OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of John Douglas Simpson-Willson**
TITLE OF COURT:	Coroners Court
JURISDICTION:	Brisbane
FILE NO:	2005/9
DELIVERED ON:	7 September 2010
DELIVERED AT:	Brisbane
HEARING DATE(s):	3 – 7 November 2008 and 30 March – 3 April 2009, 12 August 2010
FINDINGS OF:	Coroner John Lock
CATCHWORDS:	CORONERS: Mental health and intellectual disability services provided to prisoners, release planning and discharge of dangerous prisoners

REPRESENTATION:

Counsel Assisting:	Mr S Hamlyn-Harris
For Disability Services Queensland:	Mr C Chowdhury instructed by Crown Law
For Queensland Corrective Services:	Mr R Douglas SC and Mr G Handran instructed by Crown Law
For Queensland Health:	Ms L Evans and then Mr K Parrott, Crown Law
For the family of Mr Simpson-Willson:	Mr E Mac Giolla Ri instructed by McInnes Wilson

For the Public Advocate of Queensland:	Ms J Brasch instructed by the Office of the Public Advocate
For the Prisoners' Legal Service:	Ms M Alexander, Prisoners' Legal Service, and then Mr A Hoare instructed by Prisoners' Legal Service

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Glossary

In this decision a number of State Government Departments, Agencies and terms are referred to by abbreviations or acronyms for convenience. They are listed below.

AMHS	Authorised Mental Health Service
CSO	Corrective Services Officer
DSQ	Disability and Community Care Services as part of the Department of Communities previously known as Disability Services Queensland
DCS	Department of Corrective Services now Queensland Corrective Services as part of the Department of Community Safety
FCIMHS	Fraser Coast Integrated Mental Health Service
ITO	Involuntary Treatment Order under the Mental Health Act 2000
MCC	Maryborough Correctional Centre
MHC	Mental Health Court
MOU	Memorandum of Understanding
PMHS	Prisoner Mental Health Service
QH	Queensland Health

Introduction

1. John Douglas Simpson-Willson was found deceased at the Central Rotunda in the Botanical Gardens, Brisbane City on 3 June 2005. He died of head injuries which were consistent with being inflicted with some significant force by a blunt instrument.

2. On 26 May 2005 Daniel Pattel was released from Maryborough Correctional Centre having served 3 years imprisonment for an act of violence. This was his full time release date. Prior to his release a prison psychiatrist was concerned about his level of dangerousness to the community, as a result of threats Daniel Pattel had made in prison that he intended to kill someone. The psychiatrist's concerns were passed on to the Police. There were no lawful means for the prison or Police to detain him. The prison psychiatrists also did not consider that Daniel Pattel was suffering from a mental illness which would have authorised them to involuntarily detain or treat him. On 9 June 2005, Daniel Pattel told a private psychiatrist that he had travelled down from Maryborough and killed a person in the Botanical Gardens some days earlier. This person was Mr Simpson-Willson. The psychiatrist reported this information to Police.

3. The Queensland Police Service investigated Mr Simpson-Willson's death and Daniel Pattel was charged with his murder. Daniel Pattel was subsequently found to be of unsound mind by the Mental Health Court and was detained under a Forensic Mental Health Order.

4. The circumstances in which Daniel Pattel had been psychiatrically and otherwise medically treated in prison, for either a mental illness and/or for an intellectual disability, the circumstances of his release from prison and his complex mental health history and diagnosis were but some of the multiple issues which were identified for investigation and the subsequent inquest. This involved an examination in a general sense, of the services provided to prisoners where they suffer a mental illness and/or an intellectual disability and the legal framework in which those services are provided, and then a more specific examination of how those services were provided to Daniel Pattel.

5. These findings seek to explain how the death of Mr Simpson-Willson occurred and consider whether any changes to policies or practices could reduce the likelihood of deaths occurring in similar circumstances in the future. Section 45 of the *Coroners Act 2003* ("the Act") provides that when an inquest is held into a death, the coroner's written findings must be given to the family of the person who died and to each of the persons or organisations granted leave to appear at the inquest. These findings will be distributed in accordance with the requirements of the Act and also placed on the website of the Office of the State Coroner.

The scope of the Coroner's inquiry and findings

6. A coroner has jurisdiction to inquire into the cause and the circumstances of a reportable death. If possible he/she is required to find:-
    a. whether a death in fact happened;
    b. the identity of the deceased;
    c. when, where and how the death occurred; and
    d. what caused the person to die.

7. There has been considerable litigation concerning the extent of a coroner's jurisdiction to inquire into the circumstances of a death. The authorities clearly establish that the scope of an inquest goes beyond merely establishing the medical cause of death.

8. An inquest is not a trial between opposing parties but an inquiry into the death. In a leading English case it was described in this way:- *"It is an inquisitorial process, a process of investigation quite unlike a criminal trial where the prosecutor accuses and the accused defends… The function of an inquest is to seek out and record as many of the facts concerning the death as the public interest requires."* [1]

9. The focus is on discovering what happened, not on ascribing guilt, attributing blame or apportioning liability. The purpose is to inform the family and the public of how the death occurred with a view to reducing the likelihood of similar deaths. As a result, the Act authorises a coroner to make preventive recommendations concerning public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in future.[2] However, a coroner must not include in the findings or recommendations, statements that a person is or maybe guilty of an offence or is or maybe civilly liable for something.[3]

The admissibility of evidence and the standard of proof

10. A coroner's court is not bound by the rules of evidence because the Act provides that the court "*may inform itself in any way it considers appropriate."*[4] That does not mean that any and every piece of information, however unreliable, will be admitted into evidence and acted upon. However, it does give a coroner greater scope to receive information that may not be admissible in other proceedings and to have regard to its origin or source when determining what weight should be given to the information.

11. This flexibility has been explained as a consequence of an inquest being a fact-finding exercise rather than a means of apportioning guilt; an inquiry rather than a trial.[5]

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[1] *R v South London Coroner; ex parte Thompson* (1982) 126 S.J. 625
[2] Section 46 of the Act
[3] Sections 45(5) and 46(3) of the Act
[4] Section 37 of the Act
[5] *R v South London Coroner; ex parte Thompson* per Lord Lane CJ, (1982) 126 S.J. 625

12. A coroner should apply the civil standard of proof, namely the balance of probabilities but the approach referred to as the *Briginshaw* sliding scale is applicable.[6] This means that the more significant the issue to be determined; or the more serious an allegation; or the more inherently unlikely an occurrence; then in those cases the clearer and more persuasive the evidence should be in order for the trier of fact to be sufficiently satisfied that it has been proven to the civil standard.[7]

13. It is also clear that a coroner is obliged to comply with the rules of natural justice and to act judicially.[8] This means that no findings adverse to the interest of any party may be made without that party first being given a right to be heard in opposition to that finding. As *Annetts v McCann*[9] makes clear, that includes being given an opportunity to make submissions against findings that might be damaging to the reputation of any individual or organisation.

14. If, from information obtained at an inquest or during the investigation, a coroner reasonably believes that the information may cause a disciplinary body for a person's profession or trade to inquire into, or take steps in relation to, the person's conduct, then the coroner may give that information to that body.[10]

The evidence

15. It is not necessary to repeat or summarise all of the information contained in the exhibits and from the oral evidence given. However I will refer to what I consider to be the more important parts of the evidence. Unfortunately, for reasons that will become clear, the focus of the inquest became more related to Daniel Pattel and the circumstances surrounding his incarceration and release from the Maryborough Correctional Centre than on Mr Simpson-Willson.

16. At the conclusion of hearing evidence I indicated I would accept written submissions from the Public Advocate and Prisoners' Legal Service on any issues and recommendations they intended to make and after receipt of those submissions I would prepare draft findings to be distributed to the other parties. I have since received written submissions from the other parties represented at the inquest and I heard further oral submissions on 12 August 2010. These findings include further information concerning progress on some aspects of public policy and procedure which were contained in those submissions.

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[6] *Anderson v Blashki* [1993] 2 VR 89 at 96 per Gobbo J
[7] *Briginshaw v Briginshaw* (1938) 60 CLR 336 at 361 per Sir Owen Dixon J
[8] *Harmsworth v State Coroner* [1989] VR 989 at 994 and see a useful discussion of the issue in Freckelton I., "Inquest Law" in *The inquest handbook*, Selby H., Federation Press, 1998 at 13
[9] (1990) 65 ALJR 167 at 168
[10] Section 48(4) of the Act

Mr Simpson-Willson

17. John Douglas Simpson-Willson was aged 56 at the time of his death.

18. It is known that he was married and had a daughter. Approximately 10 years prior to his death, Mr Simpson-Willson's wife tried to have him admitted to hospital for treatment of a mental illness, however the precise diagnosis is not known. He also had a history of epilepsy. As a result of the hospital admission Mr Simpson-Willson moved out of the family home, retired and began to travel around Australia. He would stay in some areas for extended periods of time and would stay in various sorts of accommodation including motels, hotels, with family in Tasmania and outdoors in parks.

19. His daughter, Mrs Jodie McNamara, believed Mr Simpson-Willson had access to superannuation and Centrelink benefits but chose at times to sleep outdoors, although he was always able to reside with her. Mrs McNamara recalls that whenever she met with her father he was always well dressed, showered and looked well fed.

20. Mr Simpson-Willson used the address of his daughter as a mailing address and irregularly contacted his daughter and son-in-law to meet and receive his mail and news. They last saw him on 1 June 2005 at an arranged meeting at the Roma Street Transit Centre. At this time nothing appeared out of the ordinary and he seemed in good spirits. He did not appear depressed and spoke about making a trip to Ayers Rock.

The events leading up to the arrest of Daniel Pattel

21. On 9 May 2005 the Director-General of the Department of Corrective Services ("DCS") wrote to the Police Commissioner advising that a visiting psychiatrist had been told by Daniel Pattel that he wished to achieve a murder and the psychiatrist took his comment seriously.[11] The letter noted that the disclosure was made in the public interest and authorised under the *Corrective Services Act 2000.*

22. Mrs Kay Pattel had been actively involved in advocating about her son's treatment for his varying presenting medical issues over his life. She had been appointed his guardian. It is apparent from the evidence that Mrs Pattel had been very dissatisfied with the treatment that Daniel Pattel had received from the Maryborough based Fraser Coast Integrated Mental Health Service ("FCIMHS") over the years. This dissatisfaction also extended to the treatment he received from the Prisoner Mental Health Service ("PMHS") whilst he was incarcerated. No doubt for those reasons, Mrs Pattel made it clear to the authorities that she was not prepared to accept a referral on his discharge from prison to FCIMHS, as was suggested by PMHS, and that she had made arrangements with a private psychiatrist.

[11] Exhibit G15

23. That private psychiatrist was Dr Anderson, who had been previously engaged to see Daniel whilst he was in prison. Neither Mrs Pattel nor Dr Anderson had been informed about the concerns of PMHS and the related threats to kill and that correspondence had been forwarded to the Police.

24. On 26 May 2005 Daniel Pattel was released from the Maryborough Correctional Centre ("MCC") after serving 3 years imprisonment for assault occasioning bodily harm whilst armed and a breach of a probation order. This was his full time release date and as such DCS had no legal authority to otherwise detain him. He had been denied an earlier release on parole.

25. Daniel's first appointment with Dr Anderson was scheduled for 31 May 2005, but Daniel refused to attend, despite the encouragement of his mother and Ann Ledguard (his DSQ support officer). Ms Ledguard attended the Pattel household on her day off, and tried to assist Mrs Pattel in encouraging Daniel to attend the appointment. A second appointment was made for 9 June 2005.

26. On the night of 2 June 2005 Mr Simpson-Willson was lying on a park bench at the central rotunda in the Brisbane Botanical Gardens. It was likely he was intending to sleep there that evening.

27. The Police investigation revealed that on 2 June 2005, Daniel Pattel caught a bus from Maryborough to Brisbane which arrived in Brisbane at 6:10pm. Daniel Pattel returned to Maryborough by a bus which left Brisbane at 7:45am on 3 June 2005.

28. Mr Simpson-Willson was found lying on the ground near the park bench at the Central Rotunda of the Botanical Gardens at approximately 7:30am on 3 June 2005. It was clear to those who found Mr Simpson-Willson that he was deceased. The initial Police report indicated Mr Simpson-Willson had rolled off the park bench and struck his head on the concrete ground. Police had also received some information he may have suffered from epilepsy and there was evidence Mr Simpson-Willson was known to suffer from epileptic fits.

29. An autopsy was conducted on 3 June 2005. The pathologist, Dr Lampe, concluded that Mr Simpson-Willson died as a result of head injuries. Dr Lampe was of the opinion the injuries were consistent with an assault with a blunt force instrument and the amount of force required would be up to severe. Dr Lampe excluded a simple fall from the park bench as causing Mr Simpson-Willson's injuries due to the totality of Mr Simpson-Willson's head injuries although a fall or an epileptic fit may have resulted in some exacerbation of his head injuries. Toxicology revealed no alcohol or drugs in Mr Simpson-Willson's blood or urine.

30. Daniel Pattel and his parents travelled from Maryborough to Buderim for Daniel to see Dr Anderson on 9 June 2005. At that appointment, Daniel

told Dr Anderson he had murdered a man in the Botanical Gardens in Brisbane on 3 June 2005 by using a brick to knock his skull in. Dr Anderson spoke to Mr and Mrs Pattel who confirmed Daniel had travelled to Brisbane on 2 June 2005 and had confessed the killing to them. They had checked his clothes and shoes for blood and checked media for any reports of a death in the Botanical Gardens. Because they were unable to find anything Mr and Mrs Pattel concluded that Daniel's confession was a delusion. Dr Anderson's secretary contacted the Police to determine whether any individual had been killed in the Botanical Gardens around this time. As a result the investigating officer of Mr Simpson-Willson's death contacted Dr Anderson who outlined the confession Daniel Pattel had made. On receipt of this information, the Police immediately changed the focus of their investigation to Daniel Pattel.

31. On 10 June 2005 the Police conducted an interview with Daniel Pattel (which was electronically recorded) in which he confessed to having committed a murder in the Botanical Gardens. He stated he had travelled from Maryborough to Brisbane to commit the murder and went to the Botanical Gardens because he knew homeless people slept there. He also confessed to committing two murders on homeless people at Surfers Paradise in early 2002. He told the Police he needed to commit murders to aid in his rejuvenation so he could live the way he was supposed to live.

32. A subsequent DNA examination revealed that shoes and a red tie owned by Daniel Pattel were positive for Mr Simpson-Willson's blood.

33. The circumstances of the murder of Mr Simpson-Willson were the subject of a comprehensive criminal investigation which led to Daniel Pattel being arrested and charged. The Police investigation material was provided to the inquest and it is unnecessary to set out how the events or the investigation unfolded. There is no doubt that Daniel Pattel killed Mr Simpson-Willson.

34. During the Police interview on 10 June 2005 Daniel Pattel also admitted that in 2002 he attempted to kill a fellow male patient at FCIMHS with a toilet seat. He told Police he had removed the toilet seat and went to the other patient's room and struck him on the head with the toilet seat several times. Subsequent enquiries by Police revealed an incident had occurred on 23 February 2002 at the FCIMHS High Dependency Unit. A male patient had suffered an injury to the head but otherwise was unable to say what had happened to him. He had been seen to stagger out of his room holding a handkerchief to the left side of his head. His injuries were listed as three uneven and serrated lacerations appearing to be caused by blunt injury. It is unclear as to the extent of any investigation and extraordinarily the cause of the injury was listed as a fall because there was no other account provided at the time. There was documented evidence of a repair and replacement of a toilet seat. Presumably the two events were not at the time thought to be connected. As a result of his

admission and the other circumstantial evidence found, Daniel Pattel was also charged with attempted murder of the fellow patient.

Mental Health Court proceedings

35. Daniel Pattel's state of mind at the time of Mr Simpson-Willson's death in 2005 and in 2002 in respect of the attempted murder charge was referred to the Mental Health Court. His lengthy psychiatric history was comprehensively examined by a number of psychiatrists who provided reports and gave evidence before the Mental Health Court ("MHC") over two days in February 2007. The findings of the MHC were delivered on 6 March 2007.

36. It is unnecessary to detail, other than in a summarised fashion, the psychiatric evidence that was considered by the MHC. That is amply set out in the Judgment of the MHC. At the commencement of the inquest I made it clear the MHC findings and conclusions were accepted by this Court. The Presiding Judge, Her Honour Justice Philippides, kindly made available the transcript of evidence and the bulk of psychiatric material considered by the MHC and this was of great assistance to the inquest.

37. The material before the MHC revealed that Daniel Pattel had seen many psychiatrists over many years[12] but that it had been difficult for these psychiatrists and other health professionals to determine the extent to which Daniel suffered from a mental illness, Asperger's Syndrome and/or a personality disorder. A precise diagnosis had generally been uncertain and a matter of some debate, remaining so even as late as the hearing of evidence before the MHC.

38. Daniel Pattel's condition was complicated by a form of organic brain injury. At age 17, Daniel was diagnosed with hydrocephalus[13] and he had two operations to place in shunts[14].

39. Early on in his life Daniel had been diagnosed as suffering from Asperger's syndrome. Asperger's syndrome is regarded as a pervasive developmental disorder, sometimes considered to be an Autism spectrum disorder. It is characterised by an inability to understand how to interact socially. Typical features of Asperger's syndrome may include clumsy and uncoordinated motor movements, social impairment with extreme egocentricity, limited interests and unusual preoccupations, repetitive routines or rituals, speech and language peculiarities, and non-verbal communication problems. Individuals with Asperger's syndrome can be at a greater risk of developing psychotic symptoms.

[12] Daniel had probably seen over 30 psychiatrists and/or pschologists and neurologists throughout his childhood, adolescence and adult life
[13] Abnormal accumulation of fluid within the skull which may cause mental disability, convulsion and/or increased intracranial pressure inside the skull.
[14] To drain the excess fluids into other cavities

40. Some brain disorders can lead to psychotic symptoms and Asperger's syndrome may be misdiagnosed as schizophrenia, particularly in children.

41. The MHC noted that Dr Varghese (a very well respected senior forensic psychiatrist) thought that Daniel Pattel suffered from severe schizophrenia. He discounted an autistic disorder and Asperger's syndrome because he found Daniel's symptoms were psychotic (as opposed to fantasies and behavioural disturbance). Doctors Anderson, Varghese and Voita (Dr Voita was treating Daniel through the PMHS whilst he was in custody following his arrest for Mr Simpson-Willson's murder) all concluded that Daniel's condition was best characterised as schizophrenia.

42. Dr Varghese reviewed the lengthy clinical documentation and concluded there was evidence of a psychosis emerging probably from at least 1997/1998. He considered that at the time of both the 2002 and 2005 offences, Daniel Pattel was, as a result of a schizophrenic psychosis, deprived of the capacity to know what he was doing was wrong. Although Daniel Pattel was aware of the illegality of his actions, in accordance with his delusional thinking, he lacked any personal sense that they were wrong.

43. The MHC noted there was a strong body of evidence that, at the time of the 2005 killing, Daniel Pattel was severely psychotic. The assisting psychiatrists in advising the MHC also favoured the opinion of Dr Varghese concerning the diagnosis of schizophrenia from at least 2002.

44. Dr Jill Reddan, an experienced consultant psychiatrist also gave evidence and provided a report to the MHC. She remained of the opinion that Daniel Pattel was suffering from a natural mental infirmity, namely a pervasive developmental disorder somewhere on the spectrum between Autistic Disorder and Asperger's syndrome. She was of the view that whilst his thinking may at times have been psychotic in nature, his psychotic episodes could not be characterised as typical of schizophrenia.

45. Dr Michael Beech also provided a number of reports to the MHC. In a report dated 7 November 2005 he opined that Daniel Pattel suffered from paranoid schizophrenia which occurred in the context of a severe mental disorder (Asperger's syndrome). He considered that at the relevant times Daniel was suffering from a psychotic delusion that the act of killing was necessary for his rejuvenation.

46. In a report dated 30 January 2006 Dr Beech then expressed some reservations concerning his previous conclusion that Daniel Pattel was suffering from paranoid schizophrenia and indicated he preferred a diagnosis of intermittent psychotic symptoms in the context of a pervasive developmental disorder and Asperger's syndrome, with features of a personality disorder and schizo-typal personality disorder.

In a report dated 12 February 2007 he returned to a diagnosis of schizophrenia in addition to Asperger's syndrome.

47. I have referred to the opinions of these experienced psychiatrists to highlight the complexity of the diagnosis of Daniel Pattel's condition and to note there had been varying opinions as to the precise nature of his illness. Even with the benefit of hindsight and in the knowledge of the killing of Mr Simpson-Willson, this still remained unclear to some.

48. The MHC considered a large amount of material and noted that a *"very extensive body of clinical material has been generated over the years concerning the defendant's [Daniel Pattel] complex psychiatric presentation. The difficulties in assessing the defendant have been compounded by his ability to deny some psychotic symptoms even when these have been independently observed."*[15]

49. The conclusion of the MHC was that at the time of the attempted murder in 2002 and at the time of killing Mr Simpson-Willson in 2005, Daniel Pattel was suffering from a psychotic illness of a schizophrenic nature, and because of his delusional and psychotic ideas, particularly those relating to his ideas of "rejuvenation", he was of unsound mind. The reasons for that conclusion are compelling and are accepted by this Court.

50. The MHC referred to some disturbing evidence concerning the dangerousness of Daniel Pattel and emphasised the need for him to be treated in a high security surrounding. The MHC detained Daniel Pattel as a forensic patient to The Park High Security Program for involuntary treatment and care. It noted that approval of limited community treatment was presently entirely out of the question, and the issue of his future management would need to be approached with the utmost caution, given the grave concerns voiced by the clinical experts and assisting psychiatrists before the MHC.

Inquest Issues

51. The inquest heard evidence over a period of 10 days and considered an ever-growing list of exhibits and statements. Approximately 190 exhibits were considered and I heard from many witnesses. Leave was granted for the Department of Corrective Services, Queensland Health and Disability Services Queensland to appear and be separately represented. Leave was also granted to the Public Advocate and Prisoners Legal Service to appear and be separately represented. The family of Mr Simpson-Willson were also represented by Counsel. I was greatly assisted by Mr Hamlyn-Harris, Counsel Assisting the Coroner, and all other counsel who appeared.

[15] Decision of the MHC, exhibit D29, paragraph 46

52. A number of issues and related topics were identified to be examined, which issues were expanded upon during the inquest. The issues identified were generally as follows: -

    a) the role of mental health assessments in prison, and the application of the criteria for involuntary treatment orders, to a prisoner;

    b) the capacity of a mentally ill prisoner to give informed consent to treatment or to refuse such treatment, including medication, (bearing in mind that Daniel Pattel refused to take antipsychotic medication while in prison);

    c) whether the treatment of prisoners for mental illness, including medication, can be enforced and, if so, under what circumstances should that be done;

    d) the role and obligations of the Department of Corrective Services when dealing with a prisoner who has expressed an intention to commit acts of violence upon release;

    e) the status and treatment of mentally ill prisoners in corrective services facilities as compared to those in mental health institutions;

    f) the status and treatment of prisoners who are suffering from an intellectual disability in corrective services facilities and the role of Disability Services Queensland; and

    g) issues relating to the treatment and management of Daniel Pattel while in prison, including the question of whether psychiatrists and others dealing with his mental illness had full access to previous medical records and other relevant information, including reports from corrective services staff.

The Mental Health Act 2000 and mental health provided to prisoners

53. Conditions such as Asperger's syndrome, personality disorders and organic brain injuries simpliciter, are not considered to fall within the definition of a "mental illness" under the *Mental Health Act 2000*, unless there is also evidence of a "clinically significant disturbance of thought, mood, perception or memory" such as schizophrenia, with or without psychosis. A person suffering a mental illness (who meets other criteria outlined in the *Mental Health Act 2000*) is able to be detained for assessment and treatment.

54. Section 12 of the *Mental Health Act 2000* states that a person must not be considered to have a mental illness merely because the person has an intellectual disability, or engages in antisocial or illegal behaviour. As a result, someone like Daniel Pattel, who otherwise may have been

considered to be a person who posed a risk to the community due to an intellectual disability, cannot be detained under the *Mental Health Act 2000*, unless diagnosed as also suffering from a mental illness, and meeting the relevant assessment and/or treatment criteria.

55. I heard some general evidence of the extent of treatment options provided to prisoners with mental health or intellectual disabilities. Very similar scenarios and statistics were spoken about by a number of witnesses, quoting various published research and academic studies.

56. There are between 8000 and 9000 prisoners in Queensland, of which approximately a third will have a mental illness of some description. Most of those illnesses are mild-to-moderate in nature and do not add any additional risk to the community by virtue of that mental illness. However, approximately 10% of these individuals may have a psychotic or other severe disorder which does place them at increased risk, particularly if they do not receive any treatment.

57. Of the rest of the prison population, many of them will also have a host of characteristics which make them a risk to the community as well. Some of those will include intellectual disabilities and some will have other pervasive developmental disorders. There was evidence that also put that category of prisoners with intellectual disabilities at about 10%. Some prisoners may have both an intellectual disability and a mental illness, which may now seem how to best categorise Daniel Pattel.

58. There was uncontroversial evidence to support the conclusion that a significant percentage of people, both within the community and in the prison setting, who have intellectual and/or developmental disabilities, also have a mental illness.

59. Dr Aaron Groves (the Director of Mental Health) and Dr White (a consultant psychiatrist who provided an independent report) both indicated that the vast majority of psychiatrists in Australia have limited training with individuals with intellectual and developmental disorders and although there are some who do specialise in that area, such as Dr White, most do not. By comparison, in the United Kingdom, the provision of disability services and intellectual disability services are part of mental health services and this area is included in the training of United Kingdom psychiatrists. The core work of those two categories split in Australia some decades ago.

60. It is evident that not all psychosis can be classed as schizophrenia. Dr Groves gave a useful description of the manifestations of psychosis and schizophrenia. Psychosis results in a condition where people have a break from reality and which usually manifests itself in two ways. The first is the presentation of hallucinations where people have a perception that they hear, see, touch or feel something which is not actually there. In schizophrenia the usual hallucination is that the person hears voices talking to them but in fact nobody is there. The next most frequent

manifestation is the presence of delusions where people have fixed, false beliefs about a particular issue that are not shared by other people and which are not amenable to reason. An example of this is a person who believes they are being poisoned or being spied upon.

61. A diagnosis of schizophrenia usually requires the presence of both of these types of psychotic symptoms but there are some situations where only one occurs. In some cases people suffering other developmental disabilities such as Asperger's syndrome may experience delusions without hallucinations. This would be classified as Asperger's syndrome with psychotic symptoms, and would not necessarily be classed as schizophrenia. Other forms of psychosis can also occur in the context of drug-induced intoxication.

62. Dr Groves explained that untreated psychosis will usually follow a pattern of slow and relentless deterioration with the psychotic symptoms becoming more entrenched and more difficult to shake, even with treatment.

63. Combining the provisions of sections 13 and 14 of the *Mental Health Act 2000*, for a person to be either assessed or treated involuntarily the person:-

    a) must appear to have or have a mental illness;
    b) must require immediate assessment or immediate treatment;
    c) the assessment or treatment can be made at an authorised mental health service;
    d) there is a risk that the person may cause harm to himself or herself or someone else or is likely to suffer serious mental or physical deterioration;
    e) there is no less restrictive way of ensuring the person is assessed or receives appropriate treatment; and
    f) the person lacks the capacity to consent to be assessed or to be treated and has unreasonably refused to be assessed or to be treated.

64. The inquest heard evidence concerning how the *Mental Health Act 2000* applies to serving prisoners. Dr Groves, in concurring with other evidence on this point, was of the view that the *Mental Health Act 2000* does not allow prisoners to be treated against their will in custodial settings. A prisoner may receive treatment for a mental illness in a custodial setting providing the prisoner consents to treatment.

65. If, at the time of an assessment in a custodial setting, a doctor or authorised mental health practitioner decides the prisoner requires assessment or treatment for a mental illness, then that prisoner can be transferred to an Authorised Mental Health Service ("AMHS") for assessment and/or treatment.

66. If a classified patient consents to treatment they can be treated as a voluntary patient in an AMHS or returned to the custodial setting for voluntary treatment.

67. If the involuntary treatment criteria apply, an Involuntary Treatment Order ("ITO") can be made which gives authority for the AMHS to treat the patient without consent. When making an ITO the doctor must specify whether the patient is to receive treatment as an inpatient (within the AMHS) or within the community (which would include prison). If the prisoner is held within an AMHS for treatment, when they no longer require inpatient care, they will be returned to custody to serve the duration of their sentence and either discharged from the ITO or the ITO will be changed to the community category allowing them to continue to receive treatment within the prison. If the prisoner is returned to custody under the community category of an ITO, the administration and treatment provisions under the *Mental Health Act 2000* are the same as if the person lives in the community.[16]

68. Applying the *Mental Health Act 2000* to the prison setting, this Act permits prisoners to be treated against their will for a mental illness only if the involuntary treatment criteria applies, and provided they remain in an AMHS, rather than being placed in the community category. [17]

69. Section 21 of the *Corrective Services Act 2006* (the 2000 Act which applied at the time of Daniel Pattel's incarceration had a similar provision) provides a framework to enable involuntary treatment and assessment within a correctional centre and there is (and was at the relevant time) a DCS procedure regarding consent. Dr Richards (previously the Director of Health and Medical Services for DCS and now the Senior Director of Offender Health Services within Queensland Health) pointed out that the DCS procedure notes that the right of individuals to maintain self-determination with respect to medical care is not eliminated by reason of imprisonment. Although the *Corrective Services Act 2006* provides for the examination and treatment of prisoners against their will, Dr Richards was of the opinion that such a power must be read narrowly and in favour of prisoners.

70. Dr Richards was also of the opinion that involuntary treatment should only be invoked where an ITO has been made. Dr Falconer (the previous Director of Health and Medical Services for DCS) shared this view and indicated that during his tenure the provisions allowing for involuntary treatment and assessment within a correctional centre had only been utilised on one or two occasions in very specific limited cases.

71. Dr White also supported the position taken by Dr Groves on the matter of whether prisoners should be forced to take medication. His experience was that in prisons this was often abused and the current *Mental Health*

[16] See exhibit C16A – the statement of Dr Groves
[17] S108 Mental Health Act

Act 2000 allows for the transfer of a prisoner to an AMHS if the prisoner needs to be given medication involuntarily.[18]

72. Dr Groves thought the provisions in the *Corrective Services Acts* of 2000 and 2006, allowing prisoners to be forced to be examined or treated by a medical practitioner, were to ensure a prisoner gets appropriate health service or health care whilst in prison. The *Mental Health Act 2000* provisions were specifically to address people who require treatment particularly with medication for a mental illness. He stated that psychiatric medications, which are inherently very powerful and often mind altering, should not be used without appropriate caution and safeguards for all people, whether they are prisoners or people in the community.

73. My view is that the evidence does not support any change to the legislative framework regarding involuntary treatment of prisoners and that the provisions of the *Mental Health Act 2000* allow for prisoners to be transferred to an AMHS to be assessed and/or treated for a mental illness on an involuntary basis if required.

Prisoner Mental Health Service

74. The responsibility for the provision of general health services and mental health services to prisoners has changed since the time of Daniel Pattel's incarceration. In 2005 medical services (i.e. nurses and visiting medical officers) within the Queensland prison system were provided by DCS, and mental health services were provided by Queensland Health via the PMHS. Since 1 July 2008 all health services within the Queensland prison system, including mental health, are provided by Queensland Health. Offender Health Services (a division within Queensland Health) provides primary medical and nursing care services for prisoners. All mental health services provided to prisons are still provided by the PMHS, although this service is not managed by, or the responsibility of, Offender Health Services.

75. Dr Heffernan is the current Director of PMHS and he had some previous involvement with Daniel Pattel in various roles. Dr Heffernan explained that the PMHS has been providing mental health services to seven correctional centres since 1999. Some additional funding was received in 2006 so that the PMHS now provides a multi-disciplinary team approach to psychiatric assessment and treatment services to inmates at seven correctional centres in south-east Queensland.

76. In early 2005, at any one time, the service had approximately 500 prisoners with open cases. Currently, there are close to 1000 open cases. In 2005 there were two full-time clinicians (a social worker and a psychologist) who coordinated the PMHS psychiatrists from the Forensic Mental Health Service and provided medical sessions at various correctional centres. Additional funding was received in 2006 and 2008

[18] Exhibit G3

and there were at the time of giving evidence 12 allied health clinicians, a clinical nurse/team leader position and 3.5 full-time psychiatrists and one full-time psychiatric registrar.

77. In 2005 the capacity of the PMHS to provide psychiatric assessment and services for difficult and complex patients such as Daniel Pattel, was very limited and it is likely that still is the case. Dr Hannah (a psychiatrist with PMHS who treated Daniel Pattel) gave evidence that during the period in which she treated Daniel she would often review eight prisoners in the space of two hours, with two of these prisoners being new cases and that her review with existing prisoners could be as limited as 10 minutes.

78. Dr. Heffernan also gave evidence about the changes in the PMHS as a result of the increased resources. Noting they certainly were welcome, Dr Hannah indicated the demand for services still far outweighed the PMHS' ability to provide it and Dr Heffernan was of the view the service remained under-funded by more than 50%. In particular, he supported the evaluation of the recently established Transitional Care Coordination program with a view to supporting additional funding to enable the programs' expansion.

79. Dr Heffernan indicated he was not so concerned that people like Daniel Pattel were not being picked up under the previous services, as Daniel Pattel was well known within the prison. He was seeking additional sources which would capture those prisoners that were not being seen.

80. Dr Groves gave evidence that in 2006 a development plan for Mental Health within Queensland was undertaken and benchmarks were set and agreed to by the government. He stated he considers all elements of the mental health system within Queensland were under-funded according to these set benchmarks. He also thought forensic mental health was further away from the set benchmarks than other parts of the mental health system and prisoners' mental health was in an even worse position.

81. Dr Groves noted that in the 2007/2008 budget, an additional nine high secure beds (for prisoners) at The Park Centre for Mental Health and an extra 20 forensic beds within the general section of The Park were being constructed but ultimately that would still fall short of their benchmarks.

82. Given this evidence, it was not difficult for me to find the funding of prison mental health services in Queensland was totally inadequate and should be rectified as soon as possible.

83. In the written submissions from Queensland Health it was noted the Park Centre for mental health facility was scheduled to be commissioned in 2011 and this would go some way to alleviating any overcrowding of current mental health patients. The submission also noted that since the

completion of evidence in the inquest the number of full-time staff in the PMHS had increased from 26 to 35.

84. Whether that rectifies all of the inadequacies in funding and resources is unclear but unlikely. The under resourcing of mental health services in Australia and Queensland as mentioned by Dr Groves is well documented and has been the subject of numerous reviews and reports and ongoing advocacy from stakeholder groups over the decades.[19] The funding of Mental Health Services was once again a topical issue as this part of the decision was being written in the middle of a Federal Government election.

Support Services for those with intellectual disabilities within prison

85. Dr Groves stated that prisoners who have intellectual or other disabilities still need to have their disability support needs met wherever they may be, otherwise they would deteriorate and that who met those needs (i.e., whether it is Disability Services Queensland {DSQ} or DCS) was a matter for those departments.

86. Identification or screening of those who are intellectually disabled and are in the custody of the DCS is an important first step. Evidence was given by Dr Kingswell and Mr Mark Rallings (Acting Executive Director, Offender Programs and Services Directorate at DCS) regarding current research being conducted to develop a screening tool to identify those with intellectual disabilities within the prison setting. Mr Rallings gave evidence that DCS has for some time attempted to identify those prisoners who require further assessment through screening questions (such as whether the prisoner had attended special school or received a disability pension). However, the development of the new screening tool will be an enhancement of the current status.

87. Mr Rallings also stated that if, at the admission screening, a prisoner was identified as requiring further assessment, this would trigger a referral to one of the agency's psychologists or to another appropriate service provider. He indicated a plan would then be developed to meet that individual's needs using both agency services and other providers. Such providers could include Queensland Health, PMHS and Disability Services Queensland (“DSQ”).

88. In relation to providing disability support and other programs in the prison system, Dr Groves was aware that some jurisdictions, such as Victoria, have produced quite expansive disability services programs which are provided in prison. The Victorian model provides for Corrective Services

[19] A useful summary of the various reviews and reports and coronial recommendations can be found in the decision of Coroner Previtera “Everything changes so everything can stay the same” in the inquest in respect of the deaths of Charles Edward Barlow, Patrick Douglas Lusk and Emily Jane Baggott, pp 8-20, handed down on 15 December 2006. A copy of the decision can be found on the website of the Office of the State Coroner at www.courts.qld.gov.au/1680.htm

and Disability Services to work together, although Disability Services retains control of disability support service delivery.

89. In the Victorian model it was noted the two departments work together as opposed to a cessation and then resumption of services. Mr Rallings thought from his reading, the Victorian model was not greatly different from how he saw those services being provided in Queensland as a stated intention. As a stated intention that may be the case, but the evidence suggests that in practice, this does not occur at any adequate level at all.

90. Ms Pauline Davis (General Manager, Service Delivery, DSQ) provided a statement and gave evidence on behalf of DSQ regarding two Memoranda of Understanding ("MOU"); one between Queensland Health and DSQ, and the other between DSQ and DCS. Both MOUs had expired and the relevant departments were in the process of discussing renewing them.

91. Ms Davis stated the objective of the MOU between DSQ and DCS was "to facilitate the exchange of information to identify shared clients, allow appropriate case management, and support clients to apply for disability services or facilitate resumption of disability services post release."[20]

92. The MOU states at section 6.1(d) that DSQ will "continue to maintain minimal contact with shared clients for the duration of their sentence".[21]

93. The MOU also stated that "[w]here an offender is incarcerated QCS is responsible for providing a range of services to meet the offender's medical, psychological and physical needs. Any funding or services that an offender may have received from DSQ are ceased pending the offender's release."[22] Ms Davis clarified during evidence that where a person is receiving funding or services from DSQ, they are effectively put on hold if it is for a short period of incarceration, or ceased if a longer period of imprisonment occurs.

94. In the case of Daniel Pattel it would appear his funding package had been put on hold but was still available to him upon release. Ann Ledguard and other staff from DSQ were visiting him on a regular basis. However, it would seem those visits were not funded as such and depended on DSQ having the resources to make their own staff available.

95. Ms Davis agreed it was not the current policy for services or supports to be provided to DSQ clients in prison. She was not aware of the Victorian model for delivery of disability support when a person is incarcerated. Ms Davis also indicated the demand for DSQ support clearly outstrips its ability to meet those needs.

[20] Exhibit C54
[21] Exhibit F1
[22] Exhibit F1

96. Ann Ledguard stated that to her knowledge nobody from DSQ had visited the MCC in the last three years.

97. Mr Rallings was asked to comment as to whether this was indicative of an absence of collaboration between the two agencies in providing support to those with mental, intellectual or physical disabilities. He stated that DSQ had been clear that the level of resources and services they could provide to someone in prison was limited and the MOU did not explicitly require DSQ's presence. Mr Rallings said he would be surprised if DSQ had much capacity to regularly and systematically visit correctional centres.

98. It was acknowledged by Ms Davis that if there was funding available for someone who was in prison, then that funding could be used to purchase therapeutic type services from a psychologist, occupational therapist or a counsellor and to link a support worker from a non-government agency with that person. The prison environment would limit those services but she said it is certainly the case that support can be given which would be of value if there was a will and sufficient funding.

99. Sadly it would seem there is neither the will nor the funding. It is apparent those services were not provided in 2005 and the reality is that nothing has changed and is unlikely to change without a significant increase in funding.

Challenging behaviour and disability – the Carter Report amendments

100. Dealing with persons who have a pervasive developmental disorder can be difficult. Dr White stated in the ideal world early intervention is necessary. By the time Daniel Pattel was seen at age 15, Dr White doubted there was a lot that could have been changed. The development of social skills, empathy, anger management and various adaptive behaviour is needed for these individuals to survive in the community but providing that sort of intervention in a prison setting is very difficult and acute mental health services are not set up to provide those services.

101. Dr Kingswell and Dr Groves stated there were good mechanisms for removing mentally ill people from the criminal justice system but the same protections do not exist for the intellectually disabled. Dr Kingswell said there should be some diversion capacity that prisons can use in relation to people who are just too difficult to manage. It is reasonably clear that prisons are not regarded as good environments for people with an intellectual disability as much as they are not good environments for people who are suffering severe mental illness. Given that many of such people will inevitably find themselves in prison, more needs to be done to identify these individuals and provide them with suitable services/living arrangements whilst incarcerated.

102. In 2006, his Honour Justice Carter QC was asked to report on and investigate legislative and service options for improving responses and support services for adults with an intellectual or cognitive disability who exhibit severely challenging behaviour. As a result amendments to the *Disability Services Act 2006* and the *Guardianship and Administration Act 2006* were passed with the amendments commencing on 1 July 2008.

103. This legislation applies to adults who are 18 years or over, who have an intellectual or cognitive disability, whose behaviour either causes harm to the adult or others, (or represents a serious risk of harm to the adult or others); and are receiving disability services from DSQ or some other non-government service provider funded by DSQ.

104. Certain restrictive practices including containment or seclusion, chemical restraint, mechanical restraint or physical restraint can be approved. The intent is to provide a safe and secure service to the client and prevent them from either harming themselves or others.

105. In such cases, the service provider makes application to the Guardianship and Administration Tribunal. They are then linked with specialist response teams which assess the situation and prepare a positive behaviour support plan outlining the use of those restrictive practices, how they would be implemented, and how they would be used in the long term.

106. For containment and seclusion orders, the Tribunal has to approve the use of those restrictive practices. Other restrictive practices including mechanical, chemical and physical restraint need to be approved by a Guardian who has been appointed by the Tribunal.

107. The legislation provides that the use of restrictive practices will only be considered appropriate if it is necessary to prevent a person from causing harm to themselves or others and is the least restrictive way of ensuring the safety of the adult or others.

108. It was noted during the inquest sitting that a purpose-built containment facility was being constructed to manage those persons with particularly challenging behaviour.

109. It is not intended to consider in any detail this particular legislation. Clearly it was not available at the time of Daniel Pattel's release from prison but arguably his challenging behaviours would have met the target definition if it was considered he did not meet the involuntary mental health criteria. It is noted that the intent of containment or seclusion is not for a long term order but that is no different to the involuntary mental health regime except in relation to forensic orders such as imposed on Daniel Pattel.

110. In Daniel Pattel's case there would need to have been a thorough planning and assessment conducted well before his expected release, so that if it was thought that containment or seclusion was required upon release, this was put in place well before hand.

111. Ms Davis was not aware at the time of giving evidence whether anyone had in fact been to the Tribunal for such an order. As I understand it the high security facility has been budgeted for but not completed.

Daniel Pattel's early dealings with the justice and mental health system

112. Daniel Pattel was well-known around the town of Maryborough as a result of what many considered to be his "odd behaviour". Some of this behaviour included walking around town in little or odd clothing. Often being located in various places with razors or plastic bags threatening to kill himself, threatening his mother, neighbours and other members of the community, yelling out on the streets, pretending to shoot occupants in cars and alleged interference with cemetery graves.

113. Daniel had numerous dealings with the mental health system. When he was 13 he was admitted to the Barrett Adolescent Centre because of his disruptive and odd behaviour. When he was 17 he was diagnosed with hydrocephalus. Between the period of 1996 and 1999 he received care from Dr Spelman at the Belmont Private Hospital where he was diagnosed with organic personality disorder secondary to hydrocephalus which Dr Spelman regarded as similar to Asperger's syndrome. At times Daniel had variable psychotic symptoms described by Drs Rodney and Unwin as "atypical psychosis". He was mainly treated involuntarily at that time. He was admitted to the Oxley Memorial Hospital in 1999. Again the diagnosis was borderline personality disorder and interfamilial issues.

114. Daniel was also well-known to local Police as a result of this behaviour and numerous incidents are detailed in his Police profile.[23] Not all of these incidents will be set out but there were numerous reports recorded confirming his odd behaviour over many years.

115. He first came into significant contact with the Police in 1997 as a result of having absconded from a private psychiatric hospital and due to concerns expressed by his parents about his behaviour and welfare. On 7 August 1997 he appeared in the Maryborough Magistrates Court on five charges of possessing a replica firearm in a manner likely to cause alarm. These charges were dismissed and withdrawn under an order of the Mental Health Tribunal.

116. Daniel Pattel had been detained under the relevant Mental Health Act after committing the above offences and he was assessed by Dr Attwood (a psychologist with significant experience with Asperger's syndrome) as having many features of Asperger's syndrome and current depression.

[23] See exhibit B8

Dr Attwood recommended that his depression be treated and that cognitive behavioural therapy should be attempted.[24]

117. On 19 April 2000, Dr Alroe, a psychiatrist from the Fraser Coast Integrated Mental Health Service ("FCIMHS") who knew Daniel Pattel well, interviewed him at the Maryborough Police watch house. Dr Alroe was of the opinion that Daniel Pattel was of normal intelligence, did not have intellectual problems and did not suffer from any kind of formal mental illness.[25]

118. On 22 May 2000, Dr Donald Grant, a psychiatrist, provided a report to the Director of Mental Health assessing the need for Daniel to remain a restricted patient under the *Mental Health Act 1974*.[26]. He thought it was a difficult decision but restricting Daniel Pattel was probably not the best way his behaviour could be addressed and he required management along psycho-social lines, in the community. From a diagnostic point of view he said Daniel Pattel had subtle organic cerebral problems arising from hydrocephalus. He thought Daniel Pattel's overall intelligence was probably average but there was some evidence of an organic personality disorder. He had a long history of behavioural problems with many features described in Asperger's syndrome. Dr Grant could find no convincing evidence of a psychotic disorder. He opined that regulation and hospital admission was not likely to be helpful in Daniel Pattel's overall management. He commented this was not to say he believed there was no danger of future violent behaviour by Daniel Pattel, but rather to indicate that such future violent behaviour would in his opinion not be as a result of major mental illness.

119. On 16 June 2000 Daniel Pattel appeared in the Brisbane District Court on two charges of threatening violence. He was sentenced to probation for three years with a special condition he undergo such medical, psychiatric or psychological counselling as may be recommended and directed by an authorised commission officer. This is often a standard condition to many probation orders and in my experience means very little concerning the future direction of treatment.

120. His probation officer, Melinda Bailey, met with Daniel frequently as a result of his reported behaviour and in response to telephone calls from his mother, Mrs Pattel. He breached his probation order in January 2002 for behaving in an indecent manner and was fined $50.

121. In February 2002 Daniel Pattel became a regulated patient with an ITO under the *Mental Health Act 2000* at the FCIMHS. In mid February he absconded for a period of approximately nine days in which he returned to the FCIMHS when he ran out of money and returned to the Pattel residence. In early May 2002 Daniel again absconded whilst on leave in Brisbane to receive neurological treatment.

[24] See exhibit D11
[25] See exhibit D5
[26] See exhibit D17

122. On 27 May 2002, whilst Daniel Pattel was absent from treatment, he stabbed a taxi driver who was transporting him. As a result, he was arrested, and detained in custody. Over the period from February 2002 to June 2002 he was seen by Dr Kelly[27] and Dr Kluver of FCIMHS who both noted the previous multiple diagnoses. Neither of them found evidence of formal thought disorder and no apparent delusions when examined. Until the commission of the offence the discharge plan had been to continue the ITO with placement in the community and close follow up. He was prescribed Risperidone but Daniel was not supporting the plan. For the purposes of a report to the MHC, Dr Kluver considered that Daniel Pattel was not suffering from unsoundness of mind with respect to the offence he had been charged with and was fit for trial.[28]

123. On 13 May 2003, he was convicted and sentenced in the Maroochydore District Court for the offence of assault occasioning bodily harm whilst armed and he was sentenced to 3 years imprisonment. The 351 days he had already served in custody was declared as time served. The sentencing judge recommended consideration be given by the prison authorities to have Daniel Pattel transferred to a relevant health institution for care.

Daniel Pattel's period in prison from 2002 to 2005

124. Whilst Daniel Pattel was on remand awaiting sentencing for the assault on the taxi driver he was housed at Sir David Longlands Correctional Centre and Arthur Gorrie Correctional Centre. After he had been sentenced and following a referral to the FCIMHS (an AMHS) in June 2003 for psychiatric assessment he was transferred from FCIMHS to the Maryborough Correctional Centre ("MCC").

125. There was significant evidence before me from those associated with Daniel Pattel in the prison system concerning his behaviour. Daniel was known by prisoners and officers as "Fraido" and "Wee Wee". It would be difficult and unnecessary to describe all of the odd behaviour Daniel exhibited whilst incarcerated. What follows are just some examples from the numerous incidences involving Daniel:
    - Daniel kept his cell in a filthy state and was disciplined over this issue on a number of occasions;
    - Daniel would often spit at other prisoners/Corrective Services Officer ("CSO") staff and/or their food;
    - Daniel repeatedly washed his face/neck with a chux to the point it caused physical injury;
    - Daniel engaged in repeated hand washing;
    - Daniel showered excessively and at all hours of the night;
    - Daniel would often bang his head against the cell wall at night;
    - Daniel appeared to be talking to person/s not present or himself;

[27] Exhibit E6 pages 79-81
[28] Exhibit E6 pages 95-98

- Daniel was found on more than one occasion to have spent time "writing voluminously". These writings seemed to re-iterate the same thought over and over. Some of these included "I am the Lord Bastard" and "she is the Queen Bitch";
- Daniel repeatedly threatened to hurt and/or kill other prisoners and DCS staff;
- He often made slashing motions across his throat with his finger to CSO's;
- Daniel threatened to kill DSQ support worker Michelle O'Meara; and
- Daniel confessed to a number of CSO staff that he had committed numerous killings.

126. On 26 July 2003 he told CSO Peter Baumanis[29] that he had:

- strangled a 17-year-old girl in Maryborough in 1989 and Police recorded the death as asthma;
- committed six attempted murders and six murders in Sydney between July to December 1997;
- committed four murders in Hobart;
- committed two murders in Surfers Paradise being homeless persons he struck on the head with a metal plate. He named one of the victims who indeed had been killed in such a fashion;[30] and
- In answering why he had killed these people he stated it was for the "rejuvenation process".

127. He had similarly told CSO Stephenson about killing two people each on the Gold Coast, Sydney and Tasmania and hearing voices that talked to him about the killings and that he had killed before and would kill again. He told her he had tried to murder another person in a mental health unit.

128. The "rejuvenation process" was a constant theme in behaviours observed by a number of CSOs and psychologists, sometimes in association with head banging.

129. The above information was contained in notes made by CSOs in the "prisoner case notes", "case management monthly reports", psychological records and in some instances, reports or direct notification to the General Manager concerning Daniel's threatening behaviour. During the inquest we heard from several of the CSOs who were regularly involved with Daniel that they often stopped recording this type of odd behaviour because it was such a regular occurrence.

[29] Exhibit C6 and C6.1

[30] This case is the subject of a Police and coronial investigation in Southport. No charges were laid against Daniel Pattel and charges against two other defendants were subsequently dropped.

130. In December 2003, Felicity Hunter (a DCS psychologist)) compiled an Assessment Unit Report in relation to Daniel Pattel's application for community release. His application was not supported for reasons including "his reported motivation, previous violence, his failure to address his offending behaviour, his unrealistic future plans which outlined no violence prevention strategies and his continual threats of violence whilst domiciled at MCC."[31]

Daniel Pattel's housing in prison and the provision of programs to him

131. Mr David Brown (the General Manager of MCC at the time) noted that Daniel was a challenging prisoner to manage as he presented with some unusual conduct and behaviours which could be confronting to staff and other prisoners. Daniel Pattel was considered to be a special needs prisoner and was housed in the protection unit where his special needs could be addressed and managed appropriately. The protection unit enabled Daniel Pattel's conduct to be closely managed, and to minimise opportunities for him to act out and to minimise the risk posed to and by other prisoners. Mr Brown said an extensive multidisciplinary team approach was adopted to address his special needs. Daniel Pattel had overlapping special needs which included medical, mental health and behavioural needs. These needs were addressed by staff and included day-to-day issues such as the hygiene of his cell, repeated hand washing and showering at all hours and yelling out at all hours. He was not very engaging in his responses.[32]

132. Lisa Dalmau (a senior psychologist and later an Assistant General Manager at MCC) stated that Daniel Pattel was housed in a secure unit at the centre. This unit was usually reserved for offenders of exceptionally good institutional behaviour and conduct. Daniel Pattel was placed in this unit because those prisoners were more likely to be tolerant of his unusual behaviour. She noted that Daniel Pattel "was not suitable for group based rehabilitation programs and individual intervention to address criminogenic needs was not possible or available within the department".[33] Ms Hunter came to a similar conclusion. Ms Hunter stated Daniel's "lack of motivation to participate in programs offered at the centre made it fruitless to have him participate".[34]

133. The role of psychological and counselling services within the prison setting was not (and is not) to provide therapeutic counselling but to assess the prisoner's risk of self harm or suicide. Therapeutic counselling would only occur if the prisoner's behaviour was impacting on their performance in the facility. In the case of Daniel Pattel this was one of the reasons why Ms Hunter and other psychologists at MCC saw

[31] Exhibit C20A
[32] Exhibit C6B
[33] Exhibit C12
[34] Exhibit C20A

him quite regularly. Individual intervention in relation to criminogenic needs was not possible or available as most of the programs were group based and accordingly not suitable for Daniel. Individual therapeutic intervention was also not possible because it was against DCS policy. In any event Ms Hunter considered Daniel Pattel's lack of empathy would have made him unsuitable for individual attention.

134. Ms Hunter did provide supportive counselling because of Daniel Pattel's high needs in terms of behaviour and mental health, but ultimately that ceased as Mr Pattel no longer wanted counselling and she assessed that he did not want to make any changes to his particular behaviours.

135. Mr Rallings also stated it was not DCS core business to provide specialist and specialised services. DCS staff tried to identify those people needing specialised services and make appropriate referrals in liaising, coordinating and case management and follow-through. In this case the only response probably available was a referral to the PMHS.

136. Mr Rallings stated it would still largely be the case that DCS would be unable to provide rehabilitation programs in prison that were suitable to Daniel Pattel, although there are now other programs that can be provided which have more benefit than intervention programs. This would include the types of transition programs that will be discussed later in this decision and support services that PMHS and DSQ could provide. In principle this all sounded very sensible but in practice my concern is the funding of both DSQ and the PMHS is so limited these good intentions would be unlikely to be implemented in an effective manner.

137. What is apparent is that although Daniel Pattel was appropriately housed and fed, nothing was done about providing for his particular needs whether they be classified as mental health issues or behavioural/intellectual disability issues. This was not because DCS failed to provide services that were in existence, but because there were no such services available (other than a referral to PMHS) then or probably now. People such as Daniel Pattel simply fall between the gaps.

138. How such services are provided to prisoners is a policy decision for government. Funding would be a primary consideration when determining what services and programs are provided to prisoners, and, any increase in services and programs would require additional resources.

Mental Health care provided to Daniel Pattel at the MCC

139. Following his arrest on 27 May 2002 for the assault on the taxi driver, Daniel Pattel was initially transferred to the Sir David Longlands Correctional Centre. It would seem the general consensus of the psychiatrists who saw him in this period of time was that there were no acute psychotic concerns and his behaviours were due to a personality

disorder or a Pervasive Developmental Disorder.[35] He was generally reviewed monthly.

140. In late June 2003 Daniel Pattel was referred by Dr Kingswell to the FCIMHS (an AMHS) for assessment. This resulted from two consultations Daniel Pattel had with Dr Kingswell. On 20 May 2003 he told Dr Kingswell he had "confessed to two murders several months ago. Police had said that only one occurred and the culprit was in prison. As far as he was aware he committed the murders. He recalled killing them and went to parks at Surfers Paradise and clobbered a couple of homeless men sleeping in parks with a steel plate". On 10 June 2003 Dr Kingswell records he had a very odd discussion with Daniel Pattel when Daniel told him it was "self evident that he would not reoffend and is not a danger to the community however he repeated his confession about two murders".

141. Dr Karin Fuls assessed Daniel Pattel at FCIMHS and thought he had symptoms of a pervasive developmental disorder but no other clinically significant impairment. As Dr Fuls considered Daniel did not meet the criteria for an involuntary treatment order he was sent back to prison. On this occasion he was sent to MCC. This entire process seems to have taken place over a 72 hour period.

142. The MCC had the benefit of a District Forensic Liaison officer employed by FCIMHS who would spend three hours a week at the prison providing triage assessments, discharge planning and training, to correctional staff. Referrals were made to services which met the needs of individual prisoners and all mental health referrals were triaged out by this officer. Three hours a week does seem to be inadequate for that purpose in a prison of that size.

143. During Daniel's incarceration at the MCC he was seen regularly by both psychologists at the MCC and psychiatrists from the PMHS. Whilst it is not the purpose of a decision such as this to simply set out each and every involvement Daniel had with psychologists and psychiatrists whilst incarcerated at the MCC, I have attempted to detail some of the more significant presentations from the final year or so of his incarceration.

144. By way of background, Mrs Pattel had over many years been advocating on behalf of her son. She had received correspondence from a number of sources at various times confirming that her son did not meet the criteria for involuntary treatment and that he would continue to receive monitoring of his medical and psychiatric conditions in prison.

145. It is evident that the capacity to provide psychiatric treatment of prisoners in a prison environment is very limited. In considering prisoners such as Daniel Pattel, Dr Hannah said she was particularly looking for

[35] Reports of Dr Heffernan D18 and Dr Kluver D19, Dr Attwood D11 and referred to by the MHC at para 16 noting they were unable to find any evidence of psychotic illness or mood disturbance and his presentation was consistent with Asperger's Disorder.

whether there had been any acute changes or deterioration in his behaviour at around the time she was seeing him.

146. Dr Kingswell stated that their (PMHS) capacity to provide ongoing supervision and treatment of a mental disorder in a prison setting is very poor and the best they could do was to monitor the treatment needs of patients in prison. An assessment order may be needed if there is evidence which suggests a more fulsome assessment is needed. Accordingly, consistent with what Dr Hannah said, from the perspective of Dr Kingswell the issue of diagnosis might have been relevant but he was more interested in whether he needed to intervene for this person on this particular day, particularly on an involuntary basis.

147. In May 2004, Dr Anderson, a private psychiatrist, was engaged by Mrs Pattel and DSQ to assess Daniel and provide a psychiatric report. Dr Anderson interviewed Daniel for two hours with the permission of DCS. Daniel Pattel made reference to "the rejuvenation thing", about the killings on the Gold Coast and how he "wanted to get his murders up". Dr Anderson concluded Daniel had a "schizophrenic or schizophreniform illness with features of hallucinations, delusions, neologisms, unusual thought processes, bizarre behaviours and blunting of affect".[36]

148. Dr Anderson's understanding was that the main consideration was Daniel's dangerousness to the community. He indicated the "dangerousness will be minimised if he is not deluded or hallucinating and the appropriate treatment to control any psychotic symptoms will be one of the newer antipsychotic medications."[37]

149. It would seem that within a short time frame this report was provided to the MCC and those dealing with Daniel Pattel by either his mother and/or DSQ; and copies of Dr Anderson's report can be found in several different sections within the DCS file on Daniel Pattel. It is apparent from his evidence that Dr Kingswell does not recall having seen or read this report.

150. Dr Hannah commenced seeing Daniel Pattel in June 2004. She had by this time seen a report from Dr Anderson who suggested depot Risperidone (an anti-psychotic) as a treatment option. There was some contention raised as to whether Dr Hannah actually read the report but I accept that she did, but clearly did not accept the diagnosis.

151. Daniel Pattel refused to see Dr Hannah on 19 June 2004 but she did see him on 19 July 2004 by video link. She first saw him in person on 30 August 2004. She noted his past history and the previous diagnosis and her impression was that at this time there was no clear evidence of psychosis, although there was unusual content in response to

[36] Exhibit D6
[37] Exhibit D6

questioning regarding his offences. He was adamant he did not want medication.

152. Dr Hannah again reviewed Daniel on 15 November 2004 and she considered he was more cooperative and better overall. He again denied any hallucinations or any other psychotic phenomena. They discussed medication and Daniel stated he had previously been on anti-psychotic medication and it made him feel worse. He said he was agreeable to follow-up mental health services following his release from custody and her impression was there were no grounds for an involuntary treatment order.

153. Daniel Pattel was again reviewed by Dr Hannah via video link on 6 December 2004 and again she thought there were no grounds for enforced treatment.

154. Dr Hannah stated Daniel Pattel had made no threats towards others that she was aware of, including threats of violence to staff or other inmates. She qualified this statement later saying she was generally aware of concerns regarding his dangerousness.

155. It was clear from her evidence that Dr Hannah was not aware of the many reports that had been made by CSOs concerning Daniel's behaviour, other than in a general manner.

156. The procedure for video interviews was that the psychiatrists only received a faxed copy of any previous psychiatric progress notes that may have been made which were contained on the prisoner's medical file. When the psychiatrists were physically present at the prison they had access to the whole medical file. However, it is very doubtful that Dr Hannah or Dr Kingswell, considered anything other than the previous psychiatric progress notes. Neither of them considered such documents as the psychologists' reports.

157. Dr Hannah said when she was consulting with prisoners on video link the whole session normally ran for two hours and during that time she would see on average eight prisoners, two of whom were usually new cases. On average that meant approximately 10 – 15 minutes each for review; but often the new cases would take longer so the regular reviews might be as short as 10 minutes.

158. When Dr Hannah saw prisoners in person the time period allowed to see each of them was much the same. With that amount of time, it was impossible to conduct an entire review of the prisoner's medical file. Dr Hannah indicated she would have a look at the psychiatric progress notes first and then potentially flick through any other correspondence or reports. How long she was able to look at them was unknown. It is likely the time available was very limited.

159. Dr Hannah received a handover from Robert Pedley, the Team Leader at PMHS regarding Daniel Pattel's history and she is in no doubt that during the time she treated Daniel his risk of dangerousness was known and had been documented. She considered her main task was to examine whether there had actually been any change or difference in Daniel's behaviour. She had not seen any acute changes. Dr Hannah was not aware of many of the psychologist summaries that were on the file and she had not seen any of Daniel's writings (which referred to the "Lord Bastard" etc).

160. Ms Hunter (and a number of other psychologists) prepared a number of assessment advice reports which detailed concerns about Daniel Pattel's behaviour in prison such as headbanging, compulsive and repetitive behaviour including showering and face wiping, threats to kill people, references to hearing voices, references to becoming increasingly hostile to prisoners, presenting with macabre thought patterns and appearing to be resistant to change or restructure, threatening to knife someone and conspiracy theories in reference to the September 11 terrorist attacks.

161. These reports were placed on Daniel's medical file and were also copied to the counsellor's file and Daniel's sentence management file. The physical presentation of Daniel's medical file has the notes by psychologists in a pink divider after the psychiatric section summaries.

162. Ms Hunter also undertook a review of Daniel's case notes from time to time. This was so that she had collateral information with respect to his behaviour and, in particular, looking for any escalation in that behaviour. The intention of Ms Hunter in copying section summaries to the medical file was specifically as a point of call for the psychiatrists to see them.

163. Dr Hannah gave evidence she would have considered the most recent notes by psychiatrists who had seen Daniel Pattel but would not have considered the nursing notes or the psychologist notes. She received reports from staff that Daniel was reporting to be hearing voices but when she questioned him about this he denied it. She agreed it would have been helpful to read the information that was in the psychologist notes, although she did not think this information would have changed her diagnosis.

164. Dr Kingswell was of the opinion that Daniel suffered from a pervasive development disorder. Dr Kingswell saw Daniel on four occasions between 21 February 2005 and 9 May 2005[38]. During this period Dr Kingswell was aware a psychiatrist from the Sunshine Coast [Dr Anderson] was of the opinion Daniel suffered from schizophrenia and needed ongoing treatment for this disorder. Dr Kingswell did not share this view and it was not an avenue he was prepared to pursue.[39] It was Dr Kingswell's experience that "when Daniel described psychotic

[38] He had also seen Daniel on four occasions between 10 June 2003 and 21 November 2003.
[39] Exhibit C23B

symptoms he invariably retracted the account and when offered treatment for the possibility that a psychotic illness underpinned his oddity, he refused"[40].

165. According to Dr Kingswell, on 14 March 2005, Daniel complained of a range of symptoms that would fit within people's idea of a psychotic illness. Daniel spoke of hearing the voices of Dr Spelman and Dr Sheehan and stated he wanted to achieve a murder when he left prison. Dr Kingswell raised the prospect of medication with Daniel and he stated "the last thing I want is medication"[41].

166. Dr Kingswell conducted a video conference with Daniel on 8 April 2005. During this session Daniel denied hearing voices and Dr Kingswell did not elicit any delusions. Daniel denied having any thoughts of killing someone on discharge.

167. Dr Falconer was notified of Dr Kingswell's concerns that Daniel had claimed to be planning to kill someone upon discharge.[42] Dr Falconer subsequently advised the Director-General of DCS who in turn outlined these concerns in a letter to the Commissioner of Police on 9 May 2005.[43] This has been the only occasion on which Dr Kingswell has been confronted with such a clear threat and an imminent discharge which has prompted him to make such a notification.

168. As Dr Kingswell said in his evidence he had *"no doubt that Daniel Pattel posed a significant risk to the community. He had told me that. And he had behaved that way in the past. I knew or believed that I knew that he posed a significant risk to the community. I knew that he had a severe developmental disorder and a range of unusual behaviours and an unusual pattern of thinking. I knew that his dangerousness required some surveillance and monitoring. I knew that his mental health required some surveillance and monitoring and possibly treatments at different times and I was quite prepared to meet all of those requirements but in this particular case we were prevented from doing anything around that because Mrs Pattel had an alternate plan that she was going to put into action and she clearly did not want our assistance in the matter."* The added problem for Dr Kingswell is that he did not consider Daniel Pattel was suffering from a delusional mental illness as such and therefore there was no lawful mechanism he could use to otherwise detain him.

169. Dr Kingswell conducted a video conference with Daniel Pattel on 9 May 2005. Daniel denied having ever heard voices. Dr Kingswell noted no change in Daniel Pattel and "nil psychotic". Daniel told Dr Kingswell he expected to see Dr Anderson upon discharge at the urging of his mother and expected the issue of medication would be discussed.

[40] Paragraph 16 of C23B
[41] Page 326 – 327 of Exhibit E6 contains Dr Kingswell's notes from this session.
[42] Exhibit G7
[43] Exhibit G15

170. During cross examination both Dr Hannah and Dr Kingswell were given a description of varying behaviours over the period of time he was in prison by Counsel for the family of Mr Simpson-Willson. They were also shown the handwritten notes of Daniel Pattel that were found in his cell. In general terms the description of the behaviours included:

- He was extremely messy with rotten food left in his cell and soiling his toilet;
- Strangely, considering the above, he would engage in compulsive washing and showering and rubbing himself;
- Banging his head against the cell walls;
- Obsessive writing;
- Threats to kill or claiming to have murdered someone;
- That he wanted to get rid of his testicles because of the possibility of evil spirits;
- The belief that he was a genius and that he had a high or different intelligence;
- That the voices could be controlled by speaking to a person of higher than average intelligence;
- That he could live forever; and
- That he would speak about brain rejuvenation.

171. Dr Hannah had the opportunity to read the patient notes at a break in her evidence and stated she was aware that Daniel Pattel had a pattern of threatening to kill somebody but there had not been any escalation or change in those threats over the period of time she treated him. Although knowing this information would be relevant, she thought it would not have changed her diagnosis.

172. There is clearly a recurrent theme of “rejuvenation" in Daniel’s records. Importantly Dr Kingswell said he was not aware of that theme until he read about it in the MHC transcripts. When the description of behaviours gleaned from the progress notes was read out to him at the inquest, Dr Kingswell said in his view they now did show a persistent pattern or quality of thought and behaviour. Dr Kingswell said having such information might have changed his degree of anxiety about whether Daniel should receive some assessment and treatment against his will but it would not necessarily cement a diagnosis or change his opinion. He noted the threats were a recurring theme, and obvious to everybody, but the extra information might have alarmed him in a more urgent sense and he may have done an assessment order. He stated it did not sound like Daniel was travelling as well as he had been given to believe.

173. In relation to the repetitive notes found in Daniel’s cell Dr Kingswell stated he had never seen that correspondence and it would have been helpful to have had it for consideration. Dr Kingswell said that looking at Daniel’s writings, he considered that they were thought disordered and were “written by an insane person until proven otherwise”[44].

[44] At page 28 in the transcript from 5 November 2008

174. Dr Kingswell was quite prepared to acknowledge that with the extra information that may have been available it might have changed my view about hospitalisation if there was this compelling and consistent picture of very disorganised thinking and behaviour that place him or other people at risk. Then I would have taken a different path." He went on to say he would have found the evidence compelling and that a further assessment was required.

175. What is clear is that there was relevant information available in the prison file and more particularly on the medical file. There are multiple reasons why the material was not read or accessed. Even if there had been a willingness by them to read that material, the capacity of PMHS psychiatrists to do so was limited due to time constraints imposed upon them and by the very structure of the service being provided. Notwithstanding the time constraints the material on the medical file was at least readily accessible and should have been read. The other information was not as accessible and the issue of information sharing and how to improve it was the subject of evidence at the inquest and will be addressed in the course of recommendations.

176. Given that PMHS psychiatrists would only have ready access to what was contained on the medical file it is difficult to say whether having read only that information would have made a difference to their decisions to not refer him for assessment at an AMHS or affect any change in diagnosis. It is significant that in the course of the MHC Court proceedings, a number of psychiatrists, including the assisting psychiatrists to the court, made reference to Daniel Pattel's capacity to hide some of his symptoms in the prison environment. Even when he was held at The Park for 14 days during July and August 2005, Dr Hannah found no evidence of psychosis. Dr Hannah found during this admission that he was more disturbed in his behaviour and was more subjectively distressed than on previous occasions when she had seen Daniel. He spent the majority of his time with repetitive obsessional writing. In her opinion there was still not enough evidence of psychosis to make a diagnosis of schizophrenia.

177. Over the subsequent months after his arrest for the killing of Mr Simpson-Willson, Daniel Pattel presented at times as clearly psychotic and at other times not. By the time Dr Voita saw Daniel Pattel in July 2006 at the Arthur Gorrie Correctional Centre, she considered him to be psychotic and completed a Recommendation for Assessment and listing for a bed in the High Security Inpatient Unit. That bed did not become available until December 2006 and by that time Dr Voita thought that Daniel Pattel was clearly psychotic and remained so. He was voicing a number of bizarre, persecutory and grandiose delusional ideas and his thoughts were disordered. The fact it took almost six months to find a high security bed for someone who was considered to be clearly psychotic and had already killed a person is astounding and indicative of the urgent need for more high security beds.

178. The issue of diagnosis is complicated and the extent to which any change in assessment by Dr Kingswell at around the time of Daniel Pattel's release would have changed the outcome is speculative. Perhaps if Daniel Pattel had been taken to an AMHS for an assessment immediately after his release he may have been placed on an ITO and detained even for a short while until he could be assessed by Dr Anderson.

179. However, it was likely that any assessment referral would have been made to the FCIMHS and there was a view on the part of Dr Kingswell, and certainly Mrs Pattel, that a decision would have been made by FCIMHS that Daniel Pattel did not meet the criteria for an involuntary treatment order. Certainly the view expressed by FCIMHS representatives as recorded in minutes of a meeting held as late as 4 May 2005[45] was that Daniel Pattel had Asperger's syndrome and not schizophrenia and was ineligible for mental health services.

180. Given the history of assessments at FCIMHS the most probable result of a referral for assessment would be that he did not meet the criteria for an ITO and would not have been detained.

181. On a number of occasions during the inquest I heard some limited evidence in relation to the reported attitude of FCIMHS that they would not accept someone who met the criteria for an ITO unless they were psychotic at the time of assessment. That certainly is not what the *Mental Health Act* states and Dr Groves stated that if this was the view, then it was a misplaced view. He stated there was a very clear understanding that people are treated with severe mental illnesses because they need specialist services but that does not necessarily mean they must have a psychotic illness. Dr Kingswell gave similar evidence. I would hope by now that people in authority such as Dr Groves would have ensured this prevailing view had been well and truly put to rest.

Expert Review by Dr Paul White

182. Dr Paul White provided an independent expert report to the Coroner[46]. He is a specialist psychiatrist having worked in the prison system for many years and has published a number of research papers on the principal themes of mentally ill offenders and adults with developmental disorders exhibiting severe challenging behaviours. At the time of the inquest he was the Director of the Dual Diagnosis Unit at The Park Centre for Mental Health but was on secondment with DSQ. Given his dual diagnosis and prison setting experience he was particularly well suited to assist the Court.

[45] Contained within exhibit G9
[46] Exhibit G3

183. Dr White noted in the decade prior to the killing of Mr Simpson-Willson, that Daniel Pattel's presentations to psychiatrists had enduring themes of an emotionally cold and withdrawn young man with violent sadistic fantasies. At some time (he speculated around 2002); the dominant driver of the thoughts became paranoid schizophrenia. Severe personality disorders and head injuries are risk factors for this disorder and he thought the picture was consistent.

184. Dr White considered there were differing presentations to Dr Anderson, as distinct from other psychiatrists and health professionals whom Daniel saw within the prison system, which he thought may explain the differing opinions. Dr White thought Daniel retained the ability to suppress many of his symptoms for most of the time until after the killing of Mr Simpson-Willson. The fact he confessed to Dr Anderson days after the killing of Mr Simpson-Willson is compelling evidence of that fact.

185. Even subsequent to Daniel's arrest his diagnosis remained unclear, and the abundance of conflicting histories, diagnoses and presentations would have made a diagnosis even more difficult. Dr White noted the diagnosis of paranoid schizophrenia was made by careful examination and observation in the Arthur Gorrie Correctional Centre. He opined that Daniel Pattel's clinical state had deteriorated in prison and the illness manifested itself floridly and awfully.

186. Dr White stated in his report that he considered Daniel Pattel's treatment and management prior to his release was adequate and appropriate. Despite reports of his poor relationship with staff and threats to them, physical violence manifested itself only on one occasion in prison. He considered the actions taken by Dr Kingswell and DCS and Police were appropriate. The arrangements to discharge Daniel into his family's care and the follow-up that had been arranged by his family with Dr Anderson were also appropriate and adequate.

187. Dr White agreed that at the time of Dr Kingswell's assessment and on the basis there were no evident signs of psychosis to him, no steps could or should have been taken to prevent Daniel Pattel from being released into the community.

188. It is abundantly clear to me that the type of service provided by the PMHS in video interviews of approximately 10 – 15 minutes and occasional face-to-face meetings of a similar time frame, even with the most experienced psychiatrists such as Dr Kingswell, could not possibly be sufficient to elicit a sufficient presentation to include or exclude psychosis in a complex person such as Daniel Pattel.

189. It also seems likely the opinions of Dr Hannah and Dr Kingswell would have been influenced by the history of diagnoses that had been made by numerous psychiatrists in the past and this was an added complication to their assessment processes. For such a complex case a 10 – 15 minute interview process was inadequate and almost useless. This case called for longer observations and interviews with Daniel Pattel. More time

needed to be spent in assessing him and to read or review the vast amount of collateral information that was available, but not accessed.

190. Dr White considered that seeing a patient for 15 minutes every month is well short of an ideal consultation and that a video link is inadequate to properly assess a patient. He indicated he would expect it might take a couple of hours to assess a patient of this complexity. It is in my view significant that Dr Anderson had seen him on a couple of occasions for a number of hours before coming to his opinion and diagnosis and was not restricted to the very short interview structure which was available to PMHS.

191. Consistently with that opinion when it was suggested to Dr Groves that this type of brief consultation was not conducive to optimal therapeutic treatments or interventions, his response was that whilst it would be for a very small proportion of people, for the vast majority of people it was not going to be conducive.

192. Dr White also considered the assessment process at the FCIMHS in 2003 when Daniel was transferred from prison for assessment over a period of approximately 2.5 days. He stated he would probably have needed longer than that to assess a person of Daniel's complexity. He explained he would need between about four to six hours to assess Daniel and that normally both the psychiatrist and the patient can only tolerate about an hour or so of this sort of assessment.

193. Dr White was also asked to comment on the description of the behaviours of Daniel which had been gleaned from the psychological notes and prisoner officer reports (from his DCS file) and in particular the bizarre writings that were found in his cell. Dr White agreed that those symptoms were consistent probably with a pervasive developmental disorder, with the exception of the "rejuvenation" theme that Daniel spoke and wrote about. Dr White considered the writings were most bizarre and he thought that those described observations were consistent with a diagnosis of schizophrenia. Dr White commented there was a bizarre quality to the writings that exceeded anything he had seen in someone with a pervasive developmental disorder.

194. Nevertheless Dr White also considered that there are other contextual factors that need to be considered when determining Daniel's diagnosis including the fact that PMHS assessed Daniel in a prison environment, that Daniel had a long history of oddity and where there had been many assessments by other senior psychiatrists and medical practitioners. Dr White thought this would have resulted in a pattern of relying on earlier reports and on earlier diagnoses which it would be difficult to derail from. Even with all the extra information that Dr White was now aware of, given the past history of diagnosis and context in which the decision was being made, he could not say he would have made a different decision to that of Dr Kingswell. However, he also said that starting from scratch, and

with only that information, a finding of schizophrenia was a compelling diagnosis.

195. Dr White made the point it was human nature and the nature of medicine and not just of psychiatry, that clinicians rely on earlier reports or earlier diagnoses. It is well known in the medical field, that clinicians can place a heavy reliance on the medical history in making diagnoses and an acceptance of a diagnosis without considering other possible alternatives can lead to diagnostic error.

196. Dr Anderson stated he would not rely on opinions in other reports, but he would to some degree rely on factual information and collateral evidence which may include observations in those reports. He also stated he would need to elicit signs and symptoms himself to come to an opinion rather than be swayed by anyone else's opinion. [47]

197. Of course it could be argued that is precisely the problem Dr Hannah and Dr Kingswell faced. They considered there were insufficient signs from their observations (which were limited) to diagnose psychosis or another mental illness which could support an ITO or referral for further inpatient assessment. It would have been better if Dr Kingswell had also read and considered what Dr Anderson had written and observed although I suspect that the observations recorded in his report, other than with reference to “rejuvenation” (which in itself was fairly unspecific), would not have provided them with much other information that they already did not know.

198. An added impediment would also seem to be the lack of confidence Mrs Pattel had with decisions made by the PMHS and FCIMHS in relation to her son. There are references throughout the documentation which tend to suggest, rightly or wrongly, that the relationship between Mrs Pattel and those services and DCS was quite strained. By the time Daniel Pattel was to be released Mrs Pattel had not been included in any of the substantive release discussions that were held. Furthermore she had made it clear she was intending to engage Dr Anderson and certainly by implication (the evidence from Mrs Pattel on this issue being somewhat unclear) she would not accept a referral to FCIMHS. From her perspective this may have seemed a reasonable decision but it did create a further barrier to involvement by the mental health and DCS services post release.

199. I have no doubt there are a whole range of factors which contributed to the diagnoses of Dr Hannah and Dr Kingswell in 2004 and 2005 and which are in conflict with the findings of the MHC. They include the extensive previous history and multiple diagnoses by many other mental health clinicians; the reliance that subsequent treating doctors would have in relation to those previous diagnoses; the fact that Daniel Pattel was able to mask his psychotic symptoms at times and in particular in

[47] Transcript 7-67

the prison environment; the difficulties in the sharing of relevant information between PMHS and DCS; and the structural difficulties that were imposed on the PMHS which prevented psychiatrists having anything approaching adequate time to be able to make appropriate observations and to consider alternative diagnoses.

Disability Services Qld support to Daniel Pattel in prison

200. Limited support was available to be given to Daniel Pattel by DSQ. His support workers (Michelle O'Meara and then Ann Ledguard) visited him on a monthly basis to provide him with support.

201. Ms Ledguard told the inquest that DSQ funded the report of Dr Anderson as they (DSQ and Mrs Pattel) were concerned about the diagnosis from FCIMHS. Ms Ledguard had approximately 11 meetings with Daniel Pattel and on many occasions he spoke gibberish.

202. Prior to being incarcerated Daniel had received an Adult Lifestyle Support Package. This package (of approximately $20,000 per annum which equated to between 12 and 16 hours per week) was to recommence following his release from prison. The primary purpose of this funding was to engage Daniel in the community and to assist in independent living skills. There was also evidence that Ms Ledguard was attempting to secure additional funding for Daniel as she felt this package was inadequate for Daniel's particular needs.

203. Despite Ms Ledguard's best efforts, at the time of Daniel's release, she had been unable to secure a non-government provider to provide support to Daniel. The service providers declined on the basis they did not have the staff to support Daniel's needs and/or they were concerned about the risk Daniel posed to their staff.

204. Prior to Daniel's release, Ms Ledguard had approached DCS to obtain permission for support workers to enter the MCC and work with Daniel regarding independent living and/or life skills, prior to being released. It would seem this permission was not granted. Ms Ledguard was adamant that if a support organisation had been allowed access to Daniel prior to his release, this would have put a different light on whether the service providers she approached would be willing to provide support to Daniel as they would have had a chance to engage with Daniel whilst incarcerated to determine the level of support Daniel needed and whether the particular service would be able to provide it.

205. I have no doubt that Ms Ledguard was a conscientious and dedicated worker who was trying to find support programs to meet Daniel's needs on his release and assist Daniel and his family.

206. Ms Ledguard said there were some difficulties in flagging individuals with disabilities within the prison system but if they were flagged then DSQ may be able to provide them with either formal or informal supports. and start the application process pre-release and have contact with

them. The issue of confidentiality and the raising of such information with DSQ would require the permission of the particular prisoner. Ms Ledguard was not aware that anything like this was happening at the relevant time in 2005 or since. She was aware that a MOU with DCS had been established but at the time of the inquest she knew of no DSQ officers from the Maryborough/Bundaberg area that visited the MCC to support prisoners who may have disabilities.

Discharge planning

207. Daniel Pattel's impending release had been the subject of a number of case conferences. On 14 October 2004 a case conference, held over an hour, occurred with the General Manager, Senior Psychologist, Sentence Management Coordinator, Health Services Coordinator and Ms Ledguard. The discussions and outcomes of this meeting were noted on a minute[48]. The group discussed Dr Anderson's report and his recommendation that Daniel Pattel receive medication; and other information including his behaviour in prison. The group also explored planning for Daniel's release. The outcome of this discussion was that Ms Ledguard would continue to explore housing options and support for Daniel Pattel's release. The minute also noted that Daniel Pattel would be reviewed by a psychiatrist (including a medication review) at the next visit and the possibility of a case conference involving clinicians including psychiatrists would be explored.

208. On 16 December 2004 a case conference was held between the Health Services Coordinator and Ms Ledguard[49]. It was determined that a further case conference would not achieve a different outcome other than continued liaison between DSQ and Health Services. The purpose of the meeting was a general discussion regarding Dr Anderson's recommendations for Daniel's medication, potential release dates for Daniel, outcomes of the latest psychiatric consultations, Daniel's compliance with medication, support and housing for Daniel upon release and feedback on application for funding through DSQ. Ms Ledguard would continue to explore housing options and support for Daniel Pattel on release, there was to be continued assessment and treatment by PMHS and there was to be an exploration of the possibility of a letter of support from the Health Services Coordinator to DSQ. A letter of support was sent on 27 January 2005.[50] This letter indicated that Daniel Pattel would "require appropriate accommodation and more intensive intervention than his current funding would support."

209. On 10 March 2005 another meeting was held between the Health Services Coordinator, Accommodation Manager, Senior Psychologist and Ms Ledguard.[51] Again it was determined that a further case conference would not achieve a different outcome other than continued

[48] Exhibit G17
[49] See exhibit C53
[50] Exhibit C53 attachment 9
[51] See page 73 of exhibit E5

liaison between DSQ, Health Services and DCS. Again the participants discussed Daniel Pattel's medication, discharge date and accommodation. DSQ and DCS staff agreed the Pattel family home was not ideal accommodation for Daniel and Ms Ledguard raised the possibility of additional funding for supported/supervised accommodation. The meeting also noted that pre release programs such as daily living skills may be possible if Daniel was willing to participate. Ms Ledguard was to advise DCS of the person to deliver the pre-release program. The next meeting was scheduled for 8 April 2005.

210. On 8 April 2005 Ms Ledguard sent an email to a colleague outlining her recollection of a meeting at MCC that day.[52] Ms Ledguard indicated in both the email and during her evidence that at this meeting permission had not been granted for support workers to enter the MCC to work with Daniel.

211. During this time Ms Ledguard and others at DSQ were liaising about where Daniel Pattel could go to live, and attempting to obtain a service provider, although there were concerns about his threats to his parents and staff.

212. On 4 May 2005, a meeting was held between the QPS, DSQ, DCS and FCIMHS. Ms Ledguard was on leave but had briefed a DSQ representative. Several file notes of the meeting[53] noted that all members of the group expressed their concerns about Daniel Pattel's pending release but were not able to formalise any strategies regarding that situation.

213. One issue which became evident in relation to this meeting was that, despite what had been suggested in the meeting of 14 October 2004, no input was sought from Dr Kingswell, his treating psychiatrist from PMHS. Dr Kingswell said in his evidence he would have thought that input from PMHS would have been of assistance.

214. All those involved with Daniel Pattel whilst he was incarcerated (DSQ, DCS, PMHS) agreed that Mrs Pattel was a strong advocate for her son. In addition, Mr and Mrs Pattel had been appointed Daniel Pattel's guardian by the Guardianship and Administration Tribunal. Mrs Pattel was not invited to attend the discharge planning meeting held on 4 May 2005. I am not able to determine why Mrs Pattel was not included. It is understood there were difficulties in the relationship between Mrs Pattel and the treating psychiatrists at PMHS and FCIMHS, and probably with DCS, but if that was the reason for not including her then it was wrong. It may have also been an oversight but either way it was regrettable. Both from a legal point of view as his guardian, and from a practical point of view, her input would have been important.

[52] The email is contained in exhibit G9

[53] Two file notes were composed, one by Cheryl Walker and one by Des Evans. These file notes are contained within exhibit G9

215. In a general sense, the pre-release planning that was done by DCS and DSQ was the best they could do, subject to the qualifications I make below. Unfortunately in this case, DSQ could not find a community organisation that would provide services to Mr Pattel. Perhaps if a program or support services had been immediately available to Daniel Pattel on his release, then this may have made a difference, with him being monitored and given some structure and activities. Equally, it may have made no difference to the outcome and actions taken by Daniel Pattel.

216. Nevertheless there are lessons to be learnt to improve the process. Mrs Pattel certainly should have been included in the pre-release meetings and Daniel Pattel's treating psychiatrist from PMHS should have been present or contacted about a contribution at the very least. Dr Anderson, Daniel's proposed psychiatrist upon discharge, should also have been invited to the discharge planning meeting or at least contacted to confirm what arrangements were being made.

217. Mrs Pattel had every right to make her own arrangements for her son to attend a private psychiatrist upon discharge. Nevertheless, in such a complex and difficult case, PMHS, DSQ and DCS should have been more involved in ensuring these arrangements were being made. Dr Kingswell's concerns were notified to the Commissioner of Police who advised the local Police who made some contact with the Pattel family. However, it seems Mrs Pattel was not informed of the specific concerns of Dr Kingswell.

218. There was also no patient handover from PMHS to Dr Anderson. Nor was Dr Anderson informed of the concerns held by Dr Kingswell. That was something that could and should have been done and Dr White thought that even without the patient's consent, the treating psychiatrist should have been told.

219. The impact of hindsight is sometimes difficult to put to one side. Nonetheless looking at it as objectively as possible it is clear that the case did call for a much more comprehensive review of the file and psychiatric history as part of the discharge planning, as well as a detailed psychiatric assessment. The issues which made this case extraordinary were the concerns of future violence which were evident to all and given the seriousness that Dr Kingswell considered it, should have rung the alarm bells and resulted in a thorough discharge review involving all relevant persons.

Discharge planning policy since 2005

220. Mr Rallings stated that his directorate is responsible for the oversight and strategic direction of rehabilitation of prisoners in custody and also those under supervision in the community.

221. Specifically relating to the case of Daniel Pattel, there was no specific exit plan established for him. Mr Rallings stated this would be somewhat of an aberration but he conceded this would not have been the sole occasion where that had occurred. Despite this, he would still think a high proportion of prisoners on release would have an exit plan.

222. Since Daniel Pattel was discharged from the MCC in 2005, a number of additional programs have been introduced in Queensland. These include the Transitions Program, the Integrated Transitional Support Model and Transitional Support Service, and the Offender Reintegration Support Service ("ORSS"). I do not intend to set out in detail those various programs, all which are based on the principle that facilitating an offender's successful resettlement in the community is an important means of reducing recidivism.[54]

223. The Transitions Program has greater resources and targets prisoners assessed as having a higher likelihood of reoffending and/or having the most significant resettlement needs.

224. The Transitional Support Service is available to prisoners who are not eligible for the Transitions Program usually because they are at less risk of reoffending and/or their needs are not so great. This includes offenders who are incarcerated for shorter time frames. The program is less intensive and involves completion of a transition needs assessment and the provision of appropriate referral or support information.

225. A Transitions Coordinator is employed at each correctional centre. Following a prisoner's completion of the program a Transitions Coordinator may refer the prisoner to the ORSS program if they are found to have significant remaining reintegration needs, including those stemming from a disability or impairment.

226. In addition to these services, PMHS has also funded a transitional support service in south-east Queensland to provide resettlement assistance to prisoners with a significant mental illness who are about to be released from a correctional facility. The services are partly funded by DSQ and are provided by a non-government organisation, the Richmond Fellowship.

227. Within PMHS, increased funding has allowed clinical coordinator positions to increase from two to five and there is a greater capacity to provide discharge planning. The transitional care coordination programme is intensive and resources are limited. Specifically it is used for the 5% of the prison population seen to be most at risk so that a clinician can work with them not only on their discharge planning while in prison; but also for the first two weeks when they leave prison (this time period being the most at risk period for people when they leave custody).

[54] The statement of Alicia Eugene (exhibit G6) sets out the basis of the various programs as does the statement of Mark Rallings (exhibit G14).

The program provides some continuity of care to link the prisoner with the receiving mental health service, whether it is a district mental health service or a private psychiatrist, and tries to provide a more comprehensive link between treating services to ensure some continuity of care.

228. In relation to the ORRS programme Mr Rallings agreed that it had it had inarguably been a successful program.[55] Persons who are eligible for the ORRS program will have completed one of the transitional support programs and in the two years since the program commenced there had been 500+ participants.

229. Mr Rallings noted that the ORSS program was not offered at all correctional centres and would benefit from greater funding. He was asked about the similar Western Australian program which had four times the amount of budget allocated. Mr Rallings stated that with any increased funding for the program, he would rather see resources go to external service providers to provide these services to support prisoners returned to the community. He said that DCS' core business was keeping prisoners safe, secure and providing rehabilitation benefits and then making referrals.

230. The written submission by the Prisoners Legal Service clearly supports the proposition that the transitional programs can provide a significant benefit to prisoners, but resources were such that the demand by potential participants exceeded the supply and the programs would benefit from increased funding. Given the success of the programs, it would be uncontroversial (except in so far as it requires extra money) to find, that considering the significant benefits to individual prisoners and ultimately to the community that these programs should be adequately resourced so they can benefit a wider cohort of the prison population.

Information sharing

231. It was apparent during the course of the inquest that a recurring theme for my consideration was how better information from within DCS could be made accessible to psychiatrists and other health workers.

232. DCS kept many volumes of material concerning Daniel Pattel, much of which would not be of interest to treating psychiatrists, but some of which would be helpful, as is apparent from the evidence of Dr Kingswell.

233. Dr White stated that it would be difficult for information to be shared between departments quickly in a custodial setting where there are barriers to the free flow and dissemination of information. I agree with Dr White that in a prison environment this is going to be difficult; which is why I requested DCS and Queensland Health consult together and

[55] Although there were difficulties in comparing the statistical data some figures produced suggested that in the context of reducing recidivism this had gone from a previous 60% to approximately 3%.

advise me as to how in a practical way that works for both agencies, there could be some dissemination of information on the nature of the behaviours that were observed within the prison system by various people about Daniel Pattel and others like him in the future. This could be information that Dr White, and certainly Dr Kingswell, would now think would have been important for them to know.

234. I recognise that in Daniel Pattel's case, his behaviours were not recorded on a daily basis within the notes because after some time many of the CSOs had seen his behaviours as a recurring theme and part of his makeup.

235. DCQ and Queensland Health have provided to me a draft set of communication protocols which, in my view, certainly go a long way towards providing improvements to ensuring psychiatrists and other medical staff are provided with appropriate information concerning any notable behavioural or mental state changes in a prisoner. The proposed protocols will be annexed as an exhibit to this decision and I recommend they be implemented in full.

Training of DCS staff

236. Mr Rallings detailed some of the training provided to CSOs. He said DCS is working with PMHS to make staff available for training in dealing with prisoners with special needs such as mental health issues and challenging behaviours. Again, as a matter of principle, this certainly would be a step in the right direction, but again, issues concerning the resourcing of PMHS and the practicality of this service being able to provide such training did not seem to have been discussed to a level of benchmarking or the frequency of such training. It seemed to me this is just another good idea on paper but its implementation is somewhat doubtful.

237. CSO intake training relevantly includes two 2 hour sessions with respect to “at risk” prisoners, one 2 hour session on mental health and one 2 hour session on suicide and self harm. Mr Rallings stated it was his understanding there was training additional to that on those issues, although again, there were no specifics given.

238. I accept that CSOs are not and could not be trained to provide mental health assessments but no doubt their training could include awareness of what may be important to be passed on to psychologists and psychiatrists to consider. Dr White did not disagree with this view, although he also recognised that CSOs have an almost impossible task; and even with more training, it would still be difficult.

239. I agree and am mindful of not placing too much of a burden on CSOs. What is needed is for their observations to be recorded and assessed by someone who is trained appropriately, such as the prison psychologists, so they can identify those persons who potentially need further assessment.

Submissions

240. I have been provided with submissions from the Prisoners' Legal Service and the Public Advocate. The Prisoners Legal Service has considered the submissions of the Public Advocate and has helpfully not repeated recommendations where they agree and PLS generally endorses the submissions of the Public Advocate.

241. As I stated earlier in this decision, it was not difficult for me to find there is a significant funding gap with respect to the provision of mental health services to prisoners and that it is the responsibility of the Queensland Government to fund PMHS to ensure prisoners receive mental health services to a level comparable to those in the community.

242. The submission of the Prisoners' Legal Service helpfully identifies the expressly stated policies contained in the *Corrective Services Act 2006* and in the Standard Guidelines for Corrections in Australia which recognises that prisoners, including those who are suffering from a mental illness or an intellectual disability, have rights to have access to health services of a standard comparable to that of the general community.

243. There seems to be some confusion and tension between the access to Medicare funding at State and Commonwealth levels by serving prisoners. There is apparently historical precedent that section 19(2) of the *Health Insurance Act 1973 (Cth)* has been interpreted as excluding prisoners because medical services to prisoners are provided by the state through the prison system.

244. As the great majority of prisoners are impecunious, they have no access to funds that can be utilised to pay private medical specialists. In this case, DSQ funded Dr Anderson to provide a report, but there was no funding available to provide, for instance, psychological services, including cognitive behaviour therapy individually suited to Daniel Pattel. I have no doubt many other prisoners would benefit from psychological services they would be able to obtain whilst they are in the general community through Medicare rebates however such services are unavailable whilst they are incarcerated.

245. Dr White believed the situation has been the subject of lobbying for two decades at least and should be addressed by those who have the political power to do so. I recommend the Queensland Government and the Federal government address this situation.

246. The submissions of the Public Advocate of Queensland are comprehensive and generally uncontroversial, other than where there are clearly funding and resource issues, which no doubt will cause some impediment to their implementation.

247. Dealing with each of the submissions and recommendations proposed by the Public Advocate in turn I comment as follows: --

Diversion

248. The recommendation suggests that adequate disability support, court diversion and community corrections options are developed to keep people with impaired decision making capacity out of prison. Although I would personally endorse that such diversion programs are warranted and should be pursued by government, it is my view the inquest did not consider sufficient evidence to be able to make such a broad recommendation in those terms.

249. Diversion programs already operate within the justice system so the principle is well enough known. Initiatives such as the Special Circumstances List and Homeless Persons Court Diversion Program are already operating in the Brisbane Magistrates Court and many of those participants suffer from mental health or intellectual disabilities. There are also various alcohol related bail and Court sponsored programs operating in other parts of the state, together with drug diversion programs, all of which encompass therapeutic justice principles.[56]

250. I mention those programs on the basis that the Courts and justice system are well aware of the potential benefits that can arise through diversion programs and it can only be hoped that, as the success of those programs continues to be evaluated, the result will be a broadening of the geographic scope and number of such diversion programs.

251. I also consider the need for effective mental health services for prisoners and ex-prisoners is a principle which is well advocated by other persons and agencies, such as Prisoners Legal Service, and should be developed in that manner. A broadly stated coronial recommendation will not add to what is already known. Dr White, no doubt amongst others, stated, that as COAG reforms bind all government agencies, they bring with them the opportunity to improve services in all the relevant "*government departments in order to provide the range of health, housing and community services for people with mental illness. This must include improved and expanded prison mental health services, court diversion programs, and well resourced inpatient and community forensic services that link mental health, judicial and correctional services and provide specialist pre-release assessment, consultation and liaison for clinical managers. Diversion from the criminal justice system of mentally ill people who have committed minor offences is one of the few opportunities for community-based prevention. Access to stable housing and to appropriate vocational rehabilitation services is essential for functional recovery. All of these programs will need specially trained and*

[56] A summary of such programs are outlined at pages 86 – 99 in the Magistrates Court of Queensland Annual Report 2007-2008

supported mental health and custodial personnel, including psychologists, psychiatrists and specialist case managers."[57].

252. That would seem to sum up what is needed. It just requires the political will and resources to do so.

Screening

253. I heard evidence from Dr Kingswell, Dr White and Mr Rallings concerning efforts being made to develop an intake screening process and tool to identify prisoners with disabilities and there is clearly support for such a process. Accordingly I recommend these screening tools continue to be developed and implemented as soon as possible (if not already implemented) without a significant delay or expense. Of course, identifying such persons is the first stage. Providing services as appropriate for their needs is something that then needs to be developed and provided.

Service Delivery

254. The recommendation of the Public Advocate suggests that DCS and DSQ review service delivery models, policy and procedure regarding the interface between the case management needs of prisoners with impaired cognition and those responsible for the attention of such persons. Quite properly, the Public Advocate did not suggest a particular model and certainly the inquest did not hear any evidence which supports one model over any other. Clearly, there is a significant gap in services being provided to those within the prison system who suffer from intellectual and/or mental health disabilities.

255. Those with intellectual disabilities still have support needs whilst they are in prison and it would seem that DSQ has virtually no resources available to it to provide such services. Adequate funding should be provided to ensure that prisoners can receive disability services to a level comparable to those suffering from a disability within the community. Such services should include criminogenic support programs for prisoners with cognitive impairment and complex needs, having regard to their disability, together with transitional support programs upon their release. As to whether those programs are provided by the DCS or DSQ is a matter that needs to be decided by them but one way or the other services should be provided. My view is that DSQ would be best placed to provide these services if funding was made available.

256. I have already commented upon the evidence heard in relation to the funding of PMHS and it is very clear that the Queensland Government needs to adequately fund PMHS to ensure prisoners receive mental health services to a level comparable to community members.

[57] Exhibit G13 contains Dr White article - Prisons: Mental health institutions of the 21st century?

Communication

257. I have already commented on the communication protocols developed by DCS and Queensland Health which are endorsed and recommended by me.

Training

258. The role of substitute decision-makers entitled to make decisions for prisoners with impaired decision-making capacity was clearly an issue that came out of the evidence heard in this inquest. I support the recommendation made by the Public Advocate that calls for professional development and education concerning prisoners with impaired decision-making capacity. It would seem to me that implementing such a recommendation would not be particularly resource intensive and would not involve training of each and every corrective services officer necessarily, as there should be an emphasis on training the particular staff that will be making decisions concerning the release of prisoners back into the community. In the first instance, such officers who are involved in those decisions could be readily identified and efforts could be maximised at that level.

259. With the commencement of the amendments to the *Disability Services Act 2006* it is clear that staff will need a working knowledge of that regime, as clearly Daniel Pattel would have been a person who, potentially, would now be considered as fitting the criteria for restrictive practices and/or containment and seclusion. Early release planning would be essential.

260. I have no difficulty in accepting the recommendation that DCS review staff training and induction packages, policies and procedures to support staff at all levels to develop knowledge in disability awareness and case management. Given that induction training already includes training regarding prisoners who potentially may be suffering from a mental illness and given the evidence that a significant number of the prison population may also be suffering from forms of intellectual disability alone or in combination with mental health conditions, this would seem to be a sensible recommendation and not particularly resource intensive.

261. I am not able to make a recommendation that the Royal Australian and New Zealand College of Psychiatrists consider its current training program and its adequacy to prepare psychiatrists to assess and treat persons with a dual diagnosis of mental illness and intellectual or developmental disabilities. Although I heard evidence that since the 1970s the two areas have basically split off within the Australian profession (with a few exceptions) I did not hear from the College in relation to that issue or other professional associations and therefore am unable to comment on the efficacy and desirability of such a change.

Conclusions

262. The Mental Health Court made a finding that, at the time Daniel Pattel was released from the MCC on 26 May 2005, he was suffering from a psychotic illness of a schizophrenic nature. The fact that a number of psychiatrists over many years considered his illness was not as a result of a mental illness capable of being treated, but due to pervasive developmental disorder, does not mean that those psychiatrists simply got it terribly wrong.

263. There was a complexity to the diagnosis of Mr Pattel's condition and I do not find there was any one specific failure within the system which brought about this very sorry and tragic event. There were a series of failures, some of those were resource based and, each failure on its own, being not predictable of the eventual outcome. Whether Daniel Pattel was suffering from an intellectual/behavioural and/or a mental health disability, he received virtually no treatment for his condition whilst in prison, mainly due to the fact there was no capacity to do so. MCC was not able to provide appropriate programs and PMHS and DSQ were simply not resourced to make up the gap.

264. I have earlier identified that there were a whole range of factors which contributed to the diagnoses of Dr Hannah and Dr Kingswell in 2004 and 2005, which appear to be in conflict with the findings of the MHC, and which prevented them from referring him to an AMHS for assessment or coming to an alternative diagnosis themselves. These included the structural difficulties facing PMHS in providing mental health services, the complex diagnosis, the plethora of psychiatric opinions advanced in the past, the fact that Daniel Pattel was able to hide his symptoms in a prison environment, the limited time periods in which assessments could be made, and issues concerning information sharing and the failure to read or access the information that was available on the medical file.

265. When it came to the time of discharge there were added difficulties including the failure to consult with Mrs Pattel; the failure to include the psychiatrists from PMHS in the conversation; the evident strained relationship that was apparent between Mrs Pattel and PMHS; the failure to provide a discharge statement to Mrs Pattel or Dr Anderson setting out the information that concerned the authorities and Dr Kingswell and/or to directly consult with Dr Anderson about those concerns; and the difficulties experienced by DSQ in finding an appropriate service for Daniel immediately on his release. There were sufficient alarms about the dangerousness of Daniel Pattel that called for a thorough review before discharge that included all of the people mentioned above.

266. In a case as complex as this one, with the whole range of structural difficulties that have been identified, it is simply not possible to determine that one or another factor is ultimately determinative at pointing blame at someone.

267. The family of Mr Simpson-Willson was justly concerned that someone such as Daniel Pattel was released back into the community in the manner that occurred. They have suffered the greatest loss. The family of Daniel Pattel can also feel aggrieved that despite their extensive advocacy over many years, their concerns about his behaviour and the failure to diagnose that he was indeed suffering from a mental illness as well as other conditions, fell on deaf ears.

268. There were potentially a number of lost opportunities that if taken up may have brought about a different result. The result may also have been the same.

269. What is evident is that more can be done to ensure that such opportunities are not lost in the future. It is hoped that recommendations which include better resourcing of PMHS and DSQ, better pre-release planning and transition to pre-release and post-release and the provision of relevant information to treating psychiatrists will create an environment where better and more appropriate decisions can be made for challenging persons such as Daniel Pattel in the future.

Findings required by section 45

270. I am required to find, as far as is possible, who the deceased was, when and where he died, what caused the death and how he came by his death. As a result of considering all of the material contained in the exhibits and the evidence given by the witnesses, I am able to make the following findings in relation to the death:

a) The identity of the deceased was John Douglas Simpson-Willson;
b) The date of death was 3 June 2005;
c) The place of death was at the Central Rotunda, Botanical Gardens, Brisbane City;
d) The formal cause of death was due to head injuries;
e) These head injuries were inflicted upon Mr Simpson-Willson by Daniel Pattel, recently released from the Maryborough Correctional Centre, who used a heavy rock to deliver at least two severe blows to the head, fracturing his skull and causing bleeding over the surface of his brain and causing increased cranial pressure. Daniel Pattel admitted to inflicting the fatal injuries and intending to kill Mr Simpson-Willson, firstly to his psychiatrist and later to the Police. He was subsequently found to be of unsound mind at the time of the killing by the Mental Health Court.

Concerns, comments and recommendations

271. Section 46 of the Act provides that a coroner may comment on anything connected with a death that relates to public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in the future. During the course of my judgment I have made a number of observations and comments and have

considered a number of recommendations made by those appearing before the inquest. For the reasons I have given I published a set of draft recommendations in my draft findings. Other than some minor amendments they remain my recommendations and are produced as follows:

1. Queensland Government fund PMHS to ensure prisoners receive mental health services to a level comparable to community members; and that there be sufficient staff and resources available to PMHS such that they are able to spend sufficient time in being able to access all available information concerning those who are being assessed by them and to be able to spend sufficient time with individual prisoners to be able to properly assess their needs and mental health/intellectual state.

2. Queensland Government explore opportunities with the Commonwealth Government to provide access for prisoners to the Medicare Rebate Scheme;

3. DCS and DSQ review service delivery models, policy and procedure such that prisoners with impaired cognition are able to fully participate in prison activities and programs suitable for their particular vulnerabilities; and that DSQ be funded such that service delivery for their clients does not cease upon them being incarcerated;

4. DCS, in collaboration with Queensland Health and DSQ, continue to progress the development of a routine intake screening process which identifies prisoners with disabilities which impair cognition, their vulnerabilities and needs when entering corrective services facilities and assists and informs individual offender case management planning;

5. DCS, in collaboration with Queensland Health and DSQ, collect, collate and report statistical information about prisoners with disabilities which impair cognition, to inform ongoing policy and program development, monitoring and evaluation;

6. DCS ensure that substitute decision-makers are involved in the planning processes and in decisions regarding the release of adult prisoners with impaired decision-making capacity, for relevant matters which may include accommodation and support upon release;

7. DCS ensure that relevant staff have training and induction policies and procedures to incorporate professional development education concerning the Guardianship and Administration regime, the role of Guardians as substitute decision-makers and health decision-making including those of Statutory Health Attorneys, Guardians and Attorneys for health matters;

8. DCS review its current staff training and induction programs to include components which ensures that staff at all levels have a working knowledge of disability awareness and case management; and

9. That the draft set of communication protocols developed by DCS and Queensland Health annexed to this decision and marked “A” be implemented forthwith.

Responses to Recommendations

272. Since the hearing of evidence in this matter and the completion of draft findings and recommendations, some progress has taken place in relation to some of the issues which were identified at the inquest and which are worthy of further comment. I am under no illusions that some of that progress is due to ongoing policy development and budget advocacy by Departments and not related specifically to the factual issues raised in this inquest. Whatever is the case, progress is being made which should be acknowledged.

273. I am informed by the Acting Public Advocate that his office supports the recommendations that have been made.

Recommendation 1

I am advised that the number of full-time staff in the PMHS has increased from 26 to 35. That is unlikely to be sufficient to ensure prisoners receive mental health services to a level comparable to community members, but it is a start. I intend to make, in addition to recommendation one, a further recommendation that there be sufficient staff and resources available to PMHS such that they are able to spend sufficient time in being able to access all available information concerning those who are being assessed by them and to be able to spend sufficient time with individual prisoners to be able to properly assess their needs and mental health/intellectual state.

It is further noted that the nine bed high security facility and 20 bed extended treatment forensic facility at The Park Centre for Mental Health is scheduled to be commissioned in 2011. Although this is a welcome addition the evidence would suggest that this still does not meet the current demand.

Queensland Health also introduced in 2008 the Consumer Integrated Mental Health Applications (CIMHA) for the purpose of providing a single state information system which allows clinicians to have access to clinical information concerning particular clients across health services and districts. It is noted, however, that there are logistical difficulties in having the system available to practitioners within a custodial setting. I recommend that this be resolved at the earliest opportunity.

Recommendation 2

This recommendation has not been resisted and Queensland Corrective Services will continue to lobby through the Corrective Services Administrator's Council (CSAC) for prisoners to be able to access Medicare benefits. It is apparent from the response that State and Territory corrective service agencies have lobbied the Commonwealth government for many years to provide prisoners with access to Medicare. Subsequent to the change of government in 2007 the New South Wales Minister for Health wrote on behalf of CSAC to the Commonwealth Health Minister arguing for a change in policy. The Commonwealth's position not to provide prisoners with access to Medicare remained unchanged and was based on an interpretation of section 19 (2) (d) of the Health Insurance Act 1973 that prisoners are ineligible to receive Medicare benefits. I note that response and I intend to forward my findings to the Commonwealth Minister for Health in support of the recommendation and CSAC's position.

Recommendation 3

Both DCS and DSQ support the recommendation. Their respective submissions note that both departments are currently represented on an Interdepartmental Working Group (IWG) which is analysing the issues for people with an intellectual disability in contact with the criminal justice system, including the corrections system. In general the issues under consideration were existing support arrangements, service delivery options for those in or at risk of being in contact with the criminal justice system, diversionary options for some people with an intellectual disability, gaps in service delivery and advice for government consideration on how that should be managed.

Disability Services advised that it continues to hold funding for clients who are incarcerated for up to 12 months but to date do not provide services to those clients whilst incarcerated. Their current policy is to re-establish those services in time for their release from prison. The IWG is considering how continuity of relevant services would continue whilst clients are incarcerated. The recommendation is of course that they should continue to receive services in prison.

QCS has also received $1.46 million over the next three years for the Bridging the Gap Project. This is a pilot project which provides specialised case management and transitional planning support for prisoners with impaired cognitive functioning in south-east Queensland and is currently operating within Brisbane Women's, Wolston, Borallon, Woodford and Brisbane Correctional Centres. As part of the pilot project Woodford Correctional Centre has implemented a designated accommodation unit for male prisoners impacted by impaired cognitive functioning. Federal funding has also been provided which will allow the expansion of the Offender Reintegration Support Service. Prisoners with high needs including those identified with an intellectual disability are prioritised to that service.

Accepting that pilot projects are sometimes necessary to provide appropriate evaluations before being rolled out Statewide, it is recommended that there should be equal access to these enhanced services as soon as possible across the state and not concentrated in the South East Queensland area.

It is noted that the Memorandum of Understanding (MOU) entered into between DSQ and DCS has not been renewed as the respective roles of the Departments in relation to prisoners with an intellectual disability are under review as part of the work of the IWG. The work of the IWG should be progressed.

Recommendation 4

DCS and DSQ also support this recommendation. To date DCS has implemented a routine screening process using the Hayes Ability Screening Index (HASI) to identify prisoners impacted by cognitive impairment in south-east Queensland reception centres as part of the Bridging the Gap project funding. The screening assessment does not identify specific information regarding an individual's vulnerabilities and needs but flags those who have very broad indicators of an intellectual disability who would therefore require further assessment. My comment that this project should be implemented across the State as soon as possible is repeated.

Recommendation 5

QCS is negotiating a MOU with Queensland Health regarding information sharing and is working with DSQ to identify what mechanisms are required to allow sharing of statistical information. Statistics are also being collected through the Bridging the Gap projects.

Recommendation 6

QCS supports the recommendation and is liaising with QCAT, the Office of the Adult Guardian and the Public Trustee to develop mechanisms for identifying prisoners who have an appointed guardian and processes by which they can be involved in transitional planning for the target group.

Recommendation 7

QCS supports the recommendation and as part of a wider focus on disseminating information to educating staff regarding the Guardianship and Administration regime as opposed to focusing only on training. QCS is currently working with the Office of the Adult Guardian, QCAT and the Public Trustee to provide information and training to corrections service staff regarding the goals of these offices.

Recommendation 8

QCS does not resist the recommendation and has commenced work on the inclusion of an appropriate training module for entry level training programmes for custodial staff. The QCS Academy is developing mental health awareness packages for custodial staff in conjunction with PMHS which will be expanded to incorporate disability awareness and case management. It is expected that its use will be available by September 2010.

Fifty QCS staff have received specialist training from the Brain Injury Association of Queensland on managing challenging behaviours. It would seem this training focused on key staff at Woodford and clearly this needs to be given a statewide focus.

Recommendation 9

QCS and QH support the recommendation and have advised that they have made significant progress in developing a memorandum of understanding which incorporates communication protocols in both departments and advise that this process is in its final stages; and in some centres has already been implemented.

Condolences to the family

I noted at the beginning of this decision that the investigation and inquest ultimately focussed on Daniel Pattel and his incarceration and release from prison. That was regrettable but inevitable. We should not forget the person who suffered and lost the most was Mr Simpson-Willson and his loving family. My condolences are expressed to the family and friends of Mr Simpson-Willson.

I close this inquest.

John Lock
Brisbane Coroner

Annexure A

Queensland Corrective Services and Queensland Health Proposed Communication Protocols

It has been agreed in principle that QCS and QH will work together to develop methods of communication that enhance the safety, health and well-being of prisoners with a mental illness. At the same time, QCS and QH will work together to develop a detailed set of protocols regarding the interactions between prison staff, OHS and PMHS regarding prisoners with mental illness.

Under the in-principle protocols, the communication protocols will be as follows:

QCS responsibilities

- Where QCS has been informed about an offender identified by OHS or PMHS as requiring closer monitoring, then QCS operational staff will undertake observation of any notable behavioural or mental state changes in the prisoner, and record these changes in the prisoner's case notes. Otherwise, where QCS operational staff observe any notable behavioural or mental state changes in a prisoner they should, in the first instance, record these changes in the prisoner case notes and notify Psychological Services.
- Where QCS operational staff observe or become aware of risk factors that could have significant impact on the behaviour or mental state of a prisoner and that there is an immediate risk to the prisoner, staff or others, they should refer the matter to Psychological Services.
- Psychological Services should assess the information and if it is deemed clinically advisable, the information should be passed on to PMHS either through OHS or directly depending on the assessed risk.
- Where operational staff observe any significant notable behavioural or mental state changes in a prisoner out of "normal" business hours, these changes, while still recorded on IOMS, should be reported directly to Offender Health Services.
- Provide access to the Integrated Offender Management System (IOMS) to Offender Health Services Staff, particularly Case Notes.

Offender Health Services responsibilities

- when deemed appropriate, OHS will inform QCS of prisoners requiring closer monitoring so as to enable proper case management of the prisoner and to manage any risks associated with the prisoner's behaviour towards other prisoners, staff or visitors.
- Where OHS observe any notable behavioural or mental state changes in a prisoner, or becomes aware of risk factors that could have significant impact, these changes will be communicated to the

PMHS Clinical Coordinator at the earliest opportunity and to the General Manager of the facility or delegates with respect to safety and security issues.

- When preparing information to provide to PMHS for a prisoner's upcoming appointment, OHS may access the case notes held on the IOMS system for the intervening period since the prisoner's last contact with PMHS and may provide them with a summary of the prisoner's behaviour in unit.
- Where a prisoner is having their first contact with PMHS, OHS may provide a printout of a prisoner's case notes (either all or relevant items) to PMHS at their first appointment.

PMHS responsibilities

- Where deemed appropriate, PMHS will inform OHS (who will then inform QCS) of prisoners requiring closer monitoring so as to enable a proper case management of the prisoner and to manage any risks associated with the prisoner's behaviour or interactions towards other prisoners, staff or visitors.
- When deemed appropriate, PMHS will have regard to the case notes and IOMS printouts provided to it and if it is deemed necessary contact relevant OHS or QCS staff for further information.