QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

FINDINGS OF INVESTIGATION

CITATION:	**Non-inquest findings into the death of Bianca Girven**
TITLE OF COURT:	Coroners Court
JURISDICTION:	BRISBANE
DATE:	1 December 2017
FILE NO(s):	2010/1102
FINDINGS OF:	Christine Clements, Brisbane Coroner
CATCHWORDS:	CORONERS: Asphyxia; boyfriend charged with murder and found of unsound mind; adequacy of mental health treatment provided to boyfriend prior to incident; mental health care reform.

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Circumstances surrounding Miss Girven's death

1. Miss Girven lived at 909 Cavendish Road, Mt Gravatt in Queensland with her sister and two year old child. She was 22 years old when she died at Princess Alexandra Hospital ('PAH') on 31 March 2010.

2. Miss Girven and Mr A attended Mt Gravatt High School. They began dating at high school but broke up not long after finishing High School. Miss Girven and Mr A recommenced dating some months before March 2010.

3. On the evening of 30 March 2010, Miss Girven and Mr A attended the Full Moon Festival at Orleigh Park, West End. They travelled together in a van that Mr A routinely used though it belonged to his parents. After attending the Full Moon Festival, Miss Girven and Mr A travelled to a public car park at Mt Gravatt. They arrived around 10.00 pm. During the course of a conversation in the back of the van, Mr A struck Miss Girven to the face and then strangled her. He drove Miss Girven to his home nearby. He pulled into the driveway and summoned help. His family attended and administered effective CPR. An ambulance was called and attended at 11.30 pm. Miss Girven was pulseless. Paramedics provided emergency care and transported Miss Girven to the PAH. Miss Girven required mechanical ventilation, inotropic and fluid support to maintain adequate blood pressure. Her pupils were fixed consistent with a severe cerebral insult. A CT scan of neck and brain suggested severe hypoxic brain injury.

4. Miss Girven was admitted to the PAH Intensive Care Unit at 3.00 am on 31 March 2010 after the transfer from the emergency department. She was increasingly hemodynamically unstable. Her blood pressure became unsupportable despite aggressive management with inotropes and fluids. Treatment was withdrawn as futile at 12.10 pm and Miss Girven was pronounced deceased at 12.16 pm.

5. Mr A initially contrived a crime scene which included hitting his head on the roadway to lend support to the initial false accounts he gave to family, police and treating psychiatrists. He claimed that he and Miss Girven were both attacked at the car park by two, unknown assailants. He was charged with murder some months later.

6. The Mental Health Court subsequently found that Mr A was of unsound mind at the time of the commission of the alleged murder. The decision of the MHC was affirmed by the Court of Appeal. Mr A was detained under a Forensic Order pursuant to the *Mental Health Act 2000* ('the Act'). It was not until May 2011 that Mr A unequivocally admitted to strangling Miss Girven during psychiatric interviews as part of a MHC referral.

Establishing the cause of death by autopsy

7. On 1 and 2 April 2010, a full internal autopsy was carried out by Forensic Pathologist, Dr Alex Olumbe. External findings revealed showers of petechial haemorrhages in the face and eyes (conjunctivae and sclera) with a clear line of demarcation underneath the chin. There were multiple fresh bruises on the chest, right inguinal region, front of the right thigh and leg, front of the distal left leg, inner aspect of the right elbow, and back of the right elbow, inner aspect of the left wrist, right upper back, and left lower back. The bruises were minor and varied in dimensions.

8. There were minor abrasions on the right shoulder and right thigh. There was no ligature marking/s on the neck. There were no injuries to the knuckles or back of the hand. There was no gravel abrasion on any part of the body.

9. Internal findings of the brain showed global hypoxic-ischaemic encephalopathy i.e. extensive damage to the brain cells from inadequate oxygen and lack of blood flow. The neck showed localised fresh haemorrhage (bleed) in the middle section of the front of the neck in the clavicular head of right sternocleidomastoid over an area measuring 15mm x 20mm.

10. The laryngeal lining was congested but there were no haemorrhages including petechiae. The laryngeal skeleton and hyoid bone showed no fractures. There was significant dilated cardiomyopathy and bronchial asthma, and early bronchopneumonia. Dr Olumbe opined that the presence of changes of localised acute myocardial infarction would be consequent to the acute hypoxic-ischaemic brain injury and inotrope use in hospital.

11. There was early bronchopneumonia secondary to her unconscious state i.e. hypostatic pneumonia and was not pre-existing. There was no evidence of any other natural disease which could have contributed to her death.

12. Samples of admission (antemortem) blood and urine were requested for toxicology testing. Result of the analysis showed the presence of an antidepressant venlafaxine and its metabolite at therapeutic levels. Alcohol and other drugs were not detected in the blood and urine.

13. Dr Olumbe said that the finding of a congested face with multiple petechial haemorrhages (small red/purple spots caused by broken capillary vessels) in the face and eyes (considering a period of two days survival) with haemorrhage/bruising in the left side of the front of the neck suggest a mechanical asphyxiation due to neck compression. Upon admission to hospital it was documented that Miss Girven had oedematous suffuse face with petechial and subconjunctival haemorrhages, and abrasion on the left side of her neck. Asphyxia is the interference with the intake or utilisation of oxygen, combined with failure to eliminate carbon dioxide. The brain is the most sensitive organ to its effects. Facial and conjunctival petechiae are regarded as classic signs of asphyxial death by mechanical obstruction of upper airway.

14. Dr Olumbe opined that there are various methods of mechanical asphyxiation including pressure of hand, forearm or other limb. Depending on the method used, external and internal evidence of trauma to the neck may not be seen. The possible mechanisms of the neck compression with minimal amount of haemorrhage in the neck could be use of an arm-lock or soft ligature.

15. The presence of dilated cardiomyopathy and asthma could have contributed to her death. This is by probable cardiac arrhythmia (irregular heartbeat)/syncope (fainting) and reduction in the oxygenation in the lungs. The possible causes of dilated cardiomyopathy include genetic/familial forms, previous viral infection/autoimmune, recreation drugs and alcohol induced; or even idiopathic/unknown cause. The early bronchopneumonia was due to her unconscious state i.e. hypostatic pneumonia and was not pre-existing. The few scattered minor fresh bruises and abrasions could have been consequent resuscitation efforts or a struggle.

16. Dr Olumbe concluded that the cause of death was as follows:

    1 (a). Hypoxic-ischaemic encephalopathy, d*ue to, or as a consequence of*;

    1 (b). Asphyxia (Not otherwise specified).

    Other significant conditions were noted to be dilated cardiomyopathy, Asthma.

Mr A's mental health history

17. Mr A began smoking marijuana in his early teens and at age 16 started to experience auditory hallucinations. In 2005, he was diagnosed with schizophrenia. Throughout 2006, Mr A was charged with multiple offences including: possession of a knife in public, wilful exposure, robbery with actual violence and deprivation of liberty, unlawful use of a motor vehicle, robbery with actual violence, including whilst armed.

18. In July 2006, Mr A was admitted to the Toowong Private Hospital and then again in November 2006. Mr A subsequently became a patient of the PAH Mental Health Service ('the Service') and was involuntarily admitted to the PAH in November 2006. He was again admitted in January, July, September and November 2007. On 22 February 2008, Mr A' offending was dealt with by the Mental Health Court and he was found of unsound mind. A Forensic Order was made under the Act.

Mr A's mental health treatment at the Princess Alexandra Hospital

19. The Forensic Order for Mr A gave the Service the authority to actively monitor Mr A; he was required to undergo and comply with conditions of limited community treatment (and could be detained for inpatient treatment if required).

20. Between 2006 and 2008 while under the Forensic Order, Mr A received care with the PAH early psychosis team. Mr A's treatment included:

    - Pharmacotherapy; Clozapine, Amisulpride (Solian) and Fluvoxamine;
    - Weekly medical review and review by his case manager; and
    - Engagement with an activities coordinator and employment consultant.

21. Conditions of his treatment also included abstinence from illicit substances and compliance with random urine drug screening as exacerbations of Mr A's psychotic symptoms and deterioration in his mental state were closely linked to drug and alcohol abuse.

22. In mid-2008, Mr A's care was transferred to the Mobile Intensive Support Team for longer term rehabilitation. A Consultant Psychiatrist was working as the Director of both the early psychosis team and the Mobile Intensive Support Team at the relevant time. The Consultant Psychiatrist's first contact with Mr A was after his admission to the PAH from Toowong Private Hospital. The Consultant Psychiatrist became involved as his principal psychiatrist in 2009.

23. As at 14 January 2009, Mr A was prescribed with:

    - Clozapine 200 mg at night,
    - Amisulpride (Solian) 600 mg at night and
    - Fluvoxamine 100 mg at night.

24. Mr A experienced various symptoms associated with Clozapine: going to bed at midnight and waking at 13:00; feeling tired; drooling at night; and weight gain.

25. On 2 March 2009, The Consultant Psychiatrist notes that the Forensic Order was confirmed with a plan to seek a second opinion from city forensic services. Mr A was noted to be in cognitive remediation therapy twice weekly with the Consultant Psychiatrist. At this time he was being seen frequently by his Mobile Intensive Treatment Team (presumably a change of name from the Mobile Intensive Support Team). The team included his case manager, and social worker, who noted persistent auditory hallucinations and intermittently assessed homicidal ideation.

26. On 24 March 2009, the Consultant Psychiatrist commenced to reduce Clozapine gradually by 25mg per month. His family to report any relapse in psychotic symptoms. By 24 July 2009, he was noted by his case manager to feel much better since stopping Fluvoxamine and was now receiving treatment with Sertraline with some problems with changeover.

27. On 29 July 2009, during a review with the Consultant Psychiatrist, Mr A was alert and spontaneous. He reported residual auditory hallucinations which were not disturbing and mild paranoia. His residual symptoms were stable and he had strategies to manage these symptoms. His insight and judgment were good and her impression was that his mental state was stable. The Consultant Psychiatrist considers this had been characteristic of his mental state for some time.

28. Mr A's management plan was to continue the current regime, namely withdrawing Clozapine and introducing Amisulpride 800mg. He was noted to be tolerating his antidepressant (Sertraline). The Consultant Psychiatrist noted that the Clozapine was low and this was likely due to ceasing Fluvoxamine and because Clozapine was being withdrawn.

29. On 17 August 2009, the registrar reviewed Mr A's urine drug screening results and provided him with a request form for a further testing. The mental state assessment indicates persisting "2nd and 3rd person hallucinations, command hallucinations and running commentary". These reportedly did not cause him distress. Mr A reported being able to resist acting on the command hallucinations and said that they "do not usually involve commands to hurt himself or others". He described some "somatic passivity at times and thought alienation". His thought form was normal, insight was partial and judgement reasonable. He denied any suicidal or homicidal ideation, plan or intent.

30. On 18 August 2009, a Clinical Report Forensic Order Review ('Forensic Order Report') was prepared. The Forensic Order Report contained a copy of the mental health assessment that had been completed the previous day.

31. The risk assessment in the Forensic Order Report notes that he "has not got a history of physical violence" but does note previous charges including armed robbery and possession of a knife and his persistent positive symptoms. He was noted to be currently abstinent but to have persisting craving for substances and a social context of "easy access to illicit substances". It was noted he has a history of non-adherence to medications contributing to relapses and to have persisting symptoms of command hallucinations and running commentary hallucinations.

32. The Forensic Order Report recommended continuation of the Forensic Order.

33. On 26 August 2009, Mr A was reviewed by the Consultant Psychiatrist and addendum to the Forensic Order report was written ('Addendum Report'). This Addendum Report notes progress in the Mobile Intensive Treatment Team and states there have been no risk issues and that "the factors leading to his offending behaviour are inextricably linked to severe psychosis and substance abuse, coupled with the impulsivity and immaturity of many young men". In the management section it states:

    "The FO is likely to impede Mr A's rehabilitation in the near future. From a clinical point of view I would like to:
    - *Get a second opinion from City Forensic team about ongoing need for an FO; and*
    - *Work towards a recommendation of revoking the FO but continuing on an Involuntary Treatment Order"*

34. The Forensic Order was revoked by the Mental Health Review Tribunal ('The Tribunal') on 31 August 2009. Mr A and his father both gave evidence at the Tribunal hearing.

35. On 23 September 2009, the psychiatric registrar reduced the clozapine dose further to 50 mg as per the Consultant Psychiatrist's plan. Mr A complained of blurred vision which he attributed to amisulpride.

36. On 7 October 2009 a family meeting occurred with the case manager and the Consultant Psychiatrist at which time the family reported that he had abruptly stopped his medication two weeks prior to the massage course exam, which had occurred on 30 September 2009. The notes state that the risks were considered and alternative options discussed with three choices provided of amisulpride with gradual titration down, aripiprazole (Abilify) and paliperidone (Invega).

37. On 16 October 2009, Mr A noted to have commenced aripiprazole with no side effects.

38. On 21 October 2009, it was noted that paranoia has increased in past two weeks and that "people are following him, talking about him and cameras are taking photos". The dose of aripiprazole was increased to 10 mg.

39. On 16 November 2009, the clinical notes indicate that his medication was reviewed recently and his clozapine was discontinued due to severe side effects, with significant improvement in symptoms of sedation. He had just reported a new relationship with a previous girlfriend (Miss Girven). His mother was concerned about this due to earlier shared substance use.

40. On 20 November 2009, he was noted to present well though with persisting auditory hallucinations and thought insertion at times, neither of which were distressing. The plan was to continue aripiprazole10 mg and sertraline 100 mg.

41. On 8 February 2010, his case manager received a phone call from his mother who noted a marked deterioration in his mental state over the past two weeks but particularly the past weekend.

42. He was noted to have become socially withdrawn, was sleeping very late and very guarded. The case manager visited him and found that he reported that he was hearing voices and being suspicious but was managing. Mr A was advised that his current medication is sub therapeutic and that an increase would control his symptoms.

43. A telephone call to his mother on 9 February 2010 revealed that his girlfriend had reported that he may have been making phone calls to past friends with drug habits. His mother noted that he was irritable and argumentative and hostile. Mr A was seen that day by the Consultant Psychiatrist who noted that he had been erratic in adherence to medication and that he was irritable and had burnt himself with a cigarette butt which had been a past behaviour when unwell. He was offered weekly psychotherapy and an increased dose of aripiprazole (Abilify) with review in one week.

44. On 12 February 2010, his case manager notes that he reported that he had not been “compliant with medication or even with the increased dose”.

45. On 15 February 2010, he was seen by the Consultant Psychiatrist for psychotherapy and noted to be willing to continue with no evidence of psychosis. He was planned for review in two weeks.

46. On 26 February 2010, a telephone call was made by his case manager, to arrange a follow up. Mr A was noted to be isolative and not conversing much with family but spending time with his girlfriend who is supportive. The plan was to discuss with the Consultant Psychiatrist and to arrange a home visit the next week. The next note is on 12 March 2016 when he did not attend an appointment scheduled. She discussed with the case manager rebooking in one week whenever possible. An appointment for an outpatient review was made for 9 April 2010.

47. On 31 March 2010, the Service was advised of the incident in which Miss Girven was fatally assaulted.

Expert opinion of Independent Consultant Psychiatrist Dr John Reilly

48. During the course of the coronial investigation into Miss Girven’s death, expert advice was sought from an independent consultant psychiatrist Dr John Reilly. Dr Reilly was asked to comment on various aspects of Mr A mental health treatment at the Service prior to Miss Girven’s death. He was asked to provide his opinion whether appropriate steps were conducted with respect to any risks Mr A posed prior to Miss Girven’s death.

49. Dr Reilly said that the risk of potential homicidal violence is evident in hindsight with the following factors obvious as predictors of high and specific risk:

    - incidents of criminal charges of a violent nature assessed as being due to psychotic experiences leading to a Forensic Order;
    - persistent psychotic symptoms including command auditory hallucinations, passivity phenomena, i.e. disturbances of self-awareness with feelings of loss of control over oneself and of control by an external agent, persecutory and referential delusion lack of insight into the pathological nature of these experiences;
    - intermittent periods of use of illicit substance use including cannabis, alcohol and hallucinogens;
    - cessation of clozapine having the potential to destabilise the clinical situation in relation to mental state further, and
    - several incidents in which Mr A acted to harm people or stated that he wanted to kill people to whom he attributed his voices or persecutory intent or made statements that could suggest such intent, including on:

        - 21 January 2007 when he reportedly attempted to strangle a co-patient with a towel while he slept due to belief that he was threatening to kill his family and he had no other option to prevent

this. This incident appears to have been lost to the awareness of the treating teams since discharge;

- 12 December 2008 when he stated that he would need to go to prison in order to have the voices stop; and

- 14 January 2009 when he had thoughts of trying to find and kill them in America.

50. Dr Reilly said that in retrospect, during the time leading up to the death, though broadly aware of risk of violence, the treating team had gradually allowed its assessment of the risk of further homicidal behaviour triggered by psychotic symptoms posed by Mr A to be reduced, as if a background factor which could not be changed. Dr Reilly said that the Tribunal may not have recognised this at time of its review and decision to revoke the Forensic Order on 31 August 2009.

51. Dr Reilly said that the clinical management plan at the time leading up to Mr A's discharge from his Forensic Order was not comprehensive and not clearly documented. Although there were discussions of risk in the Forensic Order Report of 18 August 2009, these were not linked with any specific relapse management plans at the time or after the discharge from the Forensic Order. This included consideration of actions to be taken if Mr A was non-adherent to medication or showing identified relapse signs.

52. Dr Reilly said that there is no formal relapse prevention plan at any point in the notes. After the discharge from the Forensic Order, apparently unexpected by the Mobile Intensive Treatment Team, Dr Reilly found that there does not appear to be any further consideration of these recommendations as a team, by the case manager or by the Consultant Psychiatrist. This was even when on 7 October 2009 the team learnt that Mr A had self-ceased his medication in mid-September, approximately two weeks after the Forensic Order was revoked.

53. Dr Reilly said that Mr A was being reviewed by two separate psychiatrists, with an apparent separation between the Clozapine Clinic and the Mobile Intensive Treatment Team. He noted that the two psychiatrists may have been liaising closely together, however there was no documentary evidence of shared consideration of clinical risks. He concluded that this arrangement had potential for a divergence of treatment planning and for diffusion of responsibility for clinical decision making, thereby increasing the likelihood of failure to assess risk. He noted that although it had the potential encourage independent assessment of risk and of consequences of alternative management options, other than in relation to the specific issue of medication management it did not appear to do this.

54. Dr Reilly said there were opportunities to reconsider and assess risk more formally and that there were two opportunities which arose to address or at least reconsider this issue:

- Obtaining a formal forensic risk assessment. The Consultant Psychiatrist had recommended a forensic mental health service assessment of risk on two occasions while Mr A was on a Forensic Order, in March 2009 at time of an Forensic Order review by the Tribunal and then in August 2009 in the Addendum Report to the Tribunal. There is no evidence of a referral or of such an assessment having occurred. Given that this recommendation was made explicitly in the Addendum Report prior to the Tribunal and had previously been planned, Dr Reilly said that it is surprising that this did not occur prior to the decision to revoke the Forensic Order;

- A Limited Community Treatment Review Committee review. Dr Reilly said that if completed rigorously at the time of the decision to discharge Mr A from the Forensic Order, a Limited Community Treatment Review Committee review would have provided a check of the documentation and oversight by clinicians independent of the treating team. Dr Reilly says that when functioning well this process often highlights previous risks including of violence and this would also have been an opportunity for review and a greater focus on risk.

55. Dr Reilly said that overall, risk posed was assessed as being due primarily to psychosis and the risk posed by cessation of clozapine was not identified. On balance, identification and assessment of risk were not structured and not comprehensive during the period leading up to and after the discharge from the Forensic Order. Dr Reilly opined that the treating team had internal multi-disciplinary case reviews but the Consumer Case Review Summary documents prepared for these by the case manager do not adequately or correctly document the history. He said that the risk and the reviews themselves are not well documented and do not appear to rigorously consider risk in that they do not correct this. The potential review processes inherent within the Forensic Order, including Limited Community Treatment Review Committee and Tribunal, were not effective in prophylactically drawing attention to the need for a more thorough assessment of risk and management.

Appropriateness of the medications (or their combination) prescribed to Mr A

56. Dr Reilly found that psychotic symptoms associated with Mr A's schizophrenia had been persistent despite treatment with various anti-psychotic medications, including Clozapine. He noted Clozapine is the most appropriate evidence based treatment for symptoms of psychosis which are not responsive to other medications. He said that there was no apparent consideration during this period of electroconvulsive therapy which has been used as therapy adjunctive to clozapine for patients with persistent psychotic symptoms on clozapine.

57. Dr Reilly said that the medications prescribed were not effective at inducing remission at any time. He said that the Clozapine was most effective, however this was at the cost of significant side effects. There was thus a decisional balance and it was appropriate to switch from Clozapine to alternative anti-psychotic medication however contingency planning for relapse was not well documented.

Appropriateness of steps taken to ensure Mr A attended appointments, complied with treatment and address his deteriorating mental health

58. Dr Reilly said that the decision to discharge Mr A from the Forensic Order occurred at time when the intended treatment plan of reducing and ceasing clozapine was already established. He said that this raises the question of whether the assertiveness of treatment would have been different had the Forensic Order not been revoked in addition to the appropriateness of revocation of the Forensic Order.

59. Dr Reilly said that patients on a Forensic Order are expected to be monitored by the treating team more closely with a general expectation of review by a clinician at least fortnightly. He noted that the duration of no face to face contact was therefore about six weeks. Dr Reilly considers that because there were a series of contacts to schedule or reschedule further planned contacts, the case manager and team may have been satisfied that some ongoing contact was being maintained. He noted however that the nature of this contact and the duration without direct, face to face contact with assessment of mental state was not appropriately assertive within a MITT.

60. Dr Reilly noted Mr A's family had contacted the case manager on 8 October 2010 to express concern as to his mental state who was known to be non-adherent to prescribed medication and efforts to ensure follow-up. Dr Reilly considers it is possible that since he was not specifically declining review and support the National Standards for Mental health Services criterion 10.4.5 may not have been triggered.

61. Dr Reilly said that the assessments by the Consultant Psychiatrist on 9 and 15 February 2010, do not explore the symptoms of relapse identified by the patient's mother and the case manager on 8 February 2010 and the Consultant Psychiatrist herself on 9 February 2010. Given the apparent relapse with persisting hallucinations and persecutory ideation associated with increased irritability and social withdrawal in the context of Mr A's specific risk history, it would have been appropriate that the communication from the family triggered a thorough review of current mental state treatment and management.

The clinical ability to predict violence and the utility of violence risk assessments

62. Dr Reilly opined that as a general rule, the capacity of treating clinicians to predict violence with a high degree of accuracy in people with psychosis is limited. He noted that literature has highlighted the limitations of risk categorisation via screening questions and emphasise the importance of good clinical assessment and treatment approaches. Clinical wisdom does emphasise the relevance of previous behaviour as a predictor of future behaviours generally and the importance of thorough clinical history in relation to assessment of likely behaviour associated with psychopathology including psychotic symptoms.

Whether the mental health treatment (leading up to Miss Girven's death) provided to Mr A was appropriate

63. In Dr Reilly's opinion, the mental health treatment provided was not appropriate due to a lack of contact from the Mobile Intensive Treatment Team over a six week period leading up to Miss Girven's death and no apparent team based process for ensuring that this was monitored. The assessments at this time by the Consultant Psychiatrist as documented were not as thorough as was appropriate in this situation, as outlined above. He highlighted that caution is essential in linking any statement relating to appropriateness of care with causation of any particular outcome.

64. Dr Reilly said it is evident that Mr A was receiving care from a treating team which was endeavouring to support him to achieve his goals, to maximise his independence and to minimise the disability associated with his disorder and its treatment. He had received assertive treatment over an extended period on a medication, clozapine, which was not leading to remission of symptoms and was causing significant side effects. The level of risk associated with his disorder appeared to be reduced and the team, including two experienced treating psychiatrists, were no longer recognising him as being at high risk of further violence. In retrospect this was not correct but the decision making about cessation of clozapine is understandable and explicable. The decision to cease the Forensic Order at the same time was not formally advocated by the treating team, though certainly the message was that this was the direction the team was headed towards in the near future.

65. Dr Reilly said that the treating clinicians identified plans for external forensic review but did not follow up on these plans. The internal processes of care, including multi-disciplinary team meetings and completion of recovery plans, did not appear to identify any of the gaps in the quality or intensity of care delivered. The processes developed to provide independent monitoring of clinical team decisions in relation to Forensic Order patients, linked at least in part with concerns about treating clinical teams becoming less accurate in their assessment of risk over time, were ineffective in this situation. There were thus significant areas of care and monitoring of care which could have been improved.

66. Dr Reilly said that there are many possible explanations for the shift in approach and apparent failure of systems of care and monitoring. These are particularly linked to the philosophical approach to care focused on recovery emphasised by a rehabilitation service which is continually attempting to engage a person in self-management strategies and seeing the person as having capacity to make significant clinical decisions themselves. Other factors are the appropriate decision to reduce decision to reduce and cease clozapine and the agreement in regard to this decision by two experienced psychiatrists. He also pointed to the evident loss of relevant clinical history of risk over time in the clinical summaries and the very low rates of extreme events such as a homicide. Dr Reilly said that coupled with the cessation of the Forensic Order, the default presumption was likely to have become that Mr A had the capacity to make decisions about his further treatment. He considered these factors are

likely to have set up a situation in which there was a reduction in assertiveness of monitoring and a cognitive bias leading to a failure to adequately reconsider the clinical situation in light of the changing scenario.

Response from the Metro South Hospital and Health Service

67. Following receipt of Dr Reilly's report, the Service was provided with a copy and afforded an opportunity to respond. Professor David Crompton (OAM), Executive Director at the Service responded on behalf of the Service.

Revocation of the Forensic Order

68. Professor Crompton advised that the revocation of the Forensic Order was neither recommended nor expected by the Service. The Service advised that it had intended to seek independent forensic assessment as to the merits of continuing the Forensic Order prior to submitting any recommendation that it be removed to the Tribunal. This had not occurred prior to the August 2009 review because, at that time, the Service was not recommending (or expecting) the Forensic Order be removed. Demand for these assessments was high, and at the time, there were limited means to arrange such an assessment after the order was revoked.

69. The Service said that irrespective, it remained that at the time of review, Mr A had demonstrated no further offending, sustained abstinence from illicit drugs (supported by negative random Urine Drug Sample), adherence to treatment (including medication, medical review and contact with his case manager) and ability to manage his residual positive symptoms. Mr A gave evidence of these matters before the Tribunal. The Tribunal were also informed that Mr A had a significant support network, including his parents (both psychologists) who had been working closely with the Service to monitor his mental state for early signs of relapse or noncompliance with medication/treatment.

70. At all times, the Service says it was prepared to invoke the pathways available to them under the Act, if the necessary conditions were met. However, Mr A's mental state had not deteriorated to such a degree that there was an identifiable imminent risk of suicide or harm to others. Rather, he presented with an improved mental state and focus in contrast to the concerns raised in the preceding week. The Service also noted that Mr A also never refused treatment.

Whether appropriate steps were conducted with respect to any risk Mr A posed prior to Miss Girven's death

71. The Service considers appropriate steps were taken in relation to any potential risk posed by Mr A prior to Miss Girven's death. Mr A's past history and triggers always remained a background factor relevant to the risk assessment. The ability to be more assertive and intrusive into Mr A's private life was influenced by his voluntary status and lack of substantial evidence he had sustained deterioration in his mental state and/or his risk had changed.

72. Contrary to Dr Reilly's view, the Service advised that a relapse plan was in place and the strategy involved:

    - Regular contact and review (by the case manager, psychiatric registrar and/or consultant psychiatrist) to monitor mental state and risk, by telephone or in person;
    - Sustained efforts to keep Mr A engaged in community care as a voluntary patient and to remain abstinent from illicit substance use;
    - Regularly liaising with Mr A's parents to obtain collateral information to assist in monitoring his mental state and risk (including adherence to medication and/or suspected illicit substance use) and ensuring they were educated in relation to early warning signs and who to contact in the event of deterioration or concerns;
    - Regular communication, including daily handover meetings and weekly case reviews within the Service regarding patients' history, condition and progress to ensure that all members of the team (providing 24 hour, 7 days per week coverage) were aware of his situation and plan in place for any escalation (e.g. invoking processes under the Act) required in response to risk; and
    - Invoking available processes under the Act if Mr A's mental state deteriorated and/or risk of suicide or harm increased.

73. The Service advised that in terms of risk, Mr A was identified as showing signs of early relapse of mental illness and substance use in and around his review with the Consultant Psychiatrist on 9 February 2010. The Service says that it was acutely aware of Mr A's past history of self-harming behaviour, substance abuse and risk of increased psychosis and potential for reoffending if such behaviour, in particular, illicit substance abuse continued. Mr A was heavily counselled in relation to these matters and agreed to increase treatment.

74. The Service advised that at the next psychiatric review on 15 February 2010, Mr A's condition had improved. There was no evidence of exacerbation of psychosis and no further evidence of substance abuse or self-harm. He had re-engaged and consented to ongoing treatment.

75. They agreed with Dr Reilly that there are challenges in risk assessment particularly within the constraints of a voluntary patient is always challenge. At all times, the Service says it was prepared to invoke the pathways available to them under the Act, if the necessary conditions were met. However, Mr A's mental state did not deteriorate to such a degree that there appeared an imminent risk of suicide or harm to others. Nor did he refuse treatment.

76. In managing risk, the Service says that it worked closely with Mr A's parents who were well educated on his illness, the relapse plan and were a reliable source of collateral information regarding his mental state and compliance with treatment. They had a demonstrated history of contacting the Service when changes in his mental state were identified between scheduled appointments and the Service acted promptly on this information.

77. With the benefit of hindsight, the Service notes Mr A missed consecutive appointments in March 2010. However, at all times, communication channels were open with Mr A and his family. No concerns were raised by them to suggest Mr A was again deteriorating. If such concerns had been raised, the Service would have scheduled an earlier review and/or conducted a home visit (as had occurred in the past).

78. Even with the benefit of hindsight, the Service said it is not reasonably convinced that the risk in this case could have been predicted and the tragic outcome avoided. The Service considers the post-incident assessment of Mr A (undertaken by the Consultant Psychiatrist and the case manager) to be relevant to assessing pre-incident risk. Post-incident, Mr A did not present as significantly mentally unwell (putting the stress and grief of the event aside) and the Service felt psychosis did not explain the incident. Thereafter, Mr A continued to receive treatment on a voluntary basis, including in the community until he was charged.

79. The Service considers Mr A's ability to hold on to the false (but plausible) explanation for the incident for such a prolonged period to be extremely uncommon in cases where a person diagnosed with schizophrenia has committed murder. The Service considers this behaviour highlights the challenges of prospectively predicting risk in persons with mental illness.

The appropriateness of the medications (or their combination) prescribed to Mr A

80. The Service considers the medications prescribed to Mr A were clinically appropriate for treatment of his treatment resistant schizophrenia and depressive symptoms. They acknowledged that Dr Reilly has raised the prospect of using electroconvulsive therapy in his report. The Service notes the most influential publication on this issue was not published at the time of the subject events, and even now, considers there exists little evidence to support the prophylactic use of electro convulsive therapy.

Appropriateness of steps taken to ensure Mr A attended appointments, complied with treatment and address his deteriorating mental health

81. The Service concedes that ensuring that voluntary mental health patients adhere to treatment is a real and ongoing challenge for all mental health practitioners. However, in all the circumstances, the Service believes it took adequate steps to ensure that Mr A attended appointments and complied with treatment.

82. The Service says that had the Forensic Order remained in place, it is possible that Mr A's follow up and treatment may have differed. This is because the Forensic Order allows more intrusion into a person's privacy.

83. The Service contends that Mr A's non-attendance was being monitored and discussed within the team. All team members including the consultants, registrar, case manager and weekend staff were informed. The Service also

emphasised that no further concerns were raised by Mr A's family; a reliable source of collateral information. On 29 March 2010, both Mr A and his mother reported that he was well and attending university. Mr A agreed to further review at that time. Had concerns been evident during the telephone assessment or raised by Mr A's family, the Service would have pressed for a sooner face to face review (as had been done in the past) and/or invoked the processes under the Act if Mr A refused to comply. Regrettably, the incident occurred prior to Mr A next appointment.

The clinical ability to predict violence and the utility of violence risk assessments

84. The Service noted that the clinical ability to predict violence is limited and the subject of ongoing research. Assessing risk of violence is complex and involves assessing a person's clinical history, the history and pattern of offending including precursors (eg illicit drug abuse) and clinical progress. Mr A's history of offences from 2006/07 was extensively documented and well known to the Service. Exacerbations of his condition and past offending were linked to illicit substance abuse and periods where he was acutely unwell.

85. With intensive treatment (pharmacotherapy and psychosocial interventions) Mr A had demonstrated a period of sustained abstinence from illicit substances (supported by negative Urine Drug Screening) and, in turn, a relatively stable mental state with the ability to self-manage his residual symptoms. There had been no reoffending or incidents of aggressive or violent behaviour between 2007 and 2010. In his reviews both pre- and post- incident, Mr A never presented as acutely unwell or psychotic.

Whether the mental health treatment (leading up to Miss Girven's death) provided to Mr A appropriate

86. The Service believes that in all the circumstances, the mental health treatment provided to Mr A was appropriate in the circumstances. They advised that his treatment resistant schizophrenia and psychosis was managed in line with the pharmacotherapy and psychosocial interventions set out in the Royal Australian and New Zealand College of Psychiatrists clinical practice guidelines for the management of schizophrenia and related disorders. Notwithstanding that the tragic incident occurred, the Service considers Mr A received comprehensive care which included:

- Appropriate pharmacotherapy, namely with Abilify and Sertraline, following a trial of more than two atypical antipsychotic medications including Olanzapine, Solian and Clozapine;
- Cognitive behavioural therapy that was effective in reducing his paranoid symptoms and the distress associated with his residual symptoms including auditory hallucinations;
- Psychological input to address alcohol and drug issues and relapse prevention;
- Cognitive remediation therapy to address the impact of his illness on attention, memory and planning;

- Psycho-education about his illness and treatment; and
- Family education and involvement in relation to identifying early relapse signs and what to do.

Improvement actions taken by the Service

87. The Service advised that that since the incident the Service has:

    - Implemented new risk assessment training that all staff attended (24 February 2014);
    - Implemented an electronic record system and accompanying standardised state-wide forms to assist staff to document clinical reviews. These standardised forms include formal relapse prevention plans and form part of clinical governance. Additionally, morning team meetings are documented. This initiative is supported by regular chart audits; and
    - Arranged enhanced access to forensic assessment for persons who are at risk of offending, including persons who are not the subject of a Forensic Order.

88. The Service also noted the *Mental Health Act 2016* was passed earlier in 2017. The Service expects that the changes will assist in streamlining and documenting patient care. Relevant to a case like Mr A's in the future, the Service notes that the new Act will empower the Tribunal to make a treatment support order as a 'step down' from an Forensic Order (whereas, effectively, the Tribunal could only continue or revoke the Forensic Order in Mr A's case).

Next of Kin concerns

89. During the course of the coronial investigation, Miss Girven's mother, Mrs A was invited to outline her concerns to our office. Mrs A's concerns are summarised as follows:

    - Lack of qualifications of members sitting on the Tribunal;
    - Mr A's parents were allegedly friends with the Consultant Psychiatrist and their friendship with the Consultant Psychiatrist allowed them to influence Mr A's treatment; and
    - Mr A allegedly strangled a fellow inpatient shortly before Miss Girven's death.

90. It is not within the scope of the coronial jurisdiction to comment on the qualifications of members who sit on the Tribunal.

91. In response the allegation that Mr A strangled a fellow inpatient shortly prior to Miss Girven's death, our office sought and requested all clinical incident reports relating to the period that Mr A was hospitalised at the PAH. There was one incident which did involve an attempted strangulation of a fellow inpatient, however this occurred on 21 January 2007. Mr A attempted to strangle this patient with a towel as he had apparently made threats against his family. He was given PRN medication and placed in isolation. On review of the following

day, he said that he *"didn't think"* about whether or not this would harm the person. This incident was acknowledged by Dr Reilly in his expert report. Dr Reilly said that this incident (along with other predictors of high and specific risk), appeared to have been lost to the awareness of the treating team since discharge.

Response from the Consultant Psychiatrist

92. During the course of the coronial investigation, the Consultant Psychiatrist was invited to respond to, among other things, the allegation that she was friends with Mr A's parents. The Consultant Psychiatrist maintains that she had a professional relationship with Mr and Mrs A.

93. Consultant Psychiatrist says that Mr and Mrs A were very supportive of and very involved in Mr A's management. Mr and Mrs A had more regular interaction with the case manager and/or registrar. However, managing the patient's condition was under the Consultant Psychiatrist's supervision and a team effort. She therefore considers the parents' involvement with her colleagues to be part of the professional relationship she also had with them.

94. The Consultant Psychiatrist said that on occasion, Mr or Mrs A would be home when a home visit was conducted. These home visits were usually conducted by the case manager. Sometimes Mr or Mrs A would accompany Mr A to an appointment with the Service. The Consultant Psychiatrist says that she was not physically present for every review appointment. These were more regularly held with the case manager and/or registrar. The Consultant Psychiatrist notes however that clinical issues of note were raised in the daily morning handover team meetings and Mr A's care plan was reviewed formally every 91 days in the weekly team meeting which she (or another consultant psychiatrist) would attend.

95. The Consultant Psychiatrist advised that throughout the course of Mr A's treatment, the Service would receive updates from Mr or Mrs A regarding his mental health status and developments or concerns that they may have had at the time. Usually this information was relayed to her during the morning team meetings unless there was an urgent concern requiring her input. Likewise, it was the practice of the treating team to contact Mr A's parents if they had concerns arising out of a mental health review of the patient or he missed an appointment or similar.

96. When a clinical concern was brought to The Consultant Psychiatrist's attention, she says that she would call a formal family meeting, if required. She advised that she had done this on occasion when concerns were raised regarding Mr A's noncompliance with medication. The Consultant Psychiatrist advised that she would speak with the patient's parents directly in this forum.

97. In relation to the Addendum Report, The Consultant Psychiatrist said that Mr A and his parents were concerned that the Forensic Order Report did not document the progress he had made since the Forensic Order was imposed.

The Consultant Psychiatrist said that it is not uncommon for patients to raise complaints about such reports.

98. The Consultant Psychiatrist says that the nature of the Forensic Order process poses a challenge for clinicians in maintaining good rapport with their patients in the face of the patient's knowledge that the team are recommending that the Forensic Order remain in place. Engagement and compliance can be difficult if patients become increasingly disillusioned that their progress is not being recognised and there is no end in sight. It is for this reason that she agreed to prepare the Addendum Report though wished to be clear that did not change her recommendation (that the Forensic Order remain in place).

99. The Consultant Psychiatrist said that she fully expected the Tribunal would continue the Forensic Order. Following revocation, The Consultant Psychiatrist says that Mr A's health did not deteriorate to the extent he required immediate treatment or that he was likely to suffer serious mental deterioration. Mr A was not subsequently put on an Involuntary Treatment Order as he did not meet the criteria under the Act.

Domestic and Family Violence Death Review Unit Review

100. As this death occurred within the context of an intimate partner relationship a review was conducted by the Domestic and Family Violence Death Review Unit within the Coroners Court of Queensland. The review noted Miss Girven and Mr A had formed a relationship while at high school together at Mount Gravatt. This relationship ended in 2007 when Mr A attempted to strangle Miss Girven and cut her throat during an episode of psychosis.

101. It was accepted at the time that this act occurred in the context of drug induced psychosis. The relationship ended and Miss Girven subsequently travelled overseas where she became involved in a new relationship and gave birth to her son. She separated from that person and returned with her son to Australia.

102. Miss Girven and Mr A subsequently resumed their relationship, spending a lot of time together during 2009 but only officially acknowledging they had reconciled in the period leading up to her death. Miss Girven was well aware of Mr A's mental health and drug related problems, but did not consider that she was at specific risk. Indeed, Miss Girven had told a friend, who had been staying with them for 6 weeks including during February 2010, to be wary of Mr A who had gone missing at the time. She had warned her friend to stay clear of him as she was the only one who could calm him. Sadly, her belief was mistaken.

103. Miss Girven's mother, Miss A, also told police that Miss Girven had been concerned about Mr A's declining mental health in the months prior to his death but this did not extend to fears for her personal safety. While some friends thought Mr A was controlling in the relationship, it was generally considered they were happy and there was not much conflict between the couple.

104. The Review found that while there was some identifiable indicators of behaviours consistent with domestic and family violence in the relationship, there was no evidence to suggest that this was disclosed to any formal services who may have been in a position to assist. Any concerns raised with family and friends largely related to Mr A's mental health problems.

105. It is, however, clear that Mr A had been physically violent towards Miss Girven on at least two prior occasions during periods of acute mental illness and/or psychosis which included acts of non-lethal strangulation, a very serious and dangerous form of assault.

106. This type of violence is known to represent a significant increased risk of future harm and homicide within intimate partner relationships. Research suggests that this risk is further heightened in cases where the perpetrator experiences severe mental illness[1].

107. Before considering this issue further, it is important to recognise that the vast majority of people with serious mental illnesses do not engage in violence and it is extremely rare that any person with a mental illness commits murder[2]. However, deaths occurring in these circumstances are tragic and we must consider opportunities to improve the system's ability to identify and limit risk where possible.

Queensland Government review of fatal events involving people with mental health issues

108. In 2016, the Queensland Government undertook a review of recent fatal events involving people with mental health issues in Queensland, '*When mental health meets risk: A Queensland sentinel events review into homicide and public mental health services 2016'*[3].

109. It was noted in this report that people at risk of violence by consumers of mental health services may minimise or deny risks even when they have been threatened. As such clinicians need to be aware of this, and specifically address these matters.

110. Relevant to this death, a suite of recommendations were made in this final report to embed engagement with carers and family members throughout each stage of a person's care with an increased focus on:

- Obtaining and using collateral information from families and carers (Recommendation 10);
- Ensuring early and ongoing engagement (Recommendation 11);

[1] Thomas KA, Dichter ME and Matejkowski J. Intimate versus non-intimate partner murder: A comparison of offender and situational characteristics. *Homicide Studies* 2011 15: 291.

[2] Rueve, M. E., & Welton, R. S. (2008). Violence and Mental Illness. Psychiatry (Edgmont), 5(5), 34–48.

[3] Queensland Health. 'When mental health meets risk: A Queensland sentinel events review into homicide and public mental health services. Final Report, April 2016'. Accessed 29 November 2017 at: https://www.health.qld.gov.au/__data/assets/pdf_file/0026/443735/sentinel-events-2016.pdf

- Informing families and carers of potential risks to their safety and providing appropriate support and strategies to mitigate risk and ensure their safety (Recommendation 12); and
- Embedding prompts and training to ensure staff enquire and address safety and risk (Recommendation 13) including by providing information to families (Recommendations 14, 15 and 16).

111. This report also made a range of recommendations in relation to enhancing risk assessment and management processes including that mental health services should:

    - Implement a comprehensive, standardised violence risk assessment framework and response commensurate with the risk identified (Recommendations 22 and 23);
    - Adopt specialist approaches to ensure ongoing and active review of management plans with a focus on violence risk factors where high risk of violence is identified (Recommendation 24);
    - Ensure specialist forensic mental health staff are quarantined from generalist service demands to maintain role, presence and expertise (Recommendation 25);
    - Require that treatment formulations be based on a longitudinal perspective and include information about mental illness, the relationship between mental illness and risk factors for violence, and the impact of violence risk (Recommendation 26);
    - Ensure management plans are to be informed by issues identified in the risk assessment and include proposals to address these issues (including through appropriate referral to relevant non-mental health services where required) (Recommendation 27);
    - Implement strategies to improve and standardise clinical review processes and frequency by focusing on recovery, considering the effectiveness of previous care plans and prioritising risk reduction and behaviour stabilisation (Recommendation 28); and
    - Ensuring that Community Forensic Outreach Service reports are noted by a consultant psychiatrist and any changes to the clinical management plan are documented in the clinical file (Recommendation 29).

112. The review also made a suite of recommendations to increase the capacity and capability of mental health services to effectively respond to consumers who are identified as high-risk for violence through:

    - Improving responses to people with co-morbid conditions (such as substance misuse) (Recommendations 36 to 43);
    - Enhancing clinical systems and information management (Recommendations 44 and 45);
    - Building the competency and capability of staff in general and specialist violence risk assessment and management (Recommendations 46 to 53);

- Strengthening collaboration and linkages between health, other agencies and community supports (Recommendations 54 to 56);
- Improving mental health literacy across the state to improve community awareness and understanding of prevention and early intervention options (Recommendation 55);
- Enhancing communication of critical information between health and police (such as discharge of high-risk patients), updating police training and retaining a co-responder model to ensure mental health clinicians are available in the Police Communications Centre (Recommendations 58 to 60); and
- Implementing mental health quality assurance strategies including by creating a state-wide mental health Quality Assurance Committee to oversee the safety and quality of mental health services, monitor homicides and other serious violent acts and oversee the regulation and monitoring of care reviews and summaries of patients identified as high-risk for violence (Recommendations 61 to 63).

113. In their response, Queensland Health agreed in-principle to all recommendations and outlined a range of strategies to improve the safety of families and carers in circumstances of heightened risk which are currently being implemented across government.

Conclusions and request for inquest

114. Miss Girven's death was tragic and undoubtedly, a profound loss for her family. The coronial investigation into Miss Girven's death was informed by extensive information about Mr A's Mental Health Court and Court of Appeal hearing. This included reports from numerous psychiatrists and witness statements.

115. The Coroners Court of Queensland also obtained expert psychiatric advice about the appropriateness of the mental health care provided to Mr A prior to Miss Girven's death. The treating mental health service was provided with an opportunity to respond to this advice. Ultimately, it is accepted and determined that more weight should be given to the independent opinion of Dr Reilly in finding that the mental health treatment provided to Mr A was not appropriate for the various reasons stated above. The differences of opinion by reviewing medical specialists are not matters which are likely to lead to any useful recommendation or comment to prevent deaths occurring in similar circumstances.

116. Dr Reilly's view that caution is essential in linking any statement relating to the appropriateness of care with causation of any particular outcome is accepted. Similarly, it is accepted that even with the benefit of hindsight, it cannot be said with certainty that the risk in this case could have been predicted and the tragic outcome avoided.

117. It is not clear whether the Tribunal would have arrived at their decision to revoke the Forensic Order had the Consultant Psychiatrist not submitted her

Addendum Report. The evidence of the Consultant Psychiatrist and the Service to the effect that the revocation of the Forensic Order was not supported nor was it expected is accepted. Ultimately, the decision to revoke the Forensic Order was Tribunal's decision and it is not within the scope of the coronial jurisdiction to question the appropriateness of that decision.

118. The autopsy has clearly identified the cause of death. The Service has received the autopsy report and considered the findings. The Service has co-operated with the coronial investigation and clinically reviewed the events and circumstances surrounding Mr A's treatment. The factual sequence of events has been reviewed and considered by the treating team. The Service has made a number of changes to their service delivery in respect of risk assessment training; electronic record keeping and clinical documentation requirements. The Service has also improved access to independent forensic assessment of persons who are at risk of offending, including persons who are not the subject of a Forensic Order.

119. The Queensland Government has agreed to implement a number of strategies aimed at enhancing risk assessment and management processes as well as increasing the capacity and capability of mental health services to effectively respond to consumers who are identified as a high-risk for violence.

120. Importantly, the *Mental Health* Act *2016* was passed early in 2017. Relevant to a case like Mr A's in the future, the new Act will empower the Tribunal to make a treatment support order as a 'step down' from a Forensic Order (whereas, effectively, the Tribunal could only continue or revoke the Forensic Order in Mr A's case). The responses made and implemented by the Service cover the scope of any possible coronial comment which could be considered if an inquest were convened.

121. In all these circumstances it is not considered in the public interest that an inquest should be convened. The focus of the Coronial jurisdiction is to reach findings required in section 45(2) of the *Coroners* Act 2003 if at all possible. There is sufficient information to do so and the findings are as follows:

    a) The identity of the deceased is Miss Girven.

    b) The circumstances of the Miss Girven's death are not in significant dispute, having been accepted by the Mental Health Court and Court of Appeal. Miss Girven died after she was strangled by Mr A, a friend from school with whom she had a relationship over a number of years. Mr A was subsequently charged with murder and found of unsound mind at the time of the incident.

    c) Miss Girven died on 31 March 2010.

    d) Miss Girven died at the Princess Alexandra Hospital in Woolloongabba, Queensland.

    e) Miss Girven died due to:

1 (a). Hypoxic-ischaemic encephalopathy, due to, or as a consequence of;

1 (b). Asphyxia (Not otherwise specified).

Other significant conditions were noted to be dilated cardiomyopathy, Asthma

122. These findings are published to publically record the circumstances of Miss Girven's tragic death, a young mother aged only 22. Publication documents the mental health care provided to manage the young man who caused Miss Girven's death, whilst under psychiatric care. The independent review provides the opportunity for reflection and improvement, particularly in the matters highlighted by the independent psychiatrist in this document.

123. A copy of the findings is distributed to;

- Miss Girven's family;
- The Princess Alexandra Hospital;
- The Consultant Psychiatrist;
- Dr Reilly; and
- Department of Health Patient Safety.

124. Thanks are extended to Dr Reilly who assisted with this investigation.

I close the investigations.

Christine Clements
Brisbane Coroner
CORONERS COURT OF QUEENSLAND
1 December 2017