My complaint

The following is information understood from various sources. Obviously, many people have searched their memories and are trying to answer the question, “How could this attack have been prevented?”. I have compiled this information to contribute to questions and angles to be followed up in all inquiries relating to the event. It should not be considered definitive and verification of details is required. As this was a very serious attack, some of these are very serious allegations and an extremely thorough investigation is expected by Michael’s family and colleagues. The information is derived from interviews with persons tasked to care for the mental health patient. Some crucial information provided here was unwittingly handed to me as hastily scribbled notes during the course of early investigations by a senior staff member. Other information was simply available to me as the partner of Michael Corkhill.

I. Background

I.1 The patient: David Rodriguez

David Rodriguez also known as Regan, was a metal health patient of the Lismore Adult Mental Health Inpatient Unit (LAMHIU) under the North Coast Area Health Service (NCAHS) and had participated in the Housing and Support Initiative (HASI) program provided by On Track Community Programs. Regan suffers from Schizoaffective disorder.

I.2 The incident: Murder of Michael John Corkhill

Michael worked across a number of programs run by the NGO, On Track Community Programs. On 27 June 2009, whilst on night duty with the Refuge program of On Track, Michael noticed that medications were available for a female friend of Regan. The female friend was part of the Refuge program but had moved into the unit made available to Regan. As this unit is a two minute drive away from the Refuge, Michael felt it his duty and of little inconvenience to deliver these medications to the client. At the unit, an altercation arose resulting from Regan’s delusional jealousies and Michael was assaulted, causing death. News articles reflecting this case can be obtained through a Google search using the terms “Michael Corkhill” and “Lismore”.

I.3 The patient’s mental health condition: Schizoaffective Disorder (bipolar)

The following information was obtained from the internet and is not a formal diagnosis of Regan’s condition. It is presented here to provide an idea on the mental health of the patient.

Schizoaffective Disorder is a combination of two mental illnesses - schizophrenia and a mood disorder. The main types of associated mood disorder include bipolar (characterised by manic episodes or an alternation of manic and depressive episodes) and unipolar (characterised by depressive episodes).

Symptoms:

- Psychotic symptoms - losing touch with reality, hallucinations, delusions, disorganised thoughts, chaotic speech and behaviour, anxiety, apathy, blank facial expression, inability to move. They may hear voices other people don't hear. *They may believe other people are* reading their minds, controlling their thoughts, or *plotting to harm them.*
- Manic symptoms - increased social, sexual and work activity, rapid thoughts and speech, exaggerated self-esteem, reduced need for sleep, risky behaviours, impulsive behaviours such as spending sprees, *quick changes between mood states such as happiness to anger*.
- Depressive symptoms - loss of motivation and interest, fatigue, concentration difficulties, physical complaints such as headache or stomach ache, low self-esteem, suicidal thoughts, loss of appetite, insomnia.

Treatment:

A combination of therapy and drug treatments is often followed after diagnosis. A patient might be prescribed antipsychotic medication and Lithium, or anti-convulsant medication with Lithium. However, because of the relatively *close relationship between all three conditions*, schizophrenia, bipolar disorder and schizoaffective disorder, *an antipsychotic medication will usually be prescribed* ***for all three***, with an addition of either Lithium or an anti-depressant.

Regan had been prescribed the following drug treatment:

- For the treatment of bipolar disorder, two (2) drugs were prescribed.
    - **Lithium**

      Given primarily in its carbonate form, lithium is highly effective in dissipating a manic episode and in calming the individual. Lithium can cause side effects that may impair thinking or reactions.

    - **Epilim** (*Sodium valproate*)

Epilim works to treat epilepsy by preventing the excessive electrical activity (which causes fits) in the brain

- For the treatment of schizophrenia, three (3) drugs were prescribed.
    - **Respiridone** – 50mg/mL

      Respiridone is an atypical antipsychotic drug used to treat schizophrenia and the mixed and manic states associated with bipolar disorder.

    - **Seroquel XR** (*Quetiapine fumarate*)

      Seroquel XR is a drug approved to treat

        - acute depressive episodes in bipolar disorder;
        - acute manic or mixed episodes in bipolar disorder alone or when added to lithium or divalproex;
        - long-term maintenance of bipolar disorder when added to lithium or divalproex; and
        - schizophrenia.

    - **Zyprexa** (*Olanzapine*)

      Is an atypical antipsychotic, approved for the treatment of:

        - schizophrenia;
        - depressive episodes associated with bipolar disorder,
        - acute manic episodes and maintenance treatment in bipolar disorder.

I.4 The pivotal event: Abrupt withdrawal of anti-psychotics

Regan is one of few patients aware of his right as a consumer to consult his psychiatrist without a support worker present. He chose to exercise this right and hence, neither of his support workers, Michael Corkhill and a co-worker, had any knowledge of matters discussed privately between Regan and the treating psychiatrist. Regan would also choose to visit the psychiatrist on his own and his support workers would be unaware of such visits.

On 13 January 2009, one such consultation occurred. The outcome of this visit was the removal and reduction of his medications.

The following medications were ***withdrawn***:

Epilim
Zyprexa

Seroquel

The dose level of the following medication was ***reduced*:**

Respiridone – reduced by half to a dose level of 25mg/mL
Lithium – reduced by an unknown quantity

Hence, an abrupt withdrawal of a large part of Regan's antipsychotic medication was carried out, leaving little to manage the disorder of a physically large human being. Whilst this may be an acceptable practice carried out in some circumstances, it is ***well documented*** that in a large percentage of patients, abrupt withdrawal of antipsychotic medication does lead to a rebound and there is abundant evidence to suggest that a gradual discontinuation markedly reduces early recurrences of mania or depression (Baldessarini, Tondo & Viguera. 1999; Moncrief. 2006, Suppes *et al*., 1991; Viguera *et al*., 1997).

Note:

1. Regan had been on the same drug maintenance treatment since his entry into the HASI program at On Track in early 2007. No radical changes had been noted in his behaviour until ***after*** his medication levels had been altered. His medication treatment prior to this period is unknown but would be held with LAMHIU, NCAHS.

2. On Track staff were unaware of the medication changes authorised by Dr Petroff. The change was discovered only some time later (the period indicated was "weeks") when the distributed webster packs were examined. Whilst it is understood that patient confidentiality needs to be respected, it is imperative that those tasked to provide the care and support be informed of such changes so that appropriate decisions in respect of mood changes can be made. The issue in relation to self-harm or harm to others from a possible rapid rebound should also have been considered.

   It has been held in the United States that clinicians have a duty to warn those whom they believe may be in danger from patients under their care that over-rides the duty to maintain patient confidentiality (Herbert, 2002). The duty typically arises where it is considered that there is a foreseeable risk to a specific person.

3. Regan was under a Community Treatment Order (CTO). CTOs are generally given *where there is evidence* that without taking their medication (ie if the patient *does not have* the medication), the patient is at risk of harm to themselves or others. This therefore suggests that there is recognition that Regan was at risk of harm to himself or

others when not fully medicated. Yet the medications were removed abruptly and without warning to those tasked in his care.

Questions:

- Is the abrupt change in medication for Regan a responsible action likely to be taken by other treating psychiatrists given the specific circumstances pertaining to Regan (Suppes *et al*., 1991)?

- Should a more gradual decrease in medication have been adopted in this instance to avoid any sharp increase in recurrence (Moncrieff, 2006)?

II. Events and Consequences

II.1 The early signs

Following Regan's abrupt medication withdrawal / reduction on 13 Jan 2009, the following key incidences were recorded.

9 March 2009 – Regan indicated to the manager at On Track that he did not want Michael Corkhill to be his support worker as Michael was gay. Michael was removed as his support worker. Note: During periods when Regan was not actively unwell, he spoke highly of Michael, respected and held him in high regard. It was very clear to Michael that this request was a result of Regan's declining mental health. Indication of possible Paranoia.

7 April 2009 – Damage to flat. Staff made records that Regan was becoming unwell. Possible indications of Aggression.

8 April 2009 – Attacked person in community [it is unknown if the weapon used on this occasion was the same weapon used on Michael]. The attack was deflected by the victim (a client of the real estate agent handling the property adjoining that occupied by Regan) and no police report was made. Indication of Aggression.

13 April 2009 – Voluntarily admitted to LAMHIU and placed in High Dependency Unit. Acknowledgement of Regan's declining condition by LAMHIU. (Note: The delay in admission was a result of Regan absconding after the attack. He fled to Nimbin where he was eventually encouraged by a friend to admit himself to the clinic).

14 April 2009 – Abusive phone calls made to refuge whilst in Clinic. Regan persistently made calls from the clinic to male clients at the refuge to warn them to stay away from his girlfriend. A letter was written by the manager of On Track Lismore to direct Regan to stop making the calls. Dr Petroff was informed of these calls. Indications of Delusion and possible Aggression.

20 April 2009 – Records indicate he was becoming delusional.

25 May 2009 – Trial leave from LAMHIU

26 or 27 May 2009 – Pushed a refuge client to the floor in response to delusional jealousy of the victim taking away / being with his girlfriend. Indications of Delusion *and* Aggression.

27 May 2009 – Readmitted to LAMHIU.

23 June 2009 – Released from LAMHIU.

27 June 2009 – Commits murder. It is understood that statements to the police contain strong evidence of the delusional state of mind that Regan was in, that directly led to the attack and Michael's death. Indications of Delusion and Aggression recorded.

The provision of the above information serves to outline the observable behaviour of Regan after his medication was removed in mid-January 2009. It is understood and accepted that physicians are not meant to be insurers of the outcome of treatment decisions as it is difficult for anyone to predict future outcomes without sufficient evidence. However, in the case of Regan, sufficient occurrences had presented themselves in the period following the abrupt antipsychotic medication withdrawal / reduction to suggest a possible recurrence of mania. This fact was jotted down by Michael as a "to-do" list on a scrap piece of paper and included the points: "Early Warning Signs" as well as "Safety Audit" sometime prior to late April 2009. I am led to believe that additional information denoting Regan's deteriorating condition is available in the On Track case notes as are suggestions for his unsuitability for the HASI program. This information would have been communicated to the Case Manager.

Whilst admitted to the clinic, Regan was placed in the High Dependency Unit. It is understood that discharge planning is not required for voluntary patients. Regan admitted himself voluntarily to the clinic after his altercation with the Refuge resident in late May 2009. Hence, it is possible that LAMHIU / CMH may have discharged Regan on 23 June 2009 *without* a proper risk assessment being carried out.

The following are comments provided by a person with familiarity of the various NSW Health Services.

> "Depending on the 'culture' of the treating clinic and/or community mental health, a patient's history may or may not be shared with the care provider. Among clinics, LAMHIU is considered one of the more closed with provision of its information and hence, the NGO is often not provided information on the history of a patient. Support staff are often unaware of any necessary precautions to take."

> "Studies on Australian hospitals suggest that it is generally the case that the hospitals want to move someone as quickly and painlessly as possible so the psychiatrist or case manager alone would decide if someone is OK to go out into the community and ask the support organisation if they can take him/her on."

> "It is known that Richmond Clinic is particularly stretched for staff and resources, hence it is possible that adherence to procedures would be patchy."

Regan was part of the HASI program and hence had access to living quarters and was in the care of the NGO support workers. Hence, it would be plausible the view was held that Regan could be discharged into the care of the NGO even if he was not fit to be discharged. After all, the responsibility of care is placed on the NGO when a patient is discharged.

Questions:

- What discussions transpired between Regan and Dr Petroff to warrant the withdrawal / reduction in Regan's medication?
- Was careful consideration given to the decision to withdraw / reduce the medications?
- Was the medication for Regan increased (or alternate and appropriate treatment provided) when Regan admitted himself to and whilst he remained in the psychiatric unit at LAMHIU until 23 June 2009 (see Silver & Kushnir, 1998)? If not, what were the reasons for the failure to treat / review his condition?
- Were the recorded incidences provided to LAHMIU on Regan's deteriorating condition acknowledged?
- Given the recorded evidence provided to LAMHIU on Regan's deteriorating condition, was the view ever formed that abrupt withdrawal of antipsychotic medication may be contributing to the detrimental effect on his recovery?
- In the expert opinion of independent review professionals, given the above knowledge, was the possibility of self-harm or harm to others in the community given due consideration when Regan was released from LAMHIU on 23 June 2009? (Felthous, 2008; Nielssen *et al*., 2007; see Mullen, 2006 p. 243).
- Was best practice of patient management being carried out by LAMHIU?
- Was a risk assessment carried out on Regan on his release from LAMHIU on 23 June 2009? It is claimed that On Track never received any risk assessments or discharge summaries.
- In the expert opinion of independent review professionals, what risk level of aggressive and life-threatening behaviour was assessed:
    - on withdrawal of medications/ reduction of dose;
    - on release into the community.
- Regan had transient (fixed?) ***delusional jealousy*** that males were having sex with his girlfriend. Were these delusions given due consideration when he was discharged, especially considering that the chief reason for his ***aggression*** and subsequent re-admission to the clinic after trial leave on 25 June 2009 was directly related to this very delusion? It is suggested that the attack on Michael was a result of delusions (see Felthous, 2008; NSW Health Policy Directive PD2009_039, 2009).
- Pressure on bed space at public hospitals is an acknowledged reality. However, if Regan was released based on pressure on bed-space at the clinic, was this considered an *acceptable* justification for putting lives at risk? (NSW Health Policy Directive PD2008_005, 2008).

III. Case Manager's Responsibility for Clients

Each client should have both a Psychiatrist and a Case Manager from either Community Mental Health (CMH) or the Acute Care Service (ACS). The case manager for Regan is Mr Damian Clarey from CMH. The impression provided is that the Case Manager would often shrug responsibility of his clients preferring to allow the support worker to make the decisions. Often cited for shrugging responsibility is the lack of time. Michael often indicated that his work load was increasing as a result of having to take on the responsibilities of the Case Manager for which he was not suitably trained to perform.

> "CMH and NGO's like On Track presumably, at least on paper are supposed to work in partnership. However the reality is often different. Services are stretched and ways of working entrenched and co-operation between partners invariably does not occur."

It is acknowledged that Regan had a Case Manager who is known for his lackadaisical attitude and that Regan's Case Manager and his HASI partners did not effectively work together as a team. The phrase "has a work phobia" has been used to describe the Case Manager's attitude towards work.

Question:

- What are the responsibilities of the Case Manager and were they being carried out in accordance of the requirements set out by the NSW Health Policy Directives relevant to the care of mental health patients?

IV. References

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