FINDINGS of Coroner Simon Cooper following the holding of an inquest under the *Coroners Act* 1995 (Tas) into the death of:

Stephen Maxwell Powell

Record of Investigation into Death (With Inquest)

Coroners Act 1995

Coroners Rules 2006

Rule 11

Hearing Date

8 August 2019 in Launceston

Appearances

V Jones – Counsel Assisting the Coroner

Background

1. On 27 December 2017, Stephen Maxwell Powell was found by police officers dead in the unit he had lived in for 20 or more years. Apart from his pet duck Daisy, Mr Powell lived a solitary existence. He visited no one and no one visited him. He had no known friends or family. His neighbour, Mr Paul Elwell, spoke to him from time to time and occasionally helped him read his mail. But that seems to have been the extent of his social interactions.

2. Aspects of Mr Powell's life history are not completely clear given the fact that, despite a careful and thorough investigation, the Investigating Officer, First Class Constable McIvor was unable to identify any living relatives (or for that matter friends) of Mr Powell. However, the evidence enables me to find that he was born on 4 December 1945 and raised in Perth, Western Australia the son of Maxwell Dudley Powell and Norma Jean Powell.[1] He appears to have had a sister named Maureen but no trace of her was able to be found during investigations. Enquiries showed that Mr Powell's mother died in 1995 and his father on a date unknown but some time before that.

3. Mr Powell left school and joined the navy aged 16. He spent 3 years in that service. Employment on the railways and then as a taxi driver followed before

[1] See Tasmania Police Subject Report Exhibit C 1

he appears to have retired at the age of 45. Mr Powell commenced to receive Centrelink benefits. He transitioned to an age pension later in life.

4. The evidence seems to be that Mr Powell moved to Tasmania in about 1987. On 27 October 1997, he started living at unit number 2, 216 Agnes Street, George Town. He appears to have been living in squalid conditions for many years. There is no evidence he ever married. He had no children. His senior next of kin in terms of the *Coroners Act* 1995 was the Public Trustee.

5. Relevantly, Mr Powell was admitted to what was then Ward 1E of the Launceston General Hospital (LGH) as an involuntary patient on 22 May 1997 due to a diagnosis of schizophrenia. He was discharged from that facility on 29 May 1997. His medical records indicate that shortly after his discharge he disengaged with mental health support services entirely.

6. Mr Powell seems to have lived quietly and without coming to the attention of any authorities until 24 October 2017. On that date, he was admitted to Northside Mental Health Clinic at the LGH because of a Mental Health Assessment Order. After treatment at Northside, he was discharged on 14 December 2017. At the time of his discharge, he was the subject of a treatment order made under the *Mental Health Act* 2013. The terms of that order expressed it to be in force until 1 May 2018.

What a Coroner Does

7. Before an analysis of the circumstances surrounding the death of Mr Powell is undertaken something should be said about the role of a coroner. A coroner in Tasmania has jurisdiction to investigate any death which appears to have been unexpected or unnatural. I am satisfied that the death of Mr Powell meets that legislative test.

8. When investigating any death at an inquest, a coroner performs a role very different to other judicial officers. The coroner's role is inquisitorial. She or he is required to thoroughly investigate a death and answer the questions (if possible) that section 28 of the *Coroners Act* 1995 asks. These questions include who the deceased was, the circumstances in which he or she died, the cause of

the person's death and where and when the person died. This process requires the making of various findings, but without apportioning legal or moral blame for the death. A coroner is required to make findings of fact from which others may draw conclusions. A coroner may, if she or he thinks fit, make comments about the death and, in appropriate circumstances, must make recommendations to prevent similar deaths in the future. In addition, there is a special obligation to report, about which more will be said shortly, in relation to the death of people held in care.

9. A coroner does not punish, or award compensation to, anyone. Punishment and compensation are for other proceedings in other courts, if appropriate. Nor does a coroner charge people with crimes or offences arising out of the death the subject of investigation. In fact, a coroner in Tasmania may not even say that he or she thinks someone is guilty of an offence.[2] I should make it very clear that I do not consider anyone has committed a crime or offence in relation to Mr Powell's death.

10. As was noted above, one matter that the *Coroners Act* 1995 requires is finding how the death occurred. It is well settled that this phrase involves the application of the ordinary concepts of legal causation. Any coronial inquest necessarily involves a consideration of the particular circumstances surrounding the particular death (or deaths) so as to discharge the obligation imposed by section 28(1)(b) of the *Coroners Act* 1995 upon the coroner.

11. The standard of proof at an inquest is the civil standard. This means that where findings of fact are made a coroner needs to be satisfied on the balance of probabilities as to the existence of those facts. However, if an inquest reaches a stage where findings may reflect adversely upon an individual, the law is that the standard applicable is that set out in the well-known High Court case of *Briginshaw v Briginshaw*, that is, that the task of deciding whether a serious allegation is proved must be approached with great caution.[3]

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[2] See section 28(4) of the *Coroners Act* 1995
[3] (1938) 60 CLR 366

Why an Inquest Was Held in This Case

12. As noted above, at the time of his death Mr Powell was the subject of a treatment order. The order was made whilst he was an inpatient at Northside on 2 November 2017 pursuant to section 39 of the *Mental Health Act* 2013.[4] Amongst other things, the order authorised Mr Powell's admission to, and detention for treatment in, an approved facility for the purpose of receiving treatment. The order also authorised treatment in the community if appropriate. The order also mandated Mr Powell's use of antipsychotic and other medication.

13. Since the order under the *Mental Health Act* 2013 was current at the time of Mr Powell's death, he was consequently a person "held in care" in terms of section 3 of the *Coroners Act* 1995 at the time of his death. As such, an inquest into his death was mandatory and I am obliged to report on the care, supervision or treatment of Mr Powell while he was held in care.[5]

14. The ambit of any investigation under the *Coroners Act* 1995 is defined by that act relevantly section 28 of the *Coroners Act* 1995 provides:

> "**(1)** A coroner investigating a death must find, if possible –
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> **(a)** the identity of the deceased; and
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> **(b)** how death occurred; and
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> **(c)** the cause of death; and
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> **(d)** when and where death occurred; and
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> **(e)** the particulars needed to register the death under the *Births, Deaths and Marriages Registration Act 1999*.
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> **(f)** . . . . . .
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> **(2)** A coroner must, whenever appropriate, make recommendations with respect to ways of preventing further deaths and on any other

[4] Exhibit C 9.
[5] See section 28(5) of the *Coroners Act* 1995.

matter that the coroner considers appropriate.

(3) A coroner may comment on any matter connected with the death including public health or safety or the administration of justice.

(4) A coroner must not include in a finding or comment any statement that a person is or may be guilty of an offence.

(5) If a coroner holds an inquest into the death of a person who died whilst that person was a person held in custody or a person held in care or whilst that person was escaping or attempting to escape from prison, a secure mental health unit, a detention centre or police custody, the coroner must report on the care, supervision or treatment of that person while that person was a person held in custody or a person held in care."

15. I observed in findings published in 2016 and 2017 (*Mansell*[6], and *Monson, Michael and Mitchell*[7]) that the particulars referred to in section 28(1)(e) are not to be found in either the *Births, Deaths and Marriages Registration Act* 1999 or the regulations made under that *Act* (which deals only with fees). Although it is over 3 years since the matter was first highlighted, a gap continues to remain in the legislative scheme.

16. Section 28(5) of the *Coroners Act* 1995 imposes an obligation to report on the care, supervision or treatment of Mr Powell. Much of the evidence at the inquest, particularly the documentary evidence, was directed towards this issue.

The Mental Health Order

17. On 15 August 2017, Ms Kylie Hume, the Property Officer for Housing Tasmania Greater North, conducted a routine property inspection of Mr Powell's residence at 2/216 Agnes Street, George Town. She carried out the inspection in the company of a colleague. Ms Hume made two affidavits (both

[6] [2016] TASCD 01
[7] [2017] TASCD 253

of which were tendered at the inquest) and gave evidence.[8] In substance her evidence regarding the inspection was that she found Mr Powell's unit to be in a filthy and squalid state. It was evident to Ms Hume that the unit had not been cleaned for a long time. With Mr Powell's permission, Ms Hume took a number of photographs of the unit that illustrate its condition very well.[9]

18. Ms Hume said that while she carried out the inspection Mr Powell sat in his chair and did not engage with either her or her colleague. Ms Hume asked Mr Powell if he had any support to assist him with daily chores such as cleaning and he said he had no support. He told Ms Hume that he did not need help or support and not to come back. Nonetheless, Ms Hume arranged after the meeting for Mr Brian Rowe, the tenancy intervention officer for Housing Disability Community Services to contact Mr Powell. She said she did this because she formed the belief that Mr Powell's tenancy was at risk due to the filthy state of the unit, which was a breach of the lease conditions.

19. Mr Brian Wilson swore an affidavit and also gave evidence at the inquest.[10] He said that on 8 September 2017 he visited Mr Powell at his unit. Mr Wilson said he discussed with Mr Powell the possibility of agencies such as Anglicare and Housing Connect providing assistance to him. Mr Powell declined a referral to both agencies but tentatively agreed to have the unit cleaned at his own expense.

20. Mr Wilson gave evidence that he returned to see Mr Powell at his unit on 3 occasions after the first visit. His last visit was on 12 October 2017. Mr Wilson became increasingly concerned about Mr Powell's mental health. After the last visit, he felt Mr Powell was so unwell that he contacted Adult Mental Health services and completed a referral to that agency.

21. On 24 October 2017, psychiatrist Dr Michelle Yin and Ms Alison Townsend, a community mental health registered nurse with the Older Person Community Mental Health Service (OPMHS), visited Mr Powell at his unit. They carried out a mental health assessment. As a consequence of the assessment it was

[8] Exhibits C 11 and C 12
[9] See Annexure A to exhibit C 12
[10] Exhibit C 13

determined that Mr Powell was mentally unwell and specifically lacking capacity for decision making. An Assessment Order was made under the *Mental Health Act* 2013. Arrangements were made for Mr Elwell to look after Daisy and Mr Powell was transported by ambulance to the LGH. He was admitted to Northside for further assessment and treatment.

Treatment at Northside

22. Mr Powell's medical records indicate that when he was admitted to Northside he was highly delusional.[11] The notes record that he stated that "God is not a cauliflower and he is God". The notes indicate he was wearing dirty and malodorous clothing. He was recorded as lacking insight, being loud and angry and thought to be at risk of both aggression and further self-neglect.

23. The notes indicate he was reviewed by psychiatrists at Northside on 25 October, 27 October, 28 October, 1 November, 2 November, 7 November, 9 November, 20 November, 27 November, 2 December, 4 December, 7 December, 11 December and on the day of his discharge 14 December 2017. In addition, he was reviewed and treated by a dermatological team on 13 and 14 November 2017 as well as being treated for atrial fibrillation with aspirin.

24. Whilst at Northside he was treated with the antipsychotic drugs haloperidol, olanzapine and aripiprazole. A diagnosis of paranoid schizophrenia was confirmed. After switching between the haloperidol and aripiprazole, the treating team settled on haloperidol decanoate intramuscular 100 mg every 4 weeks along with olanzapine (orally 5 mg at night). This dosage commenced on 23 November 2017 and appeared to lead to a settling of Mr Powell's symptoms.

25. Mr Powell enjoyed periods of leave whilst at Northside. Initially his leave was supervised but as his mental state settled he progressed to unsupervised leave. His leave took place without incident. And whilst an inpatient at Northside Mr Powell's unit was cleaned.

26. Mr Powell continued to exhibit symptoms of paranoid schizophrenia. In

[11] Exhibit C 8

particular at discharge he was noted to still have grandiose persecutory delusions but that they were significantly less prominent than when he was admitted. The notes record that he remained insight-less in relation to his mental health. He was recorded as sleeping and eating adequately and very happy to be going home.

27. At discharge he was subject to the treatment order mentioned above and required to undergo monthly depo injections. His risk of self-harm was assessed to be low. A discharge plan was provided to him and a number of community support agencies and his General Practitioner. The discharge plan involved follow ups with urology (he complained of penile pain), plastic surgery for a skin cancer, dental support, and referrals to the LGH Eye Clinic, and the Older Person Mental Health Service. Finally, I note that by the time of his discharge Mr Powell had agreed to assistance from several community support agencies.

28. The arrangements made for support and ongoing treatment of Mr Powell were, in my view, appropriate. I observe that it is of significance that in all of his medical notes there is no mention of suicidal ideation on his part.

Mr Powell's General Health

29. Mr Powell's medical records, tendered at the inquest, show his health was, generally speaking, poor. His medical records indicate he had a history of:

- Benign hypertrophic prostate;
- Basal cell carcinoma (BCC) on chest;
- Vitamin B12 deficiency;
- Bladder stone;
- Right renal cysts;
- Left eye cataract;
- Atrial fibrillation;
- Rectal and penile pain; and
- Dental pain and jaw pain.

30. Mr Powell's general practitioner was Dr Phillip Dawson of the Anne Street

Medical Clinic in George Town. Mr Powell last saw Dr Dawson on 14 December 2017 shortly after his discharge from Northside. In addition, the BCC on Mr Powell's chest was removed after discharge and he attended a dental appointment at the LGH on 22 December 2017.

31. Follow up by nurses from the George Town Community Centre in respect of wound care and dressing changes for the site of the BCC was arranged.

32. The evidence satisfies me that the treatment Mr Powell received for his physical ailments whilst he was the subject of the order under the *Mental Health Act* 2013 was appropriate.

Circumstances of Death

33. On 27 December 2017 two community registered nurses, Ms Casey Terry and Mr Stephen Youl, from the George Town Hospital and Community Centre received a new referral to provide wound care to Mr Powell. The wound care related to the area on Mr Powell's chest from where the BCC had been removed.

34. They met at Mr Powell's unit at about 10.30am. Despite knocking on the door and ringing his mobile telephone neither nurse was able to raise Mr Powell. After speaking to Mr Elwell, Ms Terry and Mr Youl went back to the George Town Hospital and Community Centre where Mr Powell's medical records were checked.

35. The records did not assist to locate Mr Powell and so Ms Terry, still concerned about Mr Powell, contacted Tasmania Police.

36. Two officers from George Town Station went to Mr Powell's unit at about 12 noon. They affected entry to the unit and found Mr Powell dead, sitting naked in an armchair with blood on his body and pooled at his feet. The officers saw that Mr Powell had a large cut in his right thigh in the vicinity of his femoral artery. They also saw a small circular wound on his chest just below his neck (the BCC). The officers observed an electric carving knife lying on the floor in front of Mr Powell to his left side. The carving knife, plugged into a power board and turned on, was not running as the user is required to hold a button

down to operate the knife. The electric carving knife was noted to have blood on its blade.

37. The unit was secured and searched. Detectives and a specialist forensic officer was shortly afterwards on the scene and carried out enquiries. There appeared to be no signs of forced entry and no signs of a struggle or disturbance within the residence. Police noted the unit was in a dirty condition and contained only basic furniture. Mr Powell's body was photographed where it was found. There was no sign of Daisy. Police took possession of various items including a wallet and drivers licence which were used to help identify Mr Powell.

38. Police spoke to Mr Elwell. He told them that he had seen Mr Powell on Christmas Day. The following day, 26 December, between noon and 1.00pm he heard Mr Powell making what he described as a moaning noise in his unit. There was no evidence of Mr Powell being alive after this time.

Forensic Pathology Evidence

39. Mr Powell's body was removed from the unit and transported by mortuary ambulance to the LGH. At the LGH Registered Nurse (RN) Alison Townsend formally identified Mr Powell's body to police. It was then transferred (again by mortuary ambulance) to the Royal Hobart Hospital. At the mortuary the then State Forensic Pathologist Dr Christopher Hamilton Lawrence carried out an autopsy upon Mr Powell's body. Dr Lawrence's report after autopsy was tendered at inquest.[12]

40. Dr Lawrence said that the autopsy revealed a single stab/incised wound in Mr Powell's right thigh which had severed the femoral artery. Dr Lawrence also noted that Mr Powell had moderate ischaemic heart disease and a small amount of right subdural haemorrhage. He attributed the right subdural haemorrhage as likely to have occurred following a collapse. There was however no significant head injury.

41. Samples taken at autopsy were subsequently analysed at the laboratory of Forensic Science Service Tasmania. No alcohol or illicit drugs were noted to

[12] Exhibit C5

have been present in those samples. The only drug present was paracetamol at a therapeutic level.[13]

42. In summary, nothing was found at autopsy or as a result of toxicological analysis of samples giving rise to any suspicion of the involvement of any other person in relation to Mr Powell's death.

Formal Findings

43. On the basis of the evidence at the inquest, I find, pursuant to Section 28(1) of the *Coroners Act* 1995, that:
    a. The identity of the deceased is Stephen Maxwell Powell;
    b. Mr Powell died in the circumstances set out in this finding;
    c. The cause of Mr Powell's death was exsanguination (blood loss); and
    d. Mr Powell died between 26 and 27 December 2017 at 2/216 Agnes Street George Town in Tasmania.

Report on Care, Supervision or Treatment

44. As indicated earlier in these findings it is necessary for me to comment upon the care, supervision and treatment of Mr Powell whilst he was a person held in care.

45. The evidence as a whole satisfies me that the care, supervision and treatment of Mr Powell whilst subject to the order was of an appropriate standard. The care he received as an inpatient appears to have been effective and led to a clear improvement in his symptoms.

46. Whilst it is arguable that he may have benefitted from perhaps a longer stay in Northside, a comprehensive follow up plan was devised and implemented.[14] He was seen by a variety of health care professionals and appropriate supports put in place. His risk of self-harm was assessed by his treating team as being low. In

[13] see exhibit C6 affidavit of Miriam Connor Forensic Scientist
[14] See in this regard the report of Dr John Kasinathan, consultant psychiatrist, dated 20 April 2019 Exhibit C 24.

the context of his mental health Mr Powell was visited by RN Townsend on 20 December (less than a week before his death) when his monthly psychotic haloperidol injection was administered. Although described as being dishevelled and unshaven Mr Powell was cooperative and discussed with RN Townsend appointments he had at the dental clinic, eye clinic, urologist and with his GP. There was no indication to RN Townsend of any suicidal ideation or plans on the part of Mr Powell.

Conclusion

47. The circumstances in which Mr Powell's body was found satisfies me that the actions which caused his death were undertaken by him alone. Similarly, although no suicide note was located and Mr Powell had no history of suicidal ideation, the evidence when viewed as a whole satisfies me to the requisite legal standard that the actions which caused his death were undertaken by him voluntarily and with the express intention of ending his own life. The circumstances of Mr Powell's death do not require me to make any recommendations or comments.

Dated 16th day of October 2019 at Launceston in Tasmania

Simon Cooper
Coroner