TRANSCRIPT OF PROCEEDINGS

CORONERS COURT

BUCKLEY, Coroner

MARO-COR-0000076/05

IN THE MATTER OF AN INQUEST INTO THE
CAUSE AND CIRCUMSTANCES SURROUNDING
THE DEATH OF ANITA ELSA ALI-HAAPALA

MAROOCHYDORE

..DATE 31/10/2006

FINDINGS

WARNING: The publication of information or details likely to lead to the identification of persons in some proceedings is a criminal offence. This is so particularly in relation to the identification of children who are involved in criminal proceedings or proceedings for their protection under the *Child Protection Act* 1999, and complainants in criminal sexual offences, but is not limited to those categories. You may wish to seek legal advice before giving others access to the details of any person named in these proceedings.

CORONER: These are my findings in the inquest of Anita Elsa Ali-Haapala. It should be noted at the outset that under the Coroners Act 2003 a Coroner who is investigating a death must, if possible, make a finding as to the identity of a person who died, how the person died and when and where the person died, and finally, how the death occurred. A Coroner is preceded by the Act from making any finding or comment that a person is guilty of any offence or similarly liable in any way.

Evidence was given by the investigating police officers, Constable Matthew Richard Thornton and Senior Constable Denise Parer. The deceased brother, Pavo Ali-Haapala gave a sworn statement to the investigating police which was admitted and marked as Exhibit 10 and also gave oral evidence, although there was no cross-examination of Mr Ali-Haapala.

Medical evidence was given by Doctor John Patrick Miles and Doctor Cecilia Castles. When Doctor Miles gave his evidence he produced medical records in respect of the deceased, Anita Ali-Haapala. The records date back to the mid-1980's and related to a number of admissions to the Nambour Hospital, together with discharge summaries from a Victorian hospital. The records make it clear that Ms Ali-Haapala had a long history of mental health issues.

So far as the more recent events are concerned, Doctor Miles, with the assistance of the psychiatric services assessment record noted that the deceased was brought into the Nambour Hospital by her mother and brother at 10:55 p.m. on Tuesday

the 17th of May 2005. She had voiced concerns to her mother that she no longer wished to live. On the evidence before me I make the following findings.

The deceased was admitted to the LGE Ward, which is the psychiatric ward at 2:40 a.m. the following morning, 18th of May 2005, where she was given some medication to help her sleep. She was seen by Doctor Miles and Doctor Cecilia Castles. Doctor Miles made a provisional diagnosis of adjustment disorder with depressed mood and also prominent anxiety symptoms, which means that the patient was displaying prominent psychological distress and in a depressed mood. At that stage it was planned that Anita was to stay on the ward as a voluntary patient. At the time symptoms displayed were not sufficient to allow resort to the Mental Health Act by the treating medical professionals.

Later again that day, Doctor Miles returned to the ward at about 3 o'clock in the afternoon. As the Doctor indicated in his evidence, he had done is initial assessment earlier and felt that the deceased did not have any suicidal ideation, although later the deceased's mother conveyed to him that Anita had expressed suicidal ideation to her. He was however concerned that there had not been a proper opportunity for a full assessment. He felt it important that she be further assessed by nursing staff who would be there 24 hours a day.

Because Anita was not sufficiently assessed he persuaded her to stay. The deceased stayed on the ward and was given

further medication to assist her to sleep. The records then indicated that shortly before 7 a.m. on the 19th of May 2005, Anita approached the nursing staff stating she felt unsafe. It was noted that she had superficial scratches on her right wrist and stated that she did it with her earrings.

There was an improvement in the deceased's condition on the following day, Friday the 20th of May 2005. She reported herself as feeling better and ready to go home. She seemed positive about her future, telling Doctor Miles and Doctor Castles that she planned to finish modules of her TAFE course and then take a break. Most importantly, the medical records indicate that Anita denied any current suicidal ideation. The improvement was such that Doctor Miles thought that Anita could be released on leave over the weekend and for the Crisis and Assessment Treatment team to monitor her for that period before she returned to the ward at the end of the weekend visit.

It is important to note that there were objective signs of improvement, upon which the opinion was based. Anita appeared less anxious or agitated, she had made some plans with regard to doing modules at TAFE and she denied any suicidal ideation. The hospital records also indicate that the information was faxed through to CAT and it's receipt confirmed. Doctor Miles was still of the opinion, that in the state that the deceased was in, there was nothing that he could have done to prevent her from leaving the hospital in any event. It was his opinion that she did not meet the statutory criteria of the

Mental Health Act to allow her to be admitted as an involuntary patient. It is also important to note that Anita was not discharged as such, but released on leave, which allowed her to return to the ward early or telephone the ward if she had any concerns and arrangements were put in place with a view to the Crisis and Assessment Treatment team to monitor her over the weekend.

In that regard I note section 9 of the Mental Health Act 2006 which provides as follows, "The power or function under this Act relating to a person who has a mental illness must be exercised to perform so that; (a) the person's liberty and rights are adversely effected only if there's no less restrictive way to protect the persons health and safety or to protect others, and (b) any adverse effect on the persons liberty and rights is the minimum necessary in the circumstances."

I also note that section 12 of the Mental Health Act provides a definition or mental illness and that subsection (2)(K) is relevant to the extent that it provides, "However, a person must not be considered to have a mental illness merely because of any one or more of the following". There is then a list and sub-paragraph (K) says, "the person has previously been treated for mental illness or has been subject to involuntary assessment or treatment". Indeed, the tenure of the Act is that the patient is to be treated in "the least restrictive environment and with the least restrictive or intrusive treatment appropriate to the patients health needs and the

need to protect physical safety of others". That's a quote from principle 9, paragraph 1 of the United Nations Principles for the Protection of Persons with Mental Illness.

If I can use the words of C A Clements, a Deputy State Coroner in another matter with some similarities to this, "The great difficulty remains, that despite specialist training and risk assessment tools, there is no diagnostic tool to empirically assess if a person is in imminent risk of suicide, nor is there any sure method of measuring truthfulness in what a patient is communicating to a practitioner. I put these matters on record for the benefit of the family so that they may attempt to understand the obligations, and to that extent, restrictions under which the health professionals operate. If I appear to be criticising the legislatives for no good reason, I must add that the rights of the patient, him or herself were clearly uppermost in their minds at the time and that is just as clear that it might not shift from times past."

Anita, upon her release at about 2:45 p.m. on Friday the 20th of May 2005 returned to the family home at 50 McKees Road, Palmwoods and at about 4:15 p.m. stated to her mother that she was going to drive to Montville. That was something that Anita had done previously when agitated. That was the last occasion that she was seen anybody that knew her, so far as the investigation and this inquest is able to establish.

Mrs Ali-Haapala became concerned when her daughter did not return and rang her son Pavo at around 1 a.m. on Saturday the 21st of May 2005. She told her son that Anita had been released from hospital and that she had come home for about two hours before going for a drive to Montville, from which she had not returned. Mr Ali-Haapala was aware that Anita would go for a drive to relax and calm down if she was upset. As can be expected, it was resolved that little could be done at that time of night.

At around 9 a.m. that morning, Mrs Ali-Haapala telephoned her son and requested that he go and look for Anita, which he did. He commenced his search in Palmwoods and travelled up the Palmwoods-Montville Road, looking on both sides of the road in case his sister had had a car accident. Pavo drove to Baroon Dam and then continued through Montville to Kondalilla Falls. Finding no sign of Anita anywhere, he then went to Mapleton Falls where he saw a red sedan, which he believed to be hers and subsequently confirmed that to be the case. The car was locked and he immediately became fearful. The deceased's mother had already made a missing persons report on 21 May 2005 and subsequently Pavo Ali-Haapala advise police communications that he had located his sister's car at 10:51 a.m. in the car park at the Mapleton Falls.

A search of the area by Mr Ali-Haapala was unsuccessful and a full-scale search was soon commenced. The search continued over the period 21 May 2005 to 25 May 2005, when the body of the deceased was located on the valley floor beneath Perriwen

Lookout. The body was subsequently airlifted out by helicopter and then later taken to the John Tonge Centre for autopsy. Identification was confirmed by examination of dental records. It is clear that the deceased parked her car in the car park and walked a distance of about 500 metres to Perriwen Lookout. There was no indication of suspicious circumstances or foul play and there was a strong inference that the deceased caused her own death from her recent history and medical records.

There was submissions that there can be only three possible scenarios to account for the death and they are; suicide, accident or through the actions of a third party. As I said, there was no evidence of any third party being involved and the strong inference of suicide lends itself to a consideration that she did not cause her own death intentionally. Anita could have been standing on the edge of the precipice and over-balanced or slipped.

While the Court has been assisted by photographs of the scene, I can that it was only when Constable Stevens and I visited the scene that a full appreciation of the location can be gained.

On the evidence before me I find that the deceased was Anita Elsa Ali-Haapala and she died as a result of injuries received from a fall from the area of the viewing platform at Perriwen Lookout at Mapleton Falls late in the afternoon of 20 May 2005.

I am satisfied that Anita died as a result of her own actions, whether it be an intentional act of jumping or an accident which occurred unintentionally but as a result of her putting herself in that dangerous situation.

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Section 46 of the Act provides that a coroner may comment on anything connected with certain matters listed in that section. There is one comment I would like to make.

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It would seem to me that there could be an avenue for improvement in the system. If, when persons with psychological problems, such as were present in Anita, are released in similar situations that the Crisis and Assessment Treatment team make that initial contact with the patient and the family at the time that the patient returns to his or her home. To my mind, that action would reinforce to the patient and also to the family that CAT was available to provide such assistance as was required. In making that comment, I am well aware of the issues of funding at the present time. That assistance may not be possible. But I feel it is something to be considered in the future.

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