusive.
>
> She also ventilated her anger at the case manager N Miliotis for organising Peter's admission with police involvement. She stated that she said some 'nasty' things to Natasha.'
>
> (Exhibit CK27a)

3.54. Guardianship Board hearing

On 8 May 2001, Mr Klingner attended at the Guardianship Board hearing in company with his sister. Dr Naso and Ms Miliotis appeared to apply for a Community Treatment Order to enforce the need for continuing depot antipsychotic medication in the form of Zuclopenthixol deconoate. Dr Naso argued for an order lasting 12 months, however, the panel were not in favour of this and made an order for only 6 months.

3.55. Both Dr Naso and Ms Miliotis said that Mr Klingner presented very well to the Board. They pointed out the seriousness of the threats he had made, and the degree of risk associated with his condition. They both found this an unpleasant experience in view of the fact that Mr Klingner was present throughout the discussion. It was only after a considerable degree of persuasion that the Board were convinced to make an order for 6 months.

3.56. Dr Naso said that Mr Klingner was very convincing, arguing that his thoughts of harm had stopped. He promised to take oral medication, and to avoid illicit drugs, amphetamines in particular.

3.57. In an interview with Dr Naso after the Board hearing, Mr Klingner admitted lying to the Board when he promised to become compliant with oral medication.

3.58. Dr Naso noted:

> 'However, a risk will always remain as Peter presents with a fatuous affect and he has lied in the past.
>
> The family and Cheree are aware of the ongoing risk and are aware that if he makes any threats of suicide or threats to harm Cheree they are to contact the police and ACIS and he will be redetained.
>
> Cheree is also aware of restraining orders.
>
> I will discuss with consultant psychiatrist prior to discharge.'
>
> (Exhibit CK28b)

3.59. A subsequent conversation with Dr Strobel confirmed that Mr Klingner could be discharged. Mr Klingner's detention was formally revoked by Dr Naso on Dr Strobel's instructions, on 8 May 2001 at 12:20pm.

3.60. Mr Klingner was seen in the Outpatients Department of the Lyell McEwin Hospital on 15 May 2001. Dr Naso was away on sick leave. Mr Klingner had attended voluntarily for his depot medication, stating that he felt much better.

3.61. On 25 May 2001, Dr Naso saw Mr Klingner when he collected his medication. He told her that he felt 'well', that he was tolerating the depot medication and that 'the injection has taken away all my guilty and jealous thoughts'. He admitted that he had been using 'speed' although Dr Naso noted no psychotic symptoms present. She advised him against using amphetamines. She commented:

> 'Overall Peter's mental state has improved significantly with no evidence of any psycho-pathology.'
>
> (Exhibit CK27a)

4. Events of 29 May 2001

4.1. In her statement (Exhibit CK19a), Mrs Catherine Klingner said that she and Peter 'argued a bit' during the morning of 29 May 2001. She said that he was fidgety and

restless throughout the morning and was constantly on the telephone and coming and going in his car. She said:

> 'Just before Peter left he came in and said "I'm going now, see you".
>
> I said, "yep".
>
> Peter didn't say where he was going. Peter then came back in a second time and said, "see you in heaven". That was the last I saw of Peter. '
>
> (Exhibit CK19a, p7)

4.2. It would seem that Mrs Klingner was understating the severity of her argument with Peter that morning. Dr Naso telephoned her when Peter didn't arrive for his depot medication due that day. Her note of the conversation reads:

> 'Mother answered saying she had kicked Peter out today and that he was staying with his sister Debbie. She was very angry at him because he was heavily abusing speed (IV) and THC. Mrs Klingner stated that "I wont put up with this any longer". They had had an argument and he left the house with Cheree.'
>
> (Exhibit CK27a)

4.3. Dr Naso recorded that Mr Klingner had not voiced any suicidal or homicidal ideation or intent to his mother that day. Ms Dinsdale, however, was under no illusions. The letters she wrote to Mr Klingner (Exhibit CK7t) are extremely poignant. She communicates great love and affection for him, and extreme forbearance in the face of continuing physical and mental abuse. Another letter (Exhibit CK7u) is addressed 'To Whoever Reads This'. The first paragraph reads:

> 'I do not know how or when but I can feel that I will die soon. I don't know how I know but I do. I can just feel it. I am really sad and scared about it but there is nothing I can do to stop it … '

The letter goes on to say goodbye to her family and friends, in the manner of a suicide note. It is clear, however, that she expected to be killed, rather than die by her own hand, and that she felt that she was helpless to prevent it..

5. Issues arising at inquest

5.1. As I have previously mentioned, Dr Craig Raeside provided a comprehensive review of the treatment received by Mr Klingner. In his report (Exhibit CK30), he summarised Mr Klingner's condition as follows:

> 'In summary, Mr Klingner had a documented history of an underlying Antisocial Personality Disorder, drug abuse (particularly amphetamines and cannabis), and an

> evolving psychotic illness most likely Paranoid Schizophrenia. Clinically he lacked insight into the nature of his illness/condition, the need for treatment, and the impact of his behaviour on others. He was noted to be untruthful in the description of his symptoms to staff, he was assessed as being guarded and suspicious on interview at times, and family expressed considerable concern about him at times in which he said that things were going well. He made clear threats of self harm and suicide as well as expressing homicidal ideas towards his girlfriend and an unknown male with whom he suspected she was having an affair. He had acted on these ideas including setting up a noose in his shed, sought to obtain a firearm on at least three occasions, and was identified by treating staff as being at considerable risk of acting on his ideas due to his impulsivity. He was also assessed as being at increased risk when abusing amphetamines.'
>
> (Exhibit CK30, pp12-13)

5.2. Dr Raeside was complimentary about the adequacy of their assessment of Mr Klingner. He said:

> 'In my view mental health staff appeared to have performed a thorough assessment of Mr Klingner. They identified the various risk factors, identified that he was a significant risk and maintained close contact with both Mr Klingner, his family, and Ms Dinsdale over the several months in which they were involved. They applied for and obtained a Community Treatment Order (which would have required them to convince the Guardianship Board that he had a treatable mental illness) to ensure compliance with antipsychotic medication, and eventually hospitalised him after parents found that he had purchased another gun.'
>
> (Exhibit CK30, p13)

5.3. <u>Discharge on 8 May 2001</u>

Dr Raeside expressed some concern that Mr Klingner was discharged on 8 May 2001, the same day that the Guardianship Board granted the Community Treatment Order. There were serious concerns expressed by his family and Ms Dinsdale, and there was evidence available that he was untruthful about his symptoms.

5.4. Dr Naso, in particular, was concerned about the risks associated with discharge. However, Dr Raeside acknowledged that Mr Klingner's mental state had improved during the admission, particularly once the depot medication was commenced. He said:

> 'Consequently, in my opinion, the North-Western Mental Health Service appears to have provided intensive assessment and involvement. They included communication with family and Ms Dinsdale. The documentation appears comprehensive and adequate. The various risks were clearly identified. Police were notified about firearms originally and again to bring him to hospital after contact with family about a new firearm. Obviously the family were unhappy about his discharge on 8/5/01, but there was communication to

> them about contacting police should they become concerned about Mr Klingner's behaviour. I therefore believe that the various procedures and processes were followed reasonably, but clearly the judgment about his imminent dangerousness and the immediate risk of acting on it was incorrect.'
>
> (Exhibit CK30, pp14-15)

5.5. As to whether the tragic outcome in this case was preventable, Dr Raeside pointed out that Mr Klingner had long standing underlying impulsivity, antisocial personality traits and jealousy separate from his paranoid psychosis. Aggravating his poor impulse control was his abuse of amphetamines and cannabis, and there was even a suggestion that he was using these substances while an inpatient. Abuse of these drugs would not only have worsened his impulse control but aggravated his underlying paranoia. He said:

> 'Consequently, it is difficult to say that had Mr Klingner been hospitalised longer then this event would not have eventually occurred. Further, had he been adequately treated with antipsychotic medication over a longer period of time it is possible that his delusional ideas would have settled, but his poor impulse control and underlying antisocial traits would still have been operative and possibly led to the same outcome. Obviously optimum control of each of these areas (including drug rehabilitation) could have minimised the risk, but whether it would have minimised it to the point where he did not eventually act on his suicidal and homicidal thoughts is uncertain.'
>
> (Exhibit CK30, p15)

5.6. <u>Alternative management strategies</u>

As to Mr Klingner's management following discharge on 8 May 2001, Dr Raeside said that the medication regime and arranged follow-up were appropriate. He noted that contact was made with his family, and outpatient appointments were made. He said that the only other management that may have prevented the outcome would have been if Mr Klingner had been detained for a long period, possibly under a Continuing Detention Order, to observe the ongoing effects of antipsychotic and antidepressant medication (with which he had been non-compliant), to institute psychotherapeutic approaches to his aggression and violence towards Ms Dinsdale and his jealousies, and address his drug abuse. He said:

> 'Optimal treatment of his psychotic condition, without being distracted by the comorbid personality disorder and substance abuse, may have significantly reduced his dangerousness.
>
> Although there is no guarantee that this would have prevented the eventual outcome, in my opinion such an approach would have offered a greater chance of adequately treating Mr Klingner and preventing his suicidal and homicidal behaviour.'
>
> (Exhibit CK30, p16)

5.7. It is unlikely that a Continuing Detention Order would have been granted, however. Dr Naso had enough trouble getting a Community Treatment Order, let alone long-term detention, from the Guardianship Board. I do not think that this was an option in view of Dr Strobel's opinion about Mr Klingner's mental state at that time.

5.8. In answer to Dr Strobel's point about losing rapport with his patient, Dr Raeside said that it was always a difficult balance between that issue and ensuring safety, and that he would always err on the side of safety (Exhibit CK30a, p2). I agree with that philosophy.

5.9. In any event, Dr Raeside said that he might only have been able to keep Mr Klingner in detention a day or two longer, or at most, until the expiry of the 21-day order (T187). In view of the fact that the deaths did not occur until 29 May 2001, keeping Mr Klingner in detention a little longer would not have changed the tragic outcome (T194).

5.10. Counter-transference

Dr Raeside expressed concern that because Mr Klingner was an unpleasant and dangerous patient, the resultant anxiety among his clinicians may have tempted them to label his condition as antisocial personality disorder rather than a psychosis, and thereby avoid the necessity of treating him (Exhibit C30, p14).

5.11. Dr Raeside gave a very helpful definition of antisocial personality disorder as follows:

> 'A personality disorder - it is often a point of discussion, but it is generally not considered to be a mental illness at such. That is, it is not something that comes and goes or what someone develops or becomes unwell with. A personality is our way of perceiving the world and interacting with others and perceiving ourselves. A personality disorder is a longstanding maladaptive way of interacting with the world and perceiving oneself and others, such that it impairs their function even socially or occupationally. It is usually evident in childhood and persists throughout life in a variety of different circumstances. So, it is different to a mental illness which tends to have an onset and a closure or relapses or whatever. Then there are various types of personality disorders. An antisocial personality disorder doesn't refer to someone being unsociable but refers to them engaging in acts that are either unlawful or demonstrate little concern or empathy for others, perhaps they may be exploitative in relationships and often run into problems at school or at work or in positions in which they are supposed to tow the line, keep the rules. So, they often run foul of the law or run foul of people in authority. It is also associated with offending. Not everybody who offends has an antisocial personality disorder and it often also increases association with drug abuse, alcohol abuse and other forms of abuse and that may be violence as well.' (T179-180)

5.12. He explained that:

- antisocial personality disorder is a very difficult condition to treat, particularly because the subject often fails to recognise that they have a problem;
- Forming a therapeutic relationship is often difficult because the subject is often angry, abusive and generally unpleasant;
- Usually the only effective management is to deal with secondary issues such as depression, drug or alcohol abuse;
- There is no medication that is effective;
- Patients with co-morbidities with antisocial personality disorder such as a psychotic disorder, and substance abuse are even more difficult to treat.

5.13. In this case, I think that Dr Raeside's fears are unfounded. Indeed, it was apparent that Dr Naso, in particular, continued to emphasise the psychotic aspects of Mr Klingner's condition in the face of some disagreement, particularly from the consultant, Dr Strobel.

5.14. Indeed, I have already commented that Dr Naso consciously altered the diagnosis in order that Mr Klingner received treatment. If his diagnosis had merely been an antisocial personality disorder, it is doubtful that he would have been accepted by the 4C Team in the first place (T106).

5.15. Ms Miliotis also pointed out that their perception of Mr Klingner's dangerousness heightened their level of response rather than diminishing it (Exhibit CK27, p4).

5.16. Dr Raeside acknowledged these responses, observing that the NWAMHS staff did very well in maintaining contact with Mr Klingner as long as they did (T199).

5.17. <u>Post discharge management</u>

Dr Raeside observed that after Mr Klingner was discharged:

> 'Frequent home visits would have been appropriate as would urine drug testing (given concerns about deterioration of his mental state if abusing amphetamines).'
>
> (Exhibit CK39, p16)

5.18. Ms Miliotis pointed out that following the episode with the gun which led to Mr Klingner's detention, follow-up home visits after his discharge were not undertaken for safety reasons (T64). This is completely understandable.

5.19. It was pointed out that Mr Klingner voluntarily attended for medication on 15 and 25 May 2001. On the latter occasion Dr Naso saw him and noted no evidence of psychosis. He told her that the depot medication in particular had been effective in eradicating all such thoughts. He was due to attend for further depot medication on 29 May 2001, the day he and Ms Dinsdale died.

5.20. As for urine testing, Dr Naso pointed out that Mr Klingner did not hide the fact that he had resumed using amphetamines, so urine testing would not have altered management (Exhibit CK27, p6).

5.21. Dr Raeside accepted these responses (Exhibit CK30a, p3).

5.22. Limited consultant input

Dr Naso said that she consulted Dr Gipslis and Dr Roughan in the early stages of Mr Klingner's treatment (T126). She also had regular supervision sessions with Dr Roughan and Dr Lagnado throughout Mr Klingner's treatment (Exhibit CK29a, p2). Dr Strobel also saw Mr Klingner several times when he was an inpatient.

5.23. Dr Raeside acknowledged this evidence, although he maintained his position that in view of the 'high magnitude dangerousness' of Mr Klingner, the input of a forensic psychiatrist might have been helpful (Exhibit CK30, p14).

5.24. It is impossible to know whether the participation of a forensic psychiatrist might have changed the outcome. Forensic psychiatrists certainly have more experience with dangerous patients, and paranoid schizophrenics with morbid jealousy are certainly among the most dangerous.

5.25. I draw Dr Raeside's comments to the attention of the Director of Mental Health Services. He should consider whether forensic psychiatry input might be made available in such cases in the future.

5.26. Safety guarantees

Dr Yong mentioned in the clinical record on 29 March 2001 that Mr Klingner was 'able to guarantee safety overnight'. Dr Raeside commented:

> 'I have some concern about the use of 'guarantees of safety' that often appear in clinical notes in relation to a patient's risk of suicide. In this case there is documentation when concerns were raised about Mr Klingner's risk of self harm or harm to others that he guaranteed his safety, or agreed that he would not act on these ideas. In my opinion,

> such 'guarantees' are not only ineffective, but are also dangerous in leading to a false sense of security. If a person is suicidal to the point of taking their own life with all the attendant consequences including separation from their family members and distress to those family and friends, etc, they are unlikely to pause and stop simply because they told a medical health worker (often a stranger) that they would not do so.'
>
> (Exhibit CK30, p15)

I agree with Dr Raeside's concerns.

5.27. Ms Miliotis denied that this note led to a false sense of security (Exhibit CK 27, p5). Dr Naso acknowledged the force of Dr Raeside's concerns, and said that since this tragedy, ACIS education sessions have ensured that the use of such devices should be discontinued. She said that she does not use safety guarantees (Exhibit CK29a, p2).

5.28. Management of threats of violence

Dr Raeside expressed concern in his report that the police may not have been informed of Mr Klingner's threats to kill Ms Dinsdale, and his mother and father. He wondered whether, if they had, Mr Klingner might have been charged with criminal offences, which may have led him to James Nash House (the secure forensic psychiatric facility) for a more substantial period than was possible under the Act.

5.29. I heard evidence from Detective Senior Constable Muskee, who investigated these deaths on my behalf. He confirmed that SAPOL were informed of Mr Klingner's threats. He also confirmed that Mr Klingner was already the subject of a suspended sentence of imprisonment. He told me that Mr Klingner was charged with firearms offences arising from the events of 24 April 2001, but no complaints were made by the victims of the threats, Ms Dinsdale and Mr and Mrs Klingner, which might have led to criminal charges (T171).

5.30. There was no need to arrest Mr Klingner on 24 April 2001 since he was detained under the Act. The question was posed by Mr Bonig, Counsel for the Department of Human Services, whether the police should have arrested him when he was discharged from hospital on 8 May 2001. In the absence of a complaint, and in view of Dr Strobel's opinion that Mr Klingner was no longer dangerous, I fail to see how they could have done.

5.31. Detective Senior Constable Muskee said he might have been prompted to follow the matter up with Ms Dinsdale in particular if he had known that she was expressing

concern about her safety when Mr Klingner was discharged (T168). There is no evidence that the police did that in this instance.

5.32. I think that it is likely that, had he done so, Detective Senior Constable Muskee would have been met with a refusal to make a complaint by Ms Dinsdale (she confirmed Mr Klingner's improvement after his discharge) and possible hostility from Mr and Mrs Klingner (Mrs Klingner had abused Ms Miliotis for reporting her son to the police on 24 April 2001).

5.33. This is an important issue. A Memorandum of Understanding ('MOU') between the Commissioner of Police and the Chief Executive of the Department of Human Services was signed on 3 July and 1 August 2000. The MOU deals with these issues. It provides:

> 'If police apprehend a person under Section 23 of the Mental Health Act and contact ACIS for assistance, where possible, a mobile ACIS assessment team including a medical officer will attend at that location or another location to undertake an assessment. If ACIS are unable to attend, police will be directed to the nearest hospital emergency department so a medical officer can undertake an assessment. It is important for police to provide to the person undertaking the assessment information as to why the individual has been apprehended. A *Mentally Disturbed Persons Police Observations* form will be filled out by the apprehending officer and handed to the examining medical officer.'

5.34. The MOU does not deal with police follow-up when the detainee is discharged from hospital. I gathered from Detective Senior Constable Muskee that this is a discretionary issue for the police involved. If a detective rather than a uniformed patrol had been called, more follow-up may have occurred. At the very least, some liaison between NWAMHS and police at the time of discharge would have been helpful.

5.35. I understand that the MOU is being redrafted at present. I draw attention to this issue for consideration of whether a new MOU should deal with it specifically.

6. Conclusions

6.1. This is a particularly tragic case involving the loss of two young lives. It is made even more poignant by Ms Dinsdale's letters, in which she recognised the inevitability of her own death, and yet she continued to express love and support for Mr Klingner.

6.2. Mr Klingner had a condition which was intractable and dangerous. His antisocial personality disorder interacting with periods of paranoid psychosis and illicit drug use made him impulsive, aggressive, violent and unpredictable.

6.3. The evidence before me establishes that the staff of NWAMHS, in particular Dr Naso and Ms Miliotis, did their very best to provide appropriate care for Mr Klingner, and thereby protect his family and Ms Dinsdale. They persisted with their efforts to medicate him despite his resistance, and argued vigorously before the Guardianship Board. They maintained contact with him and his family when other therapists might have labelled him as having an antisocial personality disorder and not provided treatment. Dr Naso even 'bent' the rules somewhat to get treatment for him.

6.4. The only way in which this tragic outcome might have been avoided is if Mr Klingner had been detained for a lengthy period. As Dr Raeside conceded, that was not really feasible in the circumstances.

6.5. Even if proceedings had been taken in the courts to invoke the suspended sentence, it is very doubtful that Mr Klingner would have been imprisoned pending the outcome, or that he might necessarily have been imprisoned in the longer term.

6.6. In view of all that happened. I conclude that there are no grounds for criticism of any of the people involved in Mr Klingner's care. The tragic outcome was the consequence of his personality and illness, and not the fault of those who were trying to help him.

7. Recommendations

7.1. Section 25(2) of the Coroner's Act 1975 empowers me to make recommendations which might, in my opinion, 'prevent, or reduce the likelihood of, a recurrence of an event similar to the event that was the subject of the inquest.'

7.2. Although I cannot be satisfied that anything would necessarily have prevented this tragic outcome, I make the following recommendations which might prevent similar events in the future:

(1) to the extent to which Dr Naso's actions in wrongly labelling Mr Klingner's illness as 'first episode psychosis' in order to obtain earlier treatment for him discloses insufficient resources available to NWAMHS to properly treat patients

with established schizophrenia, the Department for Human Services should review the resources available to avoid the necessity for such actions in the future;

(2) the Director of Mental Health Services should consider whether the input of a forensic psychiatrist would be appropriate when 'homicidality' is an issue with a patient with a mental illness, as was Mr Klingner;

(3) the Director of Mental Health Services should consider whether the practice of obtaining 'safety guarantees' still exists among ACIS workers, and, if so, whether steps can be taken to avoid such practices in future;

(4) the Commissioner of Police and the Director of Mental Health Services should ensure that the Memorandum of Understanding regarding the interaction between police and mental health workers is executed and implemented without any further delay.

Key Words: *Psychiatric/Mental Illness; Personality Disorder; Substance Abuse; Suicide; Homicide; Gunshot Wound*

In witness whereof the said Coroner has hereunto set and subscribed his hand and Seal the 16th day of July, 2004.

Coroner