IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: 2011 / 0099

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)
*Section 67 of the **Coroners Act 2008***

Inquest into the Death of: MELANIE JANE MAHER

Delivered On:	6 MARCH 2014
Delivered At:	Coroners Court of Victoria Level 11, 222 Exhibition Street, Melbourne
Hearing Dates:	7 JUNE 2013
Findings of:	JUDGE IAN L GRAY, STATE CORONER
Representation:	Mr Robert McCloskey on behalf of NorthWestern Mental Health Service Ms Joanna Davidson on behalf of Department of Human Services Mr Guy Gilbert on behalf of Department of Health and the Office of the Chief Psychiatrist
Police Coronial Support Unit	Sergeant Sharon Wade

I, JUDGE IAN L GRAY State Coroner, having investigated the death of MELANIE JANE MAHER

AND having held an inquest in relation to this death on 7 June 2013
at MELBOURNE
find that the identity of the deceased was MELANIE JANE MAHER
born on 14 August 1997
and the death occurred 9 January 2011
at 1/76 Southern Road, Heidelberg Heights
from:

1 (a) EFFECTS OF FIRE

in the following circumstances:

BACKGROUND

1. Melanie Jane Maher was born on 14 August 1997 in Northcote, Victoria to Kylie Jane Fowler and Dominic Patrick Maher. Melanie Maher was in the permanent custody of Kylie Fowler after Patrick Maher relocated to Tasmania after the breakdown of his relationship with Kylie. Melanie was a student at Macleod Secondary College and was preparing to enter Year 8 in 2011. Melanie was 13 years old at the time of her death. There is no record of a Birth Certificate in the name of Melanie Jane Maher, born 14 August 1997, at the Registry of Births, Deaths and Marriages in Victoria. Medical records were obtained relating to the birth of Melanie Maher.

2. Kylie Jane Fowler was born Kylie Jane Fisher on 31 January 1974 in Takapuna, New Zealand to Colin and Pauline Fisher. Ms Fowler was the oldest of three siblings with a younger sister Karen and younger brother Glenn. Ms Fowler was 36 years old at the time of her death.

3. Samantha Jane Fowler was born on 17 June 1992 in Frankston, Victoria to Kylie Fowler and Gary Philip Fowler. Samantha Fowler resided with her father Gary from 2003 when he was granted full custody by the Family Court of Australia. In late 2010, Samantha Fowler began residing with Gary Fowler's former de facto wife Leanne Griffin (nee Souter) after a falling out with her father. Samantha Fowler had recently completed her Year 12 studies at Carrum Downs Secondary College. Samantha was 18 years old at the time of her death.

4. Matthew Patrick James Maher was born on 22 June 1999 in Epping, Victoria to Kylie Jane Fowler and Dominic Patrick Maher. Matthew Maher was also in the permanent custody of Kylie Fowler after Patrick Maher relocated to Tasmania after the breakdown of his relationship with Kylie Fowler. Matthew was a student at Olympic Village Primary School and was preparing to enter Year 6 in 2011. Matthew was 11 years old at the time of his death. There is no record of a Birth certificate in the name of Matthew Patrick James Maher, born 22 June 1999 at the Registry of Births, Deaths and Marriages in Victoria. Medical records were obtained relating to the birth of Matthew Maher.

5. On 26 February 1993, Ms Fowler had her first involuntary admission to a mental health facility, Larundel, where she was hospitalised until 9 March 1993. It was the beginning of her documented struggle with mental illness and she was eventually diagnosed with schizophrenia, characterised by symptoms of paranoia, auditory hallucinations and anxiety. Ms Fowler experienced numerous episodes of psychosis from that time until her death; she was hospitalized involuntarily a total of five times. Ms Fowler had always denied she suffered from a mental disorder and she had consistently rejected the notion that she would benefit from medication and ongoing management of her condition. Ms Fowler was said to have had very poor insight into her condition and as such, her self-medication was sporadic, resulting in further incidents of psychosis. Despite years of mental illness, Ms Fowler never once sought medical/psychological intervention herself, and all her admissions were involuntary.

6. Ms Fowler's status as a long-term mental health patient required monitoring and management by medical professionals. Ms Fowler was prescribed the antipsychotic risperidone, to assist in managing her mental health, which was to be taken in quantities of 3mg per day.

7. Medical records[1] revealed Ms Fowler had been prescribed this medication for many years over the duration of her mental illness. The treatment was designed to manage the symptoms of her schizophrenia and to assist Ms Fowler to maintain a relatively normal mental state. During periods of hospitalization, Ms Fowler was also administered psychoactive medications, for example temazepam, clonazepam and benztropine.

[1] Medical records of Kylie Fowler

8. Once admitted as an involuntary psychiatric patient, Ms Fowler's treating physicians aimed to monitor her thoughts and behaviour and re-establish her medication regime in an effort to alleviate her psychotic symptoms. Her various treating teams identified that Ms Fowler needed ongoing monitoring due to her poor insight into her condition and also her propensity to not take her medications.

9. After each release as an involuntary psychiatric patient, Ms Fowler was required to enter into a period of case management, which enabled her transition back into the community and monitor her mental state and compliance with medications. These management periods varied.

10. In summary, Ms Fowler was diagnosed with schizophrenia, was hospitalized five times between 1993 and 2006 and was prescribed risperidone which when taken as prescribed, appeared to control Ms Fowler's experience of paranoia, abnormal thoughts and auditory hallucinations. It is reasonable to conclude that Ms Fowler was experiencing a psychotic episode in the lead up to the events of 9 January 2011 but it remains unknown what triggered the episode. Ms Fowler died on 9 January 2011, along with her children Samantha, Melanie and Matthew, from the effects of fire which consumed the house at 1/76 Southern Road, Heidelberg Heights.

Causes of Deaths

11. Post mortems were conducted on each of the four deceased. The details are as follows:-

12. On 10 January 2011, Dr Bedford of the Victorian Institute of Forensic Medicine performed a post mortem examination on Ms Fowler. He observed that there were burns, redness and bruising to the legs, abdomen, left side of the chest, left arm, face and hands of the deceased. There was bruising on the inside of the upper left and right arms consistent with a person being grabbed. There was also blood in the mouth cavity and minor sooting in the larynx[2]. Toxicologist Kathryn Wong studied blood samples taken from the deceased and determined that the deceased had a carboxyhaemoglobin (carbon monoxide) saturation of 17% and traces of risperidone reading 40 ng/mL and hydroxyrisperidone reading 25 ng/mL.[3]

[2] Pathologist Report prepared by Dr Paul Bedford

[3] Toxicology Report prepared by Dr Kathryn Wong

13. On 10 January 2011, Dr Bedford of the Victoria Institute of Forensic Medicine performed a post mortem examination on Samantha Fowler. He observed that there were burns, redness and bruising to the legs, abdomen, arms and face of the deceased. In an area 110mm x 180mm at the back of the head there were 23 stab wounds, 1 in the left ear, 1 on the rear of the left shoulder, 2 on the left side of the neck near the lower chin and 4 on the back of the left hand that appeared to have been made by a stabbing motion rather than slicing. The deceased had sustained significant blood loss and there was very minor sooting in the larynx.[4] Toxicologist Kathryn Wong studied blood samples taken from the deceased and determined that the deceased had a carboxyhaemoglobin (carbon monoxide) saturation of 11%.[5]

14. On 10 January 2011, Dr Bedford of the Victorian Institute of Forensic Medicine performed a post mortem examination on Melanie Maher. He observed that there was full thickness burns over the entire body of the deceased. There were no obvious injuries otherwise. There was significant sooting in the larynx.[6] Toxicologist Kathryn Wong studied blood samples taken from the deceased and determined that the deceased had a carboxyhaemoglobin (carbon monoxide) saturation of 23% and traces of risperidone reading 90 ng/mL and hydroxyrisperidone reading 64 ng/mL and promethazine of 0.2 mg/L.[7]

15. On 10 January 2011, Dr Bedford of the Victorian Institute of Forensic Medicine performed a post mortem examination on Matthew. He observed that there was full thickness burns over the entire body of the deceased. In the area of the right hand, head, neck and shoulder there were 20 stab wounds. There was 1 stab wound to the webbing of the left hand. There was also minor sooting in the larynx.[8] Toxicologist Kathryn Wong studied blood samples taken from the deceased and determined that the deceased had a carboxyhaemoglobin (carbon monoxide) saturation of 27% and traces of risperidone reading of 340 ng/mL and hydroxyrisperidone reading 240 ng/mL and promethazine reading of 0.5 mg/L.[9]

16. The cause of death in each case, in summary was:-

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[4] Pathologist Report prepared by Dr Paul Bedford

[5] Toxicology Report prepared by Dr Kathryn Wong

[6] Pathologist Report prepared by Dr Paul Bedford

[7] Toxicology Report prepared by Dr Kathryn Wong

[8] Pathologist Report prepared by Dr Paul Bedford

[9] Toxicology Report prepared by Dr Kathryn Wong

- Kylie Jane Fowler – Effects of Fire
- Melanie Maher – Effects of Fire
- Matthew Maher – Effects of Fire and stab wounds
- Samantha Fowler – Effects of Fire and stab wounds.

17. On the evidence, Ms Fowler was responsible for causing the fire at 1/76 Southern Road Heidelberg Heights on 9 January 2011 and for inflicting the stab wounds on Matthew Maher and Samantha Fowler. I find that Kylie Fowler killed herself and her three children on 9 January 2011 and I infer that she did so in the course of a prolonged psychotic episode.

18. Detective Senior Constable (DSC) Mick Cashman, the Investigating Member prepared a very thorough inquest brief and stated in his summary:

"I have a thorough understanding of the facts and circumstances surrounding the life of Kylie Fowler and I have insight as to how it became possible for her to commit such a callous and violent attack against her own children. Sadly for Kylie, the contributing factors appear to have been evident since her early childhood. Kylie's battle with schizophrenia is not unique in our community; indeed, approximately 1% of individuals live with this condition with varying degrees of success – most of whom do not commit such offences. However, from time to time the community is subjected to an incident like this one that is so horrific that it defies belief. In short, Kylie's case simply fell through the cracks of the mental health systems, including primary care services and had done so for nearly 20 years. I humbly submit the following recommendations to minimise the likelihood of it happening again:

1. Make provisions under the *Mental Health Act* so that persons diagnosed with a serious mental illness and who have had more than three involuntary admissions to Psychiatric Units are placed on a life-time registry that enables the Department of Human Services to monitor their condition and movements such as address changes or interstate transfers.

2. Ensure the Department of Human Services has the resources to enable them to make such enquiries regarding the long term mentally ill to confirm compliance with recommendations from their treating physician and that they are adhering to prescribed medications.

3. Creation of a central database which details all dealings with persons who are long term mental health patients. This database needs to be accessible to agencies such as Clinical

Psychiatrists, Department of Human Services and Victoria Police (This list is not exhaustive but are the most likely to access the records).

4. Ensure that CATT services prioritise these individuals when contacted regarding an assessment.

5. Mandate the Secretary of the Department of Human Services to maintain such a registry and be responsible for compliance with amendments to the Act."

19. I agree with DSC Cashman's description of and characterisation of the circumstances in this utterly tragic case. However, his proposed recommendations need to be very carefully considered and I received submissions and comments about them that I will deal with later in these findings.

The Issues Considered

20. The issues considered in this inquest were:-

- Child Protection – The protection of Melanie and Matthew after Department of Human Services (DHS) closed its files
- Communication between Darebin Community Mental Health Clinic (NorthWestern Mental Health, 'Darebin CMHC') and the DHS
- Communication between Darebin CMHC and the Kylie Fowler's GP/the Edwardes Street Clinic
- The provision of education, information, advice and/or counselling to the children of persons suffering a mental illness.

21. Evidence was given by DSC Cashman, the investigating member, Ms Janne-Maree Blackman, on behalf of Darebin CMHC, Ms Beth Allen, Assistant Director Child Protection, and currently acting the role as Director Statutory and Forensic Services of the Department of Human Services (DHS).

22. Submissions and documents of Dr Mark Oakley Browne, Chief Psychiatrist of Victoria provided materials on behalf of the Department of Health dealing with discharge guidelines, discharge planning, information sharing guidelines and relevant protocols. Dr Browne made a statement commenting upon the proposed recommendations put forward by DSC Cashman.

23. The Department of Education and Early Childhood Development (DEECD) provided me with a statement setting out answers to specific questions posed to them arising out of the

Directions Hearings in April 2013. The material DEECD provided dealt with the issue of Melanie Maher's school absences. DEECD provided me with rules and policies governing absences, notification of absences and action following them. DEECD provided me with the Macleod College Student Engagement Policy and other documents relevant to policy and practice in respect of school attendance.

24. The final submissions were made on behalf of Darebin CMHC, and on behalf of DHS.

The Chronology Relevant to the Issues

25. 31 January 1974 – birth of Kylie Jane Fowler.

    17 June 1992 – birth of Samantha Jane Fowler.

    14 August 1997 – birth of Melanie Jane Maher.

    22 June 1999 – birth of Matthew Patrick James Maher.

    1993 – Kylie Fowler's first involuntary admission to a mental health facility.

26. Between December 1997 and December 2006 Child Protection received five 'reports' in relation to Melanie and four in relation to Matthew.[11] The first three reports for Melanie and the first two reports made in relation to Matthew were closed at the intake stage of Child Protection involvement, as Child Protection assessed that there was no immediate or significant risk of harm to the children.[12]

27. Samantha Jane Fowler was the subject of eleven reports to Child Protection, and Child Protection was last involved with her in 2005.

28. Between 5 August 2003 and 4 August 2004, the Children's Court made supervision orders for twelve months in respect of Melanie and Matthew.[14]

29. Between 2003 and 2004, the Children's Court made twelve-month supervision orders in respect of Melanie and Matthew due to concerns regarding Ms Fowler's mental health. Melanie and Matthew were placed in the care of their father, Mr Maher, for a short time

[11] Ibid, paragraph 7

[12] Ibid pg 3, paragraph 9

[14] Ibid pg 3, paragraph 12

when Ms Fowler was acutely unwell prior to final orders being made. The children otherwise resided with Ms Fowler. [15]

30. In October 2004, Child Protection ceased its involvement with the children when the supervision orders expired.[16]

31. In December 2006, Child Protection again became involved with Melanie and Matthew after receiving a report that Ms Fowler had become mentally unwell and was being admitted to hospital. Child Protection assessed that Melanie and Matthew were at risk of significant harm and initiated protection applications in the Children's Court in respect of them. Then Children's Court made interim accommodation orders placing the children in foster care.[17]

32. On 22 January 2007, the Court found the protection applications proven and made a three month interim protection order in respect of each child.[18]

33. On 19 April 2007, the Children's Court was satisfied that Ms Fowler had adhered to the conditions of the interim protection orders and, consistent with DHS's recommendation, permitted the interim protection orders to lapse without making any further orders. As neither the Court nor Child Protection considered that further orders were necessary, Child Protection ended its involvement with Ms Fowler and the children in June 2007.[19]

34. In early 2007, Ms Fowler's mental health care was transferred to Darebin CMHC from Northern Psychiatric Inpatient Unit (Epping).

35. On 26 February 2007, Ms Fowler had an appointment at Darebin CMHC with consultant psychiatrist Dr Kleeburg and psychiatric nurse Heather Creighton.

36. From April 2007 to September 2007, Ms Fowler's mental health was the subject of various reviews by Darebin CMHC.

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[15] Ibid pg 3, paragraph 13

[16] Ibid pg 4, paragraph 14

[17] Ibid pg 4, paragraph 15

[18] Ibid. pg 4, paragraph 18

[19] Ibid pg 5, paragraph 20.

[22] 'Flash Over' refers to the point at which the temperature reaches over 600 deg. Celsius and ignites the trapped fumes causing a ball of fire to expand rapidly as the fumes are consumed.

37. In September 2007, Ms Fowler was discharged to the care of a general practitioner (GP) at the Edwardes Street Clinic. On 27 September 2007, Nurse Creighton completed a discharge checklist, which she sent to Ms Fowler's GP. Dr Kleeburg also wrote to an un-named GP at Edwardes Street Clinic. There was no further contact by Darebin CMHC.

38. From 2009 to 2011, Ms Fowler, Melanie and Matthew resided at 1/76 Southern Rod, Heidelberg Heights.

39. Prior to Christmas 2010 (specific date unknown), Dr Melissa White (Ms Fowler's previous treating psychologist) saw Ms Fowler at Bunnings.

40. On 5 January 2011, Ms Fowler went to Bunnings again and to a petrol station where she purchased petrol.

41. On 9 January 2011, Kylie Jane Fowler, Samantha Jane Fowler, Melanie Jane Maher and Matthew Patrick James Maher died at 1/76 Southern Road in Heidelberg Heights.

Circumstances of Deaths

42. On Sunday 9 January 2011, a number of '000' calls were made to Emergency Services requesting Police, Ambulance and Fire Brigade to attend the property known as 1/76 Southern Road in Heidelberg Heights.

43. The first caller to '000' initially reported an assault with an unknown victim bleeding at the address, but further calls escalated to reports of a house fire. Metropolitan Fire Brigade units attended the scene and were closely followed by Victoria Police and Ambulance Victoria. Those first responders on the scene found the rear of the premises engulfed in flames and observed smoke billowing from the rear windows. Chaos reigned as reports from witnesses indicated they believed there were two people inside, one of them injured and the other allegedly armed with a knife.

44. Members of the Metropolitan Fire Brigade and Victoria Police entered the property and battled to locate the occupants under extremely hazardous circumstances. Shortly thereafter the fire 'flashed over'[22] sending a fireball racing through the interior. This caused the evacuation of members from the building. Fire fighters continued to attack the blaze from outside until it was extinguished. Only then did an inspection of the property reveal the bodies of four deceased persons. Two lay in the rear bedroom of the property, one in the study/bedroom and one in the rear hallway.

45. A crime scene was established and the scene was managed by the numerous Police units from the surrounding district, the Darebin Crime Investigation Unit and the Arson & Explosives Squad. An investigation commenced into the deaths of those people later identified as Kylie Jane Fowler aged 36, Samantha Jane Fowler aged 18, Melanie Jane Maher aged 13 and Matthew Patrick James Maher aged 11. The Police investigation was conducted by the Arson & Explosives Squad and given the codename Operation Tamasha.[23]

The Issues

Child Protection and Communication between Darebin CMHC and the DHS

46. Evidence was given on this matter by Beth Allen on behalf of DHS. Submissions were made in light of that evidence and the chronology of events. The key points made in the DHS submission were:

"...There was nothing in her history that could or should have alerted the Department to the possibility that Ms Fowler would directly harm any of her children physically, let alone in the manner she ultimately did. In particular:

(a) In no case notified to Child Protection was there any concern or suggestion that Ms Fowler posed a risk of physical violence toward the children.

(b) In notifications in which Ms Fowler's mental health was a concern, the risk of harm to the children was assessed as a risk of emotional or psychological harm as a consequence of being exposed to Ms Fowler's deteriorating mental state and her irrational behaviour. Even during her periods of acute mental illness, there was no suggestion the children were at risk of physical harm. This was particularly the case in respect of the episodes of acute mental illness resulting in Protection Orders and Child Protection involvement in 2003/2004 and in 2007.

(c) Ms Fowler was otherwise assessed as being a very caring mother."

(d) Ms Fowler's mental health had stabilised and her doctor was happy with her compliance with medication.

[23] Summary Inquest brief pages 1 & 2.

(e) There were no other protective concerns in relation to the children. Indeed, the school had considered the children to be well cared for.

47. As stated earlier, DHS concluded its involvement with Melanie and Matthew in June 2007. Evidence was given by Ms Allen on dealing with the case closure process. On the evidence, DHS did not advise the children's school or Darebin CMHC in writing of the closure of its case. In this context Ms Allen made an appropriate concession and said:

> "The Department has identified that the file reveals potential deficiencies in the case closure process (see statement of Beth Allen at paras 39-40). In particular:
>
> (a) There is no evidence of a safety plan being made with Ms Fowler that would apply after Child Protection discontinued its involvement..."
>
> (b) There is no evidence on the Department's file that Child Protection advised the children's school or Ms Fowler's mental health service provider by letter of its closure of the case. The records do not indicate that Child Protection clearly communicated to Ms Fowler's mental health service provider that the Department's decision to withdraw involvement was, in part, based upon Ms Fowler continuing to engage with its service, or that they were advised of the circumstances in which it would be appropriate to make a further report if Ms Fowler did not continue her treatment. However:
>
> (i) It is clear that Darebin Community Mental Health was verbally advised that DHS was withdrawing involvement; that there was an understanding that there were potential issues with engagement and compliance; and that Darebin's involvement with Ms Fowler would continue, including outreach visits.
>
> (ii) The children's school was aware of the involvement of Child Protection.
>
> While the Department acknowledges these deficiencies in process, it would be highly speculative to conclude that it would have made any difference to the tragic events that occurred almost four years later."

48. I agree with the final proposition. Sadly, it is not open to conclude that a better, tighter case closure process would have made any difference in the long term.

49. The DHS submission argued:

"The Department submits that an assessment and response based upon the individual circumstances of the case is the most appropriate and effective way to protect children at risk of harm, and to ensure resources are prioritised to cases where children are most at risk."

50. I accept that submission.

51. Submissions were also made on behalf of Darebin CMHC. In its submission, the clinic said: "The DHS must be aware of the possibility of an untreated relapse of a voluntary patient and need to update their information by checking with their client after ceasing current involvement."

52. Exhibit 6 confirms that Darebin CMHC provided information to DHS about Ms Fowler's mental condition in the context of DHS ceasing involvement.[24]

53. In this case there was not a written plan or written confirmation sent by DHS confirming the telephone conversations in relation to the children on or about the 19 February 2007. The DHS file note (Exhibit 5) was "that Ms Creighton said she would speak to social workers about linking Kylie and the children in with counselling groups run through DCMHC."[25] [26]

54. This very point was conceded by Ms Allen and appropriately so. However the DHS has submitted, and it is supported by the evidence, that Darebin CMHC was verbally advised that DHS was withdrawing involvement. The children's school was also aware of the involvement of Child Protection.

55. In relation to Melanie Maher's school absences from Macleod College, DEECD submitted a lengthy report under cover of a letter dated 13 May 2013. The report documented the number of absences in 2010 per term: Term 1 – 3 days; Term 2 – 6 days; Term 3 – 13 days; Term 4 – 12 days. Significantly, in its document the DEECD states:

"The College advises that Melanie Maher did not present as a student at risk, or a student with anything other than an ordinary family and home life. She was performing well academically, she was up-to-date with school work, was studious, well-behaved, well-kept and clean, brought lunch from home, went on excursions, participated in school sports and

[24] Transcript pg 25, lines 15-20.

[25] Transcript pg 23, line 2 onward.

[26] Fowler Mahar Submission – Robert McCloskey pg 3

other extracurricular activities. She had a stable group of friends and never appeared to be upset, distressed, anxious, lonely or withdrawn at school. There were no concerns held by staff about Melanie Maher's behaviour, moods, emotional state or safety at home. Neither Melanie Maher, nor any of her friends, nor any member of her family ever communicated to any teacher or principal at the College, any issues of concern.

Mr Stephen Pegg, Melanie Maher's English and Humanities teacher in 2010, has advised that he asked Melanie Maher about her absences on several occasions and she replied that she had been "sick". He believes that he asked her to bring a note to the front office to verify absences on such occasions.

In the context of other student absences, Melanie Maher's absences were not considered chronically problematic.

None of the staff at the College were aware of any issues there were out of the ordinary in relation to Melanie Maher. The College was not aware of any mental health or other issues regarding her mother (or any other family member). The College was not aware of any family involvement wit the Department of Human Services (DHS).

No further action was taken in relation to Melanie Maher's absences for the reasons set out above."[27]

56. I do not criticise the school for taking "no further action" in relation to Melanie Maher's absences.

57. The document submitted by DEECD goes on to set out changes to the procedures relating to the electronic recording of student absences since 2010. There is now an electronic role marking system for marking online and an additional process of checking and monitoring that marking system.

58. The DEECD advised that it has reviewed its attendance rules and policies; and in answer to the question "Are those rules and policies sufficient?" it set out processes intended to be implemented pursuant to the Education and Training Reform Amendment (School Attendance) Bill 2013. There is no need to detail these matters. It is sufficient to observe that the document refers to the obligations of schools to follow the processes to be

[27] Department of Education and Early Childhood Development (DEECD) Response to Coroner's Questions dated 11 April 2013 – paragraphs 2.1; 2.3 – 2.6.

implemented under the heading "Compulsory School Attendance" procedures for schools and school attendance officers". Guidelines have been developed and these provide a framework for the enforcement of compulsory school attendance and articulate the range of supports and strategies schools can put in to place to promote attendance and address non-attendance.

59. Having read the material, I accept the DEECD's assertion that: "The Draft Guidelines are very comprehensive and provide more guidance to schools, particularly in relation to reporting concerns to DHS, that the current DEECD policy 'Effective Schools are Engaging Schools: Student Engagement Policy Guidelines'"[28] This document was submitted. It was published in March 2009. The guidelines titled "Compulsory School Attendance: procedures for schools and school attendance officers" had been developed to accompany the legislation, and intended to commence of 1 January 2014.

60. The DEECD drew my attention to the section in the guidelines "Reporting Concerns: Referral to Child FIRST or report to Child Protection". I accept that this appears, at least on its face, to be an appropriate policy response to dealing with prolonged or repeated absence by students who may require assessment as to whether they are at risk or not. The DEECD highlighted the following paragraph:

"If, through enquiries and engagement with families to follow up attendance issues, a principal or other mandated staff member has formed a belief that the child has suffered or is at risk of suffering significant harm, or is in need of immediate protection, they must make a report to child protection. (Include the link to mandatory reporting training).[29]

61. The additional material provided relates to circumstances in which schools are notified of DHS involvement with families of children attending Victorian schools. The DEECD reported the only "formal" arrangements on that occasion, by DHS to schools relate to students in "out of home" care which includes a number of situations but was not relevant to Melanie and Matthew, most certainly after DHS ended its formal involvement with them in June 2007. I add that I appreciate the assistance provided by the DEECD in this inquest. I should also add that the material does not deal with any issues arising from absences (if there were any) on the part of Matthew Maher.

[28] Ibid – paragraph 5.1

[29] Ibid – paragraph 5.2

Communication between Darebin CMHC and the Edwardes Street Clinic

62. A key question here is the communication between Darebin CMHC and the family's GP clinic (Edwardes Street) at the point of Ms Fowler's discharge from the Darebin CMHC mental health service. The reason for this being a relevant question is whether more could have been or should have been done at that point to ensure that in the event of relapse or non-compliance by Ms Fowler there would be a notification to, or awareness on the part of the area mental health service (NorthWestern Mental Health/Darebin CMHC). This includes the possibility of Ms Fowler being re-engaged by Darebin CMHC, treatment being resumed and her health being improved, with the potential reduction of any risk of harm to her children.

63. Ms Blackman, Program Manager Darebin CMHC, which is part of the NorthWestern Mental Health, gave evidence and provided a statement. I accept her evidence. She dealt with the issue of the connection between the mental health service and the GP. In this context, I note the various protocols that exist governing the relationship and discharge arrangements between mental health services and GPs (and I note in this context the documents attached to the statement of Dr Browne, Chief Psychiatrist). Ms Blackman told me that Ms Fowler's treatment by NorthWestern Mental Health concluded in about September 2007. She stated that at the end of the treatment the plan was to reconnect Ms Fowler with her GP and withdraw the services Ms Fowler had been using prior to that. She was asked what was put in place in relation to the GP referral by Darebin CMHC and she said:

"My reading of the file says as part of the discharge process, Ms Fowler's case was discussed at a fully multi-disciplinary team clinic review, which was part of our process, and that that was done on two occasions, in May and again in August, and based on those discussions at the full multi-disciplinary team review, it was felt that a discharge to a GP would be appropriate. Based on reading that file, it indicates that Ms Creighton had conversations with Ms Fowler about which GP practice she utilised and my understanding is that that was the Edwardes Street Medical Clinic. She didn't have an identified GP, according to the file, and as part of the GP process, a letter was written by the treating consultant psychiatrist, Dr Kleeberg, to the GP practice and Ms Creighton forwarded a copy of a case closure, an individual service plan, which is an individual plan that is developed with the consumer and the case manager about what their goals are and their needs are, a

copy of a risk assessment that was completed and also early warning signs which clearly outline – identify when a person is becoming unwell and what to do in those situations."[30]

64. On the issue of communication with any particular GP at the Edwardes Street Clinic she was asked and replied:

"You said that documentation was sent to the Edwardes Street Clinic?" ---Yes.[31] "It is fairly common for consumers not to have one nominated GP, but they do nominate a GP practice. Yes."[32] "So the basis of the communication between your body and the GP in this case was entirely that one letter and the documents that went with it. Is that correct? ---Yes."[33]

65. In relation to the specific question about communications with a particular GP, she stated that the letter from NorthWestern Mental Health Service was sent to the practice with an attached service plan and a case closure document, including a risk assessment. She stated that there was nothing documented on the file confirming that there had in fact been direct contact made with either a doctor at the practice or the practice itself.

66. She was asked about protocols operating at the time in relation to such communications. She told me that the relevant protocols did not actually come in to practice until mid to late 2007. She confirmed that Ms Fowler was discharged in September 2007, at about the same time the protocols were coming in to operation. In relation to the practices under the protocols she said:

"So these were written in consultation with the division of general practices and this was what we agreed would be the appropriate process and I can assure you that since that time we are now using these and we are following through with them. As I say, I can't guarantee, but certainly at the point of Ms Fowler's discharge, the local process at the clinic, Darebin Community Mental Health Centre, was that we would have communication with the GP; preferably it would be verbally and written, but not always that was the case."[34]

67. In relation to what happens now, she said:

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[30] 7 June 2013 Inquest transcript pg 4 & 5

[31] Ibid page 5 line 5 & 6.

[32] Ibid page 5 line 12 – 14.

[33] Ibid page 5 line 26 - 29.

[34] Ibid page 6 lines 20-29.

"Today communication happens at the point of allocation. So the referral comes, we allocate somebody, and at that point a letter is sent to the nominated GP or the GP practice informing them that we have picked up somebody for treatment for a period of time and that we welcome the GP's to communicate with us and that we will communicate regularly to GP's. Part of our process is that we then write to the GP's on a regular basis, and we try to do that on a six-monthly basis.[35] So that still happens, but it's more about we do have a process now where we actually start working with the consumer and the GP's at a lot earlier stage than what we were doing.

So if that had been in place when Kylie was being treated, then the time period that the GP was involved would have been much longer and there would have been, for what you're saying, more opportunities for your case manager and staff to have interacted with the GP. Would that be correct? –It may have."[36]

68. Connecting Ms Fowler (and persons in her situation) to a GP and confirming that this had been done is an important element of discharge planning. The key factor being the confirmation that follow-up is actually in place and that treatment will be actively undertaken by the GP who has received the referral. In other words there has been a concrete acceptance of the referral by a relevant GP. On this point Ms Blackman said:

"Basically in the second paragraph, it says "Where the consumer fails to attend their first appointment with the GP practice an attempt to contact the consumer in the first instance and reschedule appointments" – sorry – "The GP practice will attempt to contact the consumer in the first instance and reschedule another appointment. If the consumer fails to attend, the GP will advise the triage service, who will then review the clinical notes and make a decision in consultation with the GP regarding further required action."[37]

69. After these passages of evidence, Sergeant Wade put this to Ms Blackman:

"In hindsight, and obviously hindsight is fabulous, in Kylie Fowler's case it appears that she never went to the Edwardes Street Clinic. According to the Medicare records, she never

[35] Ibid page 7 line 6 – 14.

[36] Ibid page 7 lines 30 – 31 and page 8 lines 1 – 8.

[37] Ibid pg 8 lines 29- 30 and pg 9 1 – 7.

visited that GP clinic thereafter and because this protocol wasn't in place, you weren't aware of that, your service wasn't aware of that? – No we weren't."[38]

70. It is clear that the current protocol is an improvement on processes prior to its introduction in 2007, removing the obvious gap in follow-up. Clearly the protocol was not operating at the time of Ms Fowler's discharge because she never went to the Edwardes Street Clinic. Given the time gap between Ms Fowler's discharge and the deaths, it is speculation as to whether the improved protocol would have made any difference or not. Ms Blackman made these comments:

"The new process certainly hasn't stopped people falling through the cracks; people still do. People may engage with GP's for a period of time and then fall through the cracks after that we don't know about that." "I don't know whether protocols would have actually changed anything in the long run."[39]

71. Turning to the current situation she gave the following evidence:

"Skip to today. Now that you have your three to six month process where it's a longer engagement with the GP whilst your service is still maintained with a client, if the circumstances were the same and it was Kylie you were dealing with now, would there be a process now, if she didn't engage with the GP, didn't engage with your service in that lead-up period to the end of your involvement, to notify DHS that she wasn't being supported and she wasn't engaging? ---Under the new protocol if someone wasn't engaging with a GP, if they were still willing to attend the clinic, we wouldn't be discharging them until they were engaged with a GP. In relation to notification to Protective Services, it would be really on a case-by-case basis and if the children were at risk – if the mother was parenting well and the children were safe, we felt that they were safe and that at the moment, we may not do a notification, but we certainly wouldn't be discharging someone if they were still willing to come to the clinic and weren't engaging with a GP. We don't discharge until we know that they're well engaged. The only times that we do discharge against that process is if the consumer is voluntary and they tell us they don't want to come and they disengage from the service.

[38] Ibid page 9 lines 24 – 30.

[39] Ibid page 10 line 8 – 12; lines 18 & 19.

You would notify the other service of that. Is that what you're saying? --- Sorry, notify what other service?

Notify DHS? --- Ah I said, I don't – I don't know. I mean, I wouldn't have thought so unless there was concerns around the child's wellbeing and safety. If the child was safe and happy and healthy and that, I don't think we would do that as a matter of course, no.

Not across the board, but very specifically to Kylie's case, the only concerns with the children appear to have been when she's not engaged and she goes into decline. Do you think that it might be appropriate in those very select circumstances, that a referral would occur – a notification back to DHS would occur? --- I guess in the situation we weren't sure or by reading the file we weren't sure that she hadn't engaged with the GP practice because reading the entries by Ms Creighton, the couple of times she actually made the comment that she was engaging and that she was seeing a GP. I can't say that she wasn't engaged. We didn't know that she wasn't engaged. The GP never informed us she – we never had any contact about Ms Fowler or by Ms Fowler after the point of discharge so, yes, I don't know."[40]

72. The obvious breakdown in the system here was that there was no confirmation by the GP that he/she or the GP clinic had been actively engaged by Ms Fowler prior to, at the point of or after her discharge from the mental health service. There was no confirmation by the GP/clinic that she was engaged as a patient. I note that under the current protocol there is less risk of this happening. The short point is, as made by Ms Blackman, "We don't discharge until we know that they're well engaged."[41]

73. The Chief Psychiatrist provided me with a bundle of materials relevant to this issue. (These are contained within Exhibit 8). The relevant materials are the Chief Psychiatrist Guidelines, the Discharge Planning – Program Management Circular, the Information Sharing Chief Psychiatrist Guidelines and the Department of Health and VP Protocol.

74. The Chief Psychiatrist directly addressed the proposed recommendations put forward by DSC Cashman. I will return to that point in my concluding comments. At this point I simply note the materials appended to the statement of the Chief Psychiatrist. They were helpful contextual materials.

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[40] Ibid page 11 and 12.

[41] Ibid page 12.

Mental Health Literacy – advice, education, information and/or counselling for children of parents with a mental illness.

75. In relation to the key question of the protection of children of mentally ill parents, in the context of the protocol operating today, Ms Blackman was asked about children being referred to counselling for their own sake, and for their own safety rather than as part of a programs for the benefit of their parents – or as Sergeant Wade put it "programs that don't rely on the parent to have them undertake...". She asked Ms Blackman about current arrangements and Ms Blackman's evidence was, in summary:

"So we've really over the last five years really strengthened our relationship with family services and have developed some very good strong links and the other thing that we've started doing in late 2011 is a program called Let's Talk. It's a program where the case manager works with the consumer to identify ways to talk to their kids about the mental illness and things like that. We've been doing that and that's now part of standard practice as well. The majority of the staff are actually trained in that and we provide ongoing support groups for both consultation and Let's Talk for staff. So that's something that we do now and I think certainly since we've introduced that, we've seen – I think we've certainly seen changes in the way that we do work with other services and actually utilising services and referring consumers and their children out."[42]

76. It is clear that these are better protocols and arrangements than existed earlier. It has to be observed though that they are, as Ms Blackman said, "not long term programs".

77. She was asked about "mental health literacy"[43] She was asked:

"Does it include mental health literacy, to use that expression; in other words, giving children, perhaps youngish teenagers or even younger, the ? – We have these information packs. ---a proper understanding of what is happening? Yes.

A better way to put it, a sufficient mental health literacy ? –Yes.
And understanding to be able to recognise, raise concerns about a parent and their mental health. Does it cover that? ---Look, certainly Let's Talk does."[44]

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[42] Ibid page 17 and 18

[43] Mental health literacy is when a person understands the terminology of psychiatry, including the implications of symptoms and illness. This information then informs what they understand is happening with their parent and an understanding of reasonable expectations and behaviours, including boundary setting.

78. In answer to this, Ms Blackman pointed out the difficulties of engaging directly with children in the absence of their parents' knowledge or consent or support. She said:

"We probably wouldn't engage the children without the parent's permission. What we'd probably be doing is over an extended period of time continue to approach the subject with the consumer." "We would probably approach that way rather than approach the child directly, yes."[45]

79. I accept Ms Blackman's evidence on these matters.

80. The Let's Talk program, and programs of that type, appear to offer potential assistance to children such as those of Kylie Fowler. Ms Blackman supported the emphasis on "mental health literacy". She believes the Let's Talk program addresses a gap.

Could more have been Done? Were the deaths preventable?

81. There were adults involved in Samantha Fowler and Melanie and Matthew Maher's lives who provided caring and appropriate role modelling. However, Ms Fowler had an 18 year history of episodic schizophrenia. Her symptomatology was severe enough to require involuntary admission to an acute psychiatric unit on five occasions and to have periods of extended community based case management. During that time, there is minimal evidence any of the children received information to improve their understanding of their mother's mental illness.

82. There is a large body of evidence supporting the benefits of a person understanding the terminology of psychiatry, including the implications of symptoms and illness. This information then informs what a child understands is happening with their parent and an understanding of reasonable expectations and behaviours. A review of access to these programs reveals they are not available in all regions of Victoria. Almost all of them are only accessible to children/adolescents of parents who are being looked after by the area mental health service, are reliant on individual case manager identification of need, motivation of clinicians to educate parents to the programs benefits and make referral. DHS Child Protection and other non-government service providers are in most cases unable to refer directly to the programs. Public mental health services look after people with low

[44] Ibid pages 18 and 19

[45] Ibid page 19.

prevalence disorders[46] and have a high threshold for ongoing engagement. The majority of mental health care is provided by primary health services such as general practitioners to people with high prevalence disorders.[47] However, there are many patients with low prevalence disorders that are maintained in the community and who are referred to general practitioners with the expectation by the mental health service, the patient and their family, that they will provide ongoing care. This was the case with Ms Fowler. These services do not have direct referral rights to child/adolescent peer-support programs, specific to having a parent with a mental illness.

83. I accept the evidence of the witnesses from Darebin CMHC, noting the limits of their capacity to refer these children/adolescent to peer support programs specific to Ms Fowler's mental illness. However, at the end of the day it appears that Ms Fowler's three children were not meaningfully connected to any programs which may have assisted them to recognise or avoid or report their mother's deteriorating mental health. In this context, I note the case note entered by Sarah Evans stating "Heather said she will speak to the social workers about linking Kylie and the children in with counselling groups that are run through Darebin Community Mental Health". This is a reference to Heather at Darebin CMHC (Exhibit 5).

84. Sarah Evans' general case note of 6 April 2007 (Exhibit 6) refers to advice to Heather (at Darebin CMHC) that DHS would be withdrawing its involvement on Thursday of that week and sought an update of Darebin CMHC's future involvement. One of the dot points in the information provided by Heather and set out in the general case note states "Heather will link Kylie and children in with group run through Centre for Children with Parents with a Mental Illness.

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[46] Mental health disorders that affect a low number of the population. These include schizophrenia 1%, bipolar affective disorder 2% and drug induced psychosis (Victorian Department of Human Services, 2008).

[47] Mental health disorders that affect a higher number of the population, comprising of affective disorders (of which depression is the most common) and neurotic, stress-related and somatoform disorders (which include phobias and anxiety disorders, severe stress reactions, adjustment disorders, obsessive-compulsive and dissociative disorders).

[49] The Coroners Prevention Unit is a specialist service for coroners created to strengthen their prevention role and provide them with professional assistance on issues pertaining to public heath and safety.

85. I directed the Coroners Prevention Unit (CPU)[49] to complete a case review[50], which found minimal evidence any of the children received information to improve their understanding of their mother's mental illness during Kylie Fowler's long history of episodic schizophrenia.

Comments

86. Clearly the more opportunities children such as Ms Fowler's have to understand the mental illness affecting their parent, have some understanding of changes of behaviour in that parent and an understanding of risks associated with such behaviour changes, the safer such children will be. In my opinion, one lesson from cases such as this, and perhaps the most important one, is that children of parents suffering severe or episodic severe mental illnesses, should for their own ultimate protection and safety be provided with education, information and/or counselling as early as possible in their lives either through the agency of mental health services in combination with their schools or by some other appropriate method. This is obviously a difficult area and I am very conscious of the various submissions and comments made to the effect that measures such as this, taken without the knowledge of, or in defiance of, a parent can indeed be counter productive or anti-therapeutic. However, even allowing for these complexities and sensitivities, ultimately safety of children such as Ms Fowler's, is paramount and the community has a clear duty to maximise their protection.

87. The recognition of the rights of a child of a parent with a mental illness has been recognised and written into the draft *Mental Health Act 1914* (Bill) currently before Parliament. The bill contains principles to guide the provision of mental health services and include the following that are most relevant to this case:

> "Children, young persons and other dependents of persons receiving mental health services should have their needs, wellbeing and safety recognised and protected.
> Carers (including children) for persons receiving mental health services should be involved in decisions about assessment, treatment and recovery, whenever this is possible.

[50] Including a systematic review according to the Victorian Systemic Review of Family Violence Deaths and review of the mental health treatment. The Coroners Prevention Unit is a specialist service for coroners created to strengthen their prevention role and provide them with professional assistance on issues pertaining to public heath and safety.

Carers (including children) for persons receiving mental health services should have their role recognised, respected and supported."[51]

The support for children with or without the additional burden of being their parent's carer must contain a large element of education specific to their parent's illness, needs, and the child's rights to be safe.

88. A current program supported by the Department of Mental Health, Drugs and Regions through selected public mental health services in Victoria, is the Families where a Parent has a Mental Illness program (FaPMI).[52] It closely aligned to the national COPMI Initiative (Children of Parents with a Mental Illness).[53] The 2012 evaluation of the FaPMI Strategy[54] found:

"The findings from a small (n=83) targeted survey indicated that having a FaPMI coordinator appears to increase AMHS clinician confidence, knowledge and behaviour when working with families where a parent has a mental illness. In addition, 38 interviews with key stakeholders from the four catchments highlighted that in FaPMI coordinated areas there was greater availability of specific programs for families where a parent has a mental illness. For mental health and family workers there was also greater access to secondary consultation, resources and training and specific procedures when working with these families. In addition, policy documents from FaPMI regions were prevention focused, as opposed to policy documents in non-FaPMI regions which targeted risk and child protection issues."[55] According to the FaPMI evaluation, a FaPMI worker is not available in all Victorian public mental health services or regions.

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[51] Department of Health, 2013. Mental Health Reform. Accessed at: <http://docs.health.vic.gov.au/docs/doc/6EECCA78BDB5CC00CA257C8300033000/$FILE/1402012_mental_health_act_guide_feb14_WEB_new_new_v3.pdf>

[52] FaPMI is the Victorian strategy modelled on the Commonwealth of Australia 2004, *Principles and Actions for Services and People Working with Children of Parents with a Mental Illness.*

[53] The COPMI national initiative develops information for parents, their partners, carers, family and friends in support of these children. This information complements online training courses developed by COPMI for professionals to support families either individually or through community services and programs. The website has extensive toold for children, families, professionals and others, including family care plans and where to get help links. <http://www.copmi.net.au/kids-teens-young-adults/teens/getting-support.html>

[54] Victorian Government, Department of Human Services 2012. Targeted preliminary evaluation of FaPMI Strategy.

Department of Health Targeted Preliminary Evaluation of Department of Health FaPMI strategy, accessed at: http://www.bouverie.org.au/programs/mental-health-team/fapmi

[55] Ibid, page 4.

89. The FaPMI strategy supports the provision of several peer support programs as well as the education and support of children of parents with a mental illness, including PATS and CHAMPS programs. Of particular relevance to this case is the inclusion in the CHAMPS program of a Crisis Action Plan for each child. It includes discussion with the child and family about recognising a crisis; what to do if feeling unsafe or scared by the way a parent is behaving; or if there is physical fighting between parents or other adults in the house; if a child cannot understand what his/her parents are saying or are not making sense; if a parent is hurt or if the child is alone and worried about where a parent might be.[56] From this discussion, the child is engaged in developing the Crisis Action Plan.

90. I note the Office of Chief Psychiatrist, Department of Health, 2002 "Discharge Planning for Adult Community Mental Health Services" document. The key sentence is the one "Case closure should only occur after the transitional period and successful linking of the individual to the new agency where this is indicated. The process of case closure should be reviewed by the treating team and agreed with by the responsible consultant psychiatrist."[57] It is obviously critical to ensure that the implementation/transition phase of discharge moving towards the "full GP care needs to be thoroughly implemented." The sadness here is that Ms Fowler was not in fact actively engaged with a mental health practitioner or a GP and that this complete lack of connection with medical services is likely to have heightened the risk of uncontrolled psychotic deterioration and with unpredictable consequences.

91. Dealing with the DHS Child Protection issue in this context, I note that the DHS closure summary prepared 28 May 2007 states: "The summary notes "school is aware of the protective involvement and able to monitor the situation"" However, it is not stated how DHS expected this to be achieved.

92. The closure summary notes 'currently mother's mental health is stable and she is well engaged with appropriate mental health support services to monitor her mental heath. While her mental health is stable she appears to parent the children adequately.' It is not described how Ms Fowler would remain engaged with mental health services, nor what action mental

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[56] Eastern Health 2012. CHAMPS After-School Program Facilitator's Guide. Provided by Eastern Health, Mental Health Services, Melbourne, Victoria.

[57] Office of Chief Psychiatrist, Department of health. 2002. Discharge Planning for Adult Community Mental Health Services. Accessed at http://www.health.vic.gov.au/mentalhealth/cpg/discharge_planning.pdf on 4 November 2011.

health services would follow if she discontinued her involvement. Further, there is no reference to what action would be taken by mental health services in connection to possible concerns for the children, in the event that they became aware Ms Fowler's mental health had deteriorated. While it was recognised Ms Fowler could parent well when she was not acutely unwell, it was also known that she was a person who was reluctant to accept support and had a history of disengagement. This issue does not appear to have been adequately considered, and thus there was not a clear plan in place to ensure that she did stay engaged.

93. The final comments in the DHS closure summary for Melanie and Matthew, prepared on 28 May 2007 state:

"Should her mental health decline there is an increased likelihood that safety issues may re-emerge for these children particularly given that the majority of their protective history relates to period when mother's mental health had deteriorated. Mother's mental health will be enhanced if she is able to remain cooperative with mental health support services. She has demonstrated a capacity to do this throughout the IPO, however in the past there have been periods where she has been non-compliant with support services. Should future safety issues emerge for the children, the school is aware of the protective involvement and hopefully would re-notify should this be required."

94. It appears that there was a level of reliance on the school to assist with Ms Fowler's mental health monitoring. However, to rely on the school to renotify DHS of further concerns, particularly when it was established that as part of Ms Fowler's illness pattern she frequently moved accommodation and schools, was not (with the benefit of hindsight) sufficient to ensure adequate oversight for Ms Fowler and her family.

DSC Cashman's Proposed Recommendations

95. The Investigating Member proposed five recommendations, which I set out earlier.

96. I have received submissions from all parties as to those recommendations. For a number of reasons, many inter-related, the DHS, the Chief Psychiatrist and Darebin CMHC do not support the recommendations and do not consider they could be effectively implemented.

97. Accepting the deeply held belief by DSC Cashman that some measures needed to be taken in response to these tragic deaths, I do not propose to put forward the recommendations he has suggested. I accept the legal, policy and practical arguments against making these recommendations. In particular, I accept the arguments based on the provisions of the

Mental Health Act, the philosophy underlying that Act and the Victorian Charter of Human Rights arguments. I accept the arguments relating to the impracticality and potentially oppressive nature of the Register proposed by DSC Cashman in his first recommendation. I accept the arguments relying on privacy legislation and principles in respect of the third recommendation. I accept that the CATT services are in fact available throughout Victoria, although there may be a lack of understanding about how they can best be accessed and used.

98. In relation to Dr Melissa White and the observations she made of Ms Fowler at Bunnings and her concerns about her apparently deteriorating mental state, it is clear that Ms Fowler was no longer a client of Dr White at that point. Dr White's observations, whilst prophetic, were not clinically based and her concerns were not such that she felt a sense of absolute immediacy about intervening. I do not accept that she could not have done so by some form of inquiry or report if she had felt that degree of urgency and immediacy. I tend to agree with the proposition put by DHS/Darebin CMHC that subsequent to the deaths she has elevated the matter in her own mind and has felt deeply troubled. I completely accept the sincerity of Dr White's reaction and that she was troubled at the time. However, the evidence would not support any recommendation being made about any access to or use of the CATT services. I agree with DSC Cashman that those services should prioritise those individuals who need urgent assessment and attention.

99. DSC Cashman's second recommendation related to the provision of sufficient resources to the DHS to enable it to make enquiries to "the long term mentally ill" to confirm compliance with medication is, on its face, attractive. There can be little doubt that some of the long-term mentally ill who have been treated for a severe psychosis and who become non-compliant with their medication, will become a risk to themselves and others. It would have been impossible to predict the horrendous actions taken by Ms Fowler leading to the deaths of her children and herself. However, there is a clear logic to the argument that if the system enabled and resourced ongoing monitoring of somebody like her, the risk of harm would be reduced. However, the practicalities, and the policy considerations are many and complex. The key in the end is ongoing treatment, normally from a GP after discharge from a mental health service. The gaps identified in this case relate to the non-connection with an ongoing GP service. The GP and the clinic cannot be blamed for that. Ultimately, there is a

responsibility on the part of the mentally ill person to maintain contact with the doctor, the clinic and to remain compliant with their medication requirements.

100. There is a conundrum at the heart of this case. If Ms Fowler had remained compliant with her medication and in touch with her GP it is probable that she would not have spiralled into the apparently severe psychotic vortex leading to her actions on 9 January 2011.

101. In my opinion, the lesson learned for prevention in this case is confined to the matter of mental health literacy.

102. In Australia, over a million children have at least one parent with a mental illness.[60] Therefore, it makes sense to ensure they have the best chance of understanding their parent's illness, its implications and what best to do in any situation. There was intent to refer Melanie and Matthew to counselling with Ms Fowler.[61] This did not eventuate and there is no evidence supporting they received any comparable education or information from other services. In this case, the children did not have the opportunity to be educated or given the information necessary to recognise a change in their mother's mental state, to know what to do and how to get help, not only for themselves but also their mother.

RECOMMENDATIONS:

The safety of children, teenagers and young adults is of paramount importance in this community. No stone should be left unturned to at least explore what measures/arrangements could be put in place to deliver to the children of severely mentally ill people, (even those who have demonstrated no propensity to violence towards themselves of their children) to equip them with a knowledge and understanding of the risks which may give them a chance to avoid, or report or notify the behaviour of their parent in the future to relevant authorities in a way that would protect them and others.

1. To improve the access to programs specific to improving mental health literacy for children, teenagers and young adults of parents with a mental illness, the Department of Health, Mental Health, Drugs and Regions review the scope of the FaPMI strategy rollout across all public mental health services and regions in Victoria, including:

    - Access by public mental health service families to peer support programs such as CHAMPS and PATS, regardless of where they live in Victoria.

[61] Children of Parents with a Mental Illness (COPMI) website at:<http://www.copmi.net.au/about-us.html>

- Access by families from other services that come into contact with families where a parent has a mental illness or significant mental health issue such as alcohol and drug services, family support services, child and youth services, community health, Child Protection, and schools.

I direct that a copy of this finding be provided to the following:

Mr Dominic Maher, Senior next of kin
S/C Butler, Victoria Police
Department of Human Services
NorthWestern Mental Health
Chief Psychiatrist
Department of Education and Early Childhood Development
Department of Health
Dr Jeremy Oates , CCOPMM

Signature:

JUDGE IAN L GRAY
STATE CORONER
Date: 6/3/14