CITATION:	*Inquest into the death of Gwyyneth Kintala Vaezl Cassiopeia-Roennfeldt (aka Jasmine Roennfeldt)* [2013] NTMC 023
TITLE OF COURT:	Coroners Court
JURISDICTION:	Alice Springs
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HEARING DATE(s):	13-16 August 2013
FINDING OF:	Mr Greg Cavanagh SM
CATCHWORDS:	**Fatal stabbing, care and treatment for mentally ill persons, schizophrenia.**

REPRESENTATION:

Counsel Assisting:	Dr Peggy Dwyer
NT Department of Health	Dr Ian Freckelton SC
Mental Health Association of Central Australia (MHACA)	Mr John Stirk

Judgment category classification: B

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IN THE CORONERS COURT
AT ALICE SPRINGS IN THE NORTHERN
TERRITORY OF AUSTRALIA

No. A0060/2011

In the matter of an Inquest into the death of
Gwvynth Kintala Vaezl Cassiopeia-Roennfeldt
(aka Jasmine Roennfeldt)

ON 14 NOVEMBER 2011
AT UNIT 75 NUMBER 111 BLOOMFIELD STREET ALICE SPRINGS

FINDINGS

Mr Greg Cavanagh SM:

Introduction

1. Gwyynyth Cassiopeia-Roennfeldt was born on 16 July 1975, and was christened by her parents **Jasmine Roennfeldt. To her friends and colleagues in Alice Springs she was known as** Gwyynth or Gwyn, a name she chose when she changed her name by Deed Poll several years before her death. Many of her friends and colleagues will remember her as Gwyn but to her mother, father and siblings, she was always Jasmine, and I have seen email exchanges between them in the year of her death which she signed off affectionately as Jasmine or Jas. In the official records, both the birth name and the name change will be recorded. In these findings, I will refer to her as "Jasmine", out of respect for the wishes of her family.

2. On 14 November 2011 Jasmine died as a result of stab wounds inflicted on her by her flatmate and friend, Rocky Manu, at a time when he was suffering from paranoid schizophrenia and had not been effectively treated or

medicated for some three and a half months. In the absence of treatment, Rocky's paranoid delusions became extremely dangerous and it appears that he stabbed Jasmine because he had an irrational belief that this gentle, caring women, who had befriended and helped him during the two years they lived together, was in some way trying to harm him.

3. Jasmine was only 36 years of age when she died, and the circumstances of her death have shocked her family and friends, and the close knit community of Alice Springs, particularly those who work in mental health who knew Jasmine and held her in such high regard. As was recognised throughout the inquest, her death devastated the families of both Jasmine and Rocky, and many people have been deeply affected by this tragedy.

4. On the same day that Jasmine's body was discovered, Rocky Manu was tracked down by police, arrested and detained. At his first mental health assessment he was found to be acutely psychotic, and his treatment for paranoid schizophrenia was resumed. Rocky was then charged with murder and committed for trial. In September 2012, in the face of overwhelming psychiatric evidence, he was found not guilty by reason of his mental illness and detained in Alice Springs Correction Centre pursuant to a custodial supervision order. It is part of this tragic picture that when Rocky was medicated again after being taken into custody, he slowly came to understand what he had done and in written correspondence before the Supreme Court he apologised to Jasmine's family for taking her life.

5. The functions and powers of the Northern Territory coroner are set out in the *Coroners Act* ("the Act"). Pursuant to section 34, I am required to make the following findings:

> "(1) A coroner investigating –
>
> (a) a death shall, if possible, find –

(i) the identity of the deceased person;

(ii) the time and place of death;

(iii) the cause of death;

(iv) the particulars needed to register the death under the Births, Deaths and Marriages Registration Act;

6. Section 34(2) of the Act operates to extend my function as follows:

> A coroner may comment on a matter, including public health or safety or the administration of justice, connected with the death or disaster being investigated.

7. One of the most important powers of the Coroner is contained in s35(2) of the Act, which provides that:

> a coroner may make recommendations to the Attorney-General on a matter, including public health or safety or the administration of justice connected with a death or disaster investigated by the coroner.

8. I have had the benefit of a carefully prepared brief of evidence, put together by the original officer in charge of the inquiry, Detective Senior Constable Deanne Ward. I was also grateful for the thoughtful assistance provided by Detective Sergeant Jon Beer throughout the inquiry.

9. In order to enable me to make the necessary findings under s 34(1), including a consideration of the broader circumstances surrounding the death, I had tendered in evidence the following written material: the brief of evidence, which included the investigators overview memorandum and numerous witness statements (Ex 1); Jasmine's birth certificate (Ex 2); 'Rocky Manu (RM) Referral for case management' (Ex 3); a folder of

additional statements (Ex 4); RM Discharge summary (Ex 5); Letter from support worker Bruce Macgregor (re RM) (Ex 6); Tenancy agreement (Ex 7); Case note by Bruce Macgregor (re RM) (Ex 8); MHACA Housing Application form (Ex 9); New Residential Tenancy Agreement (Ex 10); Email conversation dated 16 Nov 2011 (Ex 11); Letter dated 19 June 2009 (Ex 12) and a Bundle of documents (Ex 13).

10. I heard oral evidence from the following witnesses – Detective Sergeant Jon Beer; Senior Constable Philip Brooke-Anderson; Dr Goulnara Sowman (Psychiatric Registrar); Dr Prosper Abusah (Psychiatrist); Samuel Albury (Aboriginal Health Worker); David Hockley (former Manager, Community Team, CAMHS); Jamie Callaghan (Mental Health Nurse); Susan Coombs (former Administrator, MHACA); Donald Bruce Macgregor (Mental Health Worker, MHACA); Rangi Ponga (former Service Manager, MHACA); Claudia Manu-Preston (Rocky's sister and Chairperson of MHACA); Jacqueline Manu (Rocky's sister); Geoff Manu (Rocky's brother); Arnold Tamerkind; Bronwyn Hendry; Mary Gleeson (Jasmine's mother), David Roennfeldt (Jasmine's father) and Sandi Yandell (friend of Jasmines).

11. There is no doubt that Jasmine's death highlighted serious and unacceptable flaws in the provision of mental health services in Alice Springs. Those flaws allowed for a situation where a vulnerable young women remained sharing a flat with a large set male suffering from paranoid schizophrenia, who had a well known history of non compliance with his medication regime, persecutory delusions and verbally threatening behaviour, at a time when he was not being effectively treated and became seriously unwell. That situation must never be allowed to happen again.

12. This inquest focused on the clinical and non clinical service providers that were working with Jasmine and Rocky in the period before Jasmine's death, in order to identify room for improvement in the way they care for their clients. As was made clear during the hearing, a number of very committed

professionals were involved and the aim of these proceedings is not to lay blame for Jasmine's death with any one individual, but to recognise what and why mistakes were made, what system flaws allowed for them and how they can be avoided in the future.

13. In relation to clinical services, there were serious inadequacies in the treatment of Rocky Manu, as the Department of Health properly conceded. The inquest revealed that around the time of Jasmine's death, there was a disturbing lack of effective leadership and management of the Central Australian Mental Health Service (CAMHS), which contributed to a failure of relevant staff to fulfil their responsibilities towards Rocky. Numerous witnesses spoke of a breakdown in communication between staff in the inpatient and out patient teams with respect to the most basic issues, including what Rocky's management plan was, who was responsible for monitoring it and what would be done if he stopped complying with it. The Court also learned of deficiencies in the arrangements made by the Mental Health Association of Central Australia (MHACA) for joint tenancy of the unit that Jasmine and Rocky shared.

14. In the period since Jasmine died, significant resources have been devoted to addressing shortcomings in the provision of clinical and non-clinical services, the most significant of which are outlined in these findings. The one positive to take from this tragedy is that changes have been made that will make it less likely that such a devastating event will happen again.

15. Jasmine's good health at the time she died is a testament to the importance of mental health services in the Northern Territory, both clinical and non-clinical. With respect to her clinical needs, for over a decade Jasmine had received care and treatment from CAMHS that enabled her to live a healthy life. In terms of non-clinical services, it appears to me that the friendship and support offered by the staff of MHACA made an enormous difference to Jasmine's quality of life, and in fact was a major reason why she was happy

and confident in the period before she died. I learnt in this inquest that Jasmine loved MHACA and its staff and they loved her.

16. All mental health providers assume a heavy duty of care when they offer support to persons with a mental illness, who are among the most vulnerable in the community. Every effort must be made to ensure those workers have effective systems and competent management, so that they can properly discharge that duty of care.

17. It is clear from the evidence before me that Jasmine Roennfeldt was an extraordinarily talented women, who tackled her own mental health issues and then campaigned to empower others. Through her work at MHACA and through her friendships, she helped others to find health and happiness.

18. Just as Jasmine was a great gift to the community, she was an enormous loss when she passed away, and many of her family, friends and colleagues are still struggling with their grief. The challenge is to ensure that the reforms introduced in the wake of Jasmine's death are sustained. That is the least that we as a society can do in order to honour her life and work.

Mental Health Services in Alice Springs

19. This inquest necessarily focused on inpatient and community mental health services provided in Alice Springs and it is important to commence with a brief overview of those services, before explaining how they were accessed by Rocky and Jasmine, and how they are relevant to the tragic way in which Jasmine lost her life.

Central Australian Mental Health Services (CAMHS)

20. In the Northern Territory, specialist integrated mental health services are delivered by the Top End and Central Australian Mental Health Service. In Darwin and Alice Springs, both inpatient (or hospital) services and outpatient (or community based) services are provided. Rural and remote community mental health services are located in other parts of the NT.

21. Alice Springs Hospital has one dedicated mental health ward known as Ward 1. Patients can be admitted on a voluntary or involuntary basis for mental health assessment and treatment, and the Unit is staffed by doctors and nurses trained in psychiatric care.

22. The CAMHS outpatient service assists patients living in the community, who may attend the clinic for appointments and/or receive visits from the community team. This outpatient team includes doctors (who are otherwise based at the Hospital), mental health nurses and Aboriginal Health workers. Depending on the needs of an individual client they may be allocated a specific case worker who is then responsible for monitoring their treatment regime.

23. Mental health services in the NT, and indeed around Australia, aim to provide treatment in accordance with the principle of administering appropriate care in the least restrictive and least intrusive way[1]. In order for patients to be detained in hospital involuntarily, they must satisfy stringent criteria set out in the *Mental Health and Related Services Act* NT[2] ("the Mental Health Act"). Where involuntary treatment in the community is necessary, doctors can place patients on an interim Community Management

[1] *Mental Health and Related Services Act* NT, s 9.
[2] Part 3, *Mental Health and Related Services Act* NT.

Order (CMO) and apply to the Mental Health Review Tribunal for a longer term CMO, which is reviewed at regular intervals[3].

24. Although the criteria for involuntary treatment are necessarily strict, that cannot be used to justify a failure to intervene. The Mental Health Act specifically provides that a person "is to be provided with timely and high quality treatment and care in accordance with professionally accepted standards"[4].

The Mental Health Association of Central Australia (MHACA)

25. The Mental Health Association of Central Australia is a non profit community based organisation that offers a range of services to participants and the broader community. Those are listed on its website as[5]:

- Individual psychosocial support that is recovery-oriented
- Short-term care around relapse to minimise hospitalisation
- Suicide Prevention and research
- Training in mental health first aid & suicide intervention
- Independent housing support that is affordable and secure
- Mental health promotion to raise community awareness
- Opportunities for participant collaboration & participation
- Advocacy and participation at local, state and national levels.

26. MHACA has a system of allocating support workers to assist individual participants, where it is appropriate to do so. They provide a range of what have been termed "psycho social supports", including practical help like

[3] Part 7, *Mental Health and Related Services Act* NT.
[4] Section 9(a), *Mental Health and Related Services Act* NT.
[5] http://www.mhaca.org.au

drafting CV's and transport to medical appointments, as well as arranging for counselling and teaching personal goal setting and basic living skills (including cooking, budgeting, shopping and personal care)[6].

27. Unlike the clinical service provided by the Hospital and CAMHS, which patients might be ordered by law to attend upon in certain circumstances, participants at MHACA are always there voluntarily. They take part only if they elect to do so and they sign up for those services they think will be of benefit.

28. The organisation has a small number of staff, and for the period of time Jasmine participated it retained a consistent group of core, committed employees.

29. Under its Housing Support Program, MHACA provides long-term supported accommodation and owns seven units within the Alice Springs area - six one-bedroom units and one two-bedroom unit. Although the two-bedroom unit was initially purchased for a parent and child to share (and that is in fact what it is used for at the time of writing these findings), Jasmine was the first MHACA resident to lease it after it was purchased and she shared it with a number of different flatmates.

Jasmine's Background

30. Jasmine is the daughter of David Roennfeldt and Mary Gleeson and she is survived by both parents, her step parents and her siblings, all of whom she cared much about. When she was three years old, her family moved to Hermansburg Community, where they stayed for around seven years, and to which Jasmine would return as an adult.

[6] http://www.mhaca.org.au/pathways-to-recovery.html

31. Jasmine completed a degree in early child care education at Adelaide and the Deakin Universities, before finding employment in various positions in child care, administration and hospitality.

32. Although she was clearly a gifted young women, when she was in her early 20's Jasmine experienced mental health issues that jeopardised her health and career prospects. In 1999 she was admitted to the Psychiatric Unit at Mildura Base Hospital, Victoria, and was diagnosed with bi-polar disorder. After returning to Central Australia in 2000, she became a client of CAMHS and continued to receive some form of follow up care for most of the time until her death.

33. Between 2000 and 2005, Jasmine moved between Hermansburg and Warrnambal, and although she worked at various jobs, she struggled with mental health issues during that time. In 2006, with the encouragement and support of her family, she was admitted to the Mental Health Unit in Alice Springs Hospital and placed on a medication and treatment regime that was a great help in stabilising her. Jasmine's diagnosis changed from bipolar to schizoaffective disorder and on her release from hospital she had follow up appointments with staff at CAMHS and was able to adhere to her treatment plan. She was discharged in 2010 and came under the care of her GP for 20 months, but in September 2011, she resumed contact with CAMHS and requested a medication review. Jasmine was last assessed just one week before her death when she was noted to be free of active symptoms on her current medication regime. In the last years of her life Jasmine demonstrated great insight into her illness[7] and at the time of her death she had a happy and balanced life, which included managing medical needs, friendships and work commitments.

34. It is apparent that a very positive development in Jasmine's life came soon after her release from Hospital in 2006, when she became involved with

[7] RM Critical Incident Review- Report to the Director of Mental Health – 4.2.12

MHACA, first only as a participant, but then as both a participant and peer support worker employed by the organisation on a casual basis.

35. In 2008, Jasmine and her father became involved in a music program run by MHACA in Alice Springs and the group of 10 or so participants eventually produced a CD. During 2010 and 2011, Jasmine worked closely with Claudia Manu-Preston, MHACA's General Manager, to develop a peer support model that was appropriate to Central Australia. I was told that she was instrumental behind a change in terminology for those accessing MHACA from "consumer" to "participants". In fact, she was so admired within the organisation that she was on the MHACA management committee for two years[8] and was the first MHACA participant to be trained as a Mental Health First Aid Trainer.

36. Jasmine was highly competent as well as passionate and her success at MHACA led to her being put forward as a spokeswoman for other participants. She sat on the NT Consumer Advisory Group (NTCAG), attended a mental health conference in New Zealand as a participant representative and went to peer workforce development workshops in Sydney and Darwin on behalf of both MHACA and NTCAG. She became a consumer representative on the executive of CAMHS, and sat on interview panels for both CAMHS and MHACA.

37. At the time of her death, Jasmine was thought by MHACA staff to be so independent and well that she was not allocated an individual support worker. It is clear that she became friends with MHACA staff. She was close to Claudia Manu-Preston, particularly through their work on the peer support project, and she had an obvious friend and supporter in Sue Coombs. She had a car and would drive herself to appointments, and in fact often gave her friends a lift. I heard evidence that because Jasmine was vocal and

[8] I heard evidence about Jasmine's achievements, and a moving summary of them appears in the MHACA Newsletter found at http://www.mhaca.org.au/2012%20newsletter/web%20jan-April%20Newsletter.pdf

articulate, key staff members assumed that she would approach them if she was worried about anything or needed to discuss an issue of concern. That assumption was reasonable in the circumstances, but tragically, it was proved to be wrong.

38. From 2007, until the time that she passed away, Jasmine was sharing the two bedroom unit with another MHACA participant, first with a male from in 2007/2008, then with her female friend Sandi Yandell in 2008/2009, and finally with Rocky Manu, whom she had met through MHACA. The issue of MHACA accommodating Jasmine and Rocky together, and the subsequent monitoring of that arrangement is dealt with later in these findings.

Rocky's background

39. Rocky Manu is one of six children from a large and supportive family who emigrated from New Zealand and settled in the Northern Territory. Although this inquest necessarily focused on Rocky's mental illness, I have not forgotten that he is much loved, and the events of November 2011 were devastating to his family, who did not think he was capable of such violence and have had their own shock and grief to deal with.

40. In 1991, at the age of 23, Rocky was admitted to the Mental Health Unit known as the 'Cowdy Ward' in Darwin and diagnosed with schizophrenia (adjusted subsequently to a diagnosis of schizophrenia with paranoid and affective elements). Rocky's condition manifested itself in persecutory delusions, particularly around his family, and he experienced auditory hallucinations related to this paranoia:

> He would form beliefs that his family members were antagonistic towards him and avoid family members and others as a result. Sometimes he heard voices and responded to internal stimuli[9].

41. From the date of his first diagnosis, up until Jasmine's death, Rocky was admitted on multiple occasions to the Mental Health Unit (Ward 1) at the Alice Springs Hospital, usually after a deterioration in his mental health following a period of failing to adhere to his medication regime. Occasionally he would self present, suggesting that he had some (albeit limited) insight into his condition. Other times he would be bought in by police for an assessment and detained as an involuntary patient pursuant to the relevant mental health legislation, usually for short periods of time until he recovered sufficiently to be released.

42. From 1993 to 2011, Rocky's principal treating psychiatrist was Dr Prosper Abusah, and although other doctors assisted throughout the years, Dr Abusah maintained an ongoing relationship. It was Dr Abusah's view that he had developed a good rapport with Rocky, who would often refuse to see other practitioners.

43. In terms of his management in the community, there were occasions when Dr Abusah arranged for Rocky to be subject to a Community Management Order, to ensure that he would be monitored on his medication for a set period of time. That meant that Rocky was obliged to receive medication and would be allocated a Psychiatric case manager who would monitor the progress of his treatment and report any non-compliance to the medical officer. A CMO was not considered necessary when Rocky was well enough, or when he could convince Dr Abusah that he would comply voluntarily.

44. For some years Rocky had been treated with drugs that included antipsychotics and a mood stabiliser. His medication regime required that he

[9] Statement of Dr Prosper Abusah, 7 August 2013 [11]

take oral medications daily and attend on the CAMHS outpatient service for a fortnightly depot injection. A depot is an injection of a pharmacological agent which releases its active compound consistently over a long period of time, and in Rocky's case, lasted between two and four weeks.

45. It is clear that Rocky was often resistant to taking his medication and he could sometimes react angrily towards those who tried to encourage him. Samuel Albury, an Aboriginal Health worker who has been with CAMHS since 2004 and often assisted in giving Rocky his fortnightly injection, offered this insight[10]:

> We had difficulties in the past given (sic) him his injections and he would refuse it. Sometimes he would get aggressive and staff would get scared of him. I never saw him hit anyone though. He is a big boy and he is one of our scarier clients. When he is happy he is a good guy.

46. In oral evidence, Mr Albury confirmed that Rocky was intimidating because of his size, and the way he spoke, rather than any act of physical violence[11].

47. That is consistent with the evidence of Dr Abusah, who wrote that:

> Rocky would also behave in a verbally aggressive way toward both other clients and staff in hospital on occasions when he was unwell. He sometimes made verbal threats but would not be physically aggressive. I did not consider him to be a violent person in the sense of posing a significant risk of physical violence toward people. This was not his track record[12].

48. Before Jasmine's death clinical staff were aware of a number of very concerning incidents. Hospital records show that Rocky had threatened to

[10] Statutory Declaration, 17/11/2011 [7].
[11] Transcript, 14/8/2013, p 107
[12] Statement of Dr Prosper Abusah, 7 August 2013 [12]

kill members of his family during previous acute exacerbations of illness[13]. Dr Abusah drew the Court's attention to an incident in 2005 when Rocky was found in a public place carrying an axe that he had said was to protect himself. Furthermore, he was aware of a note in the clinical file relating to an incident in Ward 1 in May 2009, when Rocky patted down another client and then threatened a nurse who subsequently regarded him as a high risk of being violent to staff and other patients[14]. Nevertheless, Dr Abusah did not think that he would carry out the threats and until Jasmine's death, he held the view that Rocky posed a low risk of harm to others.

49. While there was ample evidence before me to suggest that Rocky could be verbally threatening and aggressive when unwell, there was no evidence of any actual physical violence towards family, friends or medical staff, at any time prior to Jasmine's death. Rocky had a criminal history that showed only minor offending and he had never been convicted of a crime of violence.

50. However, that is not to suggest that the acts of verbal aggression were insignificant. Although they did not necessarily show that Rocky would progress to physical violence, they were clear indicators that he would be hard to manage in the community and they certainly suggested that if he became unwell, those close to him (including a flat mate!) might be seriously frightened.

51. Rocky's family has been heavily involved in his care and treatment, as his health records demonstrate. His situation is somewhat unusual in that the siblings in this articulate and impressive family have a detailed knowledge of mental health issues, with several working in health services. As a family, they tried extremely hard to help Rocky, even in circumstances where he resented their intervention and rejected their support.

[13] RM Critical Incident Review – Report to the Director of Mental Health.
[14] Statement of Dr Prosper Abusah, 7 August 2013 [12] & [14].

52. On a number of occasions, and particularly in the two years before Jasmine died, Rocky's family disagreed with Dr Abusah as to the appropriateness of his treatment. Rocky had a particularly difficult year in 2009 and was admitted to Ward 1 from 25 April to 13 May and from 30 May to 29 July[15], following about 18 months without medication. Although there had been discussion of a CMO during the course of the later admission, at the time of discharge the plan changed and no application was made. Rocky's history of medication refusal and relapse was of great concern to his family and in the second half of 2009 Claudia Manu-Preston made a complaint to the Community Visitor Program expressing her dissatisfaction with Rocky's case management and lack thereof. She felt that the absence of effective follow up and early intervention resulted in him becoming unwell and needing longer stays in Hospital.

53. I heard evidence from Ms Manu-Preston that after an investigation into the complaint, she was satisfied that she had been listened to and that there would be better case management and more proactive treatment of her brother after that date[16]. In April 2011, when Rocky became seriously unwell once again, she again clashed with Dr Abusah and again lobbied for a CMO and more vigilant treatment for her brother, as is discussed below. It must be deeply distressing to Ms Manu-Preston that in spite of the reassurances she was given in 2009, there were monumental failures in the mental health care provided to her brother after that date, and a complete break down of case management in the period leading up to Jasmine's death.

Rocky's involvement in MHACA

[15] Statement of Dr Goulnara Sowman, 7 August 2013 [7].
[16] Transcript of the evidence of Claudia Manu-Preston, 15/8/2013, pp 243-244.

54. Rocky Manu had spent some time around MHACA at various stages after he was diagnosed with a mental illness, but it appears he engaged with the service as a participant around 2005, about 18 months after his sister, Claudia Manu-Preston, had taken on the role of General Manager[17]. Before Ms Manu-Preston applied for the job, she asked her brother if he had any difficulties with her doing so, but he told her he did not. As it will become evident, she was mindful of the potential for a conflict of interest between her role as Rocky's sister supporting him through his mental illness, and being the General Manager of a service that he accessed, and she tried to put in place systems to avoid or at least manage that conflict[18].

55. In 2008, Donald (aka Bruce) Macgregor was appointed as Rocky's Support worker. It is clear that he liked Rocky and they had a decent rapport, but Rocky engaged with MHACA sporadically and there were significant periods of time when there was little or no contact. Mr Macgregor was aware that Rocky regularly stopped complying with his medication regime. In a statement to the Court, he noted that:

> Rocky is very independent and would only consult with myself and other MHACA staff occasionally. Lack of medication would often lead to further illness. When challenged I have known Rocky to be aggressive verbally but I have never known him to get Physical[19].

56. In late 2009, Mr Macgregor supported Rocky's application to become a joint tenant in the flat with Jasmine. He read into evidence a letter that he had written on Rocky's behalf[20] in which noted that Rocky had been involved with MHACA for many years and had periods of relapse that meant he had need for MHACA support and services to assist in his longer term recovery. It reads as follows:

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[17] Transcript of the evidence of Claudia Manu-Preston, 15/8/2013, p 242.
[18] Transcript of the evidence of Claudia Manu-Preston, 16/8/2013, pp 262-263.
[19] Statement of Bruce Macgregor, 16 November 2011.
[20] Letter dated 22 October 200 is Exhibit 6, referred to in Transcript of the evidence of Bruce MacGregor, 14/8/2013, p 122.

> Rocky Manu is a very likeable, charming and respectful person. I feel that the opportunity for him to be able to be accommodated in share accommodation will give him a further opportunity to improve his life. This will give Rocky personal security of accommodation, to be compliant with his medication, and will assist him towards a better well-being.

57. There is little doubt that staff at MHACA genuinely held the view that it was in Rocky's best interest for him to be accommodated with Jasmine. The question is whether sufficient thought was given to the risk it might pose for Jasmine, especially if Rocky became non compliant with his medication. It was clear from Mr Macgregor's evidence that the fact Rocky moved in with Jasmine did not change the way in which Mr Macgregor interacted with Rocky as his case worker, or the frequency of their contact. Those issues are canvassed further below.

Mental health deteriorates in 2011

58. By 18 April 2011, after yet another period of non-compliance with his medication, Rocky's mental health had seriously deteriorated and he was again detained as an involuntary patient in Ward 1 of the Alice Springs Hospital. He was assessed on that occasion by Dr Goulnara Sowman, a Psychiatric Registrar working under the supervision of Dr Abusah, who had known Rocky for several years and had developed a good rapport.

59. Dr Abusah outlined Rocky's condition at the time of his admission in April:

> He had become isolative and his family was concerned about him. His judgement was impaired and he was quite guarded, His mood was dysphoric – he was belligerent, irritable and suspicious. His paranoid ideation had returned. It appeared that he may be reacting to internal

stimuli. However, when police bought him to Hospital he did not behave violently21.

60. Rocky was reviewed by Dr Abusah soon after his initial detention and by 20 April 2011, he had agreed to remain in Hospital voluntarily. It seems that he was prepared to work with both Dr Abusah and Dr Sowman, but he had strong views on how he wanted to be managed in the community and he made it clear that he did not want to be subject to a CMO or case managed by CAMHS.

61. On 27 April 2011, Dr Abusah met with Rocky and Claudia Manu-Preston to discuss the management of Rocky's mental illness in the community. The heated debate Ms Manu-Preston had with both Rocky and Dr Abusah on that date is indicative of the concern she had for her brother and her willingness to advocate for restrictive treatment where she felt it was necessary for his safety and well being. The following exchange took place with my Counsel Assisting:

> Claudia Manu: So I went along and attended the meeting and made it very clear that I thought he was becoming unwell and that I thought he should be case managed and that he should be on a community management order and we had a pretty big fight in front of the clinical team. And I - I said some things to him about him taking responsibility also for his recovery and keeping up his medication and it was - it was quite humiliating actually to be in that meeting and not to have been taken - I felt - as - for my concerns not to be taken seriously.
>
> Counsel Assisting: Who was in that meeting?---
>
> Claudia Manu: There was Dr Abusah, a Registrar - not Dr Sowman, and two nurses.

[21] Statement of Dr Prosper Abusah, 7 August 2013 [21].

Counsel Assisting:	Do you agree that it was for Dr Abusah to decide whether or not Rocky should be on a community management order?---
Claudia Manu:	Yes
Counsel Assisting:	And is it fair to say that you were urging him during that meeting to put Rocky on a community management order?
Claudia Manu:	---That's right.

62. Thirteen days later, on 3 May 2011, Dr Abusah discharged Rocky back into the community, not subject to a CMO, but with a plan that he be followed up by both Dr Abusah and Dr Sowman at the Alice Springs Hospital and by a case worker at CAMHS.

63. Dr Abusah gave evidence of his impression of Rocky on the date of his release of 3 May 2011[22]:

> Rocky was very well. He was compliant, he agreed to all the things we asked him to do, to have a depot injection, to have a case manager who he would come to every two weeks to have the depot injection and I had no problem with him at all to come and see me at the Outpatient clinic to see Dr Sowman at the Outpatient clinic. He agreed to everything and he agreed that – the last time I saw him was 12 July. He was doing that for all that period.

64. It was clearly Dr Abusah's intention for Rocky to be case managed in the community, even if not subject to a CMO. On 28 April 2011 a document headed 'Community Mental Health Team Referral for Case Management', signed by RN Gina Owens, was sent to the community team at CAMHS[23].

[22] Transcript, 13/8/2013, p 54.
[23] Exhibit 3.

Unfortunately, as the inquest revealed, that request was at best misinterpreted, and at worst ignored.

Should Rocky have been put on a CMO?

65. Although in hindsight it is extremely regrettable that Rocky was not placed on a CMO, that decision was ultimately a matter for Dr Abusah, exercising his clinical judgement, and balancing the principles set out in the Mental Health Act. On the one hand, there were many factors pointing in favour of a CMO, including the concerns articulated by Rocky's family that he had a lengthy history of non compliance. However, Dr Abusah provided a number of reasons for not putting Rocky on a CMO on this occasion. First, Rocky did not want to be on a CMO and Dr Abusah wanted to gain his cooperation with the treatment plan post release so that he wouldn't leave the jurisdiction or stop complying with his daily oral medication. Second, Rocky was presenting well on 3 May 2011 and Dr Abusah doubted whether he satisfied the legal criteria for a CMO. Third, Dr Abusah had a management plan for Rocky that included regular medical appointments, a case worker and fortnightly depot injections, and at the time of discharge, Rocky was willing to cooperate with it.

66. After reviewing the evidence I am not overly critical of Dr Abusah for failing to put Rocky on a CMO, but that decision could only be justified as long as a comprehensive, well structured management plan was in place, and ongoing (it was not), and as long as Rocky continued to cooperate (he did not). The real shortcomings in the care provided by Dr Abusah relate to the failure to prepare an adequate management plan and the failure to effectively communicate that plan to all those involved. That was compounded by the complete absence of any effective system to ensure ongoing supervision of the plan devised. This systems error allowed Rocky

Manu to fall through the gaps, seriously jeopardising his health and well being, and ultimately Jasmine's.

The Case Management Plan post release

67. A Psychiatric Discharge Summary tendered in these proceedings was the document used by clinical staff to record the "Management Plan" for Rocky following his release on 3 May [24]. It reads as follows:

> Rocky has an appointment with Dr Goulnara Sowman on 10 May 2011 and with Dr P Abusah on 21 June 2011. His next depot is due on 17 May 2011. As Rocky was not keen on going to GP for his physical cholesterol abnormality he will need to have regular blood tests for possible metabolic syndrome at our OPD, opportunistically.

68. Although the Discharge Summary does not outline a plan beyond 21 June, Dr Abusah gave evidence that he intended for Rocky's treatment to be ongoing, and he would have reviewed the treatment plan after June, had his appointments with Rocky continued.

69. When Claudia Manu-Preston learnt that her brother had been released without a CMO, she emailed Dr Abusah to express her grave fears that Rocky may not be properly monitored in the community. In what now seems to be tragically prescient, Ms Manu-Preston referred to the their earlier tense meeting at the Hospital, and wrote:

> As noted at the meeting my biggest concern is related to him getting into trouble with the police as with the last episode resulted in Rocky being charged for something … when he was unwell. Also, if he is unwell how that would impact onto his living arrangements. ... as he

[24] Exhibit 5. See the evidence of Dr Abusah, Transcript, 13/8/13, at p 54

> has left one flat before because he thought the place was evil and paranoia. It is therefore very important that he remains well and insightful into his illness and behaviour.

70. It is impossible to read that email without being struck by the emotional intelligence of Ms Manu-Preston, and by the love and care she had for her brother. She went on to draw attention to the difficulty she had because of her position as General Manager of MHACA and the need for her to try to remain distant from Rocky's care to avoid a potential "conflict of interest". Nevertheless, as she wrote to Dr Abusah:

> I am first and foremost his sister and will act as an advocate for him because of my love for him and my 'duty of care' if I believe that the system of support is not being provided in the way it should be.

71. Ms Manu-Preston advised Dr Abusah that she was going overseas shortly and was seeking information as to how Rocky's medication regime would be maintained in circumstances where he was refusing case management and did not want a MHACA support worker.

72. Dr Abusah responded promptly to the email and sought to reassure Ms Manu-Preston that there was a case plan in place that was "sufficient to keep Rocky well". That case plan involved three separate practitioners and had three separate levels, which according to the email were as follows:

> 1. A case manager who would "see to Rocky's fortnightly depot injection". Dr Abusah noted that "Mark A has been nominated to be Rocky's case manager for this".
>
> 2. Fortnightly appointments with Dr Goulnara Sowman, Psychiatric Registrar, which Rocky had agreed to, and
>
> 3. Monthly appointments with Dr Abusah.

73. A number of interested persons were copied in to that email setting out the case plan, including David Hockley, a Team Leader at the CAMHS outpatient service, Rangi Ponga, (MHACA Services Manager) and Bruce Macgregor, who regarded himself as Rocky's support worker at MHACA, even if Rocky disengaged with the service around that time.

74. I reject the assertion made for the first time in closing submissions by Senior Counsel for the Department of Health, Dr Freckleton, that the case management plan was only intended to operate for a limited period until Rocky agreed to attend his Outpatient appointments independently. That submission implies that somehow Dr Abusah and/or other members of the CAMHS team were absolved from any responsibility to monitor Rocky after a date at which he agreed to comply. This doesn't fit with the evidence that Rocky agreed to attend outpatient appointments on 3 May 2011, the date he was discharged. It also flies in the face of the frank admission made by Dr Abusah that the Management Plan was intended to be ongoing, as he had indicated in the email to Claudia Manu-Preston.

Failure of Communication at CAMHS

75. Although that three-tiered management plan looked good on paper, there was a failure to properly advise all of the nominated practitioners as to what was required of them, and a critical breakdown of communicate between the staff of the in-patient and out-patient services. Dr Goulnara Sowman gave evidence that she was not aware of any regular fortnightly commitment she was supposed to have to see Rocky. She was on leave for significant periods in 2011 and since she was not even informed of what her own commitment was, she could hardly arrange for someone to fill in while she was away. Mark A was Mark Ashford, who left CAMHS soon after the email exchange

and was replaced by James Callaghan, who was never instructed that he was Rocky's case manager. In spite of the 'Community Mental Health Team Referral for Case Management', faxed on 28 April 2011, and the email copied to David Hockley, Mr Hockley did not appear to understand that it was his job to appoint a case worker, and he failed to do so.

76. Furthermore, although Dr Abusah had committed to seeing Rocky once a month on an ongoing basis, he saw him for the last time on 12 July 2011 only two months after Rocky's discharge from Hospital. In oral evidence, Dr Abusah told the court that he intended to have a follow up appointment with Rocky in a month or six weeks time, and when he had finished seeing Rocky on 12 July, he "would have" told him to go to the reception desk to make a future appointment. The following exchange took place with my Counsel Assisting[25]:

Counsel Ass:	Okay. So you told Rocky that he should come again in a month's time?
Dr Abusah?:	---Yes.
Counsel Ass:	And was it for Rocky to make an appointment with you at that stage?
Dr Abusah?	---Yeah. He go to the reception desk to make an appointment, yes. …..
Counsel Ass:	Did you make a note in your own diary or any notes to remind you sometime in August that Rocky was due for an appointment?
Dr Abusah:	---No, I didn't make that because I make all the notes in the file and then in the CCIS.
Counsel Ass:	Was there any system that you were aware of at that stage that would alert you or any staff member to the fact that a patient hadn't come in for their scheduled appointment?---

[25] Transcript, 13/8/2013, p 64.

Dr Abusah: Unfortunately at that time there was no system like that.

77. Dr Abusah's evidence reveals the complete absence of any system at CAMHS to ensure appropriate follow up. That is extraordinary and utterly unacceptable in circumstances where clients had complex needs and were often non-complaint or resistant to treatment. Dr Abusah thought that Rocky had been appointed a case manager at CAMHS, in accordance with the fax request of 28 April, and as a result he expected to be notified by CAMHS outpatient staff if Rocky refused his medication. Yet, as I have foreshadowed, and discuss further below, the Team Leader at CAMHS and the mental health nurse nominated to provide the care did not understand that even if there was no CMO in place they still had to report a patient's non-compliance.

The Management Plan breaks down

78. For a short time after Rocky's release he continued to see staff at CAMHS and to take his medication, although there were early indications that he remained unwell and would require careful follow up. An entry on the CCIS notes by Dr Sowman for 10 May 2011 noted that Rocky was "still very guarded and suspicious" and that she was concerned that he "may have to go on a community order" and she would discuss the issue with Dr Abusah[26]. There is no subsequent record of any such discussion or its outcome. On 12 May 2011, Dr Sowman made a notation that reads "openly refusing case manager with either CAMHS or MHACA".

79. When Rocky was reviewed by Dr Abusah on 21 June 2011, he told him that he didn't like his injections and he threatened to stop coming in for them. Dr

[26] RM Critical Incident Review –Report to the Director of Mental Health, p 7.

Abusah appears to have talked Rocky through that issue and he recorded on CCIS notes that Rocky was stable, although lacking insight into his condition.

80. Dr Abusah had his last appointment with Rocky on 12 July 2011, when he noted that Rocky was resistant to receiving his medication by injection. There is no reference in the clinical notes to the possible need for a CMO and no directions as to what case management would be required in the event that Rocky refused to attend or comply in the future[27].

81. Although he was occasionally late for his appointment, Rocky received his medication in May, June and July 2011. Clinical notes suggest that the last time he received his depot injection was 26 July 2011. An entry by RN James Callaghan on 12 August noted that Rocky was four days late for his injection (due on 8 August), and that the plan was to "await presentation". On 22 September 2011, when Rocky was nearly two months overdue, there was a note from David Hockley, Team Leader, that Rocky was "to be reviewed at next OPD appointment", but there were no further entries until after Jasmine's body was discovered on 15 November 2011.

82. The lack of follow up after July 2011 stems from a failure of CAMHS staff to understand what was required of them. That was certainly not the fault of RN James Callaghan, who impressed me as a dedicated and caring nurse who did all that could be expected of him in the circumstances by alerting his team leader when Rocky became non compliant. I accept the evidence of RN Callaghan, consistent with the CCIS notes, that he told his Team Leader David Hockley that Rocky had stopped attending for his medications, and that Mr Hockley told RN Callaghan that Rocky was Dr Sowman's client and that she and the family were dealing with it[28]. Although Mr Hockley suggested in oral evidence that he "would have" suggested to RN Callaghan

[27] RM Critical Incident Review –Report to the Director of Mental Health, p 7.
[28] Statement and oral evidenceof RN James Callaghan.

that he follow it up with Dr Sowman, he could not recall having given those instructions and I do not accept that he did. As I noted earlier, RN Callaghan's recollection is consistent with the CCIS notes and with Mr Hockley's decision that James Callaghan was only giving Rocky the injection because he was the "depot nurse" for that period, not because he had been appointed Rocky's case worker.

83. In an exchange with Counsel Assisting, David Hockley himself suggested that communication problems were behind the failure of CAMHS to follow Rocky up[29]:

> Counsel Ass: So you allocated James Callahan to be the person who would give Rocky the depot medication when Rocky came in voluntarily, is that the case?—
>
> Hockley: -Yes, because Jamie was looking after the depot clinic.
>
> Counsel Ass: Okay, but Jamie didn't have any particular responsibilities in terms of reporting back to Dr Abusah when he didn't take his medication, is that right?---
>
> Hockley: Well if he wasn't taking his medication I would have thought that that would be reported to Dr Sowman or Dr Abusah if they were seeing him fortnightly or monthly.
>
> Counsel Ass: But reported by whom, who did you think would report it?---
>
> Hockley: Well it would have to be the person that was allocated him or the case manager if you want to use that term, yes.
>
> Counsel Ass: But isn't this where Rocky fell through the gap, Mr Hockley, because no case manager was formerly appointed to Rocky so there was nobody who clearly understood that it was their role to

[29] Transcriot, 15/8/2013, p 204.

report back to Dr Abusah or Dr Sowman when Rocky didn't turn up for his medication?

Hockley: ---Well I guess yes you can say that. I guess it's about communication.

84. In fact, there was no adequate coordination or communication between CAMHS staff from the time Rocky was released on 3 May 2011 to the date of Jasmine's death. Frankly, that beggars belief and reveals a very grave systems failure. It cannot be allowed to happen again.

Was there a problem with the MHACA co-tenancy arrangement?

85. The Inquest inquired into two issues with respect to the shared tenancy arrangement created by MHACA. First, was it ever appropriate for Jasmine and Rocky to share a Unit in circumstances where they both had vulnerabilities and Rocky had a history of being non-complaint with his medication? Second, once the tenancy was in place, were there appropriate systems and safeguards to ensure that both tenants, and particularly Jasmine, remained safe and well?

86. The system for allocating a tenancy in 2009 was that when a space became available, a participant would submit a formal application and MHACA would convene a panel composed of representatives from NT Housing and CAMHS, working alongside the MHACA Service Manager and Landlady[30].

87. It appears that with respect to Rocky's application to share with Jasmine in 2009, no formal panel was convened, but a series of emails were exchanged and the relevant professionals asked to contribute agreed that Rocky should be permitted to move in. As the tenant who was currently residing there,

[30] Evidence of Sue Coombs, Transcript, 15/8/2013, p 173.

Jasmine had the right to decide whether he could move in and according to the landlady Ms Coombs, she did not raise any objection.

88. Although the application forms were completed by Rocky, and Jasmine was offered an opportunity to refuse him as a flatmate, it is not at all clear to me that an appropriate risk assessment was done before Rocky and Jasmine were permitted to share the unit. The tenancy arrangement was finalised in November 2009 and as noted above, Rocky had been admitted to Alice Springs Hospital twice that year and had exhibited behaviour that was of serious concern to his family, including his sister Claudia, the General Manager of MHACA. I do not suggest that a male and female should never be able to share the flat. I do not even go so far as to say that Rocky and Jasmine should never have been able to share, but given that Jasmine was clearly vulnerable, and Rocky was a large man who had a history of non compliance with his medication, there should have been a much more rigorous risk assessment, performed by an appropriately trained professional.

89. If such an assessment had been carried out and a conclusion reached that the risks of any share arrangement could be managed, it should have been subject to the following basic conditions:

- First, Rocky should have been made aware that a condition of him being granted co-tenancy was that he take his medication and comply with his treatment regime. Ideally, he should have signed an agreement to that effect, but at the very least he should have been advised that this was a condition.
- Second, Jasmine should have been interviewed by a trained support worker and advised of any risk, and asked specifically whether she had any concerns, and the conversation file noted.

- Third, Jasmine should have been advised that she was to speak with a specific staff member if she had any concerns that Rocky was not well, or if she became uncomfortable in the unit.
- Fourth, a plan should have been developed to deal with a situation in which one housemate reported a difficulty with another.
- Fifth, there should have been appropriate communication between Rocky's support worker at MHACA and his case Manager at CAMHS to ensure he was complying with his treatment regime.
- Finally, MHACA should have had a system that allowed for regular review of the joint tenancy, by trained support workers, to ensure that both tenants were happy.

90. No one at MHACA could have predicted the tragic events of November 2011, just as none of the clinical staff did, but there should certainly have been an appreciation of the risk that Rocky's health might decline. It should have been obvious that Rocky might become non compliant with his medication, which, at very least, had the potential to become uncomfortable for Jasmine and capable of jeopardising her wellbeing. More should have been done to safeguard her from that possibility.

91. Although I am critiquing the systems in place at MHACA in relation to the accommodation program, I am not questioning the care or competency of the individuals who were working for that organisation in the year that Jasmine died. On the contrary, I was impressed with the services offered by MHACA, and I have no doubt that the staff loved Jasmine, particularly Claudia Manu-Preston and Sue Coombs, who worked so closely with her.

MHACA loses track of Rocky

92. Although Bruce Macgregor had been Rocky's support worker for some years before Jasmine's death, it is evident that staff at MHACA, including Mr Macgregor, communicated very infrequently with Rocky after his release from hospital in May 2011. A review of the MHACA electronic notes for the second half of 2011 reveals a small number of entries relating to Rocky.

93. One of the most significant was made on 14 June 2011 and records that Rocky had told Mr Macgregor of his paranoid belief that his flatmate was trying to poison him. It reads:

> He still has thoughts around paranoia of someone wanting to do him harm, especially this time his flat mate. He feels that she's not well, and maybe they aren't taking their medication'. They tried to get to him through drinking Coca Cola that his flat mate gave him, doesn't want to return to the unit at present but happy to keep paying the rent. I will be talking to the flat mates support worker at MHACA ASAP about all of this.

94. Unfortunately, it appears that Mr Macgregor did not "talk to the flat mates support worker at MHACA" as no doubt he had planned to do when he typed the note. He assumed that Jasmine's support worker was Rangi Ponga, and he initially gave evidence that he had "probably" discussed the issue with her. However, he had no memory of any such conversation and made no note of it, and I do not think it occurred[31].

95. To his credit, Mr Macgregor did communicate with CAMHS at that stage and sent an email to Jamie Callaghan to express his concern that Rocky was paranoid and needed to see Dr Abusah. Nurse Callaghan replied promptly

[31] Transcript, , p 160.

the next day to advise that at that stage, Rocky was still attending for his depot medication and had a plan to see Dr Abusah within a week.

96. Mr Macgregor provided important evidence that helps understand his reticence to scrutinise Rocky more closely. In order to maintain Rocky's trust, and to keep him cooperating, Mr Macgregor felt that he had to allow Rocky to interact with the service on his own terms and he accepted conditions set by Rocky that he not interfere too much. He agreed with Dr Freckleton when it was put that he would not intrude on Rocky unless he thought he was getting unwell or was a risk to himself or others[32]. The difficult with that position is that when Rocky stopped interacting with MHACA, Mr Macgregor had no way to monitor his illness and he did not find out when Rocky became seriously unwell and a risk to himself and others.

97. Although MHACA participants attend voluntarily, there is a duty to provide whatever services are offered responsibly, and subject to appropriate safeguards that recognise the vulnerabilities of many persons living with a mental illness. That is particular so in relation to the provision of accommodation. It appears that Rocky interacted with Mr Macgregor and MHACA sporadically, and on his own terms, even after he became a co-tenant in the house he shared with Jasmine.

98. On 23 June 2011, Rocky attended at MHACA to sign the lease agreement that Sue Coombs had prepared for he and Jasmine[33]. After that date, no one took responsibility for ensuring that Jasmine and Rocky were happy and safe living together, and there were no policies or procedures in place to allocate that responsibility to any one individual.

99. Although the Tenancy Agreement provided for flat inspections of each of the MHACA properties at six month intervals, Ms Coombs gave frank

[32] Transcript, pp 161-162.
[33] Exhibit 7.

evidence that she got so busy that she fell behind in this task and there may have been no inspections at all in 2011. In my view, the absence of inspections is not of great significance since they were only for the purpose of making sure that the flat and furniture were being looked after and Ms Coombs, a dedicated 'jack of all trades' (responsible for "finance, HR, IT corporate services, admin and whatever else needed to be done"[34]), was not given the task of assessing the flat mate's wellbeing.

100. I am satisfied that prior to Jasmine's death MHACA staff were not aware that she had any difficulties with her living arrangements, although I have no doubt that she was fearful of Rocky at times and that it had become very difficult for her in the house. It is clear from Jasmine's email exchange with her father in the week before she died that she had been planning to move out and was on the cusp of telling someone at MHACA about the difficulties with Rocky's behaviour.

101. I also accept the evidence of MHACA staff that they believed that Jasmine would have spoken up for herself if she had any concerns. I have already mentioned how clever and articulate Jasmine was and how she had become part of the MHACA team. Unfortunately, it is likely that her generous nature meant that she put Rocky's interests before her own and that may be one explanation for why she did not confide in MHACA staff, who she knew cared about her.

102. Jasmine was clearly a very loyal person and she no doubt cared for Rocky. She probably did not want to get him in trouble with MHACA. It may also be that she didn't want to upset Claudia Manu–Preston, by saying anything negative about Rocky, although I have no doubt that Claudia would have ensured that decisive action was taken to remove Rocky from the flat if she had any notion that Jasmine was unsafe.

[34] Transcript, 15/8/2013, at p 172

103. In the absence of an appropriate system for ongoing risk assessment, the co-tenancy became untenable, and staff at MHACA had no idea of how vulnerable that left Jasmine.

The period immediately before Jasmine's death

104. Although it is now clear that Rocky had not been taking his medication for a period of three and half months before the tragic events of 14 November 2011, the gravity of his decline was not always obvious, even to those closest to him. Such is the complexity of the illness he suffered from that even his close family members were confused as to how unwell he was at that stage.

105. Rocky's sister Jackie Manu had been concerned about Rocky's behaviour in June 2011 and she spoke to staff at CAMHS on the 7th and 11th of that month, after which Rocky did turn up for his medication. In September 2011, Rocky confided in Jackie that he was off his medication, but it was not unusual for Rocky to stop complying for short periods and Jackie was not alarmed at that stage. By October, when Jackie met up with Rocky at Claudia's house to celebrate her daughter's birthday, she assumed that he was back on his medication because "he was so well and he was joking like he normally does and we were all just celebrating the birthday and having fun"[35].

106. Even in the last week of Jasmine's life Rocky's presentation was confusing. On Monday 14 November Jackie picked Rocky up in her car in the afternoon, as he had asked her to, and she noticed some strange behaviour. First, he didn't recognise her car, even though he had travelled in it many times. Second, when Jackie offered him a drink of cordial he didn't want to take it (a sign she recognised as paranoia because Rocky had previously

[35] Transcript, 13/8/2013, p 27.

declined food or drink when he thought his family were trying to poison him) and he didn't look well. That prompted Jackie to ask Rocky if he was hearing voices, which he denied. When she suggested they should call the Crisis Assessment Team (CAT team), Rocky abruptly terminated the visit. He got up and told her that she could take him home and when she dropped him off, he told her that he wouldn't be talking to her again for a while.

107. Early on the morning of Tuesday 15 November 2011, Jackie phoned her sister Claudia Manu-Preston (whom I will refer to as Claudia for the remainder of the findings to avoid confusion between the sisters) and told her she was concerned about Rocky after the events of Monday afternoon. However, from Claudia's perspective, given that Rocky often behaved unusually and had the capacity to "self correct in some circumstances", this was not a trigger for serious concern. Further, Claudia had herself received a call from Rocky that afternoon to discuss a family member who was in hospital and he had sounded quite well. He even asked her if he could come over for tea, and she said they should definitely catch up. When Jackie suggested on Tuesday that the CAT team should be phoned Claudia was not particularly happy about it, but she told Jackie to make the call if she wanted to, and when she got off the phone, she understood that Jackie would phone David Hockley and request that the CAT team be sent[36].

108. When she got into work that morning, Claudia explained Jackie's concerns to Bruce Macgregor and asked if he had seen Rocky. According to evidence given by Claudia (which I accept), Mr Macgregor told her that he didn't think Rocky was "tracking too bad"[37].

The Decision to call off the CAT Team

[36] Transcript, 15/8/13, p 251.
[37] Trancript, 15/8/13, p 252.

109. Following that conversation, Claudia called David Hockley, Team leader at CAMHS, and asked his advice as to whether the CAT team was necessary. She expressed her concern that sending in the CAT team might be excessive, given what she knew of Rocky's presentation, and she suggested that it might be better to allow the family to engage with him instead.

110. When Jackie Manu called David Hockley on Tuesday morning, he arranged for a CAT team to be assembled that included Dr Goulnara Sowman and a mental health nurse. Bizarrely, in response to Claudia's call, Mr Hockley called the team off, even though they were in the car and ready to drive out. Although Mr Hockley may have acted in response to Claudia's call, it was he who made the decision and must take responsibility for it. Claudia is not a clinician and she was calling David Hockley for his professional advice. It was CAMHS that had access to Rocky's medical history and staff had the electronic CCIS service at their fingertips to check whether Rocky had been on his medication. Mr Hockley did not tell Claudia that her brother had not been taking his mediation for three and a half months (even though he had been told weeks earlier by RN Callaghan that Rocky had become non-compliant) and I have no doubt that Claudia would have immediately asked for an urgent CAT visit had she been told that crucial piece of information.

111. Even more bizarrely, Mr Hockley took it upon himself to call off the CAT team without consulting with Dr Abusah, Rocky's long term treating clinician. Dr Abusah gave evidence that he was extremely disappointed that he had not been consulted. If he had been, he would have realised that Rocky had been off his medication for months and would have called on the CAT team to assess him. It is strange that Mr Hockley did not even consult with Dr Sowman, a psychiatric registrar who knew Rocky well and was in the car ready to drive out. Neither did Dr Sowman feel confident to voice her opinion that the Team should attend on Rocky at that time. This incident provides clear evidence of yet another communication breakdown and systems failure at CAMHS.

Contact between MHACA and Jasmine's family

112. At around 2.30pm on Tuesday afternoon, Jasmine's mother, Mary Gleeson, was so concerned about her daughter that she phoned MHACA from the United States where she was on holidays, and spoke with Claudia for the first time. She told her that she was worried about Jasmine and she read to her from an email Jasmine had sent revealing that Rocky was behaving strangely. Ms Gleeson also told Claudia that when they skyped Jasmine at the flat, Rocky was so paranoid that Jasmine couldn't say his name out loud. It is clear from the contact Jasmine had with her family and friends that she had been concerned by Rocky's behaviour for some time, but Jasmine wanted those concerns to remain confidential and that made it hard for those who received the information to report it. It is entirely understandable that Jasmine's mother did not feel she could breach her daughter's confidences at any time before Tuesday 15th, but by that time Ms Gleeson was seriously worried.

113. Claudia gave evidence that although she accepted Ms Gleeson's concerns as genuine, she did not share the view that Jasmine was in any danger. I have no doubt that Ms Gleeson was upset and concerned when she called and she would have wanted to convey that. However, Claudia had not spoken to Ms Gleeson before that Tuesday and she may not have recognised the urgency in her voice.

114. Claudia explained to Ms Gleeson that the phone call placed her in some difficulty because Rocky was her brother and she had to manage the 'conflict of interest', but she assured Ms Gleeson that she would investigate the matter further, which she duly did. After finishing the call, Claudia went to see Sue Coombs in the office nearby and asked her if she had any concerns about Jasmine. Ms Coombs did not. She then went to see Bruce Macgregor and Jasmine's friend Sandi Yandell, to ask if either of them had

seen Jasmine that day, which they hadn't. It was agreed that Claudia would drive around after work and check up on Jasmine and Rocky.

115. At around 5.30pm, Claudia drove to the unit that Rocky and Jasmine shared and knocked loudly on the door for 10 minutes, but there was no answer. She arranged for her husband to do the same on his way home from work. She then called Jasmine's friend Sandi Yandell to check if she had seen her at the pool (Sandi and Jasmine regularly met at the pool in the afternoons) and she called Sue Coombs, who agreed to drive to the flat at around 9.00pm to check if any lights were on. When Ms Coombs called Claudia back shortly after visiting the flat, she reported that there was one light on upstairs, a fact that gave Claudia some comfort at the time, although in hindsight it appears that the light may have been on in the afternoon but not visible.

Wednesday, 16 November

116. The events of this terribly sad day are etched on the minds of all those involved. When Jasmine had not come to work by mid morning, Claudia hatched a plan with Ms Coombs and Mr Macgregor for the two of them to attend the flat with keys and an inspection letter, which would give them an excuse to enter. Tragically, when they arrived around midday Jasmine was already deceased and the police hunt for Rocky Manu began.

117. When Rocky was detained later that evening (after an efficient and effective police operation) he made no effort to escape or to hide what he had done. In a psychiatric assessment conducted soon after his death, it was noted that Rocky "appears to be acutely psychotic"[38].

[38] RM Critical Incident Review – Report to the Director of Mental Health, p 7.

118. Claudia Manu-Preston gave evidence that if she had any idea that Rocky was not taking his medication, she would have arranged for the CAT team to attend immediately after she received the phone call from Mrs Gleeson, and she would have gone to the house herself immediately. There are a number of reasons why that should be accepted. First, she impressed me as an honest witness, who conducted herself in court with integrity, as she has done throughout her career. She was willing to make concessions where it was appropriate to do so. Second, as demonstrated by her 2009 complaint and her email exchange with Dr Abusah in May 2011, she had prove herself to be very proactive in getting her brother medical attention when she believed him to have deteriorated and if she had any idea how ill he was, she would not have hesitated to demand help, as she had done in the past. Third, she had expressed her concern to Dr Abusah in the May email that if Rocky came off his medication he may get into trouble with the police. Ms Manu-Preston loves her brother Rocky very much and has tried hard to protect him. She also had a lot to lose from him getting into trouble with the police (professionally and personally) and would not have taken the risk if she had any idea he was capable of harming Jasmine. Finally, it is patently clear that she genuinely cared for and admired Jasmine and for that reason alone I have little doubt that she would responded with greater urgency if she had known Jasmine was in danger.

119. It must be born in mind that Claudia was making an assessment of the events reported to her by Ms Gleeson while labouring under the mistaken view that Rocky had been taking his medication for the last three months. In light of the assurances she had been given by Dr Abusah, she assumed that Rocky was abiding with his three-tiered case plan - receiving fortnightly depot injections from a case worker, seeing Dr Sowman fortnightly and meeting with Dr Abusah monthly. She had no idea that he had been non compliant for so long. Rocky's behaviour, both at the family gathering in October and during her phone call with him on Monday afternoon, reinforced her belief

that he was reasonably well. Furthermore, when she asked Mr Macgregor, Rocky's MHACA support worker, whether he had any concerns, he failed to tell her that he hadn't seen Rocky for months and left her with the impression that Rocky was tracking reasonably well.

Date of death

120. It will be clear from what I have said to date that I am satisfied that Jasmine died at sometime in the evening of Monday, 14 November 2011. MHACA staff saw her when she came to work that morning, and she swam with her friend and neighbour Sandi Yandell that afternoon. However on Tuesday she didn't come into work, didn't return any phone calls and didn't respond to Claudia or her husband banging loudly on the flat door. Neither did she respond to repeated attempts to contact her on Wednesday.

121. There are many people who gave evidence of their sincere regret, and even torment, at not having done more to help Jasmine on the Tuesday. The sad fact is that even if the CAT team or Claudia or the police had been sent out on Tuesday it would almost certainly not have saved Jasmine's life. I hope that this finding will help some of those affected by this tragedy to move forward.

Significant changes since Jasmine's death

122. In the wake of Jasmine's death, the NT Department of Health commissioned a thorough report to determine what had gone wrong and what they could do to avoid this ever happening again[39]. MHACA completed it's own Critical

[39] RM Critical Incident Review- Report to the Director of Mental Health. Annexure A, statement of Bronwyn Hendry (4/2/12).

Incident Report[40]. Following those reports, a separate review was instigated to look at the issue of communication between the two services and what could be done to improve it[41]. I was very impressed with the detailed analysis of this case and the work done to improve the systems failures that were identified.

Changes to Clinical service –Hospital and CAMHS

123. The review of clinical services identified multiple gaps in service provision, which included:

a) An inadequate system of clinical records, and failure to record treatment decisions or the proceedings of case management meetings;
b) Lack of medical supervision of the care of some CAMHS clients, meaning a failure by many clinicians to attend meetings or supervise case management;
c) Lack of integration of the doctor's outpatient clinic with the other arms of the service;
d) Inadequate systems to ensure continuity of care in the event of the absence of key personnel;
e) No effective mechanism to review the quality of care or quality of record keeping
f) Under use of CMO's.

124. As a result, 17 recommendations were made for improving client care and those recommendations have been swiftly implemented. In my view, the most important reform is the appointment of a Clinical Director of CAMHS

[40] Critical Incident Reporting, November 2011.
[41] Critical Incident Review (Dr Olav Nielssen, Professor Robert Parker, Richard Ashburner) (21/3/12).

who is responsible for implementing reforms, overall supervision and management and ensuring adequate liaison with non-clinical services, including MHACA. Another was the implementation of a very simple white board system to ensure appropriate follow up for clients who are not on a CMO, but need case management and become non-compliant.

Changes at MHACA

125. MHACA has also implemented changes after a lengthy period of sole searching. They include better communication with CAMHS and a review of confidentiality and privacy policies to ensure that information is shared with clinical service providers where appropriate.

Need for further reform

126. I am satisfied that most of the important reforms have already been implemented following the expert reviews that occurred before this inquest began. What still concerns me, however, is the issue raised by Ms Gleeson that these reforms must now be sustained into the future. They cannot be allowed to lapse due to pressures on the mental health system or the issues of staff turn over that often plague the Northern Territory. For that reason, I will make significant recommendations after my formal findings.

Conclusion

127. The death of Jasmine Roennfeldt has deeply affected the lives of all who knew and loved her – her friends, family and colleagues - and I express my sincere sympathies to them.

128. The real issue in this case was again expressed eloquently by Jasmine's mother, Mary Gleeson, in her final statement to the Court, when she said:

> I would just like to say I'm fully aware that everyone in this world makes mistakes and I think mistakes from individuals, when they're trying their damnedest to do their jobs, is acceptable. It's sad, has sad consequences; all that stuff but they don't mean to do it and they don't try to do it. I do think that it's not acceptable for us to accept that our systems can make mistakes like this. It's just not acceptable.

129. I agree completely that the gaps in the mental health system illuminated by Jasmine's death are just not acceptable, and they must be permanently rectified.

130. It is both appropriate and commendable that the Department of Health has apologised to the families of both Jasmine and Rocky for the gaps in the system of mental health care that let both of them down. I was genuinely impressed by the work that has been done since to address those shortcomings.

131. I was moved to hear that some members of Rocky's and Jasmine's families have met since Jasmine died and Geoff Manu revealed a lot about both families when he told the Court that he was touched at the grace that has been shown to him and his family. I know that their pain is not over, but I hope that this inquest has helped them in their journey forward.

132. I thank Jasmine's family for providing me with some photographs of her and I am grateful to her family, friends and colleagues for giving the court a sense of who she was. I was told that one of Jasmine's oft-repeated phrases was "see the person, not the illness" and I certainly got a sense of the wonderful person she was and the legacy she left.

Formal Findings

133. As a result of evidence adduced at the public inquest, and pursuant to section 34 of the *Coroner's Act*, I find as follows:

(i) The identity of the deceased was Gwvynyth Cassiopeia-Roennfeldt (aka Jasmine Roennfeldt), born on 16 July 1977 in the State of Victoria, Australia.

(ii) The probable time of death was some time between 5.30pm and 11pm on 14 November 2011. The place of death is unit 75, number 111 Bloomfield Street Alice Springs, in the Northern Territory.

(iii) The cause of death was internal injuries consequent on being stabbed repeatedly by Rocky Manu, a man with paranoid schizophrenia who was acutely psychotic at the time.

(iv) The particulars required to register the death:

1. The deceased was Gwvynyth Kintala Vaezl Cassiopeia-Roennfeldt (aka Jasmine Roennfeldt).
2. The deceased was not of Aboriginal descent.
3. The deceased was employed as a peer support by the Mental Health Association of Central Australia (MHACA).
4. The death was reported to the coroner by a member of the Northern Territory police force.

5. The cause of death was confirmed by post mortem examination carried out by Dr Terence Sinton.
6. The deceased's mother is Mary Gleeson of Victoria.

Recommendations

To the Minister for Health

134. That the role of Clinical Director of CAMHS be maintained, and that in the event of the current Director leaving the role, steps be put in place to ensure she is replaced as expeditiously as is feasible.

135. That a quality assurance mechanism be set up to monitor implementation of the recommendations that were made in the "Critical Incident Review (Confidential report to the Directors of MHACA and Mental Health)" and the "RM Critical Incident Review - Report to the Director of Mental Health" commissioned following the death Gwyyneth Cassopeia-Roennfeldt (aka Jasmine Roennfeldt).

136. That the Office of the Northern Territory Coroner be advised of the mechanism referred to in 2 above within three (3) months of the date these findings are published.

Dated this 15th day of October 2013.

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GREG CAVANAGH
TERRITORY CORONER