MAGISTRATES COURT of TASMANIA

CORONIAL DIVISION

Record of Investigation into Death (With Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Olivia McTaggart, Coroner, having investigated the deaths of John Henry Evans and Jillian Louise Evans with an inquest held in Hobart, make the following findings:

Hearing Dates

1 July 2016 in Launceston and 17, 18, 19 and 20 July 2017 in Hobart; submissions received by 17 November 2017

Representation

Counsel Assisting the Coroner	Mr M Allen
Counsel for Dr Surinder Johl	Mr M Wilkins
Counsel for Dr Paul Scott	Mr C Law
Counsel for Dr Helen Dixon	Mr C Law
Counsel for Dr Cyril Been	Mr C Law
Counsel for Launceston General Hospital	Ms L Brooks

Introduction

On 2 September 2013 Mr John Evans, aged 62 years, caused the death of his wife of many years, Mrs Jillian Evans, by using a pole to hit her to the head and then applying force to her neck. Shortly after she had died, Mr Evans made a telephone call to emergency services, advising the operator of his home address and that he had killed his wife. Before the arrival of emergency services, Mr Evans ended his own life by shooting himself to the head whilst at the same time hanging himself with rope.

The evidence indicated that Mr Evans may have been suffering a psychotic illness that caused or contributed to his actions.

The facts surrounding the deaths and the cause of the deaths were clear on the comprehensive investigation material. As I suspected homicide in the case of Mrs Evans' death, an inquest was mandatory pursuant to section 24(1)(a) of the *Coroners Act* 1995. The inquest commenced on 1 July 2016. However, just prior to that date, expert evidence was received in the investigation to the effect that treatment for Mr Evans' mental health over the four months before his death, including during inpatient admissions in two hospitals, may not have been adequate to prevent his apparently psychotic state. I therefore adjourned the inquest, sought further expert evidence, and allowed interested parties an opportunity to participate and obtain expert opinion. This inquest, upon its resumption on 17 July 2017, was primarily concerned with the adequacy of the treatment of Mr Evans' mental health condition by his general practitioners and treating psychiatrists in the period leading up to the deaths.

Background and circumstances surrounding the deaths

Mrs Jillian Evans was born on 28 September 1950 in Campbell Town in Tasmania. Mr John Evans was born on 19 September 1950 in Hobart. The pair married in 1972 and their daughter, Tina, was born the same year. Tragically, Tina died in 1989 at the age of 16 from injuries suffered in a motor vehicle crash. Mrs Evans also had a son from a previous relationship, Michael Richardson, born in 1967. Mr and Mrs Evans lived at 36 Orana Place in Riverside, a house that they owned.

At the time of her death, Mrs Evans was employed on a full time basis at the Launceston General Hospital ("LGH") as a cleaner. She had held this employment since 1985.

Mr Evans had worked for ACL Bearing Company at Mowbray for 34 years. Several years prior to his death he accepted a redundancy from the company and retired.

Mr Evans had experienced difficulties with his mental health for many years. His first reported contact with psychiatric services was in 1973, after a serious assault upon Mrs Evans. He was placed on probation as part of his sentence by the court and referred to treatment. Subsequently there were no recorded episodes of violence by Mr Evans.

It is likely that that Mr and Mrs Evans became sexually estranged before the death of Tina and they slept in different bedrooms. Hospital records in 1988 indicate that Mrs Evans was becoming concerned about Mr Evans mental illness and its impact upon Tina. In the notes the social worker states *"it appears Mrs Evans has learnt to cope with a difficult husband by staying quiet and avoiding confronting him but has now realised that their daughter has not*

been able to protect herself in the same way". It appears that Mrs Evans experienced a degree of fear in her relationship with Mr Evans.

In 1990, after the death of their daughter, Mr Evans' depressive symptoms worsened. It was reported that he became reclusive, cut ties with friends and family and worried excessively. He was diagnosed with severe anxiety disorder and was prescribed medication to treat it.

From May 2013 Mr Evans commenced more frequent appointments with his regular general practitioner, Dr Paul Scott, complaining of both physical and psychological difficulties. Between 1 May 2013 and 17 July 2013 Mr Evans presented to the surgery on nine occasions. On seven of these occasions he saw Dr Scott. Of the remaining two occasions, he saw Dr Nathan Lucas on 10 May 2013 and Dr Helen Dixon on 8 July 2013. His physical complaints were various and included respiratory difficulties, abdominal pain and nausea, headache, and generalised pain. His psychological symptoms involved significant anxiety and manifested principally in obsessive concerns about his neighbour's wood heater blowing smoke into his property and house and its effects upon him. Investigations regarding his physical ailments, with which he was preoccupied, were appropriately conducted by his general practitioners. He was prescribed medication for his anxiety. Although Mr Evans was quietly spoken and pleasant, he was a challenging patient to treat due to his refusal to acknowledge the extent of his psychological symptoms or to comply with his general practitioners' recommendations for referral to counselling or further specialist assistance in this regard.

On 8 July 2013, being the last of these nine attendances at the surgery, Mr Evans told Dr Dixon that he thought his *"nerves had collapsed";* that he felt *"hopeless, shivery and shaky";* that *"everything was going wrong";* and that he felt *"out of control".* On this occasion Dr Dixon added the medication Anafranil to his prescriptions to reduce his symptoms and noted that he would be reviewed by Dr Scott within a short time.

On 17 July 2013, and before further review by Dr Scott, Mr Evans was taken to the Department of Emergency Medicine at the LGH by Mrs Evans who was concerned about his behaviour. It appears from the records that Mrs Evans was away from the home when she received a phone call from an inconsolable Mr Evans who told her that someone had sprayed their dogs with poison and that he feared for his life and the lives of the dogs. When Mrs Evans arrived home she found Mr Evans in a state of high anxiety and begging her to leave the house to escape as he smelled poison inside. He would not allow Mrs Evans to

enter the house. The hospital notes indicate that Mrs Evans herself was “distressed and labile” concerning Mr Evans’ state of mind.

At the LGH Mr Evans was reviewed by Dr Andrea Stone Shayer, emergency medicine consultant, who assessed Mr Evans as being paranoid. She medically cleared Mr Evans for physical causes of his symptoms, noting that his CT brain scan, blood tests and chest x-ray were all found to be normal. She then referred him to the mental health team, whereupon Mr Evans was interviewed by experienced social worker, Ms Kaye Berry, who was tasked to perform a mental health assessment.

Ms Berry recorded in her notes that Mr Evans said that he was concerned to go home because of chemicals infiltrating his house. He told her that an unknown person had put chemicals on his dogs which were now infiltrating every part of the house. He feared that the situation was worsening and that he and Mrs Evans would be unable to enter their home. He experienced a severe smell and felt that it had entered his body and involved a stinging sensation. He indicated to Ms Berry that he did not have such concerns until three days previously. However, he told her that over the past 6 to 8 weeks smoke from his neighbour’s chimney had been coming through the roof tiles and gaps around his windows and so he had replaced all the lights and sealed the windows and doors. He said that he was always a worrier but that he had no suicidal thoughts or plans.

Following Ms Berry’s assessment, Dr Stone Shayer formed the view that Mr Evans should be subject to an order as an involuntary patient under the *Mental Health Act* 1996 to enable a psychiatric evaluation to take place. She gave evidence at inquest that, upon presentation, Mr Evans was rambling, paranoid, pacing and was trying to leave. She also formed the view that he lacked insight as to what needed to happen to assist and treat him.

Dr Stone Shayer gave evidence that, in a paranoid state and lacking insight, a patient such as Mr Evans may be a danger to himself and others due to an irrational perception that others are trying to harm them. Therefore, at 12.35pm, Dr Stone Shayer signed an Initial Order (“the Order”) to detain Mr Evans for psychiatric evaluation. She prescribed him Risperidone, an anti-psychotic medication. That ended her involvement in the care of Mr Evans. He was formally admitted to the Northside Clinic of the LGH under Dr Cyril Been, an experienced psychiatrist.

Mr Evans remained an inpatient overnight on 17 July 2013 awaiting psychiatric evaluation by Dr Been. Although he was distressed and paranoid he does not appear to have caused any trouble for doctors or staff at the LGH.

On 18 July 2013 Dr Been reviewed Mr Evans on two occasions, being 10.00am and 3.30pm. He also interviewed Mrs Evans on these occasions. At his first review with Mr Evans, Dr Been noted the same concerns from Mr Evans relating to an increase over the last three days in his neighbour's smoke, which was spreading and covering the house so that he could not breathe and would not go outside; that the dogs were sprayed or painted with chemicals; and, despite washing, the smell would not disappear. He also expressed concern about tractor tyres being missing, domestic furniture "broken down" and noises from the heat pump motor at night. He told Dr Been that he would remain at the LGH but Dr Been nevertheless found him to have limited insight into his condition. He noted that it was likely that Mr Evans suffered depression with psychosis. Like Dr Stone Shayer, he ordered administration of the anti-psychotic, Risperidone, as well as an anti-depressant medication.

After his first review of Mr Evans, Dr Been upheld the Order made by Dr Stone Shayer. Upon his second review, however, he discharged the Order so that Mr Evans was no longer an involuntary patient. Dr Been's decision came after extensive discussions with Mr and Mrs Evans and on the basis that Mr Evans agreed to continue treatment as a voluntary patient at St Luke's Calvary Hospital ("St Luke's"). A critical element of the decision by Dr Been to discharge the Order was the concern expressed by both Mr and Mrs Evans about Mr Evans' presence in the LGH at a time when Mrs Evans was employed within the hospital. They were concerned that Mr Evans' admission may be the subject of comment and stigma. The transfer of Mr Evans to St Luke's was therefore arranged. Dr Been considered that an immediate voluntary transfer to St Luke's would address the risk of harm, the need for treatment and the distress caused by Mr Evans remaining in the LGH.

A letter was generated by Northside Resident Medical Officer, Dr Htet Aung, on behalf of Dr Been for the attention of Dr Surinder Johl, an experienced consultant psychiatrist who would treat Mr Evans at St Luke's. The letter principally outlined: the nature of Mr Evans' delusions; his suffering of olfactory hallucinations and visual hallucinations; that he was orientated and conscious with no thoughts of suicide or harm to himself or others; and that he had poor insight and judgement.

Accordingly, in the morning of 19 July 2013, Mr Evans was transferred to St Luke's for voluntary admission, where he remained until he was discharged on 26 July 2013. At St Luke's Mr Evans came under the care of Dr Johl.

Upon his admission, Mr Evans was assessed for risk, being risk to himself and/or others arising from his mental state. On this day Mr Evans was assessed to be of low/medium risk

and requiring low/medium level of observations. His score for hallucinations was “moderate”. On the evening of 19 July Dr Johl saw Mr Evans. He ceased Mr Evans’ anti-psychotic medication, Risperidone, which had been prescribed at the LGH. He was not willing to form a diagnosis at that stage but required Mr Evans to be monitored.

It is apparent from the records that during his inpatient stay Mr Evans continued to be assessed as low-risk in relation to suicidal intent but that he was prone to worry excessively.

It appears that by 24 July 2013 Mr Evans had become less confused and more relaxed, although he still suffered some ongoing anxiety and delusional ideas. For example, he told staff that he became unnecessarily upset about an issue that was puzzling him and that he could still not work out the odd odour from his dogs. It appears that by this time his interaction and eye contact with the staff had improved and he wished to leave the hospital to go home.

On 25 July 2013 Dr Johl assessed Mr Evans as feeling much improved and no longer focused or worried about smoke, odours or his dogs.

On 26 July 2013 he was discharged home in the care of Mrs Evans. It was noted before discharge that he had no suicidal thoughts or plans. Both Mr and Mrs Evans were given instruction regarding his medication and appeared to have full understanding of the requirements. Dr Johl had prescribed Mr Evans the medication quetiapine at a dosage of 25mg nocte (to be taken at night). As will be further discussed, such a dose represented an appropriate response to anxiety symptoms, whereas a higher dose of 200-300mg represented the most effective treatment for psychosis.

On 30 July 2013 Dr Johl wrote to Dr Scott about Mr Evans’ recent admission to St Luke’s and his assessment of the current state of his mental health. Dr Johl advised Dr Scott that Mr Evans was neatly groomed, cooperative and forthcoming with information but needed frequent prompting to keep to the subject. Relevantly, Dr Johl advised:

> *“He clearly has a few perceptual disturbances but they are becoming less firm in his mind. It appears that many of his delusional ideas have not been well developed and are appearing to become less intense… My impression is that it is likely he has been experiencing severe anxiety and constant worry, which has led to some psychotic features that are resolving quickly with the help of medication. His current diagnosis is a severe anxiety disorder. It is likely that he experienced a brief psychotic episode.”*

Dr Johl advised Dr Scott of Mr Evans' medication and the fact that he would continue to see him for a period of time to assist with his recovery.

On 7 August 2013 Mr Evans presented to Dr Scott and stated that he was not worried about those matters that caused his presentation to hospital. Dr Scott noted in his records *"sounds like he's not convinced that his thoughts (re smoke/plants being poisoned/fear of being killed) were delusions but is able to ignore them currently. Wants something to relax himself."* Dr Scott noted that Mr Evans presented as anxious but not aggressive. Dr Scott telephoned Dr Johl for management advice but as he was unavailable. Dr Scott left a message for him to return his call within one day.

On 9 August 2013 Mrs Evans contacted Dr Scott regarding Mr Evans' worsening insomnia. Dr Scott advised that Mr Evans should try temazepam (half of one tablet) and he would try to contact Dr Johl "on Tuesday".

On Tuesday 13 August 2013 Dr Scott spoke with Dr Johl on the telephone and they discussed Mr Evans' condition. Dr Johl advised that his quetiapine medication could increase to 50mg per day.

On 20 August 2013 Dr Johl reviewed Mr Evans at his consulting rooms. Mr Evans complained to Dr Johl that he was continuing to worry excessively and was frequently anxious and tense. He was concerned that he was unable to keep his house clean because of his dogs. He stated that the smell from his neighbour's chimney was no longer a problem. He was concerned that he and his wife might run out of money. He was also afraid that Mrs Evans might leave him. Dr Johl interviewed Mrs Evans separately on this day. She stated that Mr Evans worried about *"everything, cleaning and the dogs and about money."* However, she told Dr Johl that he was better overall and that he had not said too much about the wood smoke. He was given a further appointment for 1 October 2013.

During the whole period of Mr Evans' treatment by his general practitioners and during hospitalisation at LGH and St Luke's, Mr Evans expressed no homicidal ideation nor any ideas that could reasonably be interpreted as manifesting an intent to harm any other person. His presentation universally was that of a polite, quietly spoken, neatly dressed man who was generally anxious as well as concerned about physical ailments.

On 30 August 2013 Mr Evans did not attend his scheduled appointment with Dr Scott. It does not appear that Dr Scott or his staff actively followed up on the missed appointment.

On Sunday 1 September 2013, Mrs Evans attended work at the LGH between 6.00am and 2.00pm. At 11.58am that day Mr Evans sent Mrs Evans a text while she was at work, stating *"Jill I think you better ring me it's urgent… It's for real".*

Upon leaving work, Mrs Evans spoke to her work friends stating that she would see them on Wednesday after having two days off. No one appears to have had contact with Mrs Evans or to have seen her after this time.

At 5.01pm on Monday 2 September 2013, a communications officer at Radio Dispatch Services of Tasmania Police received a phone call from the emergency "000" line from a male person. He gave his name as John Evans and his address as 36 Orana Place, Riverside. He advised that he had murdered his wife and was sorry.

At 5.12pm uniformed police officers arrived at 36 Orana Place and were required to force entry into the residence by breaking the glass beside the front door. Once inside, the officers located Mrs Evans lying deceased on her back on the floor of the main bedroom. Mrs Evans was clothed and partially covered by a quilt. Some personal items had been placed on her stomach area and a timber stick with cloth taped around one end of it was located near her. She appeared to have significant facial and head injuries and there was blood stains surrounding her body.

Mr Evans was located deceased in the bathroom, hanging with a blue nylon type rope around his neck from a roof joist in the spa bath area of the room. He appeared to have head trauma consistent with a gunshot wound. A .22 calibre Stirling rifle was located near Mr Evans.

Officers from the Criminal Investigation Branch, Forensic Services and Ballistics Services attended the scene of the deaths. The State Forensic Pathologist also performed autopsies upon Mr and Mrs Evans.

Attending officers located in the kitchen a note, which I am satisfied was written by Mr Evans, as follows:

> *"Jill's friend is John Nielsen of ACE Window Cleaners in America for another week. Please look after the dogs. Tina Simone Evans. Teen Angle (sic) (illegible)… to something. Daughter's grave is at Car Villa plenty of money in the bank account to put Jill there. I'm so sorry I loved Jill and the dogs but somehow everything has got away and can't be fixed. Jill should not take the shame of this house (….illegible) It's me. We*

are infested now bugs fleas because we did not know this would happen. I love you Jill and the dogs."

I am satisfied that a thorough investigation took place to determine the cause of death and the immediate circumstances surrounding the deaths. The investigation comprised of an opinion of the State Forensic Pathologist relating to the causes of the deaths; relevant civilian and police affidavits; forensic evidence; ballistics report; scene examination; scientific scene analysis; photographs; telephone analysis; and medical information.

The evidence in the investigation does not indicate that any other person was present in the house or involved in the circumstances surrounding the deaths.

I conclude upon the evidence that, sometime before 5.00pm on 2 September 2013, Mr and Mrs Evans were at their home address. I cannot determine the nature of any verbal or physical interaction between the two at that time, there being no witnesses. However, Mr Evans struck Mrs Evans around the rear of her head and face, most likely with a wooden handle covered at the contact end with a small towel. Mrs Evans bled profusely from this trauma. Mrs Evans attempted to defend herself and in that process scratched Mr Evans' face. Mr Evans then compressed Mrs Evans' throat, probably with his hands, such strangulation causing her death. Mr Evans then attempted to move the body of Mrs Evans but was unsuccessful. He then placed upon her body a photograph of their daughter, Tina, and Mrs Evans' iPad, mobile phone and reading glasses. He then covered her body with a bed quilt.

Mr Evans then made some attempt to clean Mrs Evans' blood from his hands with paper towel which he placed in the kitchen sink. He then wrote the above note and placed it on the kitchen table. He then used a crowbar to break a hole into the plaster ceiling in the bathroom preparatory to hanging himself before placing a blue nylon rope over the freshly exposed roof joist in the bathroom. He then called 000, provided his details and told police that he had killed Mrs Evans. Mr Evans was not a licensed firearm holder but owned the rifle, which he had likely possessed for many years. He loaded the rifle and took it with him to the bathroom. He then went to the bathroom placed the blue rope around his neck and stood on the side of the bath. Mr Evans then placed the loaded firearm in his mouth and attempted to discharge it but, due to a faulty cartridge, it did not discharge. He then attempted to load a second cartridge but this was dropped in the bath. He then placed a third cartridge into the firearm, placed the firearm in his mouth and discharged the cartridge causing death instantly. He then dropped from the side of the bath, this action causing fatal compression of his neck.

About 12 minutes later police officers arrived upon the scene in response to the emergency call by Mr Evans.

I am satisfied from the evidence in the investigation that the house or property at 36 Orana Place was not infested with insects, permeated by toxic smoke from the neighbouring property and was not a hazardous environment in any other respect. I am satisfied that the two dogs owned by Mr and Mrs Evans were not under threat from poisoning or other means. I am also satisfied that Mr and Mrs Evans were not the subject of any malicious actions or threat from any other person.

Issues for examination at Inquest

The primary issues for examination at the inquest were the extent of Mr Evans' psychosis (if any) at death and in the preceding months, and whether both deaths could have reasonably been prevented if the severity of Mr Evans' psychosis had been diagnosed and treated, in particular by those medical practitioners caring for him before he took his life and that of his wife. In terms of my functions under the *Coroners Act* 1995, these issues pertain to the question of how death occurred, required under section 28(1)(b), as well as the making of recommendations and comments, if appropriate, pursuant to sections 28(2) and 28(3) respectively.

Before the inquest hearing, the expert and documentary evidence obtained for the investigation suggested that Mr Evans was in a psychotic state at the time of his death; that delusions indicating psychosis had been present and able to be detected by medical professionals for some months; and that with appropriately high doses of anti-psychotic medication, his psychotic condition would likely have resolved prior to the tragic events of 2 September 2013.

Specifically, the main issues at inquest were as follows:

1. The nature of the mental condition of Mr Evans when he killed himself and Mrs Evans, including whether he was suffering psychosis.

2. Whether Dr Scott should have diagnosed and treated Mr Evans for psychosis rather than anxiety.

3. Whether Dr Dixon, in her consultation with Mr Evans on 8 July 2013, should have diagnosed and treated Mr Evans for psychosis.

4. Whether Dr Been performed an adequate assessment of Mr Evans' mental state upon him presenting at the LGH; whether he prematurely discharged Mr Evans from the Order under the *Mental Health Act* 1996; and whether he provided adequate discharge information or communication to Dr Johl and/or St Luke's regarding the severity of Mr Evans' psychosis.

5. Whether Dr Johl was correct in downgrading Mr Evans' diagnosis to an anxiety disorder when the correct diagnosis should have remained as psychosis and have been treated accordingly, including prescribing an appropriately high level of anti-psychotic medication.

6. Whether the medical records and/or discharge summary for the LGH admission were passed to the subsequent treating psychiatrist in a timely manner; whether the discharge summary contained sufficient detail regarding the seriousness of Mr Evans' condition or that it was completed immediately upon his discharge; and, generally, the adequacy of the LGH records regarding Mr Evans' condition and documentation surrounding the Mental Health Order.

Before discussing the above issues it is appropriate to make some preliminary comments regarding the question of whether different treatment or improved communication procedures in relation to Mr Evans' mental health and treatment may have prevented the outcome and how this issue should be approached in making factual findings.

Firstly, there is no evidence that the particular tragedy could have been reasonably foreseen by any of Mr Evans' medical practitioners. The evidence indicates that Mr Evans made no threats of violence or suicide during the course of his illness in 2013. At inquest, Professor Matthew Large, senior clinical psychiatrist and Professor of Psychiatry, gave evidence, which I accept, that about one in 1 million persons per annum in Australia commit a homicide/suicide. Therefore, at least two persons per one million die in this circumstance. It is therefore a rare occurrence. However, there was a consensus on the part of all experts at inquest that there is a significant risk of harm to a person or others when that person remains in an untreated state of psychosis. This risk arises from responses to delusional thinking, often persecutory, and lack of insight into the falsity of the delusions.

Secondly, I recognise, particularly in relation to this inquest, that whilst the expert evidence is very clear regarding risks of harm associated with a state of psychosis, each of the treating

practitioners could not have perceived that a homicide and suicide may be committed by Mr Evans.

Thirdly, the duty of the medical practitioners was to treat competently upon the information that they had or should reasonably have had at the time, rather than on the basis of all of the evidence that has subsequently become available at inquest. Having listened to the views of the experts, diagnosis of any particular mental health condition can be difficult and is a matter of judgement formed by considering the history, demeanour and presentation of the patient over a period of time, as well as consulting collateral sources of information. In this case it is particularly important to note that in light of the ultimate event better processes and opportunities to prevent the deaths appear clearer in hindsight. The risk in the inquest setting is that the tragedy becomes the all-consuming focus of attention, and this must be guarded against when making findings regarding appropriate diagnoses and treatment.

Fourthly, I was impressed by the evidence of Mr Evans' treating medical practitioners at inquest. Their evidence was helpful and credible notwithstanding the potential for criticism of their actions. The additional independent expert psychiatrists called were Dr Ian Sale, Dr John Kasinathan and Professor Matthew Large. Dr Shane Dorney, general practitioner, also gave expert evidence. In general terms, the experts gave credible and balanced evidence. I have been greatly assisted by the level of expert detail and opinion that has been provided in respect of the relevant issues. Mr Allen submitted, providing reasons, that the evidence of Professor Large was not as helpful or balanced as the other experts. Certainly, I did not find that Professor Large was as helpful to the court as the other experts in several areas, particularly where concessions or a more moderately argued explanation might have been expected. Nevertheless, he was a well-qualified expert whose views I take into account. Given my ultimate conclusions, there is no need for me to make further general comments regarding the overall quality of his evidence. With the benefit of such expert opinions, it places the difficulty of treating Mr Evans at the time into the context in which their decisions should be viewed.

Finally, I do not ultimately make criticism that any of Mr Evans' treating doctors fell below an acceptable standard in diagnosing or treating Mr Evans. The evidence at inquest involved detailed medical reports and oral evidence concerning Mr Evans' diagnosis and treatment of psychosis. On balance, and with the benefit of all information, there was a concerning deterioration in his mental state towards psychosis from May 2013. Although I make comment regarding areas of practice that may have been more optimal, the diagnosis and treatment decisions from that date until his death were reasonable.

Was Mr Evans in a psychotic state at the time of the deaths?

Dr Johl, as Mr Evans' treating psychiatrist, gave evidence that there was nothing suggesting he suffered psychosis during the killing upon his review of the evidence. He did not consider that a delusion of infestation of the house was a sufficiently personally threatening event to explain the dramatic circumstances of the deaths. He speculated about why, if Mr Evans thought that Mrs Evans could not manage the threat posed by the infestation and he must kill her out of love, he would bludgeon her when he had a gun?

Professor Large gave evidence that it was difficult to ascertain whether Mr Evans was psychotic, citing the proposition that an apparent infestation of bugs and fleas as per the note would be less serious than the typical type of delusions involved in a psychotic homicide/suicide.

Dr Sale was firm in his opinion that Mr Evans was psychotic at the relevant time and that such psychosis motivated the homicide and suicide.

Dr Kasinathan also believed that Mr Evans had a delusional pre-occupation at the time, stating *"it was probably a resurgence of his delusional disorder and is incredibly sad."*

I prefer the evidence of Dr Sale and Dr Kasinathan on this issue. The evidence indicates that Mr Evans was a quietly spoken, anxious man, who had an occasional tendency to anger. This anger manifested in a conviction for seriously assaulting Mrs Evans in 1971, some 42 years before their deaths. There is also evidence of aggressive behaviour after the death of Tina whereby he became obsessed about the driver of the car being charged with murder. Generally, the evidence would suggest that while Mr Evans presented passively, he was capable of aggressive or violent actions on occasions. It appears that his personality style was not conducive to him adopting appropriate ways to resolve his feelings.

Even noting a propensity to violent outbursts of anger, I do not accept that the motivation for killing his wife and himself was anger unaccompanied by delusional thought.

The text message sent to Mrs Evans by Mr Evans the previous day referring to an urgent situation that was *"for real"* points to an overwhelming delusion of some unknown harm, possibly an infestation of the house. Mr Evans' note before his death clearly links an infestation of the house to the reason for his actions. The hallmark of Mr Evans' psychosis leading to his presentation to the LGH was an infestation of his house, (albeit not by bugs and fleas), and the consequent threat to himself, Mrs Evans and his dogs. Whilst such a delusion may not be typical of those persecutory delusions usually accompanying such an

event, the serious threat posed to him by infestation of the house was a repeated theme of his discussions with treating doctors. Upon admission to the LGH he articulated a fear for his own life by the person who was trying to poison his dogs. His expressed love for Mrs Evans in the note was accompanied by the thought that her death had to occur to effectively save her from the *"shame of the house".* In the deluded mind of Mr Evans, it was a response proportionate to the magnitude of the threat. His thoughts and reasons for his actions on a more detailed level will remain unknown.

I therefore find that Mr Evans was in a psychotic state when he killed himself and Mrs Evans.

Diagnosis and treatment of Mr Evans

Dr Paul Scott

Dr Dorney provided credible and knowledgeable expert evidence regarding diagnosis and treatment of Mr Evans by a general practitioner in Dr Scott's position. Dr Dorney considered that the persistence of Mr Evans' obsessional beliefs should have raised concerns with Dr Scott in the weeks before his admission to the LGH.

Dr Scott presented in his evidence at the inquest as a caring doctor, doing his best to manage a difficult patient who presented on a regular basis with a variety of physical and psychological symptoms. He was helpful and clear in his answers. He described Mr Evans as generally anxious, difficult to manage, of little health literacy, reluctant to recognise psychological symptoms, and refusing of referrals to a psychologist or psychiatrist right up until his admission to the LGH. Dr Scott adopted the strategy of engaging Mr Evans in areas of difficulty where he was likely to comply with treatment – such as his insomnia and goal of giving up smoking. He said Mr Evans was willing to try and make lifestyle changes and it was important for Dr Scott to develop a therapeutic relationship with Mr Evans based upon trust. In that way, Mr Evans would remain connected and visit regularly.

In his evidence at inquest, Dr Scott was firm in his opinion that there were no indications in Mr Evans of psychotic symptoms before his admission. He was surprised when Mr Evans was admitted to hospital as he did not predict a psychotic episode.

I accept, based upon all of the medical evidence at inquest, that the detection of the delusions in Mr Evans indicating that psychosis was present was a most difficult question, even for experienced practitioners reviewing this matter in hindsight and with the benefit of more information. This was particularly the case as the subject of the obsessional

beliefs/delusions was initially related to his neighbour's chimney smoke, a matter that could be seen as grounded in reality.

Notwithstanding this observation, by June 2013 Mr Evans had raised serious worries regarding the neighbour's smoke on four occasions, including that he may die due to its toxicity. Dr Dorney said that Dr Scott had the options of obtaining collateral information from Mrs Evans and home visits in order to test the veracity of the beliefs. He was of the view that Dr Scott could have been more open to the possibility of the development of delusions leading to psychosis rather than assessing them as overvalued ideas or obsessions which were the symptoms of anxiety. He considered that Dr Scott should have completed his own assessment or diagnosis with regard to DSM-V criteria. More active steps could have been taken, he said, by contacting a psychiatrist for advice or mental health services.

Dr Dorney stated that medical management of Mr Evans would have also benefitted from a detailed management plan, particularly in the event that he was seen by another practitioner either at the same practice as Dr Scott or elsewhere. This would have allowed another general practitioner to appreciate Dr Scott's thinking and approach to Mr Evans' complex issues. This is evidenced by the difficulty Dr Dixon experienced in accurately assessing and understanding Mr Evans' detailed and complex medical history in a short time prior to seeing him.

Dr Scott was aware that he could take steps to arrange involuntary mental health assessment for Mr Evans, and presumably was also aware he could involve the Crisis Assessment and Treatment Team. However, the evidence does not establish that, at any time that he saw Mr Evans, that he met the statutory test in the *Mental Health Act* 1996 (s 24) for such action.

A question was raised at inquest as to whether Dr Scott could have been more proactive in following up with Mr Evans for his missed appointment on 30 August 2013. Mr Allen submitted, based upon the evidence of Dr Dorney, that by such time Dr Scott was aware of Mr Evans' serious mental health condition, and was also aware that he was very likely to be experiencing delusions. Thus Mr Evans' unexplained non-attendance might have triggered concern. Dr Scott conceded in evidence that it is normal practice for the medical centre to contact non-attending patients, but he was unaware as to what, if anything, was done on this occasion. I consider, however, that to criticise Dr Scott for not following up the missed appointment is not appropriate. Dr Scott gave coherent evidence that he saw no evidence of delusions in his consultation with Mr Evans on 7 August 2013, and his presentation on that

date was consistent with Dr Johl's diagnosis of a brief psychotic episode that had resolved. He had no reason to think that Mr Evans at that time was suffering anything but anxiety.

Thus, I took Dr Dorney's evidence to be that there were opportunities for a more optimum standard of care in respect of several aspects of Dr Scott's treatment of Mr Evans regarding ascertaining the existence or the differential diagnosis of psychosis. This is so as the evidence establishes that the alternative diagnosis of psychosis was extremely serious, and would have benefited from early detection and treatment.

However, Dr Dorney both in evidence and in his report for the inquest, expressed considerable sympathy for the challenge faced by Dr Scott in achieving treatment compliance from Mr Evans, who was clearly resistant. Dr Dorney also expressed the valid point that Dr Scott's notes do not convey "the full story" in terms of the characteristics of the patient. I accept that Dr Scott recognised the extent of Mr Evans' anxiety and felt that it was preferable to maintain a positive relationship with him, including appropriately treating his physical ailments, to ensure that Mr Evans retained trust and consistency of treatment. In that way, it would be more likely that Mr Evans might eventually accept psychological assistance.

Dr Kasinathan gave evidence that it would have been very difficult for Dr Scott, prior to Mr Evans becoming critically ill three days before his admission to the LGH, to determine whether Mr Evans' beliefs regarding the neighbour's wood smoke were overvalued ideas or whether they were delusional. Dr Kasinathan said in evidence that "with the benefit of hindsight that was probably more indicative of a delusional disorder shifting in terms of content – but for clinicians, for medical practitioners in the coalface, very difficult to distinguish that from his long-standing generalised anxiety disorder."

Dr Kasinathan gave evidence that it would have helped in May 2013 for the general practitioners to speak with Mrs Evans regarding whether the beliefs were delusions or a real occurrence. I accept that this would have been a very helpful step to take. However, he gave evidence that Mr Evans was a man that had anxiety about a number of things, including his physical health, and the smoke was but one of those matters. I also note that, whatever serious concerns Mrs Evans harboured privately about her husband's precarious mental state, she may not have provided significantly useful information for treating practitioners at that stage, other than to repeat her refrain that Mr Evans "was a worrier".

Dr Kasinathan commented that the investigations carried out by the general practitioners with regard to Mr Evans' physical symptoms were very thorough, and treated and diagnosed

reasonably, particularly as Mr Evans declined to see a psychologist at their suggestion. He emphasised that it is a priority to treat the physical symptoms. He said that Dr Scott could not have done much more. He also commented that Mr Evans' multiple health concerns, resistance to mental health treatment, and unusual personality style caused real difficulties in treatment by Dr Scott. I accept that the evidence fully indicates this problem.

I am satisfied that Dr Scott's medical treatment of Mr Evans did not fall below the standard required of a competent and thorough general practitioner.

Dr Helen Dixon

Dr Dixon saw Mr Evans only on 8 July 2013, as Dr Scott was unavailable. Her evidence was that she had limited time to review his medical records before seeing him. The consultation lasted no more than 15 minutes, which is a standard consultation time. On that day Mr Evans presented as visibly upset and agitated, with symptoms of depression. At this consultation Mr Evans' psychological symptoms had worsened considerably to the point of him shivering and shaking and saying that his nerves had collapsed. Dr Dixon immediately prescribed Mr Evans the medication Anafranil (Clomipramine) in the hope of providing him with immediate relief. She then asked Mr Evans to see Dr Scott shortly after that treatment commenced.

Dr Dixon did not detect psychosis in Mr Evans. I again note the difficulty of detecting Mr Evans' emerging psychosis at this stage. It does not appear that the wood smoke issue was raised with Dr Dixon. Dr Dixon only saw Mr Evans once in this critical period and, apart from treating him for his immediate symptoms, appropriately recognised that Dr Scott was his regular general practitioner and that he would consult Dr Scott in the near future.

Dr Dorney, who reviewed Dr Dixon's treatment, was critical of her choice of medication. He describes Anafranil as an unusual choice for relief of depression or anxiety in modern general practice, with newer alternatives available. Dr Dixon defended her choice, indicating that it was prescribed to give Mr Evans some immediate relief from insomnia and depression. She indicated that she had previously prescribed it successfully to other patients.

Dr Dixon accepted that another option available to her was to commence Mr Evans on a benzodiazepine to reduce his anxiety, and to refer him back to his usual general practitioner very quickly for a decision to be made about commencing him on any long term medications.

Dr Dorney in his report of 3 May 2017 was only mildly critical of the prescription of Anafranil, although in his further report and oral evidence he became firmer regarding the desirability of a prescription to Mr Evans of a benzodiazepine and provided details of some possible negative effects of Anafranil, including an increase in anxiety during the first few days of the prescription. Dr Dixon herself provided detailed and intelligent reasons for her prescription, primarily because she perceived that Mr Evans' thoughts had an obsessive quality to them and would respond to that particular medication. Professor Large supported the prescription of either Anafranil or a benzodiazepine.

The evidence therefore suggests that reasonable medical opinion could differ regarding Dr Dixon's choice of medication in the circumstances. Overall, the evidence does not establish that Anafranil was a medication that no practitioner acting reasonably could have prescribed, nor that the prescription of that substance contributed to Mr Evans' psychotic episode. It does not establish that a benzodiazepine would have prevented his psychotic episode. I do not criticise Dr Dixon's choice of medication.

Dr Dixon admitted to feeling under time pressure to deal with Mr Evans. She indicated that with the benefit of more time to review his medical history, she may have appreciated Mr Evans' documented recent history of delusional thoughts. This point highlights the critical nature of the general practitioners' role in correctly diagnosing patient illness, and underlines the difficulties and complexities inherent in the task.

Dr Dixon approached a difficult and complex patient diligently and competently, and plainly acted in the best interests of the patient. Her patient notes were appropriate and enabled an understanding of her treatment. She took a reasonable approach to appropriate follow up and discussed the patient with his usual practitioner. Dr Dixon's response is reflective of the challenges and complexities of the time pressures upon general practitioners.

Psychiatrists

Dr Cyril Been

The primary issue concerning Dr Been was whether he should have discharged the Mental Health Order in respect of Mr Evans when he did.

The *Mental Health Act* 1996, now superseded by the *Mental Health Act* 2013, provides for the care and treatment of persons with mental illness, including making provisions for involuntary admission under an Initial Order, a Continuing Care Order or an Authorisation for

Temporary Admission. By section 24 of that Act, a person could be detained as an involuntary patient in an approved hospital if, *inter alia*, the person appeared to have a mental illness, there was a consequent significant risk of harm to the person or others, and detention of the person as an involuntary patient was necessary to protect the person or others. An Initial Order for admission as an involuntary patient is made by a medical practitioner. Such an Order continues for a maximum period of 72 hours. Within the first 24 hours of that period, an approved medical practitioner, such as Dr Been, must carry out an assessment, failing which the Order lapses. As a result of the assessment the approved practitioner may uphold or discharge the Order.

As previously discussed, at about 10.00am on 18 July 2013 Dr Been upheld the Mental Health Order. At about 3.30pm the same day, he discharged the Mental Health Order. If he had not discharged it at this time, it would have remained until 12.35pm on 20 July 2013.

Dr Been diagnosed Mr Evans with major depressive disorder with psychotic features. Upon all of the expert evidence this diagnosis was correct, as was his decision to administer Risperidone, an anti-psychotic medication, and Venlafaxine, an anti-depressant.

Mr Allen submitted that the decision of Dr Been to discharge the Order could not be properly reviewed as the records do not provide sufficient detail for this to occur. There is merit in this submission. Before I heard the sworn testimonies of Dr Been, Dr Sale, Dr Kasinathan and Professor Large, it appeared from the documentation surrounding the decision to discharge the Order that the wishes of Mrs Evans to avoid the LGH setting may have been given undue primacy over a detailed assessment of risk relating to Mr Evans' condition.

Mr Allen further submitted that it was unclear whether, and if so to what extent, the assessment of Mr Evans' significant risk of harm had changed in the hours between the Order being upheld by Dr Been, and then discharged by him.

I am satisfied, having heard all evidence at inquest, that Dr Been's decision-making regarding the discharge of the Order and subsequent transfer of Mr Evans to St Luke's was reasonable. While Dr Sale's opinion was that it would have been better practice to keep Mr Evans at Northside and observe and document a clinical change in him before agreeing to transfer, he conceded in his oral evidence that the decision to discharge was not unreasonable where the circumstances of those presenting to emergency departments in a mental health crisis can change rapidly. Dr Kasinathan and Professor Large supported the decision as being consistent with normal clinical practice. Dr Johl was not critical of the

decision, and relevantly, he was the practitioner most likely to have been adversely affected by a premature discharge of the Order.

Dr Been himself provided clear, logical evidence under detailed questioning from counsel assisting as to his decision making process leading to discharge of the Order. He said it was an important factor that Mr Evans had presented voluntarily and was willing to be transferred immediately to St Luke's from the LGH. Additionally, he explained that he believed Mr Evans had at least sufficient insight to understand that he required further inpatient treatment. Dr Been's assessment in this regard proved accurate, given that Mr Evans remained at St Luke's for seven days as a voluntary inpatient. His decision also took into account the statutory requirement of ensuring that restrictions on the liberty of the person are kept to the minimum necessary to protect the person and others.

I am satisfied that it was reasonable for Dr Been to discharge the Order.

Launceston General Hospital Documentation

It is appropriate at this point to comment upon the adequacy of the LGH documentation relating to the assessments and condition of Mr Evans, as well as that surrounding the Mental Health Order.

I initially observe that, while Dr Stone Shayer and Ms Berry were competent and thorough in their duties, their notes do not record in any detail the matters relating to their determination of the existence of a significant risk of harm that made it necessary that Mr Evans be involuntarily detained for his or other people's protection. Notes to this effect would have been useful for Dr Been, and later for Dr Johl, in conducting their own assessment of both the severity of Mr Evans' condition and the attendant risks to both himself and others, including those involved in his care. Detailed notes are also important in the event of any sort of systemic review, including under the *Coroners Act* 1995.

Dr Been did not complete the relevant sections of the Order, namely *Section E – Approved Medical Practitioner Assessment*, and later *Section F – Approved Medical Practitioner Discharge*. Dr Been was unable to explain why this was not completed. The completion of this documentation is a critical part of the procedure applicable to the involuntary detention of people under the *Mental Health Act* 1996.

In conjunction with the non-completion of these sections of the form, the notes regarding the decision-making by Dr Been around the upholding and subsequent discharge of the Order are somewhat scant. The notes, again, do not adequately disclose the reasons for either the

upholding of the Order, or the reasons for its discharge, as they relate to the relevant matters contained in section 24 of the *Mental Health Act* 1996.

Mr Allen submitted that the communication of information regarding Mr Evans' transfer to St Luke's was inadequate, a submission having some force. Dr Johl, Dr Kasinathan and Professor Large suggested that the letter from Resident Medical Officer, Dr Aung, contained an appropriate summary of Mr Evans' clinical condition and I accept that this is so. However, the absence of any reference to his involuntary admission should be regarded as a significant omission in the picture. All medical professionals giving evidence accepted the desirability of that information being transferred either before or at least with the patient. It is not open on the evidence to conclude that the timely transfer of that information would have changed the decision by St Luke's to receive Mr Evans, Dr Johl's assessment and treatment, or the course of events that followed his discharge from St Luke's. However, it would have emphasised that the nature of the risk created by the persecutory delusions and lack of insight described by Dr Aung had reached the threshold for involuntary admission. This may well have prompted Dr Johl to consider obtaining further history, delaying the downgrading of the diagnosis and alerting him to consider treating for psychosis with appropriate doses of anti-psychotic medication.

Additionally, the discharge summary from the LGH was not completed by Dr Been until 30 July 2013, some 12 days after his transfer to St Luke's. An examination of that document also does not convey any information regarding Mr Evans' involuntary status, and in fact erroneously records that Mr Evans was a "*voluntary admission to Northside.*" The failure to complete the discharge summary at a time proximate to the actual discharge of Mr Evans is not representative of best practice. The failure to communicate the summary to the psychiatrist responsible for Mr Evans' continuing care is also not best practice. The lack of detail and inaccuracy in the report means that, even if it had been transferred to Dr Johl, it is unlikely to have assisted him in any meaningful way.

I accept Dr Sale's evidence that the communication between hospitals regarding the transfer of Mr Evans was not adequate. Best practice would have involved communication of all relevant facts, including the existence of the Order and the reasons for its imposition as they related to the considerations under the *Mental Health Act* 1996 and similarly for its discharge or discontinuance. Telephone communication between hospitals about the severity of Mr Evans' condition should have occurred, preferably at consultant level, to allow for input from the receiving psychiatrist, and the formulation of an agreed plan that ensured the continuity of Mr Evans' care.

Dr Surinder Johl

Dr Johl's evidence, both in his reports and given orally at inquest, was that Mr Evans' diagnosis was that of a severe anxiety disorder. He stated that his severe anxiety and constant worry led to psychotic features in the several days prior to, and during, his presentation to the LGH on 17 July 2013. He described Mr Evans as having a brief psychotic episode during those days which subsequently resolved with medication. In coming to this diagnosis, Dr Johl thought that Mr Evans had some delusional ideas but considered that they were not "firmly fixed". He took into account information received to the effect that Mr Evans had been worried about the effects of his neighbour's chimney smoke for up to 3 months before his hospitalisation. However, again, he did not consider those to be fixed delusional beliefs, stating that he could be talked out of them.

In evidence, Dr Johl stated that during his initial interview with Mr Evans at St Luke's he did not find any delusions. Dr Johl said *"he had some delusive ideas… But there were no hallucinations whether olfactory or visual, there weren't any of them there. So that's why I wasn't very keen to see him as psychotic at that point in time because those features weren't evident to me and I spent time talking to him to try and establish whether the ideas he had were true or not…".*

Dr Johl gave Mr Evans the preliminary diagnosis of delusional disorder with associated anxiety, based on the information and diagnosis made by Dr Been at the LGH. He said that he wanted to observe Mr Evans for a longer period to be certain that he was treating a psychotic condition, and consequently discontinued both the Risperidone and Venlafaxine that had been recently commenced at the LGH. Dr Johl said that he was conscious that a diagnosis of a psychotic condition is both serious and requires long term care, so he was cautious in his approach to the diagnostic task.

Ultimately, Dr Johl thought that Mr Evans had a severe anxiety disorder, and had experienced a brief psychotic episode that was resolving without medication.

Dr Johl, in support of his diagnosis, explained that he saw no psychotic behaviour on the part of Mr Evans whilst at St Luke's that, in his view, justified anti-psychotic treatment. The hospital progress notes appear to support Dr Johl's evidence in this regard, being that the delusional ideas still present in Mr Evans were vague and not firmly fixed. Dr Sale observes that there may be reasons to explain the apparent resolution of the more severe psychotic symptoms and to justify a cautionary approach. These include: the possibility that Mr Evans was able to minimise his symptoms, particularly as he was anxious to go home; that

distressed and anxious patients often appear to settle soon after hospital admission because they are removed from an environment that has become threatening or fearful; and because medication and reassurance are being provided.

However, I also note the submission of Mr Wilkins, counsel for Dr Johl, that it is not reasonable to find that Mr Evans, a man of relatively low intelligence, could have deliberately minimised his symptoms over his extended hospitalisation so as to have "fooled" trained and experienced psychiatric professionals as well as Mrs Evans, who expressed no concern as to his discharge. In the circumstances, I find that it was quite reasonable for Dr Johl to form the view that Mr Evans' delusions became much less firmly fixed in the safe environment of the hospital.

Both Dr Sale and Dr Kasinathan gave evidence that they disagreed with Dr Johl's assessment that Mr Evans had suffered a brief psychotic episode having regard to the duration of his symptoms, lasting more than one month. Dr Kasinathan, in particular, refers in his report to Dr Johl's comment that Mr Evans had elicited 6 to 8 weeks of hallucinations and fixed beliefs prior to his arrival at St Luke's, as well as the referral letter from Dr Aung referring to disturbance in the "*last few months.*" I accept the submission of Mr Wilkins that the letter from Dr Aung was unclear as to the length of time over which Mr Evans suffered hallucinations. A very careful reading of the letter may have prompted thought, or at least further enquiry, as to whether the hallucinations had been existing for quite some time before presentation to the LGH. If this was obviously the case a diagnosis of psychosis should have been maintained.

However, the question of whether Dr Johl should have altered the diagnosis given to Mr Evans at the LGH is a difficult one. Dr Kasinathan was of the view that Dr Johl's treatment and diagnosis was not unreasonable given the denial of psychotic symptoms during the St Luke's admission and Dr Johl's psychiatric clinical impression that Mr Evans' psychotic episode was brief and fully resolved. However, Dr Kasinathan favoured the diagnosis of delusional disorder based upon a more long-standing history of delusions than Dr Johl had taken into account. As stated above, Dr Johl specifically based his diagnosis upon a history of delusions that were not fixed or alternatively categorised as "overvalued ideas" arising as a result of anxiety. Upon consideration of the evidence, there is nothing to indicate that Dr Johl perceived a clear history of firmly fixed delusions enduring for longer than one month before his admission to LGH. For example, in his letter to Dr Scott dated 30 July 2013, after Mr Evans' discharge from St Luke's, he noted the worsening of Mr Evans' perceptual disturbances over the past three months, including worry about smoke from his neighbour's

chimney spreading into his house and picking up strange odours. However, consistently with his evidence at inquest, Dr Johl categorised such symptoms as delusional ideas that were not firmly fixed and a product of severe anxiety and constant worry at least until the brief period of psychosis in hospital, after which they reduced to again being not well formed or firmly fixed.

Dr Sale also provided an opinion regarding the downgrading of the diagnosis by Dr Johl. He gave evidence that he believed that Dr Johl "drifted away" from his initial view that Mr Evans was suffering from a delusional disorder because he did not have the clear impression that there had been problems for several weeks. Dr Sale then gave evidence, perhaps somewhat contrary to his written reports, that Dr Johl's downgraded diagnosis was reasonable because of the following features: the fact that Dr Johl was unaware that Mr Evans was so unwell that he was placed upon an Order at LGH; that Mr Evans presented well, with Mrs Evans consistently categorising her husband as a "worrier" rather than delusional; the fact that he observed no significant perceptual disturbances in Mr Evans at St Luke's; and the fact that he did not have information from the general practice regarding the more long-standing nature of the problem and details of the possible delusions.

Dr Sale did not suggest that it was Dr Johl's responsibility to obtain any further information than he was given. The evidence was that Dr Johl was not under any professional obligation to seek out such information.

I now turn to the medication and its dosing as prescribed to Mr Evans by Dr Johl. Once Dr Johl assumed care of Mr Evans at St Luke's he discontinued the medication administered to Mr Evans at the LGH. This was for the purpose of clarifying mental state examination and psychiatric diagnosis. While Dr Sale did not criticise this general approach, he indicated that he would have only ceased one medication for this purpose, that being the anti-psychotic medication. He believed the benzodiazepine should still have been taken for calming purposes. The approach of discontinuing the one medication may have been more desirable in the circumstances of Mr Evans' transfer from Northside to St Luke's, particularly given what was known about the severity of Mr Evans' condition at that time. However, again, there is no evidence that this clinical decision on the part of Dr Johl was unreasonable.

The downgrading of the diagnosis by Dr Johl from depression with psychotic symptoms to severe anxiety disorder caused Dr Johl to correspondingly downgrade the dose of Mr Evans' anti-psychotic medication, both while an inpatient at St Luke's and on discharge, from that prescribed at the LGH by Dr Been. Dr Johl discharged Mr Evans on the anti-psychotic drug

quetiapine at a dose of 25mg nocte. The evidence was that it was not prescribed for any anti-psychotic purpose, but rather to manage Mr Evans' ongoing anxiety. The expert evidence was that this lower dose would not be effective to treat psychosis.

Dr Johl's prescription of a lower dose of quetiapine follows logically from his diagnosis of Mr Evans' condition. As submitted by his counsel, it would not have been appropriate to prescribe an anti-psychotic dose, being 200-300mg, prophylactically when he took the view that the psychotic episode had resolved and that he saw no ongoing evidence of psychosis.

Dr Kasinathan and Dr Sale were in substantial agreement that if they had been in Dr Johl's position they would have prescribed quetiapine, but at a much higher dose of around 200 – 300mg to treat the psychotic features of Mr Evans' condition. I accept the evidence that if this dose was administered there would be a much reduced chance of experiencing a relapse of delusional disorder and consequently reduce the likelihood of Mr Evans taking the lives of himself and his wife whilst in the grip of delusions. I accept the evidence of Professor Large that two thirds of patients prescribed quetiapine for psychosis obtain full or partial remission, with the treatment having no effect on the remaining one third of patients.

I do not take the evidence of Dr Sale and Dr Kasinathan to mean that an anti-psychotic dose of quetiapine should have been prescribed prophylactically to Mr Evans when psychosis was not the applicable diagnosis. I took their evidence to indicate that Dr Johl should have remained with the diagnosis of psychosis based upon the history and treated accordingly. As previously discussed, Dr Sale moved away from his criticism of Dr Johl in this regard when giving evidence upon recognising the advantage of more information and a more careful consideration in hindsight.

However, in line with the evidence of Dr Sale, there was reason for Dr Johl to be extremely cautious in downgrading the diagnosis as quickly as he did, in circumstances where Mr Evans had experienced a psychotic episode requiring hospitalisation, on a background of increasing perceptual disturbance.

I add that, when Mr Evans was reviewed on 20 August, Dr Johl obtained the history that he was no longer worried about the smoke but expressed other concerns, primarily being, that he will have no money, that his home was destroyed, that his wife would leave him and that he had "nothing".

Upon Dr Johl separately interviewing Mrs Evans she stated at that time that Mr Evans was tense and anxious and tended to "worry about everything". She also confirmed that Mr

Evans no longer spoke about the smoke. Dr Johl saw no aggressive traits in Mr Evans at this time indicating that he would perpetrate any violence towards his wife. I suspect that Mr Evans may, upon discharge from St Luke's, have deliberately concealed some of his ideas, particularly about the wood smoke, from his wife for fear that he may again be hospitalised. This is simply speculation based upon the tendency observed by Dr Johl in Mr Evans to minimise and rationalise his behaviour.

It therefore appears that Mr Evans was in significant distress at this stage. In this regard, Dr Johl had authorised Dr Scott to increase Mr Evans dose of quetiapine to 50mg on about 13 August 2013 for his anxiety. However, there was no evidence at inquest that Dr Johl should have changed his diagnosis to one of psychosis as a result of this review. Dr Kasinathan stated that as Mr Evans presented with generalised anxiety, being worry involving several domains, this was consistent with Dr Johl's working diagnosis of anxiety disorder. Similarly, Dr Sale thought the fact that Mrs Evans indicated that her husband "worried" and indicated his lack of concern about the smoke might be seen to be consistent with Dr Johl's diagnosis of anxiety.

However, Dr Sale was of the view that Mr Evans' expressed beliefs appear typical of the nihilistic beliefs found in severe depression (presumably associated with an increased risk of psychosis).

Dr Johl's decision to downgrade Mr Evans' diagnosis at St Luke's and treat him with medication only to combat anxiety arguably may not have been the ideal approach. It may not have placed sufficient emphasis upon the likely longevity and quality of the delusions. However, Dr Johl was in the best position at the time to assess Mr Evans personally. The reasoning behind Dr Johl's diagnosis and treatment of Mr Evans discloses a careful and responsible approach towards Mr Evans' care, and a desire to accurately diagnose and treat his condition consistently with the presentation of Mr Evans. Dr Johl's oral evidence to the inquest was open, helpful and balanced. It was clear to me that Dr Johl's approach was not the subject of gross criticism by the experts, who were broadly supportive of his reasoning.

There is no evidence indicating that Dr Johl should have acted to re-institute an Order under the *Mental Health Act* 1996 on Mr Evans while he was a patient under Dr Johl's care at St Luke's.

I do not criticise the decision by Dr Johl to support the discharge of Mr Evans from St Luke's as and when he did. Dr Johl's evidence was to the effect that while he would have preferred

Mr Evans to remain a while longer, there was no basis upon which he could reasonably refuse Mr Evans' request to be discharged. This accords with the expert evidence at inquest.

I also find that there was no duty on Dr Johl to seek further information from the LGH regarding Mr Evans upon his transfer. Dr Johl was entitled to assume that he had been informed of all the essential facts relevant to his acceptance of Mr Evans as a patient under his care at St Luke's. One of these essential facts was that Mr Evans had been subject to an Order under the *Mental Health Act* 1996, and the reasons for the imposition and later revocation of that Order.

Launceston General Hospital

As previously discussed, there is a deficiency in some of the record-keeping relating to Mr Evans' hospital admission. Examples include the failure of Ms Berry to fully complete the assessment form, in particular the 'Risk Assessment' section; Dr Been's acknowledged failure to complete the sections relevant to him on the Order; deficiencies already identified in the discharge summary; and a general deficiency in the detail in the medical notes, particularly relating to decision making under the *Mental Health Act* 1996. Improvements are desirable and I have made recommendations pertaining to this issue.

Further, the discharge summary was not completed in either a timely or accurate manner. It contained material omissions relating to Mr Evans' status, albeit a brief one as an involuntary patient while at the LGH, and fails to record adequate reasons for the decision to either institute the Order or to discharge/discontinue it. The discharge summary also contains a material inaccuracy, in describing Mr Evans as a voluntary patient at Northside. Discharge summaries can convey crucial information regarding a patient's hospitalisation. It was not explored in depth at inquest as to where lay the responsibility for completing a discharge summary and conveying it to treating practitioners in a timely manner. It would appear that Dr Been had responsibility for completing the Order. The LGH presumably has responsibility for the oversight of the process of the discharge summary.

The discharge summary in this case did not add to any extent to the information conveyed immediately to Dr Johl by Dr Aung. Therefore, I cannot find that the timely transfer of the discharge summary would have made any material difference to the events that followed, particularly as it also failed to communicate that Mr Evans had been subject to an involuntary Order.

However, the issue is an important one. Recent findings of coroners in this jurisdiction have emphasised the importance of hospital discharge summaries containing accurate information and being provided in a timely manner to treating practitioners; see *Hosking, Jason Mathew Henry 2017 TASCD 380* and *AH 2017 TASCD 405.* In these cases, Coroners Cooper and Chandler respectively made recommendations for improvements relating to provision of discharge summaries by the Royal Hobart Hospital. My recommendation set out below is appropriately confined to mental health patients at the LGH, given the content of the evidence. It may be however, that, when considering implementation of all of these recommendations, the Tasmanian Health Service could give consideration to developing and implementing uniform processes across the state.

Section 28 Findings

a) The identities of the deceased are John Henry Evans and Jillian Louise Evans;

b) Mr and Mrs Evans' deaths occurred in the circumstances set out in this finding;

c) The cause of Mrs Evans' death was neck compression and blunt force head injuries inflicted on her by her husband, Mr Evans;

d) The cause of Mr Evans' death was a self-inflicted gunshot wound to the head; and

e) Mr and Mrs Evans died on 2 September 2013 at 36 Orana Place, Riverside in Tasmania.

Summary of other key findings

1. Mr Evans was psychotic at the time of his death and that of Mrs Evans. The psychotic delusions suffered by Mr Evans at that time were an operative reason for killing Mrs Evans and himself. Whilst Mr Evans intended to cause his own death and that of his wife, his delusional state in formulating such intention rendered him incapable of rational decision-making in this regard.

2. From 10 May 2013 Mr Evans presented regularly to his general practitioners with anxiety, a deteriorating mental state and emerging psychosis, manifesting in delusions relating to toxic effects of his neighbour's chimney smoke. The detection of an emerging psychosis was a very difficult diagnosis for his treating medical practitioners to make.

3. On 17 July 2013 Mr Evans presented to the LGH after a severe downturn in his mental health, correctly assessed and diagnosed by Dr Been as being a major depressive episode with psychotic features.

4. Mr Evans' general practitioners, Dr Scott and Dr Dixon, were reasonable in their diagnosis and treatment of Mr Evans' mental state before his hospitalisation.

5. Mr Evans was not prematurely discharged from the Order by Dr Been.

6. The decision to discharge Mr Evans from the LGH was appropriate.

7. The diagnosis and treatment of Mr Evans by Dr Johl was reasonable.

8. There were deficits in the completion of important LGH documentation pertaining to Mr Evans' mental state and the Order, and deficits in the transfer of information to St Luke's, Dr Johl and his general practitioners.

Comments

In connection with his evidence regarding how Mr Evans' increasingly psychotic state might have been detected and treated at an earlier time, Dr Sale made comment generally regarding the lack of psychiatrists in the public system in Northern Tasmania compared to the south of the state. He said that there were insufficient psychiatric registrars and that those in such positions were overworked. He stated that registrars require access to consultants with supervisory status and qualifications, a situation that he indicated was currently in jeopardy, such that there is doubt as to whether the training program is able to continue to support registrar positions.

In respect of the ability of general practitioners to seek advice from specialist psychiatrists, Dr Sale indicated that the north of the state was approaching a situation "akin to a rural environment" in respect of the mental health sphere, explaining that rural doctors have very limited access to specialist services. As such they need to become more adept in managing a much wider range of problems, including psychiatric issues. I accept Dr Sale's evidence. Dr Johl did not give evidence in respect of the adequacy of numbers of psychiatrists in Northern Tasmania. However, Dr Scott gave evidence that there were few private psychiatrists available for assistance.

Whilst I cannot attribute the tragic outcome to this background of insufficiency, there is always the possibility that the lack of psychiatrists may place an undue burden upon general practitioners dealing with complex psychiatric issues, and limit their access to specialists for

advice. It may also impact upon the ability of psychiatrists in the public system to complete crucial paperwork in a timely manner. These difficulties will ultimately affect the treatment of the patient.

Recommendations

I **recommend** that the LGH review its procedures relating to ensuring satisfactory completion of all documentation relating to the reasons for decision-making under the *Mental Health Act* 2013, particularly those decisions affecting a patient's rights and liberty;

I **recommend** that the LGH review its procedures for the timely provision of critical clinical information to the receiving hospital and treating practitioners in the case of transfer of mental health patients from the LGH to another hospital; and

I **recommend** that the LGH review its procedures regarding the timely provision of discharge summaries to the patient's treating practitioners in the case of mental health patients.

I have appreciated the competent assistance of all counsel in this matter. I particularly express my appreciation to counsel assisting, Mick Allen, as well as Rebecca Lancaster (prior to her period of leave). I also thank Sergeant Anthony Peters for his valuable work in the preparation of this matter.

Finally, I express my condolences to the family members of Mr and Mrs Evans.

Dated: 28 February 2018 at Hobart in the State of Tasmania.

Olivia McTaggart
Coroner