IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2013 0217

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)

*Section 67 of the **Coroners Act 2008***

I, Peter White, Coroner having investigated the death of Craig Doherty
without holding an inquest:
find that the identity of the deceased was Craig Doherty
born on 16 March 1963
and the death occurred on 14 January 2013
at 126 Racecourse Road, Flemington,Victoria

from:

1(a) Multiple injuries from a fall at height

Pursuant to section 67(1) of the **Coroners Act 2008**, I make findings with respect to **the following circumstances**:

1. Mr Craig Doherty[1] was 39 years of age at the time of his death. He was the son of Mrs Helen Doherty and Mr Denis Doherty (who died in May 2000). Mr Doherty has a younger sister, Joanne.

2. Mr Doherty married Ms Julia Wong in March 1999 and they had one son, Jack. Mr Doherty separated from Julia in 2003 and continued to see his son regularly.

3. Prior to his death Mr Doherty resided in a single room in shared accommodation that he rented from his local doctor, Dr Jay Hewa.

4. Mr Doherty was located deceased by police at the Ministry of Housing High Rise Flats situated at 126 Racecourse Rd, Flemington at approximately 4:48pm on 14 January 2013.

[1] Referred to in my finding as Mr Doherty

Forensic pathology

5. A forensic pathologist from the Victorian Institute of Forensic Medicine, Dr Melissa Baker, performed an external examination on the body of Mr Doherty and reviewed a post mortem CT scan.

6. Dr Baker reported that the external examination revealed extensive trauma to Mr Doherty's head, left arm, left side of the abdomen and left leg.

7. In the absence of a full post mortem examination Dr Baker concluded that a reasonable cause of death would appear to be 1(a) Multiple injuries sustained in a fall from a height.

8. Toxicological tests indicated that Mr Doherty had approximately 0.03g/100mL ethanol in his blood at the time of his death and no common drugs or poisons were detected.

Investigation

9. The purpose of a coronial investigation into a reportable death is to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which the death occurred.[2] In the context of a coronial investigation it is the medical cause of death together with the context of background and the surrounding circumstances of death, which are proximate and causally relevant to the death.

10. The circumstances of Mr Doherty's death have been the subject of investigation by Victoria Police on behalf of the Coroner.

11. The Coroner's Investigator, Detective Senior Constable Cameron Ryan, prepared a coronial brief of evidence comprising a range of evidentiary material with witness statements, visual material, and medical reports.

12. In December 2014, after considering all the available evidence and a particular request from Mr Doherty's mother, I decided that it would not be necessary to hold an inquest into Mr Doherty's death.

<u>Background</u>

13. Mr Doherty's mother described Mr Doherty as someone who made friends very easily, and that he always craved attention for a self-confidence boost.

14. Mr Doherty started working at his father's business selling 'Rolex' watches when he

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[2] Section 67(1) of the *Coroners Act 2008*

was 20 years old. Mr Doherty ceased working there when he was 37 years old, shortly after the death of his father. From that time Mr Doherty started his own jewellery business.

15. In the three years prior to his death Mr Doherty had been drinking heavily and become physically aggressive, which was described by his mother as abnormal for him.

16. Between September 2010 and December 2011 Craig travelled internationally and during this time his communication with his mother indicated that he drank very heavily and was abusive.

17. In January 2012 Mr Doherty's mother asked him to leave her house as he was getting drunk and threatening her. Mr Doherty left and immediately travelled overseas again.

18. In August 2012 Mr Doherty returned to Australia and Mr Doherty's mother states that in November 2012 he started drinking considerably again, that he could do nothing and was not motivated anymore.

19. On 17 December 2012 Mr Doherty said to his mother that he had had a bad night as there were people coming through his window and on 20 December 2012 he was observed to drink a bottle of wine and became very violent to his mother, resulting in her making an application for an intervention order.

20. On 10 January 2013 the Melbourne Magistrates Court granted a Family Violence Intervention Order against Mr Doherty.

Mental Health History

21. Dr Ruth Vine, Director of Mental Health and Deputy Chief Psychiatrist of Waratah Mental Health, reviewed Mr Doherty's medical file and reported that he was admitted to the Royal Melbourne Hospital on 28 August 2012 due to an accidental overdose of quetiapine[3] and excessive alcohol consumption.

22. Mr Doherty stayed as an involuntary patient for two weeks and was noted to have an elevated mood and persecutory beliefs and a past history of Bipolar Affective Disorder. Mr Doherty's presentation was seen to be consistent with a manic relapse of Bipolar Affective Disorder.[4]

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[3] Short acting anti-psychotic used to treat bi-polar disorder, branded as Seroquel

[4] Report of Dr Ruth Vine, North Western Mental Health

23. Following Mr Doherty's release from the Royal Melbourne Hospital in September 2012 he went to reside with his mother.

24. At this time Mr Doherty was referred to the Continuing Care Team at Waratah Clinic under the supervision of Dr Jones, consultant psychiatrist, and case manager Ms Stefanie Griffiths.

25. Dr Jones made the decision to continue Mr Doherty's involuntary treatment under a Community Treatment Order as he was in the early stages of recovery after his hospital admission. Mr Doherty's medication at the time consisted of Lithium and Olanzapine.

26. His case manager on the Continuing Care Team, Ms Stefanie Griffiths, who engaged him in treatment and provided psycho-education around managing his bi polar affective disorder, saw Mr Doherty fortnightly.

27. Mr Doherty's medical history indicates he had not been compliant with the Olanzapine he had been prescribed to counteract the effects of his manic episodes.

28. Dr Jones, who was his treating psychiatrist from 25 September 2012, discussed Mr Doherty not taking his Olanzapine with him on a number of occasions. Mr Doherty indicated that he did not like the side effects and that he continued to take his lithium.

Days immediately preceding Craig's death

29. Mrs Doherty did not see her son between the time she applied for the intervention order on 20 December 2012 and 13 January 2013.

30. The application for the intervention order was heard on 10 January 2013, and included that Mr Doherty's son was covered by an intervention order prohibiting him witnessing family violence.

31. On 10 January 2013 Mr Doberty's case manager, Ms Stefanie Griffiths, contacted Mr Doherty and he reported he had moved out of his mother's house as he found living with his mother too stressful.

32. Mr Doherty also reported delusional beliefs about being kidnapped by the Hells Angels over Christmas.

33. Following this call Ms Griffiths contacted Mr Doherty's GP, Dr Hewa, and his mother, noting deterioration in Mr Doherty's mood and behaviour.

34. On 11 January 2013 Mr Doherty called Ms Griffiths and indicated he was considering moving from his rental property, and reported a paranoid ideation that Dr Hewa was injecting him. Mr Doherty specifically denied any homicidal or suicidal ideation when asked by Ms Griffiths.

35. On 12 January 2013 Mr Doherty's mother spoke to him on the phone and he told her that bikies had done terrible things to him, and that a doctor was giving him injections in his legs.

36. On 13 January 2013 at approximately 8:00am Mr Doherty telephoned his mother indicating that his lawyer had told him he could not see her. Mrs Doherty told him this was incorrect and that he could come and see her.

37. Later that afternoon, around 2:30pm, Mr Doherty arrived at his mother's place in a restless state saying he had murdered Daniel Grollo and was worried that his mother's house was bugged and that he was leaving as he wasn't feeling well.

First attendance at Flemington Police Station

38. At 7:21am on 14 January 2013 Mr Doherty attended the Flemington Police Station and was served with the Family Violence Intervention Order relating to the incident against his mother on 20 December 2012.

39. Constable Marco Michetti was working at the Flemington station when Mr Doherty attended to pick up the intervention order.

40. Constable Michetti found Mr Doherty's demeanour to be calm and responsive and that he spoke very clearly. Constable Michetti says that Mr Doherty was in good spirits, he accepted all the conditions of the order without showing any resentment about it, and thanked Constable Michetti when he left the police station.

41. Constable Michetti then called Mr Doherty's mother to inform her of the service of the intervention order.

GP Appointment

42. Mr Doherty's mother later ran into Mr Doherty by chance in Wellington Street at approximately 8:10am, when he told her he had been walking around Fitzroy all night as he could not get into his locked accommodation, the room he was renting from Dr Hewa.

43. Mr Doherty and his mother walked back to her house in Wellington St, Flemington and then walked to Dr Hewa's office for a 9:00am appointment at the Wellington Street Medical Centre.

44. Mr Doherty and his mother went to get the spare key from Dr Hewa and while they were there Dr Hewa took a blood test to test Mr Doherty's lithium levels.

45. Dr Hewa's notes from 14 January 2013 indicate that Mr Doherty presented as disturbed and irrational, and that he could not recall taking his prescribed dose of Lithium the night before.

46. Dr Hewa contacted Waratah Mental Health and it was arranged for Mr Doherty to be seen by his case manager as soon as possible.

47. Mrs Doherty also contacted Waratah Mental Health, requesting an appointment due to how unwell Craig appeared. An appointment was made for 10:00am.

48. Dr Hewa identified paranoid features in Mr Doherty, that he is probably not taking his medication, drinking alcohol and that he needed to attend Waratah to have his medication reviewed and a supervised treatment plan as an inpatient put in place.

49. Dr Hewa's report indicates that Craig's current medication included Aspirin, Betamin (Thiamine Hydrochloride), Lithicarb and Minax (Metoprolol tartrate).

50. Dr Hewa's notes refer to the contact with Mr Doherty's case manager and includes *'Discuss with staff concerns, needs admitted (sic) to royal avenue.'* [5]

Waratah Mental Health: attendance at Crisis Care

51. North Western Mental Health reports indicate that Mr Doherty was given an urgent appointment to be seen by his case manager and Dr Heneghan, a medical officer, on 14 January 2014.

52. It was noted that Mr Doherty might be presenting 'in crisis' for his appointment at 10:00am on the morning of 14 January 2013, and the need to again prescribe Olanzapine was identified.

53. Dr Heneghan, from the Continuing Care Team, states that Mr Doherty presented as compliant with his medication (lithium 750mg BD) and that he presented as calm, polite,

[5] This may be a reference to Royal Melbourne Hospital

talking clearly and coherently with no evidence of pressured speech or thought disorder, and no clear signs of anxiety.

54. Mr Doherty told Dr Jones **(corrected to Dr Heneghan)** and his case manager, Ms Griffiths, that he had been up all night. He expressed delusional beliefs regarding the Hell's Angels holding a conference in Melbourne and was worried about being kidnapped by them.

55. Mr Doherty described people trying to enter his room, which is consistent with the comments Mr Doherty made to his mother. Mr Doherty also expressed delusions about Dr Hewa injecting him with rohypnol.

56. It was noted that Mr Doherty specifically denied suicidal ideation and expressed no plans to harm others.

57. It was identified that Mr Doherty's mental state was deteriorating and an increased preoccupation that others were trying to harm him was noted.

58. The options that were identified following the assessment were of admitting Mr Doherty to a psychiatric inpatient ward, or for him to remain in the community and start oral antipsychotic medication (Olanzapine) immediately with supervision from the Crisis Assessment and Treatment Team.

59. Mr Doherty wanted to avoid hospital admission and agreed to have his medication administration supervised at home that evening and for the next few nights, to monitor his mental state. [6]

60. Following his appointment at Waratah Mental Health Mr Doherty returned to his room to drop off his prescription and then returned to his mother's house at approximately 11:30am with a few clothes, a bottle of wine and half a dozen cans of beer after asking if he could sleep over that night.

61. At 2:45pm Mrs Doherty left home for an appointment and it appears Mr Doherty proceeded to consume approximately five cans of beer throughout the afternoon while at her house.

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[6] Report of Dr Ruth Vine, North Western Mental Health

63. Constable Wes McCade states that Mr Doherty was calm in his actions and that he said that the bikies were making a movie about him, with actors playing the parts of himself and his mother.

64. Constable McCade found that Mr Doherty did not appear to be substance affected during the conversation.

65. Constable McCade then spoke to Sergeant Reid, who had had previous dealings with Mr Doherty due to the intervention order.

66. Constable McCade and Sergeant Reid discussed concerns for Mr Doherty's welfare and whether he was likely to harm himself or others and Constable McCade felt from his observations of Mr Doherty's demeanour and behaviour that he did not appear to provide a risk.

67. Sergeant Reid observed Mr Doherty from behind the one-way glass in the watch-house area and observed that he appeared calm, but seemed concerned about issues with his mother.

68. Sergeant Reid and Constable McCade both concluded that while Mr Doherty was producing fictitious stories they had no immediate concerns for his welfare or that he would hurt himself or another person.

69. The security footage of the police station shows Mr Doherty sitting calmly in the foyer. [7]

70. Sergeant Reid outlined to Constable McCade that Mr Doherty was prone to making up stories regarding bikies and money and that Constable McCade should test the veracity of Mr Doherty's stories to the best of his ability.

71. Constable McCade spoke further to Mr Doherty, who made no further mention of the bikies and said he was going home. Constable McCade told Mr Doherty that as the police station was just next door he could come in again if he had any concerns.

72. Constable McCade then concluded the most appropriate action was to place a Person Warning Flag on the police system noting Mr Doherty was creating fictitious stories.

73. Security footage obtained during the investigation shows Mr Doherty leaving Flemington Police Station at 4:03 pm.

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[7] Exhibit 2

Flemington High Rise

74. Footage from security cameras obtained during the investigation shows Mr Doherty entering the Ministry of Housing building situated at 126 Racecourse Rd, Flemington, and taking the central elevator to the top floor.[8] There is no camera footage from the 20th floor, the top level.

75. At approximately 4:45pm Mr Doherty placed a chair next to the balcony window, opened it and jumped out.

76. Mr Doherty was located deceased at the base of the Ministry of Housing High Rise Flats at 126 Racecourse Rd, Flemington by police at approximately 4:48pm.

77. Detective Senior Constable Ryan, Coroner's Investigator, states that he observed that Mr Doherty's watch had stopped at 4:45pm, believed to be his time of death.

78. There were no witnesses to Mr Doherty's death.

79. Initial investigations indicated that Mr Doherty may have made the decision to take his own life prior to leaving his mother's house as when police later attended at Mr Doherty's mother's premises it was noted that a number of beer cans were left next to a newspaper with front page containing a large colour picture of high rise flats with the title 'Grim Towers to go'.[9]

Police contact

80. As a result of Mr Doherty's contact with police just prior to his death 'active oversight' of the investigation occurred, pursuant to the Victoria Police Oversight Framework.

81. Police descriptions of Mr Doherty's demeanour are consistent with the statements of Mr Doherty's treating doctors he saw on 14 January 2013, who described him as calm, although displaying persecutory beliefs.

82. Mr Doherty attended with his mental health caseworkers on the morning of his death, but they did not consider that he required involuntary incarceration at the time and he could appropriately be supervised on medication in the community.

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[8] Exhibit 1

[9] Exhibit 6. It is noted that this is not the same block of flats and that attending police believed the idea may have been conceptualised upon Mr Doherty viewing the photo.

83. Mr Doherty did not express any suicidal ideation to the police, to his GP or to the Continuing Care Team members who saw him on the day of his death.

84. A review of the CCTV footage from within 126 Racecourse Rd and security footage from Flemington Police Station shows that Craig appears calm in the footage.

85. I note that Mr Doherty's mother has not raised any issues with Mr Doherty's care or contact with police.

Findings

Having considered all the evidence, I find that Mr Craig Doherty died as a result of multiple injuries after a fall from height on 14 January 2013, in the circumstances outlined above, and that his actions were intended to bring his life to an end.

I find that the police dealings with Mr Doherty did not directly contribute to his death.

I further find that Mr Doherty was not a *person placed in care or custody* as defined by section 3(1) of the *Coroners Act 2008* immediately before his death.

Pursuant to section 73(1A) of the **Coroners Act 2008**, I direct that a copy of this finding by published on the internet.

I direct that a copy of this finding be provided to the following:
Mrs Helen Doherty
Detective Senior Constable Cameron Ryan, Coroner's Investigator
The Chief Psychiatrist
Mr Peter Kelly, Director Operations, North Western Mental Health

Signature:

PETER WHITE
CORONER
Date: **29 May 2015**

Coroners Court of Victoria