CORONERS ACT, 2003

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 4th, 5th, 6th, 7th, 8th, 18th and 19th days of September 2006, the 14th and 17th days of November 2006, and the 13th day of December 2006, by the Coroner's Court of the said State, constituted of Elizabeth Ann Sheppard, a Coroner for the said State, into the deaths of David Gerard and Michael Eldridge.

The said Court finds that David Gerard aged 56 years, late of 105 Huckel Road, Karte died at Karte, South Australia on the 12th day of September 2001 as a result of a stab wound to the chest.

The said Court finds that Michael Eldridge aged 55 years, late of 31a Elder Terrace, Glengowrie died at the Royal Adelaide Hospital, North Terrace, Adelaide, South Australia on the 16th day of April 2003 as a result of multiple stab wounds to the chest.

The said Court finds that the circumstances of their deaths were as follows:

1. Reason for joint Inquest

1.1. A decision was made to hold a joint Inquest into the deaths of David Gerard and Michael Eldridge because these two men were killed by persons who had been diagnosed with a mental illness and had previously been managed by the State's Mental Health Service. The incidents in which Mr Gerard and Mr Eldridge were killed are otherwise unrelated and occurred 18 months apart. It is now accepted that at the time Mr Gerard and Mr Eldridge were fatally stabbed, Anthony Butler and

Barry Simper acted whilst in a psychotic state, thus rendering both men mentally incompetent to commit murder.

1.2. Mr Butler had a history of one episode of violent behaviour in 1997, in the setting of substance abuse, at which time he was diagnosed with schizophrenia. During a twenty month Court ordered period of supervision on licence in Glenside Hospital, Mr Butler was required to abstain from illicit drugs and alcohol and to comply with a prescribed medication regime. He demonstrated reluctant compliance until the day he was released. As soon as his licence expired in March 2000 Mr Butler cut his ties with the mental health service and stopped taking his prescribed medication. He travelled to Pinnaroo and then interstate via Melbourne to Sydney where he lived on the streets of Kings Cross for about six months. During this time he is said to have possessed a knife, was abusing drugs and alcohol, and was unwell. He travelled back to South Australia in September 2001. The fatal stabbing of Mr Gerard occurred impulsively 'during a brief period of extreme anger', against a background of chronic paranoid ideas whilst Mr Butler was in a severe psychotic state[1].

1.3. At the time of Mr Eldridge's death, Mr Simper was living in the community. He had numerous admissions to hospital over a period of 10 years to treat his chronic schizophrenia. One month before fatally stabbing Mr Eldridge, Mr Simper was detained and hospitalised following a severe relapse of his mental illness. Over the following three weeks Mr Simper was managed in a closed ward setting, under detention, between Glenside Hospital and The Queen Elizabeth Hospital (TQEH), during which time he was sometimes violent and aggressive. When Mr Simper was discharged, his treating doctors considered that he had settled sufficiently to be discharged back to the community. Whilst they would have preferred Mr Simper stay in hospital a little longer, and spend a few days in the open ward at TQEH, in their view there was insufficient justification to detain him for an additional period under the Mental Health Act (1993). In hindsight, it is now clear that at the time of Mr Simper's discharge he remained quite unwell and was under-medicated. His previous history illustrated a pattern in which one could predict that Mr Simper would take much longer than a few weeks to settle and that during these periods, he was likely to be aggressive and violent. The fatal stabbing of Mr Eldridge in a hotel in Adelaide

[1] Exhibit C26

six days after Mr Simper's discharge from TQEH was subsequently held by the Supreme Court to have occurred whilst Mr Simper was acting in a psychotic state.

1.4. Evidence received during the Inquest examined the circumstances in which Mr Butler and Mr Simper were managed by the Mental Health Service in the time leading to their release into the community and whether relevant practices, systems, legislation and resources could be improved to reduce the likelihood of a recurrence of events similar to those leading to the deaths of Mr Eldridge and Mr Gerard.

1.5. It is acknowledged that the passage of time between the involvement of treating medical practitioners and the time of giving evidence has compromised the ability of these practitioners to recall certain aspects of their involvement, particularly with respect to Mr Butler's management. Notwithstanding these deficiencies, the evidence overall enables me to make findings relevant to the circumstances culminating in these two tragic deaths.

2. Circumstances leading to the death of David Gerard

On 12 September 2001, David Gerard was with Mr Butler at a camp site in Karte, about 25 kilometres north west of Pinnaroo, when insulting words allegedly uttered by Mr Gerard caused an angry reaction in Mr Butler, whereby Mr Butler produced a double edged throwing knife from his pocket and stabbed Mr Gerard in the chest, piercing his heart and killing him. Mr Butler made an attempt to hide his actions by moving Mr Gerard's body about 60 metres away, wrapping it in a sleeping bag and covering it with leaves and twigs to disguise it. When Mr Gerard's friends inquired as to his whereabouts, Mr Butler told them that he had gone for a walk. On 14 September 2001, a friend reported Mr Gerard missing to the local police officer who questioned Mr Butler later that day[2]. Mr Butler had some turpentine in his rucksack which he later explained he intended to use to dispose of Mr Gerard's body. When Senior Constable Peter Mann was about to examine the rucksack, Mr Butler suddenly admitted that he had killed Mr Gerard by stabbing him because Mr Gerard had provoked him during an argument[3]. It is accepted that around the time of the stabbing, Mr Butler had been consuming marijuana and alcohol.

[2] Exhibit C11k
[3] Exhibit C11g, Exhibit C12a

3. Post mortem examination of David Gerard

3.1. On 17 September 2002, a post-mortem examination was conducted by Forensic Pathologist Dr John Gilbert at the Royal Adelaide Hospital Mortuary. Dr Gilbert observed a near horizontal stab wound measuring 2 x 2.5 centimetres to the central chest which extended between the fourth and fifth ribs into the left pleural cavity and left lung. Dr Gilbert described the fatal injury to the heart as follows:

> 'The wound then crossed the left lateral aspect of the pericardium, causing a 7cm long horizontal defect over its lateral aspect. The pericardial defect exposed a similar 7cm long slice-like stab wound involving the lateral aspect of the mid portion of the left ventricle. The central 3cm of the left ventricular wound was full thickness (i.e. extending through the full thickness of the left ventricle).[4]

3.2. Dr Gilbert located 1300ml of liquid and clotted blood in the left pleural cavity. No other injuries were noted including defensive injuries to the arms or hands. I take this to indicate that there was virtually no opportunity for Mr Gerard to attempt to deflect the knife away from his chest before he was stabbed.

3.3. I accept the observations made and opinions formed by Dr Gilbert and find that the cause of Mr Gerard's death is a stab wound to the chest[5].

4. Criminal proceedings arising out of the death of David Gerard

4.1. In criminal proceedings for the murder of David Gerard, Mr Butler successfully raised a defence of mental incompetence pursuant to s269 Criminal Law Consolidation Act 1935 (SA). Psychiatrists Kenneth O'Brien and Chris Branson provided reports in which they expressed the opinion that at the time of the alleged offence, Mr Butler was suffering from chronic paranoid schizophrenia and was psychotic. On the basis of these opinions, Mr Butler was found to have been mentally impaired and therefore not guilty of the murder of Mr Gerard. The reports indicate that Mr Butler had probably been suffering from this chronic illness for about 6 years.

4.2. His Honour Justice Lander noted that the evidence suggested that Mr Butler's mental illness 'is capable of being controlled to some extent by medication but only if the accused is prepared to submit to and to continue with that medication'[6] *(my emphasis)*.

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[4] Exhibit C5a
[5] Exhibit C5a
[6] Exhibit C12b

4.3. On 14 January 2003, Mr Butler was committed to detention and ordered that he be liable to supervision for the period of his life. Mr Butler is now 41 years old. In Dr Branson's opinion, it will be essential that if Mr Butler is released into the community on licence, that he receive antipsychotic medication 'under the closest possible supervision'[7].

5. Mr Butler's background

5.1. Mr Butler is said to have a history of violence when he was a child. He trained as a nurse between 1990 and 1992, but was unable to establish employment in the profession and remained unemployed. In interviews with various health professionals, Mr Butler has spoken about a history of depression and psychiatric intervention to deal with that. He acknowledged abusing alcohol and illicit substances from an early age. A consistent theme in the various psychiatric reports concerning Mr Butler is the difficulty each psychiatrist has encountered in getting him to engage with them and to talk about his psychotic symptoms. Amongst the challenges in managing Mr Butler has been his tendency to conceal his symptoms, as well as his limited insight into his illness.

5.2. Mr Butler's first episode of violent behaviour

Mr Butler first came to the attention of the Criminal Justice System and the South Australian Mental Health Service when he was alleged to have committed an act of threatening to kill his stepfather with a knife in August 1997.

5.3. The incident involved Mr Butler attending the home of his mother and stepfather after they had retired for the evening. Acting under a delusional belief that his stepfather had abused Mr Butler's daughter, Mr Butler raised a sharp knife over his stepfather who was lying in bed beneath him and threatened to kill him. The intervention of Mr Butler's mother defused the situation until the police arrived about forty-five minutes later. This was clearly a terrifying ordeal for his mother and stepfather and is the first indication of Mr Butler's propensity for extreme violence when actively psychotic[8].

[7] Exhibit C26
[8] Exhibit C30

5.4. Mr Butler was taken into custody and detained in James Nash House where he was assessed as suffering from paranoid schizophrenia. Treatment was commenced which included the administration of antipsychotic medication.

5.5. <u>Abuse of drugs and alcohol while on bail</u>

After considering a number of reports from psychiatrists who had evaluated Mr Butler in James Nash House, he was found to have suffered from a mental impairment at the time of the incident concerning his stepfather and was therefore found not guilty of the offence of 'threaten life' on 23 February 1998. He was released on bail on the basis of psychiatric opinion provided to the Court which indicated that Mr Butler was stable enough on medication to be released, on condition that he comply with psychiatric treatment regarding medication and medical appointments.

5.6. Three weeks after being released on bail, Mr Butler is said to have started drinking heavily and consuming illicit drugs. He admitted himself into a detoxification unit at Warinilla. When Forensic Psychiatrist Dr Craig Raeside reviewed Mr Butler at about this time, he reported to the Court that Mr Butler was at high risk of further relapses of his schizophrenic illness despite the use of antipsychotic medication and further, that his substance abuse would need close supervision. Whilst Dr Raeside considered that Mr Butler's prognosis was guarded, he supported release on licence into the community, but warned that if he continued to abuse substances, there was a risk of further offending[9].

5.7. After his release again in March 1998, Mr Butler commenced a thirteen week course known as the 'Bridge Programme' run by the Salvation Army to deal with drug and alcohol abuse. During this period, Dr Maria Tomasic, Senior Registrar in Forensic Psychiatry at James Nash House, reviewed Mr Butler and reported that he appeared to be complying with his oral medications, but he had little insight into his condition and the need for the medication[10].

5.8. When Dr Raeside reported to the Court again the following month, he expressed concern that Mr Butler returned to alcohol abuse so soon after being released on bail

[9] Exhibit C30, report dated 25/3.98
[10] Exhibit C30, report dated 25/3/98

and stated that if Mr Butler lapsed from the Bridge Programme, the prognosis may be 'far more guarded' or 'not good at all'[11].

5.9. Absconding whilst on bail

Mr Butler failed to attend a scheduled appointment with Dr Tomasic on 17 June 1998 and made no contact. He was said to have been 'unsettled' during the Bridge course and quit the programme on 19 June 1998. The evidence suggests that Mr Butler ceased his medication and was later found in a dehydrated 'almost catatonic' state in the Northern Territory. He was admitted to hospital in Alice Springs on 22 June 1998 and brought back into custody and readmitted to James Nash House on 30 June 1998 where he remained for the next five months.

5.10. In Dr Tomasic's report to the Court dated 15 July 1998, she expressed the view that this episode represented an acute exacerbation of his chronic schizophrenia probably due to non-compliance with his medication. Whilst there was no evidence available to Dr Tomasic to indicate what if any role alcohol or drugs may have played in this episode, it could not be ruled out as a contributing factor[12].

5.11. Mr Butler was granted release on licence by Judge Anderson on 27 November 1998 for a period of twenty months to reside at Glenside Hospital, subject to conditions that Mr Butler abstain from alcohol and other illicit substances and that he comply with the treatment plan and undertake testing for the presence of alcohol and illicit drugs as directed[13].

5.12. Period spent 'on licence' at Glenside Hospital

On 9 December 1998, Mr Butler was transferred to Glenside from James Nash House as an 'extended detainee'. The summary of his admission prepared by Dr Nance, the then Registrar at James Nash House, is brief as follows:

> 'Mr Butler is currently an extended detainee found not guilty by reason of mental impairment. Prior to this admission he had been released to the community on licence. However, at that time he stopped taking his medication and for reasons he could not describe, went to Alice Springs to see Ayers Rock. He became dehydrated and was admitted to hospital at Alice Springs.

[11] Exhibit C30, report dated 6/4/98
[12] Exhibit C30
[13] Exhibit C13, page 119

> On admission Mr Butler was able to provide little information about his behaviour, but denied specific psychotic symptoms. His stay in James Nash House has been marked by aloofness and a reluctance to engage in conversation with staff. He has continued to deny psychotic symptoms.
>
> Mr Butler has been granted licence and is being transferred to Glenside Hospital.'[14]

5.13. The remainder of the discharge summary noted that the principal diagnosis was 'schizophrenia' and additional psychiatric problems included depression (in remission), alcohol and substance abuse. At the time of discharge from James Nash House, Mr Butler was receiving an injection of Zuclopenthixol deconate 200mg every two weeks, Olanzapine 20mg each night and Sertraline 100mg each morning.

5.14. It is noteworthy that the psychiatric reports generated for the benefit of the District Court criminal proceedings were not made available to medical and nursing staff at Glenside Hospital who became responsible for his management and ultimately his discharge into the community. Nowhere in the Glenside Hospital medical notes is there any comprehensive summary of the facts of the violent conduct which led to Mr Butler's detention in the first place. Without this information, I consider that the multidisciplinary team responsible for Mr Butler's future management were only able to speculate about Mr Butler's risk of harm to others in the event of non-compliance with medication. In Dr Branson's opinion, this type of information is necessary, but it requires someone taking the initiative to search for it[15]. I say more about this topic later.

5.15. Mr Butler was transferred firstly to the closed ward, known as Kurrajong at Glenside and then Eastwood and the Glen open wards. He was said to be supervised by consultant psychiatrists Dr Clayer, who was very ill over much of this time, Dr Harry Hustig, the clinical Director of Glenside Hospital and part time consultant Dr Mark Scurrah. Dr Scurrah, who has practised interstate for the past several years, explained that he had absolutely no recollection of being involved in Mr Butler's management at Glenside Hospital. The absence of any notation in Mr Butler's medical file which might be attributed to Dr Scurrah suggests that he was not actively involved, but may have been one of the consultants responsible for the ward which housed Mr Butler at the time of his discharge. He is named as 'the consultant' on Mr Butler's discharge summary.

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[14] ExhibitC13, page 130
[15] Transcript, page 727

5.16. The career medical officer responsible for the day–to-day medical management of Mr Butler was Dr Marion Drennan. During the course of Mr Butler's time at Glenside Hospital, he was administered the same medications as he was receiving at James Nash House as well as Omeprazole 20mg each morning.

5.17. Essentially, Mr Butler completed his period 'on licence' without incident. The bulk of Mr Butler's time in Glenside Hospital was characterised by minimal communication or interaction with nursing staff and other patients. He made it clear that he was simply 'serving his time'.

5.18. He was said to be in remission and did not display any active features of his illness throughout his period of detention. It is fair to say that he complied reluctantly with the conditions of his licence. If not for his licence conditions, there would have been no clinical basis to keep Mr Butler hospitalised. His management was largely left to the psychiatric nurses supplemented by monthly clinical reviews with consultants attending if they were available[16]. Having considered the entries in Mr Butler's Glenside Hospital notes, it seems clear that there was very little by way of psychiatric evaluation of Mr Butler whilst he was at Glenside. I have no doubt that he was not regarded as requiring the level of intervention necessary for the majority of other patients housed at Glenside.

5.19. <u>Dr Marion Drennan</u>

Dr Drennan commenced at Glenside in 1998 as a junior practitioner responsible for the day-to-day general health concerns of patients. She did not have training in psychiatric medicine at that time. Dr Drennan negotiated an agreement with Drs Hustig and Clayer in which it was accepted that decisions concerning the psychiatric management of extended detainees would be made by the consultants. This arrangement occurred around the time that a patient who had stabbed and killed a female career medical officer at Hillcrest Hospital in 1992, was transferred to G1enside[17]. Dr Drennan made some decisions for 'voluntary' patients concerning their psychiatric management under the supervision of the consultant psychiatrists, but for extended detainees such as Mr Butler, she deliberately refrained from making any decisions about them or taking any actions which might be regarded as creating a potential risk to her safety. Dr Drennan gave evidence about her involvement in

[16] Transcript, page 35
[17] Transcript, page 23

Mr Butler's management, repeatedly stating that it was the role of the consultants to make any decisions regarding Mr Butler's psychiatric management. Dr Drennan explained that she had a huge workload and while she worked at Glenside, there were insufficient sessional consultants to provide adequate support[18]. I formed the impression that this special arrangement concerning Dr Drennan, whilst understandable, was quite impractical. According to Dr Hustig, since Dr Drennan's departure, there are now medical officers who are prepared to be actively involved in psychiatric management of the extended detainees (now referred to as forensic patients) and that this seems to be working well.

5.20. <u>Applications by Mr Butler's defence counsel for trial leave</u>

On 23 September 1999, District Court Judge Anderson granted an application to vary Mr Butler's licence conditions to enable him to leave the hospital grounds between 5:00pm on Fridays and 5:00pm Sundays. Mr Butler's medical records indicate that he was permitted leave of this description regularly and that he was compliant with conditions attached to his leave. On 2 February 2000 he was granted a further variation to enable longer periods of leave between 10:00am Wednesdays to 5:00pm Sundays. Again, the records indicate that Mr Butler was granted leave regularly between these times without incident in excess of 60 days. Random drug and alcohol testing confirmed his abstinence from illicit drugs and alcohol during this period. According to Dr Hustig, these periods of approved 'leave' were regarded as a prudent way of gradually integrating a detainee back into the community before his licence expired.

5.21. <u>Plans undertaken for Mr Butler's discharge and follow-up</u>

According to Dr Drennan, it was common practice at Glenside to consider and plan the type of support a patient would be requiring once they were discharged, from the time they were admitted to hospital[19]. In Mr Butler's case, his licence was due to expire on 24 March 2000. In April 1998, even before Mr Butler's charge of murder had been dealt with, a social worker recorded in Mr Butler's medical file that an application had been made for priority housing through the Housing Trust. Notwithstanding numerous follow-up attempts by the social worker and encouragement for Mr Butler to provide adequate documentation in support of his

[18] Transcript, page 67
[19] Transcript, page 28

application and to participate in an interview, the application was not processed in time for his discharge in March 2000. It is well known that the Housing Trust has enormous demands upon its facilities. According to Dr Drennan, the social worker at Glenside Hospital was under a great deal of pressure, given the type of patients housed in Glenside[20]. In the circumstances, it seems to be a complete waste of the social worker's time to try to organise letters of support for applications for housing when the main problem seems to be that there is not enough public housing to meet the demand. It was never going to be easy to secure appropriate priority housing from the Housing Trust for an uncooperative person such as Mr Butler and yet, in this case, I find that the issue of housing was a critical factor to the success or otherwise of any follow-up in the community, which was necessary in his own interests and in the interests of the community.

5.22. Dr Drennan emphasised that she was not responsible for the discharge planning upon the expiration of Mr Butler's licence. Entries in Mr Butler's medical file indicate that arrangements for discharge planning were shared mainly between, Clinical Nurse Consultant Orr, Registered Nurse Bossenberry, Social Worker Ann Hillam and Dr Drennan. Dr Drennan prepared the discharge summary intended to go to the general practitioner who was to provide ongoing management in the community.

5.23. On 30 January 2000, RN Bossenberry referred Mr Butler for assessment by the Eastern Region, Mobile Assertive Care Team (MAC). If the MAC team agreed to provide their services to Mr Butler once he had returned to the community, they could have provided intensive follow-up if required, but only if he remained in the metropolitan area[21]. In the referral form seeking this assessment, Mr Butler is described by RN Bossenberry as presenting a low risk of harm to others[22]. Whilst the previous threaten life charge is mentioned, there is no detail provided which would alert the MAC Team to the potential risk of relapse or violent behaviour in the event that he was non-compliant with medication and resumed his intoxicant behaviour. There is no evidence however, which would enable me to find that if this information had been included, it would have influenced the decision ultimately made. No doubt there is great demand upon the services of

[20] Transcript, page 68
[21] Transcript, page 92 and page 105
[22] Exhibit C13, page 155a, page 66

the MAC Teams and at the time of the assessment, Mr Butler's mental illness was in remission controlled by medication.

5.24. On 24 February 2000, Mr Butler was assessed by the MAC Team as not requiring their level of intervention and it was suggested that he be monitored in the community by the lower level of service offered by the Continuing Care Team (CCT). This service was dependant upon housing becoming available, at which time Mr Butler would be assigned to the service which covers that region. In other words, without a specified place of residence, the service was unavailable[23]. The community teams have nurses and social workers who monitor patients and encourage them to attend follow-up appointments at regional clinics for their antipsychotic injections and for review. When properly resourced, this service is said to provide an early intervention mechanism when patients become non-compliant or relapse through drug and alcohol abuse.

5.25. <u>Psychiatric review of Mr Butler before discharge</u>

An entry in Mr Butler's Glenside Hospital notes on 17 August 1999 indicates that he was to be assessed by Dr Clayer to gauge his level of depression, yet this does not appear to have taken place. The only note by a consultant in the several months before his release is a brief one by Dr Hustig concerning Mr Butler's trial leave arrangements on 26 November 1999. A report to Mr Butler's legal representative dated 21 September 1999 was generated in response to an application to change Mr Butler's licence conditions. In Dr Hustig's two page report, he mentions having an interview with Mr Butler, but that does not seem to have been noted in Mr Butler's medical file[24]. I accept that there may have been more direct assessment of Mr Butler by consultants than is reflected in the notes, but I have a concern overall about the lack of documentation which suggests that there was no formal clinical assessment of Mr Butler prior to discharge. This is all the more concerning, given that Dr Drennan took no responsibility for Mr Butler's psychiatric management.

5.26. <u>Mr Butler's departure from Glenside without follow-up arrangements</u>

On 22 March 2000 Mr Butler was permitted to leave the hospital for 'trial leave', after which time his licence expired. The final entry explaining Mr Butler's departure is

[23] Transcript, page 25
[24] Exhibit C15a

made by Clinical Nurse Consultant Orr to the effect that Mr Butler was given oral medication for seven days and he is said to have agreed to see a local GP for a prescription for more medication. Mr Butler received his last injection of Zuclopenthixol deconate 200mgs on 20 March 2000. His next injection was due on 3 April 2000.

5.27. Mr Butler informed CNC Orr that he intended to reside at an address described as 'Karte Hall via Pinnaroo'. The note continues as follows:

> 'Anthony does not wish any community input from mental health services now his licence has expired! Anthony's behaviour and conversation was appropriate and intelligent as it has been over the major part of his stay here. I have spoken to him re previous behaviours and drug use. He is aware of the need not to use drugs as it will lead to further difficulties for him. He has agreed not to use illicit substances.'[25]

5.28. <u>Discharge Summary prepared by Dr Drennan</u>

Dr Drennan explained in evidence that she had the task of preparing discharge summaries and when Mr Butler left the hospital, stating his intention to reside in Pinnaroo, she produced a discharge summary expecting that it would be faxed to a general practitioner (GP) in Pinnaroo. The document contains a brief outline of relevant information which I find was insufficient in the circumstances, although as things turned out, this deficiency is unlikely to have influenced the events which followed. The fax cover sheet which might have specified who the discharge summary was sent to is absent from Mr Butler's medical file and Dr Drennan was unable to recall that detail. Once Mr Butler's licence expired, he was free to live where he wanted. The nearest community service available operated in Murray Bridge and was not an option for people with mental illness as far away as Pinnaroo. In any event, Mr Butler had made it clear that he did not want community support. His departure to Pinnaroo marked the beginning of an itinerant period which saw him immediately stop taking his medication. He travelled interstate and resumed his illicit drug taking in Sydney, before returning to South Australia and ultimately back to Karte where he fatally stabbed David Gerard on 12 September 2001.

[25] Exhibit C15a

6. Review of Mr Butler's management before discharge

6.1. Inadequate communication with GP

Dr Ken O'Brien, Director of James Nash House and the Forensic Mental Health Service, became familiar with Mr Butler's management when he was requested to provide the District Court with an opinion concerning the potential defence of mental incompetence. In evidence at the Inquest, Dr O'Brien expressed the view that Dr Drennan's discharge summary was too brief and it should have been supplemented by the provision of additional psychiatric reports. He stressed that there needed to be a discussion between Dr Drennan and the GP at Pinnaroo and to make an arrangement for the GP to inform staff at Glenside if Mr Butler did not attend the surgery for his depot injections and prescriptions[26]. I endorse Dr O'Brien's opinion on this topic, yet acknowledge that in Mr Butler's case, once he had left the hospital, effectively, he was not compelled to do anything. The options were limited. Even if the local GP had received the discharge summary and took the trouble to contact staff at Glenside when a week had passed and Mr Butler had not made contact, according to Dr O'Brien, there was nothing anyone could do about it, other than to ask police to keep an eye on him[27].

6.2. Dr O'Brien explained that within the past fourteen months or so, resources have been made available for the provision of ten nurses linked with James Nash House to participate in the discharge plans for forensic patients following the expiry of their licences and to provide a limited supervisory role following discharge. The James Nash House team is now said to handle the referrals to the MAC Teams and Community Teams. I endorse these changes which should improve the quality of arrangements made for post discharge follow-up in the community, subject to available resources. Unfortunately, the lack of services available to those discharged to most regional centres remains a major concern[28].

6.3. Mr Butler's insight into his mental illness and the need for medication

In a report to the District Court for the purpose of considering an application to vary Mr Butler's licence conditions in September 1999, Dr Hustig stated that Mr Butler

[26] Transcript, page 427
[27] Transcript, page 426
[28] Transcript, page 463

demonstrated a 'reasonable insight into his current medication and the need to maintain his medication in the long-term'[29]. Yet the impression gained from the extensive notation by CNC Orr and others throughout Mr Butler's period of detention, is that he was doing only what was required to get to the end of his licence period. In hindsight, it is difficult to see how the treating team could ever have had confidence that Mr Butler had insight into his illness and the need to continue taking medication following discharge. A perusal of Mr Butler's medical records indicates that CNC Orr, who was responsible for his day to day management and supervision, observed on 12 June 1999 that Mr Butler 'requires prompting on almost every occasion to present for medication'[30].

6.4. One week before his discharge, CNC Orr made the following notation:

> 'Anthony is reluctant to do anything. He needs to be encouraged out of bed every day. His appearance is dishevelled, dirty, without pride in his appearance. He is monosyllabic in and out of groups. He is passive aggressive and surly most of the time. He complies reluctantly with ward routine and norms.'[31]

6.5. When Drs Hustig and Drennan were questioned about this topic, both practitioners asserted that they saw no evidence to suggest that he would be non-compliant when discharged, having regard to the numerous times he had successfully completed trial leave[32]. I accept that the evidence overall suggested, that Mr Butler was not refusing to take his medication whilst he was required to take it, in accordance with the conditions of his licence. That is not to say that he would continue to take the medication once his licence expired.

6.6. <u>Alcohol and Substance Abuse</u>

On the basis of Dr Branson's interview with Mr Butler in 2002, he expressed the view that abuse of illicit substances and alcohol may not have been a major factor in Mr Butler's acute episode of psychosis leading to the stabbing of Mr Gerard[33]. On balance, I am inclined to accept the views on this topic by Drs Hustig and Raeside that it was a significant factor[34]. Whilst Dr Hustig acknowledged that it was predictable that Mr Butler would resume drug taking at some stage, the difficulty was

[29] Exhibit C15a
[30] Exhibit C13, page 50
[31] Exhibit C13
[32] Transcript, page 54, page 78 and page 89
[33] Transcript, page 735
[34] Transcript, page 106

trying to predict when it might occur. Given the potent nature of cannabis available, Dr Hustig claimed that it was not surprising that he developed psychosis when he resumed consumption of the drug[35]. When Dr Hustig examined Mr Butler in November 1998, following the first episode of violent behaviour, he thought that it was clear that he would always be more physically aggressive in the setting of substance abuse such as cannabis or amphetamine and that this would often be complicated by the 'co-use' of alcohol[36].

6.7. <u>Final 'Trial Leave' when discharge arrangements were unresolved</u>

Because the discharge arrangements were unresolved due to difficulties with accommodation, Dr O'Brien considered that Mr Butler should not have been granted the final period of trial leave[37]. An alternative option was to give consideration to making an urgent application for a Continuing Detention Order but, in Dr O'Brien's view, it would not have been appropriate to do this[38]. Dr Hustig suggested that there was insufficient clinical justification to merit such an application because Mr Butler's mental state indicated that he did not need further hospitalisation[39]. In Dr O'Brien's view, there were pointers in Mr Butler's history which should have alerted staff to the need to be very assertive in the way he was discharged[40]. I accept Dr O'Brien's opinion that, given the severe nature of the incident with his step-father, Mr Butler's itinerant lifestyle, history of alcohol and drug abuse and intermittent non-compliance with medication, there needed to be a clear management plan[41].

6.8. I accept that Mr Butler did not need continued detention in Glenside from a clinical perspective, but I find that he should not have been granted 'trial leave' when the question of housing remained unresolved immediately before his licence expired.

6.9. Mr Butler's medical notes contain a large number of forms signed by medical practitioners authorising trial leave, however there is no form in the notes authorising this final period of leave. Dr Drennan acknowledged that she signed many forms authorising Mr Butler's leave up to the time of discharge, but could not assist the Court as to who authorised this final period of leave. According to Dr Drennan, she

[35] Transcript, page 97
[36] Exhibit C15, Transcript, page 76
[37] Transcript, page 452
[38] Transcript, page 450
[39] Transcript, page 82
[40] Transcript, page 428
[41] Transcript, page 427

could not see a problem with Mr Butler being granted this final trial leave in the few days before his licence expired[42]. The absence of this legal document in the case notes is a concern and suggests that the leave was not properly authorised.

6.10. Community Treatment Order option

In a report by Dr Branson in August 2002 concerning his assessment of Mr Butler's mental state at the time when he stabbed Mr Gerard, the following observations were made about Mr Butler's discharge from Glenside:

> 'It was of considerable concern to me that in view of Mr Butler's history, no steps were taken to enforce antipsychotic medication on him at the time of his discharge from Glenside Hospital on 24.3.00. In view of the fact that his Licence expired at that time, an order from the Guardianship Board such as a Community Treatment Order, would have been necessary to ensure that he continued to receive medication in the community. No consideration was apparently given to applying for such an order'.[43]

6.11. According to Dr Branson there was sufficient evidence in Mr Butler's history to merit an application being made for a CTO, particularly the evidence which demonstrated that 'when he became psychotic, he was inclined to become violent or threatening'[44].

6.12. An application to the Guardianship Board for a Community Treatment Order (CTO) pursuant to Section 20 of the Mental Health Act (1993) required the applicant to demonstrate that Mr Butler was likely to fail to undergo treatment which should be given for his own health and safety or for the protection of other persons. The problem with this criteria is that it places a burden upon psychiatrists to provide sufficient evidence in support of the application and to estimate the degree of likelihood that the patient will become non-compliant in circumstances where the patient has not been adequately tested over an extended period of time in the community. Dr Hustig also expressed the view that the level of risk to the patient or others, which practitioners need to demonstrate in applications to the Board, seems too high. Whilst the orders, if granted, provide the legal power to enforce treatment in the community upon reluctant patients, they do not authorise compulsory abstinence from illicit drugs and alcohol. Another shortcoming of these orders is that they are unenforceable interstate.

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[42] Transcript, page 69
[43] Exhibit C26
[44] Transcript, page 722

6.13. According to Dr Hustig, the advantage of having an order in place for Mr Butler following discharge, is that it would provide a mechanism for early detection of deterioration in his mental state provided he resided in a serviced area within South Australia[45]. However he considered that it was 'extremely doubtful' that the Guardianship Board would have granted an order concerning Mr Butler in March 2000[46].

6.14. One major disincentive to making applications for CTOs was said to be the 'culture' which previously existed within the Guardianship Board. Drs O'Brien and Hustig explained that in about the year 2000, applications made to the Board were often unsuccessful because a legally trained senior member of the Board imposed a legalistic, adversarial style into the application process in which medical practitioners were subjected to intimidating questioning. Dr O'Brien explained that he had to stop the more junior practitioners from appearing before the Board because of the distress involved. An equally serious outcome of this phase in the life of the Guardianship Board was said to be that when applications were rejected, the 'therapeutic alliance' between doctor and patient was irreparably harmed. In this climate, practitioners are said to be very reluctant to make applications where there is a risk of rejection[47].

6.15. Dr Hustig explained that at that time, even if a GP in Pinnaroo advised Glenside staff that Mr Butler failed to turn up for his required medication, that would not have been enough to justify making an application for a CTO[48]. Clearly there is a problem with the way the legislation is being interpreted. I accept the evidence given by Dr Hustig on this topic concerning his experience with the Guardianship Board, endorsed by Dr O'Brien, and find that the demonstrated attitude of the former Guardianship Board to CTOs, prior to Mr Butler's release from Glenside Hospital, influenced the treating practitioners to avoid serious consideration of this option in the ongoing management of Mr Butler in the community after his discharge. According to Dr O'Brien, there have been changes to the Guardianship Board, which appear to have resolved this particular problem, although a measure of inconsistency and unpredictability remains[49].

[45] Transcript, page 98
[46] Transcript, page 94
[47] Transcript, page 94, page 441 and page 443
[48] Transcript, page 114
[49] Transcript, page 442

6.16. Dr Hustig suggested that there was a need for changes to the Mental Health Act (1993) to provide orders which require some patients to remain within the State, and to reside in a particular location. I accept that this would help community teams to more adequately supervise and treat patients in the community[50].

7. Causal connection between the circumstances of Mr Butler's discharge and the fatal stabbing of David Gerard

7.1. Having considered the evidence concerning how Mr Butler was released at the expiration of his licence from Glenside, I am satisfied that if he was released into the metropolitan area into suitable accommodation, community workers assigned to monitor his compliance with ongoing treatment may have been able to minimise the risk of an acute relapse, at which point he may have been successfully detained and treated in hospital. One clear advantage of being housed appropriately would have been that he would be less likely to become itinerant. But taking into account his poor insight, history of non-compliance and reluctance to be monitored by community based mental health services, it would have been a challenge to keep Mr Butler compliant with prescribed medication and away from illicit drugs and alcohol in the absence of a CTO. When one considers the potential for Mr Butler to become extremely violent when unwell, I find that he posed an ongoing risk to the community which required the imposition of an appropriate level of monitoring of his behaviour for the foreseeable future. I consider that a CTO should have been sought in a timely fashion prior to the expiration of his licence. If Mr Butler chose to travel interstate, then I accept that there is nothing which could be done to enforce the CTO in the absence of some form of national cooperative arrangement. If the Guardianship Board is not functioning as it is intended to, rather than tolerating an unsatisfactory situation to the detriment of their patients and the community, medical practitioners should be encouraged to raise the matter with their seniors, who should act on their concerns by bringing them to the attention of the Minister.

7.2. Because Mr Butler was not subject to a CTO, it should have been reasonably predictable that he would decline to engage with any service offered to him. He was therefore able to cease medication and abuse drugs and alcohol until his behaviour attracted the attention of authorities, as indeed it did when he stabbed Mr Gerard.

[50] Transcript, page 101

Given the passage of time between Mr Butler's release into the community and the stabbing of Mr Gerard, I am unable to conclude that a CTO, if granted, would have altered the outcome. I find however, that if an order had been granted and successfully renewed twelve months later, subject to Mr Butler being provided with appropriate housing, the risk of what ultimately occurred would have been significantly reduced.

8. Circumstances leading to the death of Michael Eldridge

8.1. On 10 April 2003 Mr Simper, aged 38 years, was discharged from the Cramond psychiatric unit at TQEH following a three week period of detention for an acute relapse of chronic paranoid schizophrenia, a condition for which he had been treated in hospital and in the community for ten years. Mr Simper's psychiatric condition is complicated further by an anti-social personality. From 1992, Mr Simper had over fourteen psychiatric admissions to hospital, including James Nash House in 1994. He had a documented history of aggressive and violent behaviour when he was unwell and a history of non-compliance with oral medication and other prescribed treatment.

8.2. Mr Simper's hospital and community mental health records are so extensive that it takes an experienced forensic psychiatrist at least five hours to review them[51]. By all accounts, Mr Simper is a complex person to manage and one who requires an enormous amount of resources to manage successfully. I have been advised that whilst Mr Simper was at the extreme end of the spectrum of patients suffering this type of condition, there may be several hundred people like him in the community[52].

8.3. When discharged from hospital on 10 April 2003, Mr Simper was referred back to the community mental health team based in Port Adelaide. Social Worker Michael Wooden was familiar with Mr Simper, having supervised him over a number of years in the community. He was well aware of Mr Simper's potential violence and danger to others when he was under-medicated. He also knew that Mr Simper complained regularly to his doctors about sexual dysfunction, a common side effect of his antipsychotic medication (Zuclopenthixol) which was administered by injection each fortnight.

[51] Transcript, page 495
[52] Transcript, page 606

8.4. During 1999 and 2000 Mr Simper failed to attend outpatient appointments for medication and follow-up. He was hospitalised five times within six months in 2000. During this time he is said to have assaulted two people and engaged in threatening, impulsive and destructive behaviour. After a period of extended detention in 2000, Mr Simper was eventually stabilised on a dose of Zuclopenthixol deconate 400mg per fortnight. In April 2001 the dose was reduced to 350mg. In April 2002 it was reduced again to 300mg. Throughout this period, Mr Simper was required to submit to prescribed medication pursuant to 12 monthly CTOs granted by the Guardianship Board [53]. On one occasion in June 2000, police were called to assist the community nurse to administer the depot medication in his home. Mr Simper's last CTO was due to lapse on 23 May 2003.

8.5. Notwithstanding the CTO, Mr Simper was not reviewed by a medical practitioner for over twelve months before March 2003. The Port Adelaide Community Team doctor, Carlene Ward, assessed Mr Simper for the first time on 7 March 2003 and agreed to reduce his dose of Zuclopenthixol to 250mg and then to 200mg over two months and to start a trial of a new medication (Solian). This was said to be done in response to Mr Simper's complaint of sexual dysfunction. Dr Ward also told Mr Simper that another CTO would be sought to ensure his compliance with treatment. When Mr Wooden discovered that the depot medication was to be reduced, he was quite angry about it and raised his concerns with the practitioner. When he took Mr Simper home after the appointment with Dr Ward, he raised the topic of the CTO which produced an aggressive response from Mr Simper who insisted that he would 'get a lawyer and fight it all the way'[54].

8.6. Mr Simper failed to attend the clinic to receive his fortnightly depot injections and on 17 March 2003, he refused an injection during a visit by the community nurse[55]. As Mr Simper's key worker, it was Mr Wooden's responsibility to track Mr Simper down and encourage him to cooperate with the treatment. I accept that this was a very labour intensive exercise given the large number of patients subject to CTOs under his supervision[56].

[53] Exhibit C17, page 70
[54] Exhibit C17, page 34a
[55] Exhibit C17, page 62
[56] Exhibit C23

8.7. As a result of the fatal stabbing of Mr Eldridge, the Clinical Director of Mental Health from TQEH, Dr Hundertmark, took the extraordinary step of writing to the then President of the Guardianship Board to complain about the fact that CTOs were being granted without recognition of the capacity of the Community Health Services to supervise them[57]. I consider that a more appropriate response to the problem might have been a request to the Minister for additional resources.

8.8. In hindsight, it is now clear that with the gradual reduction in the dose of Mr Simper's fortnightly medication and his non-compliance with treatment, his condition became unstable. By the time he was admitted to hospital on 17 March 2003, he was acutely unwell and dangerous. Neighbours are said to have noticed threatening behaviour by Mr Simper including hearing him say that he wanted a gun to shoot people. During a visit to Mr Simper's home that day, Mr Wooden was sufficiently troubled by what he encountered to arrange for an urgent assessment by Dr Geddes in the home, the outcome of which led to Mr Simper's detention and transfer to TQEH.

8.9. Dr Geddes had taken over from Dr Ward in the Port Adelaide Community Team. He completed paper work recording his assessment, which then became part of TQEH records for Mr Simper. Dr Geddes noted that this episode was an exacerbation of chronic schizophrenia, that Mr Simper had refused to take medication and was experiencing auditory hallucinations. With reference to the criteria for detention under the Mental Health Act (1993), Dr Geddes documented that Mr Simper was a danger to himself and to others. Dr Geddes excluded any history of alcohol or drugs in this episode, but noted that Mr Simper had been well over the past twelve months 'until 2 weeks ago'[58]. In hindsight, it is clear that Mr Simper was becoming unwell for a much longer period than two weeks.

9. Failure of care provided in the community

9.1. Having considered the evidence of events leading to this admission, the inescapable conclusion I have reached is that the management of Mr Simper's chronic illness in the community was a failure. Notwithstanding the best efforts of those working in the community to keep him functioning, those efforts fell short of the type of supervision which Mr Simper needed for his own health and safety and the safety of others.

[57] Exhibit C24a
[58] Exhibit C18, page 93

10. Admission to The Queen Elizabeth Hospital 17 March 2003

10.1. Mr Simper was brought to TQEH in an acutely psychotic and aggressive state. He was initially physically restrained, sedated and placed in a 'seclusion' room where he was monitored by staff. On 18 March 2003 Mr Simper's behaviour remained extremely disturbed. When he was released into the common room for a short period, he suddenly lunged at a male nurse who happened to be walking past him. He punched the nurse to the face, wrestled him to the ground and continued to punch the nurse repeatedly until staff were able to intervene.

10.2. The following morning Consultant psychiatrist, Dr William Goh signed documentation confirming Mr Simper's three day detention order, noting his attack upon the nurse and the risk of further violence to others. In this documentation and also in Mr Simper's progress notes, Dr Goh stated that Mr Simper had a history of schizophrenia with non-compliance and was experiencing command auditory hallucinations[59].

11. Transfer to Brentwood Ward at Glenside Hospital 18 March 2003

11.1. In the afternoon of 18 March 2003, Mr Simper was transferred to the more intense closed ward in Brentwood at Glenside Hospital, where he remained aggressive and threatening over the next few days. A very brief discharge summary, (prepared by Dr Chitrarasu and co-signed by Dr Goh), was provided to staff at Brentwood in which Mr Simper's principal diagnosis was said to be 'chronic schizophrenia – acute exacerbation due to ?non-compliance'. I make no criticism of the decision to transfer Mr Simper for management in a closed ward at Glenside following the attack upon the nurse at Cramond.

11.2. When he arrived at Glenside, staff discovered that Mr Simper had $1,000 in cash in his possession. In the closed ward at Brentwood, seclusion, restraint and sedation were employed to manage his continued aggression. I have no doubt that Mr Simper would have been an extremely difficult patient for staff to deal with. When Psychiatrist Dr Kneebone attempted to assess him, Mr Simper was said to be 'malodorous, grandiose, irritable and threatening'. On 19 March 2003 he remained hostile, abusive and threatening. Staff were required to restrain him to administer his

[59] Exhibit C18

depot medication. On 20 March 2003, Dr Kneebone reviewed Mr Simper and confirmed a 21 day detention order. When Mr Simper was advised that he would be remaining in hospital, he tried to strike one of the nurses and later tried to strike a medical practitioner[60].

11.3. After five days of intense supervision, medication and restraint in Brentwood, Mr Simper is said to have settled somewhat, but started to complain about sexual dysfunction again. On 25 March 2003 Mr Simper is said to have agreed to a period in an open ward and, from that time, he had to wait for an available bed in the open ward in Cramond at TQEH. While waiting, he expressed his anger and frustration about being detained in Brentwood. He was non-compliant with his prescribed oral Sodium Valproate, hiding the tablets in his pocket. He also declined to take his nightly Haloperidol.

11.4. By 28 March 2003, Dr Kneebone considered discharging Mr Simper directly back to the community from Brentwood. Entries in Mr Simper's medical notes suggest that there was pressure on Dr Kneebone to discharge Mr Simper to free up his bed in Brentwood. When Michael Wooden heard about the plan to discharge Mr Simper directly from Brentwood, he persuaded Dr Kneebone to keep him longer until an open ward bed became available.

12. Transfer to Cramond from Brentwood 4 April 2003

12.1. On 4 April 2003, Mr Simper was transferred back to Cramond. The system operating at that time and currently, dictated that even though there was an open ward at Glenside Hospital, Mr Simper was required to be housed in an open ward at Cramond Clinic, subject to bed availability, because he was linked with the Port Adelaide area by reference to his residential address[61]. I accept the opinion from the Professor of Psychiatry at University of Adelaide, Dr Robert Goldney that Mr Simper's illness was not sufficiently under control at the conclusion of this period in Brentwood to be transferred back to Cramond. He needed a longer period of review in a closed ward facility[62]. Secondly, I accept Professor Goldney's opinion that when Mr Simper was sufficiently controlled to be transferred to an open ward bed, he should have remained at Glenside under the care of the same treating team and be placed in an open ward

[60] Exhibit C20a, page 22
[61] Transcript, pages T323,363
[62] Transcript, page 558

there. This would have achieved continuity of care and created less disruption at a time when Mr Simper remained irritable and under-medicated[63].

12.2. When Mr Simper arrived at Cramond he was so irritable that staff decided to keep him in the closed ward. A cautious approach was adopted, taking into account what had occurred previously[64]. He was prescribed Sodium Valproate 1000mg morning and night and Haloperidol 10mg nightly. Lorazepam three times per day was commenced on 7 April 2003.

12.3. Over the following week, Mr Simper was assessed in the closed ward by Dr William Goh and by Senior Registrar Dr Douglas Wilson. Dr Wilson had completed his training in psychiatry, but had yet to be admitted to the College of Psychiatrists. He was familiar with Mr Simper from an earlier period when he was his treating practitioner at the Port Adelaide Community Health Service about 18 months previously. Dr Wilson had treated Mr Simper in that capacity periodically for at least two years and had known him to be non-compliant with medication for a schizo-affective disorder. Dr Wilson was generally familiar with his multiple admissions to hospital following periods of non-compliance with medication[65].

12.4. On 5 April 2003, Mr Simper was given two doses of oral Clopixol, an antipsychotic medication (prescribed on an as needed basis) as well as a tranquilliser (Lorazepam) after Mr Simper was observed speaking loudly, pacing the floor and becoming aggressive. When given the medication, Mr Simper is said to have stated that 'he would murder someone, wouldn't care who it was, just to get out and see his girlfriend'[66]. On the following day, 6 April 2003, he was given three more doses of PRN Clopixol. At 11:15pm he received 20mg Clopixol and 2mg Lorazepam.

12.5. Before Dr Wilson assessed Mr Simper in the closed ward on 7 April 2003, he reviewed the notes of the previous three weeks including the faxed notes from Brentwood and the brief discharge summary. According to Dr Wilson, Mr Simper was hostile, irritable and angry about being kept in a closed ward when he had been told at Brentwood that he would be transferred to an open ward at Cramond. He was prescribed a sedative, Lorazepam, three times daily and granted escorted trial leave for half an hour in the open ward at Cramond. According to a subsequent nursing

[63] Transcript, page 559
[64] Transcript, page 320
[65] Transcript, pages 299-303
[66] Exhibit C18

note, this trial period took place without incident and Mr Simper appeared to be 'superficially settled', presumably as a result of receiving the extra medication.

12.6. At 6:30am on 8 April 2003 Mr Simper was overheard by a nurse speaking on the phone to his mother 'where he constantly discussed themes of anger and potential violence which included pointed and specific statements about nursing staff…'[67].

12.7. <u>Dr Goh's assessment - 8 April 2003</u>

When Dr Goh assessed Mr Simper about five hours later in the closed ward, he is said to have done so without the benefit of looking at any of Mr Simper's medical notes which recorded all previous notations by medical and nursing staff[68]. Given the passage of time, Dr Goh was unable to say with certainty what information he may have been given before he reviewed Mr Simper. Whilst Dr Goh agreed that he had ultimate responsibility for Mr Simper's management, he explained that he had very little time available as a part time consultant and therefore relied heavily upon his registrar, Dr Wilson, whom he regarded as a 'de facto' consultant[69].

12.8. Dr Goh explained that he believed he was unfamiliar with Mr Simper when he interviewed him on 8 April 2003 and would not have recalled confirming the three day detention order following his initial detention and the attack on the nurse three weeks earlier. According to Dr Goh, his assessment made on 8 April 2003 was not a comprehensive assessment[70]. He described it as 'a cross-sectional view of someone in the ward who may need some additional opinion or contribution,' and it was based upon Mr Simper's presentation over a period of 15 to 20 minutes[71]. Dr Goh's entry in Mr Simper's notes reads as follows:

> 'Appeared quite settled today after being prescribed Lorazepam over the past day and a half. Said that his main problems revolve around his feelings of frustration and anger, with rapid mood swings; frustrated as he had been impotent and this was affecting his relationship with his partner over last 2 years. Believed impotence is due to psychotropic medication.
>
> Also six months ago heard that his children by previous relationship were killed in a motor vehicle accident. Still grieving their loss. Used to hear voices when using marijuana in early 1990s. Voices stopped in 1995 also when he stopped using illicit drugs. Has a long track record of minor violent behaviour which he says was due to

[67] Exhibit C18
[68] Transcript, pages 185, 571-573 and 577
[69] Transcript, page 226
[70] Transcript, page 185
[71] Transcript, page 191

> frustrations. He related well, reasonably articulate, range of affect appropriate, no overt delusions or hallucinations noted. His story and presentation do not support a diagnosis of schizoaffective disorder unless there are data which I do not have. He probably had a drug induced psychosis and an underlying personality with difficulty in anger management. Currently depot medication to be reduced and at follow-up will require consultant review of his management at depth'.[72]

12.9. I return to the topic of this assessment shortly when I discuss the opinions of psychiatrists who have carefully reviewed Mr Simper's management with the benefit of hindsight as well as with more detailed historical information. In essence, I find that Dr Goh's assessment was flawed in several respects, but that even if he had been more thorough, Mr Simper would probably have been released from hospital on 10 April 2004 nevertheless. I acknowledge that had it not been for Mr Wooden's insistence upon keeping Mr Simper until an open ward bed became available, Dr Kneebone may have discharged Mr Simper back to the community a week earlier.

12.10. Having reflected on the evidence, I consider that Dr Goh's assessment was influenced partly by the pressure on practitioners in his position to discharge patients as quickly as possible and to free up beds for more urgent cases[73]. According to Dr Craig Raeside, it is a 'nightmare' trying to balance the needs of patients occupying beds with patients who are waiting for those beds. In his experience, whilst the hospital administrators insist that these decisions are for doctors to make on clinical grounds, Dr Raeside conceded that in reality there is enormous pressure with the limited number of available beds which in turn leads to patients being discharged prematurely[74].

12.11. Dr Goh explained that he made a decision to retire early partly because he was unhappy with the changes to the mental health services which saw the concept of 'asylum' abandoned and replaced by a short term approach involving speedy diagnosis, medication and discharge[75].

12.12. Dr Goh acknowledged that if he had been in receipt of a comprehensive summary of Mr Simper's longitudinal history, this might have influenced his assessment on 8 April 2003. I find however, that there was information available from the notes of Mr Simper's admission on 18 March 2003 and subsequently, which if perused in a

[72] Exhibit C18
[73] Transcript, page 231
[74] Transcript, pages 528-530
[75] Transcript, page 274

relatively efficient manner, should have influenced Dr Goh's assessment of Mr Simper. An examination of Mr Simper's medical notes, which covered the current admission, would have indicated that the history relied upon by Dr Goh, from Mr Simper, was factually incorrect in several critical respects,. When Dr Goh came to write his entry in the notes on 8 April 2004, it would not have taken long to peruse the previous entries.

12.13. I readily acknowledge how difficult it must be dealing with patients like Mr Simper, particularly when under time pressure, but as an experienced consultant it is surprising that Dr Goh contemplated a change to Mr Simper's diagnosis without seeking corroboration of the history given[76]. It appears that by considering a 'drug induced psychosis' as the explanation for Mr Simper's previous symptoms, Dr Goh was led to thinking short term which influenced his decision that Mr Simper did not require further hospitalisation[77]. Anyone reading Dr Goh's entry for 8 April 2003 would be entitled to expect that he had considered the circumstances of the past three weeks in arriving at his assessment, notwithstanding the qualification made in his entry about data which he may not have had in forming his view.

12.14. One of the issues ventilated in evidence concerned who was responsible for assessing Mr Simper's detention status. Although Mr Simper's 21 day detention order was due to expire two days later, Dr Goh stated that he did not assess Mr Simper to make a decision about his 'detention' status. If he did so, Dr Goh explained that he would have headed his entry 'detention review' in accordance with his long standing practice. In any event Dr Goh maintained in evidence that he believed that Mr Simper was not detainable as of 8 April 2003[78]. Dr Goh was the only member of the treating team legally entitled to authorise a period of further detention for 21 days. If this occurred, it required an additional assessment by a second psychiatrist. Whilst in his view Mr Simper was not 'detainable', Dr Goh acknowledged that he would have preferred Mr Simper remain in hospital a little longer on a voluntary basis[79]. When asked whether, with the benefit of hindsight, Mr Simper should have been detained for a further 21 days or less, Dr Goh maintained his view that Mr Simper was not detainable when he saw him, because he was not psychotic. I take this to mean that Dr Goh did not observe any features of psychosis during his twenty minute interview.

[76] Transcript, pages 496, 492 and 507
[77] Transcript, page 520
[78] Transcript, page 206
[79] Transcript, page 212

12.15. Dr Wilson suggested in evidence that he gave Dr Goh a quick handover, giving the essential background before Dr Goh interviewed Mr Simper. Whatever information might have been conveyed, it did not feature in Dr Goh's assessment. Both doctors agreed that they discussed Mr Simper following Dr Goh's assessment, although there is no note to confirm that a discussion occurred. Having heard the evidence concerning the two practitioner's respective roles in Mr Simper's management, I accept that a discussion took place after Dr Goh's assessment, in which Dr Goh expressed his view that Mr Simper could be discharged. It was then up to Dr Wilson to implement the decision. I accept that during this discussion, Dr Wilson is likely to have reminded Dr Goh of the history relevant to Mr Simper's management, but that ultimately the decision arrived at was that Mr Simper could be discharged. The entries which follow in Mr Simper's notes tend to confirm this sequence of events, albeit with significant omissions.

12.16. Dr Wilson balanced Dr Goh's assessment with one of his own which he documented in Mr Simper's medical notes on 9 April 2003. This was said to be necessary to ensure that Dr Osenk (the Resident Medical Officer) would produce a balanced discharge summary, a copy of which would remain in Mr Simper's hospital file and another sent to the Port Adelaide Community Team. The summary sets out an outline of the admission including diagnosis, treatment and follow-up plans. According to Dr Wilson, he felt the need to acknowledge in the medical notes that Mr Simper did have an Axis I diagnosis, most likely bipolar disorder, although this was said to be a grey area with the treatment being virtually the same for schizophrenia, bipolar or schizo-affective disorder. In his view, Mr Simper needed to continue with Zuclopenthixol depot medication and if it was to be reduced, it needed to be done very slowly and cautiously. Mr Simper's medical files indicate that he received an intra-muscular injection of Zuclopenthixol, 300mg on 9 April 2003.

12.17. Discharge from Cramond - 10 April 2003

When Dr Wilson asked if Mr Simper would consider staying on as a voluntary patient, Mr Simper refused[80]. Dr Wilson considered that whilst there was still some sign of illness, there was insufficient indication to justify a further detention order. He emphasised that the decision about detention was the responsibility of the consultant[81]. Whilst he was not legally entitled to order detention, Dr Wilson was authorised to revoke a detention order. He decided that rather than release Mr Simper at midnight, it was best to revoke the order to enable him to leave during the afternoon of 10 April 2003. When he saw Mr Simper before completing the form recording revocation of the detention order, Dr Wilson remained of the view that he was not detainable. Dr Wilson interpreted Mr Simper's persistent aggression and irritability as being focussed upon his continued detention in the closed ward at Cramond.

12.18. In a subsequent review by Professor Goldney, it is said to be significant that Mr Simper was given an additional dose of Clopixol at 11:30pm the previous night to 'slow his thoughts after being given Lorazepam with no effect[82]. According to Professor Goldney the need for extra PRN antipsychotic medication was an indication that Mr Simper was not yet stabilised[83]. Dr Wilson responded by stating that it was relatively common for a patient to be a little unsettled just before discharge[84].

12.19. The discharge summary prepared by Dr Osenk contains a combination of observations from Dr Goh's entry together with those from Dr Wilson. Bearing in mind what had transpired over the preceding three weeks, I find this summary to be a confusing and unsatisfactory document which had the potential to mislead practitioners who were destined to manage Mr Simper thereafter[85]. It is hardly surprising that Dr Osenk would have struggled to reconcile the two differing assessments from her supervisors. As things turned out, the events of 16 April 2003 overshadowed what might have occurred in reliance upon this document. When the document was put to Dr Goh during evidence, he commented that the principal diagnosis specified as 'bipolar disorder' was new to him and was inconsistent with his

[80] Transcript, page 335
[81] Transcript, page 387
[82] Exhibit C24
[83] Transcript, page 646
[84] Transcript, page 359
[85] Transcript, page 493

assessment on 8 April 2003[86]. Dr Goh conceded that he co-signed the discharge summary as he was required to do, but that it was impractical to read all discharge summaries which he signed[87]. I infer from this evidence that Dr Goh did not read the document before signing it. In my view, if the consultants do not have time to read these documents, they should not sign them.

12.20. Community Team response to Mr Simper's discharge

Mr Wooden tried without success to influence staff at Cramond to place Mr Simper in an open ward before he was discharged. It is generally accepted by psychiatrists that for chronic patients like Mr Simper, it is undesirable to discharge them directly from a closed unit back into the community. In Mr Simper's case, no open ward bed was made available for this 'step-down' trial period to take place, although he was permitted to spend a few hours in the open ward before his discharge.

12.21. An additional concern Mr Wooden had was that while Mr Simper was detained in Brentwood, he learned that Mr Simper's Housing Trust residence had been broken into and vandalised. Apart from causing additional distress to Mr Simper once he heard about this, Mr Wooden was required to deal with the situation and arrange for funding and quotes for everything to be cleaned up before Mr Simper could return there. Given the pressures upon Mr Wooden's time, it is no wonder that this could not be arranged in the short time available before Mr Simper's discharge. In a candid statement received into evidence, Mr Wooden asserted that there simply is not enough suitably trained social workers and nurses employed in community mental health services to do the work which is required of them. I say more about this topic later.

12.22. When Mr Simper was discharged from the hospital he was prescribed oral Sodium Valproate 1000mg twice daily, Haloperidol 5mg in the evening and Diazepam 5mg twice daily. He was also due for his next depot injection of Zuclopenthixol on about 24 April 2003. A follow-up appointment was arranged with Dr Geddes at the Port Adelaide Clinic on 17 April 2003.

12.23. Mr Wooden was very unhappy when Mr Simper was discharged back to the community because he knew from experience that it was going to be difficult to manage him. On 12 April 2003, two days following his discharge, there was a report

[86] Exhibit C18 and Transcript, page 264
[87] Transcript, page 267

to the Western Assessment and Crisis Intervention Service (ACIS) from Mr Simper's mother about an incident earlier that day in which her son had behaved aggressively and frightened a female employee at an ice cream shop[88]. Not surprisingly, Mr Simper's mother declined to have her son stay with her after his discharge because of previous threatening and aggressive behaviour towards her. One episode where Mr Simper was said to have attempted to strangle his mother led to his admission to Hillcrest Hospital, where he escaped after breaking a window[89]. In more recent years, when Mr Simper's mother lived in the same neighbourhood as her son, neighbours regularly complained to her about her son's behaviour[90].

12.24. When Mr Wooden heard about the incident at the ice cream shop during a team meeting on 14 April 2003, it prompted him to arrange a home visit later that day, accompanied by a male nurse for security purposes. Upon arrival, Mr Wooden found Mr Simper's house to be almost uninhabitable, but Mr Simper appeared contrite about his aggressive behaviour at the ice cream shop and promised to take his medication and present for his next injection when it was due. Mr Wooden obtained a prescription from Dr Geddes for Mr Simper's oral medications and is said to have returned to Mr Simper either with the script or medication or both. This is the last contact Mr Wooden had with Mr Simper before the fatal stabbing of Mr Eldridge two days later. According to Mr Wooden, when he last saw Mr Simper, he did not see anything to suggest that he was actively psychotic, although it is acknowledged that he was not qualified to make such an assessment.

12.25. <u>Mr Simper's activities in Hindley Street</u>

On 15 April 2003 Mr Simper was seen walking along Hindley Street, in a dishevelled state, yelling abuse to pedestrians nearby. At about 2pm Mr Simper tried unsuccessfully to book a room for two nights at the Quality Hotel in Hindley Street. Later that afternoon he checked into the Paringa Hotel in Gilbert Street, paying $350.00 in cash for two nights. The following morning he requested to extend his stay, but the request was declined. It was observed that Mr Simper had been smoking in his room and he was reminded that it was a non-smoking room[91]. At about 12:15pm Mr Simper purchased a 16 centimetre knife for $50.00 cash from Aussie

[88] Exhibit C17, page 47
[89] Exhibit C22
[90] Exhibit C17, page 58
[91] Exhibit C8g

Disposals in Hindley Street and went directly back to the Paringa Hotel where he was approached by the Hotel Manager, Michael Eldridge. Mr Eldridge had intended speaking with him about the smoking policy. Before he had a chance to do so Mr Simper suddenly stabbed Mr Eldridge in the chest and abdomen and continued stabbing in a frenzied attack until he stopped, walked outside and sat on the pavement. A passer-by courageously took the knife from him without any resistance. Mr Simper walked away, but was easily identified to police and arrested a short time later.

12.26. Within minutes of the stabbing, police found Mr Eldridge in a lifeless state and attempts to resuscitate him were unsuccessful.

13. Post Mortem Examination

13.1. A post mortem examination was conducted by Forensic Pathologist Dr John Gilbert on 16 April 2003. During Dr Gilbert's examination, he observed a total of 42 individual stab wounds to Mr Eldridge, mainly to the chest and abdominal region. Dr Gilbert summarised his opinion concerning the cause of death as follows:

> 'Death was due to multiple stab wounds. Many penetrated the chest cavity and/or upper abdomen with additional stab wounds to the left and right upper arms (injuries 5 and 27 respectively) and to the neck (injury 2). Three injuries to the hands consistent with defence injuries were noted (injuries 29, 30 and 31). One stab wound entered the spinal canal but did not injure the spinal cord (injury 37).
>
> Internally, the wounds to the chest resulted in seven full thickness punctures of heart chambers (6 to left ventricle, one to right atrium), any of which in isolation could have proved rapidly fatal. In addition, there were multiple punctures of the lungs (13 in total), two stab wounds to the liver and one to the spleen.
>
> Death resulted from rapid loss of blood from the circulation largely due to the cardiac stab wounds. There was no reasonable prospect that medical intervention, even if it was immediate, could have prevented the death due to the large number of rapidly lethal injuries.'[92]

13.2. In Dr Gilbert's opinion, there were indications that 'considerable force' was used to inflict some of the stab wounds to Mr Eldridge, by reference to penetration of bone including ribs, sternum, left scapula and thoracic vertebral lamina[93].

13.3. I accept the opinions expressed by Dr Gilbert in his comprehensive report concerning the injuries sustained by Mr Eldridge and the cause of death.

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[92] Exhibit C5b, page 22
[93] Exhibit C5b

14. Toxicology - Mr Simper's level of antipsychotic medication

14.1. A sample of blood taken from Mr Simper following his arrest on 16 April 2003 was analysed for various drugs and alcohol by Peter Harpas, from the Forensic Science Centre. The results revealed a trace of Diazepam and Nordiazepam but no alcohol, cannabinoids, opiates, amphetamines, valproic acid, Olanzapine, tricyclic antidepressants or other basic drugs. Surprisingly, even though Mr Simper was administered an injection of 300mg Zuclopenthixol a week earlier on 9 April 2003 there was no trace of this antipsychotic medication detected[94].

14.2. During the course of the Inquest, Mr Harpas was requested to re-test the sample for Zuclopenthixol and when re-tested, this time with more sophisticated equipment, Zuclopenthixol was detected, but at a very low level estimated at 0.004mg per litre[95].

14.3. A request was made following receipt of the revised toxicology results for a review of the available information from Professor Felix Bochner from the Department of Clinical Pharmacology at the Royal Adelaide Hospital. Professor Bochner kindly agreed to review Mr Simper's medication history in the period leading to the fatal stabbing of Mr Eldridge and to provide an opinion about what level of Zuclopenthixol might have been expected in Mr Simper's system at the time of the stabbing. According to Professor Bochner, a sample taken six days following administration of the depot medication would normally be expected to be at a concentration close to the maximum level, due to the nature of its slow release oil based formula. It has been estimated that this level would be somewhere between 0.0112mg and 0.019mg per litre, whereas minimum levels occurring at the time the next injection is due (ie after 14 days) would be expected to range between 0.0032mg and 0.0136[96]mg per litre.

14.4. Professor Bochner suggested three possible explanations for the unusually low level of the drug in Mr Simper. The dose given may have been too low. Secondly, Mr Simper may be an ultra-rapid metaboliser of the medication which occurs in about 1% of the population. The third suggestion is that because Mr Simper was a big man, weighing 124 kilograms, it is possible that when the last injection was given into the right buttock (as recorded in the hospital notes), the needle may not have penetrated into muscle and instead could have lodged in the fat and subcutaneous tissue above

[94] Exhibit C7b
[95] Exhibit C27
[96] Exhibit C28

the muscle. If this medication is not injected into muscle, according to Professor Bochner, it would not be absorbed efficiently. This view was confirmed by Professor Robert Goldney, who explained how difficult it can be to give intra-muscular injections to people who are very overweight[97].

14.5. Professor Bochner researched this topic in detail to reveal that the increasing incidence of obesity in the community here and overseas has resulted in a gradual recognition that there should be some revision of the guidelines for the administration of intramuscular medication, particularly for psychiatric patients. In other words, the needles may need to be longer than the ones currently in use. This problem is said to be exacerbated by the fact that antipsychotic medications like Zuclopenthixol can cause significant weight increase. I accept Professor Bochner's opinions expressed in his report and encourage pharmaceutical companies and researchers to undertake studies concerning this issue.

14.6. I note that information received during the Inquest indicates that since Mr Simper's detention in April 2003, he has been stabilised on medication which includes 400mg Zuclopenthixol administered intramuscularly every two weeks. Whether the needle length is a potential problem is one for his treating practitioners to contemplate in the light of Professor Bochner's report.

15. Review of Mr Simper's management at Brentwood and Cramond

15.1. Reports from Psychiatrists Dr Christopher Branson and Dr Craig Raeside were received into evidence concerning Mr Simper's mental state at the time of the fatal stabbing of Mr Eldridge. Both psychiatrists reviewed a large amount of material including Mr Simper's medical records.

15.2. Dr Branson's assessment

Dr Branson concluded that Mr Simper was probably psychotic for a number of months before the fatal stabbing. When he interviewed Mr Simper on 11 February 2004, Mr Simper admitted lying to his doctor at TQEH about not hearing voices because he wanted to get out of hospital. Dr Branson summarised his assessment of Mr Simper's management at TQEH as follows:

[97] Transcript, page 620

> 'It is clear that by the end of his admission to hospital, staff were under the impression that Mr Simper was no longer experiencing psychotic symptoms as he was denying these. However, there were some episodes of belligerent or angry behaviour that were simply blamed by the hospital staff on their perception that Mr Simper has a rather antisocial personality style. In retrospect, I believe that this behaviour indicates that Mr Simper was indeed not well. There is even a suggestion that the hospital staff were beginning to think that Mr Simper did not indeed suffer from paranoid schizophrenia (a diagnosis which had been long established and is in my view quite convincing and conclusive) but that he had principally a mood disorder and that any aggressive actions were a result simply of his personality style. Whilst this did not alter the way in which the hospital staff were prescribing medication for Mr Simper, I believe that this misunderstanding about their interpretation of his behaviour led to him being discharged from hospital earlier than was appropriate. On the other hand, decisions such as these are notoriously difficult to make with a patient who is not being open and forthright about the symptoms that they are experiencing.'[98]

15.3. As to the question of detention, Dr Branson suggested that Mr Simper was probably detainable at the time of his discharge on 10 April 2003, but he acknowledged that it would have been a difficult assessment for the treating doctors to make because Mr Simper was concealing his symptoms to get out of hospital[99]. One way of dealing with this type of patient in Dr Branson's view, is to question the patient with a degree of 'suspicion' and try to elicit psychotic symptoms[100]. I accept that where practitioners are under pressure to discharge patients as quickly as possible, there is little incentive to use this type of assertive strategy[101].

15.4. <u>Dr Raeside's assessment</u>

Dr Craig Raeside provided a report detailing a comprehensive summary of Mr Simper's psychiatric history, featuring violent episodes and non-compliance with medication. He examined Mr Simper on several occasions and has treated him in the Adelaide Remand Centre following his arrest in April 2003[102].

15.5. According to Dr Raeside, Mr Simper acknowledged that when he was discharged from TQEH in April 2003, he was not well, contrary to the description in the discharge summary. Dr Raeside elaborated as follows:

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[98] Exhibit C26a
[99] Transcript, page 731
[100] Transcript, pages 732 and 740
[101] Transcript, page 741
[102] Exhibit C22

> 'He said he had been spitting out medication (due to side effects-his usual practice) and lied to staff that he was no longer hearing voices so he could leave. The detention order was due to expire anyway and he believed that they were keen for him to leave due to pressure on inpatient beds.'[103]

15.6. Having reviewed Mr Simper's management in Brentwood and Cramond, Dr Raeside made the following observations:

> 'Obviously, a more extensive review of all the documented information strongly suggests the presence of a psychotic disorder, independent of illicit drugs. Consequently, a decision was taken not to renew the 21 day order when it expired on 10.4 03 and there is even a recommendation that medication doses be decreased, despite clear evidence of decompensation due to non compliance with medication.'
>
> 'In my view a more longitudinal review of Mr Simper's psychiatric history suggests more strongly a formal psychotic disorder such as Schizophrenia or Schizoaffective Disorder, although clearly mood disturbance was evident at times as well.'[104]

15.7. In a subsequent report to the Coroner, dated 2 December 2005, Dr Raeside elaborated by expressing the view that by the time of Mr Simper's discharge, it was unlikely that his psychotic symptoms had resolved. Whilst acknowledging the benefit of hindsight, Dr Raeside concluded as follows:

> '… an incorrect understanding of Mr Simper's longitudinal history was a significant factor in his precipitous (early) discharge from hospital whilst he remained unwell'.[105]

15.8. Dr Raeside pointed to contemporary information which was available to the treating doctors which was sufficient to justify an extension of his hospital admission to 'ensure the stability and to observe more carefully for any ongoing psychotic symptoms rather than simply relying on his history'. In Dr Raeside's opinion Mr Simper should have been further detained and continued on antipsychotic medication, especially if there was any suggestion of a reduction in this medication. In his view, Mr Simper would require several months to settle, rather than weeks[106]. In Dr Raeside's view, if Mr Simper received ongoing treatment in hospital until his acute relapse had truly resolved, he could then have been discharged to the community with 'his levels of aggression and dangerousness significantly reduced'[107].

15.9. Dr Raeside elaborated during his evidence to the Inquest about the need for a longitudinal view of patients such as Mr Simper. He stated that hospital staff

[103] Exhibit C22
[104] Exhibit C22
[105] Exhibit C22c
[106] Transcript, pages 516 and 519
[107] Exhibit C22c

commonly mistake unpleasant behaviour for anti-personality disorders without historical information to support the diagnosis. Dr Raeside expressed a concern about inexperienced doctors who alter a long established diagnosis based upon a simple presentation at interview[108]. In his view, the critical decision in Mr Simper's case was whether to detain him further and in that regard the wrong decision was made because Dr Goh appeared to address how Mr Simper appeared at the time of his assessment. Dr Raeside regarded Dr Goh's note of 8 April 2003 as inferring that Mr Simper did not need further detention[109]. I agree with this interpretation.

15.10. In Dr Raeside's view, psychiatric training does not deal adequately with the interpretation of the 'detention' provisions of the Mental Health Act[110].

15.11. <u>Professor Goldney's assessment</u>

At the request of Associate Professor Phillips, Director of Mental Health, Professor Robert Goldney from the University of Adelaide provided a comprehensive assessment of Mr Simper's clinical management in a report dated 16 August 2004. After reviewing Mr Simper's medical files, Professor Goldney expressed reservations about Mr Simper's treatment at Glenside and TQEH, but readily acknowledged the challenges presented by a patient such as Mr Simper as follows:

> 'It is personally demanding having a patient with a history of violence; who is so insightless; who is reluctant to divulge information; and who is probably deceitful (eg denial of hallucinations, hiding of medication). It is also very time consuming in referring to all previous clinical information, but it is crucial to have such information. It is also challenging to clinicians when pressure of beds demands a through-put of patients which is simply not appropriate for persons with such severe illnesses. Extra time, both in terms of individual professional involvement, and in terms of length of stay and bed accessibility, should have been available for the management of Mr Simper.'[111]

15.12. Professor Goldney concluded that Mr Simper had a convincing history of long standing Schizo-Affective Disorder 'with associated aggression and lack of both insight and compliance which over a number of years had required significant psychotropic and social intervention to gain control'. Essentially, Professor Goldney shared many of the views expressed by Drs Raeside and Branson concerning Mr Simper's presentation and management between his detention on 17 March 2003 and

[108] Transcript, page 496
[109] Transcript, pages 503 and 521
[110] Transcript, page 523
[111] Exhibit C24

discharge three weeks later[112]. He concluded that there was insufficient regard to his chronic history and non-compliance which called for an increased dose of longer acting intra-muscular medication[113]. Professor Goldney commented that when faced with pressure from Mr Simper to reduce his medication, one needed to be fully informed about his history to be able to confidently resist such pressure. In his view, when non-compliance is suspected, practitioners should consider monitoring blood levels of oral medication and to increase the dose of longer acting intra-muscular medications when necessary[114].

15.13. In his opinion, when Mr Simper was discharged, his psychotic condition was not under control, notwithstanding that he presented as tolerably well at times. Professor Goldney considered that by 16 April 2003, Mr Simper would have had 'appreciably less antipsychotic medication in his system than he would have had when he was in hospital'[115]. Professor Goldney considered that the extra doses of Clopixol and Lorazepam may have given Mr Simper a temporary 'settled' presentation when Dr Goh assessed him on 8 April 2003, which may have misled Dr Goh to some extent. Professor Goldney was critical of the decision to discharge Mr Simper directly from the closed ward following an inadequate trial in the open ward. In his view, it was unrealistic to expect Mr Simper to have coped in the community[116].

15.14. As to whether it could have been predicted that Mr Simper would become violent following his discharge, Professor Goldney emphasised that the best predictor of future violence was his past violence. I endorse Professor Goldney's view that there was evidence available to Mr Simper's treating team of his past violence, although I accept that it is not possible to predict when it might occur again with any precision[117].

15.15. Professor Goldney suggested that in complex cases such as this, there is a need for a periodic review of the medical notes by an experienced psychiatrist, with a view to producing a working summary document covering the relevant longitudinal history, including presentation, diagnoses, treatments, CTOs, detention, medication, non-compliance and previous episodes of violence[118]. I find that if this had been available

[112] Transcript, pages 571-573, 568, 574 and 577)
[113] Transcript, pages 581 and 600
[114] Exhibit C24
[115] Exhibit C24
[116] Exhibit C24
[117] Transcript, pages 557, 609 and 643
[118] Transcript, pages 584, 603 and 607)

to Mr Simper's treating team in the community and to the hospitals, it may have led to more appropriate management decisions which may in turn have minimised the risk of future violent behaviour. This type of document would also be useful in making applications to the Guardianship Board for future CTOs. I understand that this would be a very time consuming exercise, but one which Professor Goldney and others acknowledge should be undertaken for the management of chronic patients with multiple admissions to hospital over the course of many years[119].

15.16. Professor Goldney acknowledged the difficulties faced by Mr Simper's treating doctors when Mr Simper's detention order was due to expire. In his view, there was scope to detain Mr Simper for a further period after 10 April 2003, but in his experience, if Mr Simper had appealed the decision, he expected that the order would be defeated. His position on this was similar to that of Dr Branson[120]. Professor Goldney acknowledged that under the provisions of the Mental Health Act (1993) there seemed to be insufficient scope to create adequate time frames within which to adequately assess and medicate some patients before the expiry of detention orders. The evidence suggests that most psychiatrists interpret the 21 day detention criteria conservatively, in the sense that unless they perceive an 'immediate' or 'imminent' threat to the patient or others (arising out of the patient's mental illness) the patient is not usually detained.

15.17. I am inclined to question whether psychiatrists may be taking an unduly narrow approach to these orders, perhaps in response to the stated objectives of the Mental Health Act (1993) and the Guardianship and Administration Act (1993), which emphasise the need to minimise restrictions upon a patient's liberty[121]. I am also mindful of the onerous documentation which is required to be generated by psychiatrists when making these very important decisions[122]. The evidence also suggests to me that outcomes following successful appeals, as well as the fear of litigation, may contribute to the conservative approach taken by some practitioners[123].

15.18. <u>Summary of Findings concerning Mr Simper's management</u>

[119] Transcript, page 583
[120] Transcript, page 590
[121] Section 5(1)(b) of the Mental Health Act (1993)
[122] Transcript, page 604
[123] Transcript, page 642

The evidence enables me to find that:

1. Mr Simper's management in the community over several months leading to his admission to hospital was inadequate;

2. The resources of the Port Adelaide Mental Health Community Team were insufficient to provide the level of supervision which Mr Simper required;

3. Notwithstanding the existence of a CTO, Mr Simper was non-compliant with medication and medical appointments;

4. Decisions made to reduce Mr Simper's dose of Zuclopenthixol gradually from 400mg to 300mg and lower, were unwise. The lack of an adequate documented longitudinal history to assist some of the treating practitioners may explain why there was no effective resistance to Mr Simper's complaints about sexual dysfunction. Where practitioners have no psychiatric training, this would be even more challenging;

5. Mr Simper's detention on 17 March 2003 was necessary in his own interests and in the interests of others;

6. Mr Simper's history indicated that following an acute relapse he would require a period of months, not days or weeks, before he was well enough to return to the community. This fact was not appreciated by his treating practitioners at Glenside or TQEH;

7. The decision to transfer Mr Simper to Glenside Hospital following his attack upon a nurse was appropriate, as was the decision to impose a 21 day detention order at the expiry of the initial three day order;

8. The assessment made at Glenside Hospital on 25 March 2003 that Mr Simper was sufficiently settled to be transferred to an open ward bed was premature. It is likely that the decision was influenced by the pressure to free up a bed at Glenside;

9. The practice which dictated that Mr Simper could only occupy an open ward bed at TQEH, rather than at Glenside, complicated his clinical management and was disruptive to Mr Simper;

10. The decision to manage Mr Simper in the closed ward at Cramond once he had been transferred back there on 4 April 2003 was appropriate;

11. The assessment by Dr Goh on 8 April 2003 was compromised by a failure to review the available material in Mr Simper's medical file;

12. Dr Goh's assessment was neutralised by the subsequent contribution of Senior Registrar, Dr Wilson, who was generally familiar with Mr Simper's history;

13. At the time of Mr Simper's discharge on 10 April 2003, he remained unwell and needed to stay in hospital for further closed ward management, followed by an adequate period in an open ward. Monitoring Mr Simper in an open ward is likely to have revealed any residual symptoms due to illness as opposed to his anti-social personality;

14. I agree with Dr Raeside that a further 21 day detention order was justified on a more assertive interpretation of the Mental Health Act and should have been made. I acknowledge that the prevailing view of psychiatrists is that Mr Simper was probably not detainable at the time of discharge in accordance with a conservative approach to the provisions of the Mental Health Act (1993);

15. When considering whether it is safe to discharge a patient, it is relevant for psychiatrists to take into account the adequacy or otherwise of the resources available to the Community Teams to supervise the patient in the community;

16. The pressure on treating practitioners in public hospitals to free up beds acts as a disincentive to order detention for those like Mr Simper who need extended hospital care;

17. Mr Simper's treating practitioners at Glenside and TQEH failed to appreciate from the lengthy history of Mr Simper's illness that he would require a higher dose of Zuclopenthixol than he was receiving;

18. When Mr Simper was discharged, he was under-medicated;

19. Mr Wooden was unable to do what was required to ensure that Mr Simper's home was in a proper state in the brief period before he was discharged;

20. The uninhabitable state of Mr Simper's home is likely to have led him to seek hotel accommodation in the city at a time when he was very unwell;

21. If Mr Simper had remained in hospital for a longer period of treatment with adequate medication, the risk of future violence to others following discharge, would have been minimised, at least in the short term.

16. The need for a Centre of Excellence in Psychiatry

16.1. Dr Branson expressed his regret over the demise of Hillcrest Hospital and explained that this was the reason he has subsequently withdrawn from public sector psychiatry[124]. According to Dr Branson, the psychiatric orthodox continues to favour de-institutionalisation of mental health services. Dr Branson candidly expressed his opposition to the philosophy which he understood was designed partly to create a more cost effective option for treatment in the community which would be equal to the quality of hospital based care. It was also intended to destigmatise mental illness. In Dr Branson's view however, the present mental health service is inadequate[125].

16.2. Professor Goldney supported the call for a concentration of skill in a Centre of Excellence, especially for the management of severely ill and chronic patients, requiring long-term treatment[126]. In his view, there are some patients who should not be sent back to the community under the care of a GP, because to do so would be unfair to both the patient and the practitioner[127]. Professor Goldney acknowledged that whilst there are some very good practitioners working in psychiatric units in public hospitals, they are dispersed across a number of areas, whereas it would be better to concentrate the expertise in one facility[128].

16.3. I note that the former State Coroner, Mr Chivell, made a recommendation calling for the creation of a Centre of Excellence nine years ago when reviewing the operation of several aspects of the mental health system during an Inquest which raised similar issues to those arising in this Inquest[129].

16.4. When pressed about the deficiencies in the mental health system, Professor Goldney conceded that his profession should have taken a stand years ago, but instead, they

[124] Transcript, page 742
[125] Transcript, page 746
[126] Transcript, pages 633-635
[127] Transcript, page 608
[128] Transcript, page 636
[129] Inquest 20/1996 into the death of Nandadevi Chandraratnam

tried to 'cover over the cracks' and 'battle on'. Meanwhile, patients are said to be suffering[130].

16.5. Having heard evidence which comprehensively examined several aspects of the mental health system operating within South Australia in the period leading to the deaths of Mr Gerard and Mr Eldridge, I consider that there is a need to re-examine the philosophy underpinning the Mental Health Act (1993) and to give serious thought to the re-establishment of a properly staffed psychiatric teaching hospital with the capacity to offer short-term as well as extended care beds to all patients requiring it. In my view, the fragmentation of psychiatric services in this State has led to a decline in the quality of care which will only worsen as experienced practitioners, nurses and social workers abandon the system in favour of less stressful work.

16.6. There was a suggestion during evidence that there may currently be a review under way to re-examine the operation of the relevant legislation, however, I have not received any confirmation of this.

[130] Transcript, page 631

17. Recommendations

17.1. In accordance with the provisions of Section 25(2) of the Coroner's Act 2003, the following recommendations are made in anticipation that they might prevent or reduce the likelihood of or recurrence of an event, similar to the events, the subject of this Inquest.

17.1.1. That the Government give serious consideration to the re-establishment of a Centre of Excellence in Psychiatry.

17.1.2. That provision be made to increase the number of hospital beds available for patients with mental illness, to facilitate acute management as well as medium and long-term management.

17.1.3. That the Minister for Mental Health consider abandoning the system which requires patients to be transferred during one episode of illness from one hospital to another for the purpose of being housed in an open ward prior to discharge.

17.1.4. That the Minister for Mental Health do what is possible to secure dedicated residential accommodation in areas supported by community health workers, for patients with chronic mental illness who are deemed capable of living in the community, but who pose a potential risk of violence to members of the community when they become unwell.

17.1.5. That the Government consider amending the Mental Health Act (l993) to broaden the scope of Community Treatment Orders to require that a person resides in an area serviced by Community Mental Health Teams.

17.1.6. That where non-compliance is considered a potential problem, random testing be conducted both in hospital and post-discharge, to monitor levels of prescribed oral medication for patients suffering mental illness.

17.1.7. That the Government allocate more resources to the Community Health Teams which are required to monitor patients subject to Community Treatment Orders.

17.1.8. That the Government consider negotiating with interstate Ministers for Mental Health with a view to addressing the jurisdictional limitations to Community Treatment Orders.

17.1.9. That the Government consider amending the Mental Health Act (1993) with a view to enabling psychiatrists to order a further period of detention for patients who may not appear acutely psychotic, but require a longer period in hospital to clarify their mental health status before they can be discharged safely into the community.

17.1.10. That a panel of senior psychiatrists be established to undertake a periodic review of the medical files of patients with chronic mental illness whose longitudinal history is deemed to be essential knowledge for those who are required to manage the patients in the future. The periodic reviews should result in the production of a comprehensive summary, made available either electronically or in hard copy, to psychiatric units in public hospitals as well as Community and Crisis Assessment Teams .

17.1.11. That consideration be given to making available all or part of the contents of Court ordered reports concerning forensic psychiatric patients, for the benefit of treating practitioners to ensure that all relevant background information, including details of previous violent conduct, is taken into account when managing their in-patient treatment and discharge.

17.1.12. That senior psychiatrists consider imposing a requirement that before a 21 day detention order is revoked, a comprehensive assessment takes place by a sufficiently senior practitioner who has familiarised himself or herself with the patient's longitudinal history where relevant. The assessment should be documented in the medical notes under an appropriate heading.

17.1.13. That consideration be given to revising the procedures for the administration of intramuscular antipsychotic medication to patients who are obese.

Key Words: *Homicide; Stabbing; Psychiatric/Mental Illness; Psychiatric Institution; Detention Order*

In witness whereof the said Coroner has hereunto set and subscribed her hand and

Seal the thirteenth day of December, 2006.

Coroner