IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2021 000288
Related matter: COR 2021 000287
COR 2021 000289
COR 2021 000290

FINDING INTO DEATH FOLLOWING INQUEST

Form 37 Rule 63(1)

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

Inquest into the Death of: MATTHEW PERINOVIC

Findings of:	AUDREY JAMIESON, CORONER
Delivered On:	15 November 2022
Delivered At:	Coroners Court of Victoria 65 Kavanagh Street, Southbank, Victoria, 3006
Hearing Dates:	15 November 2022
Counsel Assisting:	Nicholas Ngai Coroners Court of Victoria
Senior Next of Kin:	Stephanie Wallace Counsel
NorthWestern Mental Health:	Stephanie Moussa Lander & Rogers
Dr Abid-ur Rahman:	Shashi Silva Sparke Helmore Lawyers
Keywords	Filicide; Family violence; Mandatory Inquest

I, AUDREY JAMIESON, Coroner, having investigated the death of MATTHEW PERINOVIC

AND having held an inquest in relation to this death on 15 November 2022

at the Coroners Court of Victoria, 65 Kavanagh Street, Southbank, Victoria

find that the identity of the deceased was MATTHEW PERINOVIC

born on 6 June 2017;

and the death occurred on 14 January 2021

at 4 Burgess Street, Tullamarine, Victoria

from:

1(a) MUTIPLE STAB WOUNDS TO THE BACK

In the following summary of circumstances:

Matthew Perinovic suffered from fatal stab wounds inflicted by his mother, Katica Perinovic, in their home at Burgess Street in Tullamarine. Despite resuscitative attempts by paramedics, Matthew, his siblings and his mother were later declared deceased.

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BACKGROUND CIRCUMSTANCES

1. Matthew Perinovic was born on 6 June 2017 and was three years old at the time of his death. Matthew lived with his parents, Katica and Tomislav Perinovic and his two siblings in Tullamarine, Victoria.

2. Katica met Tom in early 2011 and they were married on 17 March 2012. The couple had three children, Claire, born 31 July 2013, Anna, born 10 May 2015 and Matthew, born 6 June 2017.

3. Matthew was a very tall, clever and strong boy. He loved his father and was always spending time with his father when he was home. He loved playing with his toy cars and spending time with his big sisters and cousins. All three siblings loved swimming, dancing together and going to the park to play with other children.

SURROUNDING CIRCUMSTANCES

4. In November 2020, friends and family noticed a decline in Katica's mental health and detailed instances in which Katica displayed paranoid thought and anxiety[1]. Katica abruptly quit her job as a physiotherapist in a clinic where she had worked for 16 years, as she was reportedly paranoid about her work colleagues.

5. Katica had no known history of mental illness or suicidality prior to this, although her personality was described as being a worrier, anxious, abrupt and impulsive at times. She had a family history of schizophrenia in her sister and there was suggestion that another sister may have experienced significant depression including a possible previous suicide attempt.

6. Katica initially sought the assistance of her general practitioner (**GP**), Dr Abid-ur Rahman, in relation to stress and anxiety on 9 and 10 November 2020. Dr Rahman referred her to a private psychologist, Kathy Carrozza.

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[1] Coronial Brief, Statement of K Benz, 346; Coronial Brief, Statement of T Tomislav, 66; Coronial Brief, Statement of J McCure, 486; Coronial Brief, Statement of S Moore, 414; Coronial Brief, Statement of B McGrath, 495; Coronial Brief, Statement of G Bonaddio, 498; Coronial Brief, Statement of A O'Connell, 506; Coronial Brief, Statement of R Gionfriddo, 522.

7. On 16 November 2020, it became apparent that she was paranoid and Dr Rahman referred her to NorthWestern Mental Health Service (**NWMH**) on 17 November 2020[2]. NWMH called Tomislav to offer an appointment for Katica the following day which he accepted. Tomislav called NWMH the following day to cancel the appointment as Katica did not want to engage and, on discussion with Katica, she denied paranoia or risks. Tomislav called back on 19 November 2020 to say that he wanted Katica assessed because she was reportedly paranoid and talking to herself. Another appointment was scheduled for 20 November 2020.

8. Katica was reviewed by clinicians from the brief intervention stream[3] of the Hume Community Team Wellness and Recovery (part of the NMWH service) on 20 November 2020[4] with Tomislav present. She was initially prescribed 1mg of risperidone[5] and diagnosed with First Episode Psychosis.[6] Katica was booked for a review with a psychiatric registrar, Dr Soumitra Das, on 24 November 2020. She attended the review on 24 November 2020 with her mother and a plan was made which included increasing her risperidone to 2mg after three more days, brief reviews by a clinician every other day and a medical review in two weeks if it was deemed necessary.

9. Clinicians from the NWMH team made phone calls to Katica on 26 and 30 November 2020 and conducted a face-to-face review on 27 November 2020. During all of these interactions she continued to exhibit paranoia but appeared to have made some improvement. Katica was regularly discussed at clinical review meetings and on 30 November 2020 a plan was made for her to receive phone calls every three days until she was allocated a case manager in the self-leadership stream[7] of the Hume Community Team Wellness and Recovery. The treating team noted that face-to-face reviews were preferred.

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2 Coronial Brief, Appendix F – Medical Records (Tullamarine Complete Health Care), 613.

3 The brief intervention stream provides mental health assessments and short term support.

4 Coronial Brief, Statement of Dr T Fong, 534; Coronial Brief, Appendix F – Medical Records (NorthWestern Mental Health) – Perinovic, Katica, 990-994.

5 Risperidone is an atypical (second-generation) antipsychotic drug effective against the positive and negative symptoms of schizophrenia.

6 Coronial Brief, Statement of Dr T Fong, 534; Coronial Brief, Appendix F – Medical Records (NorthWestern Mental Health) – Perinovic, Katica, 990-994 & 962.

7 The self-leadership stream provides medium term support for patients with good supports and stability but who would benefit from assistance learning to manage their mental illness.

10. Katica was transferred to the self-leadership stream and allocated case manager Maeve O'Dowd, psychiatric registrar Dr Surabhi Hiwale and consultant psychiatrist Dr Thomas Fong[8]. Katica saw Ms O'Dowd and brief intervention stream psychiatric registrar Dr Soumitra Das face-to-face on 8 December 2020[9]. This was the only contact after the initial intake assessment that did not occur via phone. Ms O'Dowd spoke with Katica by phone on 18 December 2020, 21 December 2020, 4 January 2021 and 12 January 2021. Katica missed a scheduled appointment with Dr Fong on 11 January 2021 and this was rescheduled for 18 January 2021 (after the fatal incident)[10].

11. It appeared that Katica's mother transported her to the 8 December 2020 face to face review but did not attend this review and NWMH staff did not speak with her[11]. At this review, Katica acknowledged previous paranoid thoughts about her colleagues but denied having these thoughts currently and as such, she thought she could stop taking risperidone. Ms O'Dowd and Dr Das explained the risk of relapse and recommended that she continue. Katica suggested that she reduce to 1mg and Dr Das advised against this[12]. During the session, Katica was preoccupied with her husband, saying she wanted to talk with him about things but would not disclose what these were, and indicated she thought he wanted to separate from her. Dr Das documented that Katica presented as "*very superficial and monologue in her speech*", that there was some level of regression in her speech and behaviour and that she did not appear to take on the psychoeducation provided.

12. Dr Das considered increasing the dose of medication but noted the risk that Katica would become more resistive to medication if he attempted to increase it at that time, so he planned to increase the dose after providing further education at future sessions. Dr Das also documented that Katica may stop taking her medication or reduce her dose due to poor

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8 Dr Fong was involved in discussions regarding Mrs Perinovic's treatment, but did not review Mrs Perinovic. There was no evidence that Dr Hiwale had any involvement in treatment.

9 A review had been scheduled for 3 December 2020 which Mrs Perinovic did not attend.

10 Coronial Brief, Appendix F – Medical Records (NorthWestern Mental Health) – Perinovic, Katica.

11 The medical record documented "[Mrs Perinovic] said she came to the appointment today with her mother".

12 The medical record entry by CM O'Dowd documented "Katie said she would continue with the medication but had said that 'maybe I can do just 1mg'. Dr. Das explained that this would be sufficient", however this appeared to be an error. Dr Das's medical record entry was clear that Mrs Perinovic was to continue taking 2mg.

insight. Katica declined ongoing case management but agreed when Ms O'Dowd asked her to "*try and see it more as support as [Katica] has been through a stressful time and it was to help [her] stay well*". Katica was offered an appointment with Ms O'Dowd for the following week, which she declined but agreed to a phone call the following week. Ms O'Dowd documented a plan to call Katica and organise a face-to-face review. Dr Das documented a plan for Katica's case manager to "*review weekly or at least 2 weekly to focus on psychoeducation, emphasise [sic] on need for involving family > if agreed then family sessions/SSFC*". [13]

13. Between 8 December 2020 and 11 January 2021, Ms O'Dowd spoke with Katica via phone three times. During all calls, she appeared to be less overtly paranoid as she was more willing to engage via phone than previously and no longer expressed concerns about her phone being hacked. She was described as being "*friendly*" during the first two contacts and denied any concerns or suicidal ideation during all three contacts. The first two contacts were noted to be brief (the first because Katica was on holidays) and the last appeared to be for the purpose of scheduling a medical review with limited details regarding her progress or current psychotic symptoms. None of the three phone calls included psychoeducation recorded in case notes.

14. During the period of 16-17 December 2020, Katica took an overdose of risperidone. Tomislav called an ambulance reporting that Katica took 16-17 tablets. When paramedics arrived, they documented that she took 15 tablets. Katica stated that she took the tablets because she couldn't sleep and denied suicidal intent. Tomislav told the emergency services operator that he did not believe this was an attempted suicide. Katica declined transportation to hospital and was advised to see her GP the next day. On seeing her GP the next day, Katica reported taking 14 tablets and stated that this was to help her sleep, denying suicidal ideation. NWMH remained unaware of this event until after Katica's death.

15. On 11 January 2021, Katica missed her scheduled psychiatrist appointment and when called by Ms O'Dowd the following day, she reported that she had taken her kids to the pool, she had no concerns, and the appointment was rescheduled for 18 January 2021. This phone call

[13] Coronial Brief, Appendix F – Medical Records (NorthWestern Mental Health) – Perinovic, Katic, 961-962. SSFC - Single Session Family Consultation

also appeared to be for the purpose of scheduling a medical review with limited details regarding her progress or current psychotic symptoms and with no psychoeducation recorded in case notes. This was the last contact that NWMH had with Katica. There were no other known contacts with health professionals between 12 January 2021 and the fatal incident on 14 January 2021.

IMMEDIATE SURROUNDING CIRCUMSTANCES

16. On the morning of 14 January 2021, Tomislav left his home at approximately 10.24am to purchase a television. At the time of his departure, Katica was awake and their children were playing in the rear living room of the house.

17. Tomislav drove to JB Hifi in Westfield Shopping Mall at Airport West and found that the television he was seeking was not stocked, so he drove to The Good Guys at Essendon Fields, where he arrived at 10.49am.[48] He ordered and paid for a television, but it was not in stock so he was sent to the Good Guys Hoppers Crossing store to collect his purchase.

18. Tomislav left the Good Guys Hoppers Crossing store at about 11.48am and arrived home at about 12.15pm. He parked in the carport and entered through the back door, where he found Matthew injured on the floor in the rear living room. Tomislav picked up Matthew and carried him to the front lounge room.

19. At 12.19pm, Tomislav called emergency services from the landline telephone in the house and advised that he had found his son in the house with injuries to his head and arm, which were causing him to bleed heavily. The call-taker instructed Tomislav to perform first aid until paramedics arrived in the house.

20. At 12.29pm, paramedics arrived and Tomislav let them into the address and escorted them to where Matthew had been placed on the floor in the front room. Paramedics attended to Matthew but found no signs of life.

21. While paramedics were dealing with Matthew in the front lounge, Tomislav went into the rear living room and returned, whereupon he yelled, "*They're all dead*."[67]

22. Paramedics were shown to the rear living room by Tomislav, where they observed Katica, Claire and Anna. Tomislav was asked by attending paramedics to wait outside whilst they assessed Katica, Claire and Anna. No signs of life were detected, and they were declared deceased.

23. Police arrived at the residence at approximately 12.45pm and Tomislav was conveyed to the Broadmeadows Police Station and interviewed by members of the Homicide Squad.[74]

24. During his interview, Tomislav detailed his movements over the day. Enquiries were undertaken by police to corroborate his account of the day, including obtaining closed-circuit television (**CCTV**) footage from multiple locations, examination of telephone records,[77] interviews of witnesses, examination of transaction records and review of 000 call recordings. Tomislav's account of his movements was found to be entirely consistent with the available evidence.

25. Tomislav provided background information to investigating police members about Katica's recent mental health issues. He was released without charge shortly after completing his interview.

THE PURPOSE OF A CORONIAL INVESTIGATION

26. Matthew's death constitutes a "*reportable death*" under the *Coroners Act 2008* (Vic) (the Act), as Matthew ordinarily resided in Victoria[14] and the death appears to have been unexpected and violent.[15]

27. Pursuant to section 52(2) of the Act, it is mandatory for a coroner to hold an inquest if the death occurred in Victoria and a coroner suspects the death was as a result of homicide and no person or persons have been charged with an indictable offence in respect of the death.

[14] Section 4 *Coroners Act 2008*
[15] Section 4(2)(a) *Coroners Act 2008*

28. Section 52(1) of the Act further provides that a coroner may hold an inquest into any death that the coroner is investigating. This discretion must be exercised in a manner consistent with the preamble and purposes of the Act.

29. It was apparent, upon reading the coronial brief of evidence, that the events leading up to the fatal incident gave rise to community concern about issues of public health and safety. Consequently, I determined that these issues warranted further investigation to:

    a. Ascertain what mental health treatment was provided to Katica in the lead up to the fatal incident; and

    b. Learn from the deaths of Katica and her children to potentially reduce the risk of such an event occurring again and to ensure that key services are better able to support individuals receiving mental health treatment and respond to similar circumstances.

30. The jurisdiction of the Coroners Court of Victoria is inquisitorial.[16] The Act provides for a system whereby reportable deaths are independently investigated to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.[17]

31. It is not the role of the coroner to lay or apportion blame, but to establish the facts.[18] It is not the coroner's role to determine criminal or civil liability arising from the death under investigation,[19] or to determine disciplinary matters.

32. The expression "*cause of death*" refers to the medical cause of death, incorporating where possible, the mode or mechanism of death.

33. For coronial purposes, the phrase "*circumstances in which death occurred*,"[20] refers to the context or background and surrounding circumstances of the death. Rather than being a

[16] *Coroners Act 2008* (Vic) s 89(4),
[17] *Coroners Act 2008* (Vic) preamble and s 67.
[18] *Keown v Khan* (1999) 1 VR 69.
[19] *Coroners Act 2008* (Vic) s 69 (1).
[20] *Coroners Act 2008* (Vic) s 67(1)(c).

consideration of all circumstances which might form part of a narrative culminating in the death, it is confined to those circumstances which are sufficiently proximate and causally relevant to the death.

34. The broader purpose of coronial investigations is to contribute to a reduction in the number of preventable deaths, both through the observations made in the investigation findings and by the making of recommendations by coroners. This is generally referred to as the Court's "*prevention*" role.

35. Coroners are also empowered:

    (a) to report to the Attorney-General on a death;[21]

    (b) to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice;[22] and

    (c) to make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice.[23] These powers are the vehicles by which the prevention role may be advanced.

SOURCES OF EVIDENCE

36. This Finding is based on the totality of the material produced by the coronial investigation into Katica's death. That is, the investigation and brief of evidence compiled by Coroner's Investigator, Detective Sergeant Luke Farrell (**DS Farrell**). The brief will remain on the coronial file, together with the Inquest transcript.

37. In writing this Finding, I do not purport to summarise all the material and evidence but will refer to it only in such detail as is warranted by its forensic significance and in the interests

[21] *Coroners Act 2008* (Vic) s 72(1).
[22] *Coroners Act 2008* (Vic) s 67(3).
[23] *Coroners Act 2008* (Vic) s 72(2).

of narrative clarity. The absence of reference to any particular aspect of the evidence does not infer that it has not been considered.

STANDARD OF PROOF

38. All coronial findings must be made based on proof of relevant facts on the balance of probabilities.[24] In determining these matters, I am guided by the principles enunciated in *Briginshaw v Briginshaw*.[25] The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about individuals, unless the evidence provides a comfortable level of satisfaction that they caused or contributed to the death.

INVESTIGATIONS PRECEDING THE INQUEST

Identity

39. Tomislav Perinovic visually identified the body of the deceased to be his son, Matthew Perinovic born 6 June 2017.

40. Identity is not in dispute and requires no further investigation.

Medical cause of death

41. On 15 January 2021, Dr Heinrich Bouwer, Forensic Pathologist at the Victorian Institute of Forensic Medicine (**VIFM**) attended the scene of the fatal incident the preceding day on 14 January 2021 at approximately 6.00pm to perform initial examinations of the bodies of Katica and her children. Dr Bouwer performed an external examination upon the body of Matthew Perinovic the next day.

Post-mortem examination

42. Dr Bouwer reported that the anatomical findings were consistent with the known mechanism of injury.

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[24] *Re State Coroner; ex parte Minister for Health* (2009) 261 ALR 152.
[25] (1938) 60 CLR 336.

Toxicology

43. Toxicological analysis of Matthew's postmortem blood did not identify the presence of any common drug or ethanol (alcohol).

Forensic pathology opinion

44. Dr Bouwer ascribed the cause of Matthew's death to multiple stab wounds to the back.

Coroners Prevention Unit – Mental Health and Family Violence investigations

45. For the purposes of the Family Violence Protection Act 2008, the relationship between Katica and her children was one that fell within the definition of "*family member*"[26] under that Act. Moreover, Katica's actions in fatally stabbing herself and her children constitutes "*family violence*".[27]

46. In light of Matthew's death occurring during a family violence incident and Katica receiving mental health treatment in the proximate period leading to the fatal incident, I requested that the Coroners' Prevention Unit (**CPU**)[28] and Victorian Systemic Review of Family Violence Deaths (**VSRFVD)**[29] examine the circumstances of Katica and her children's deaths and the mental health treatment provided to Katica.

47. A thorough review of the available material found no evidence to suggest that Katica was a victim of family violence prior to her death. As part of routine screening, Katica advised Maternal and Child Health services on 2 August 2019 that she was not in fear of Tomislav or a victim of family violence. [30] Statements from friends indicate that they did not witness

[26] Family Violence Protection Act 2008, section8(1)(e)
[27] Family Violence Protection Act 2008, section 5
[28] The Coroners Prevention Unit is a specialist service for Coroners established to strengthen their prevention role and provide them with professional assistance on issues pertaining to public health and safety
[29] The VSRFVD provides assistance to Victorian Coroners to examine the circumstances in which family violence deaths occur. In addition the VSRFVD collects and analyses information on family violence-related deaths. Together this information assists with the identification of systemic prevention-focused recommendations aimed at reducing the incidence of family violence in the Victorian Community.
[30] Coronial Brief, Appendix I – Hume Council Maternal and Child Health Records, 1096.

any violence in Mrs and Tomislav's relationship and Katica denied family violence when directly asked[31].

48. Assessments undertaken by NWMH indicate that Katica was not at risk of harming herself, that there were no concerns in relation to the welfare of her children and that Katica had the support of her mother and husband to care for the children[32]. Following the fatal incident, NWMH undertook an internal review of the service provided to Katica and her family. This review found that "*there was not a detailed exploration of [Katica's] delusions and how they related to her husband and potentially her children. This was partly due to lack of collateral information about the significant day-to-day fluctuations in her symptoms*"[33].

49. A detailed analysis of the mental health treatment provided to Katica is provided below.

Direction Hearings

50. Direction Hearings were held on 17 February 2021 and 4 July 2022, Family Violence Senior Solicitor, Nicholas Ngai appeared to assist me at each of these hearings.

51. The initial Directions Hearing was held for the purpose of determining what further materials were required to progress my investigation.

52. The second Directions Hearing was to enable interested parties to raise further matters that might warrant the holding of a Summary or a full Inquest and consideration of an application for a suppression order. I dismissed the application for a suppression order on the basis that:

    a. the circumstances of the deaths of the Perinovic family were reported ostensibly by the media at the time of the fatal incident in January 2021;

    b. publicity of significant family violence cases can highlight prevention opportunities and identified concerns; and

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31 Coronial Brief, Statement of T Tomislav, 79; Coronial Brief, Statement of M Sumic, 310 & 322; Coronial Brief, Statement of S Moore, 474.

32 Coronial Brief, Statement of T Tomislav, 79; Coronial Brief, Statement of M Sumic, 310 & 322; Coronial Brief, Statement of S Moore, 949.

33 Coronial Brief, Appendix F – Medical Records (NorthWestern Health) – Perinovic, Katica.

c. the past coronial investigation into the death of Luke Batty (COR 2014 0855) benefitted from significant media coverage and public interest that ultimately led to a Royal Commission into Family Violence being convened to explore issues raised in the coronial investigation.

53. A copy of my ruling regarding the application for a suppression order can be found online on the Coroners Court website at: https://www.coronerscourt.vic.gov.au/inquests-findings/orders-and-rulings.

THE INQUEST

54. Pursuant to section 52(2) of the Act, it is mandatory for a coroner to hold an inquest if the death occurred in Victoria and a coroner suspects the death was as a result of homicide and no person or persons have been charged with an indictable offence in respect of the death.

55. Whilst Katica died from an apparent suicide, her children died in circumstances indicating possible homicide. Section 52(1) of the Act further provides that a coroner may hold an inquest into any death that the coroner is investigating. This discretion must be exercised in a manner consistent with the preamble and purposes of the Act.

56. I considered it appropriate to use my discretion to hold a Summary Inquest on 15 November 2022. However, I did not deem it necessary to hear from any witnesses as the concerns identified in the coronial investigation had been ventilated in substantive correspondence between the Court and interested parties.

COMMENTS

I make the following comment(s) connected with the death under section 67(3) of the Act:

Adequacy of NWMH's clinical reviews and frequency

1. Katica was initially assessed face-to-face by Dr Das on 24 November 2020 with her mother present. Katica was commenced on 1mg risperidone for three days and she was to then

increase to 2mg. PBS[34] records reflect that Dr Das provided a prescription for 60 x 1mg risperidone tablets with no repeats on that day, which Katica had dispensed the same day.

2. A plan was made for brief reviews every two days and another medical review in two weeks. This plan was largely adhered to, with phone reviews on 26 and 30 November 2020, a face-to-face review on 27 November 2020 and a review with Dr Das scheduled for 3 December 2020. The three contacts all included review of psychotic symptoms, noting Katica to still be paranoid. She was also asked whether she increased her risperidone as per the plan and advised that she did.

3. On 30 November 2020, Katica was discussed at the clinical review meeting and the frequency of contact reduced to every third day. From 8 December 2020 until Katica's death, it appears that the frequency and quality of reviews was suboptimal and did not adhere with the plan documented by Dr Das on 8 December 2020. Of the four phone contacts that Ms O'Dowd made with Katica between 8 December 2020 and her death on 14 January 2021, two were documented to be brief; one because she was on holidays and requested a call another time, and the other without an explanation for why it was brief. The other two appeared to be with a focus on scheduling a medical review. There appeared to be limited exploration of Katica's symptoms, progress, mental state or risks despite Ms O'Dowd documenting a plan after the 8 December 2020 review and the 21 December 2020 phone call to "monitor mental state and risk"[35].

4. None of the four phone contacts appeared to question Katica specifically about her recently expressed psychotic beliefs and only one contact documented anything about psychotic symptoms[36]. None of the contacts recorded any psychoeducation, as per the plan from Dr Das, which was hoped to improve Katica's compliance with treatment. Each of the phone contacts included that Katica reported the medication was going "fine", "well" or helped her sleep and each contact included that she felt "well", "things are OK" and/or that she denied

[34] The Pharmaceutical Benefits Scheme (**PBS**) is a program of the Australian Government that subsidises prescription medication for Australian citizens and permanent residents, as well as international visitors covered by a reciprocal health care agreement.

35 Coronial Brief, Appendix F – Medical Records (NorthWestern Health) – Perinovic, Katica, 955 & 961.

36 The phone contact on 21 December 2020 documented "denies psychotic phenomena" as a part of the mental state examination.

worries or concerns. Only one of the contacts documented a formal mental state examination (**MSE**), which appeared brief and lacked detail. None of the contacts documented a formal risk assessment or Katica's assessed level of risk.

5. The MSE is a clinical tool used to gain an understanding of the patient's psychological functioning at a particular point in time and informs appropriate direct care planning and delivery. It is recognised that mental health clinicians often complete MSEs intuitively while engaging with and observing a patient as opposed to the formal interview, however the reliability of an MSE is dependent on the information available and sought by the clinician at the time.

6. The reliability of any MSE completed with Katica after 8 December 2020 would have been diminished due to these being brief and via phone. This resulted in 1) limited exploration and questioning of Katica about her mental state, 2) limited information regarding her appearance and behaviours which may have indicated the presence of symptoms and 3) Katica possibly not disclosing information freely, due to her concerns that her phone calls were being monitored. A review of the progress note entries do not contain information that would meet the contemporary expectations of the content of a mental state examination[37].

7. In addition to the frequency and quality of reviews being suboptimal, there appeared to be a lack of psychoeducation recorded after 8 December 2020. It appeared to be Dr Das's opinion that provision of optimal treatment was reliant on regular psychoeducation being provided to Katica. It would be reasonable to expect that in a first episode psychosis, a patient would become more willing to take and increase doses of medication with more education about their illness, prognosis, risks and the role of medications in the person's recovery.

8. Katica was reluctant to take medication and increase her dose, however the medical record reflects that she was responsive to psychoeducation and agreed to continue medications after expressing a wish to cease. It is likely that the brevity of reviews from 8 December 2020 onwards and lack of face-to-face or telehealth reviews contributed to psychoeducation not being provided, and this may have also contributed to her non-compliance.

37 Trzepacz & Baker, Conducting a Mental Status Examination in Psychologists Desk Reference, 2013.

9. Dr Devapriya Rudolph, Acting Director of Clinical Services (North West Area Mental Health Service), provided statements to the Court disagreeing that there was any substantive deviation from the documented treatment plans, stating that the treatment plan evolved based on Katica's engagement level.[38] If the treatment plan evolved as Dr Rudolph stated, it remains unclear what the treatment plan was at each point in care, and what interventions were planned to address Katica's suboptimal engagement. There was also no explanation offered as to the documented treatment plan on 30 November 2020 for reviews every three days, with no attempts made to review Katica for eight days after this.

10. Dr Rudolph's explanation of the treatment plan being adhered to appeared to focus primarily on the number and date of attempts to contact Katica, rather than the treatment and monitoring provided. There was no explanation as to why face-to-face appointments were not offered with Ms O'Dowd and only medical reviews were being offered, why psychoeducation was not provided as per the treatment plan nor why comprehensive mental state and risk assessments were not being completed during phone contacts. Although Katica declined to schedule reviews on multiple occasions, she did not decline to engage in further treatment. She required some level of encouragement to schedule appointments, however the evidence indicated that she did agree to reviews with encouragement. The frequency of appointments appeared to be reduced due to the combination of Katica's and the medical registrar's availability and this would increase the importance of offering reviews with Ms O'Dowd.

11. The lack of face-to-face or telehealth reviews, limited exploration of Katica's mental state during phone calls and the lack of collateral information sought appears likely to have led to the NWMH treating clinicians being unaware of the severity of Katica's presentation and thus not providing adequate treatment. Given the brevity of contacts which lacked recorded psychoeducation and exploration of mental state, the purpose and therapeutic benefit of the phone calls between 8 December 2020 and the fatal incident was unclear.

12. NWMH identified that concerns around COVID-19 contributed to the reliance on phone assessments and that they were slow to move back to face-to-face assessments when

[38] Statement of Dr Devapriya Rudolph dated 3 March 2022, 2-3

restrictions lifted on 7 November 2020. However, this does not explain why telehealth assessments were not offered, which was common practice during COVID-19 lockdowns and face-to-face reviews occurred during the earlier stages of Katica's treatment while restrictions were in place but stopped from 8 December 2020 after restrictions were lifted.

NWMH clinicians' monitoring Katica's risperidone use

13. It appeared that Katica was non-compliant with medication from at least 19 December 2020, however this was not known by NWMH. Post-mortem toxicology analysis for Katica found the presence of metabolite hydroxyrisperidone but not risperidone.

14. According to PBS records, a prescription for 60 x 1mg risperidone tablets with no repeats was provided by Dr Das on 24 November 2020 and dispensed the same day. The NWMH documentation from Dr Das's review on 24 November 2020 indicated that Katica would take 1mg risperidone for three days and then increase to 2mg. With risperidone usually taken at night due to sedating properties[39], Katica should have increased to 2mg on the night of 27 November 2020[40].

15. If Katica took the prescribed 2mg daily and accounting for the overdose of at least 14 tablets on the evening of 16-17 December 2020, she would have had only one tablet remaining on 19 December 2020. If Katica had not taken the overdose, the 60 tablets would have lasted until 25 December 2020 and therefore, NWMH should have been aware that she would run out of medication.

16. Dr Rahman provided an additional prescription on 17 December 2020 however NWMH were unaware of this and according to PBS records this does not appear to have been dispensed. Dr Rudolph stated that NWMH were responsible for providing Katica's prescriptions. There was no communication from NWMH to Dr Rahman requesting that he

[39] The medical record indicated that Mrs Perinovic found risperidone sedating, supporting that she took it at night.

[40] There was no evidence that Mrs Perinovic was asked whether she increased to 2mg when planned, however on 8 December 2020 CM O'Dowd documented *Katie said she does not want to become dependent on medication and said she would like to stop. Writer and Dr. Das explained that it could be a risk stopping medication at this stage. Writer and Dr. Das explained that it is likely that Katie could relapse and would need more medication in the future. Katie said she would continue with the medication but had said that "maybe I can do just 1mg"*. This would suggest that Katie had increased to 2mg by that time.

provide ongoing prescriptions nor to confirm whether Dr Rahman had provided a further prescription. There was also no enquiry with Mrs or Tomislav documented about whether a new prescription had been obtained from elsewhere.

17. Both the *Royal Australian and New Zealand College of Psychiatrists Clinical Practice Guidelines for the Management of Schizophrenia and Related Disorders* and Orygen Youth Health *Australian Clinical Guidelines for Early Psychosis* discuss the risk of non-compliance in first episode psychosis and recommend frequent and ongoing review of compliance and addressing any barriers to compliance. Psychoeducation is recommended by both guidelines and this is a reasonable plan to address barriers to compliance, particularly in Katica's case where barriers appeared to relate to her insight more than practical barriers or side effects. The available evidence indicates that psychoeducation was not provided as planned, this along with a lack of oversight by clinicians possibly increased the likelihood of non-compliance.

18. Dr Rudolph acknowledged in his statement to the Court that non-compliance is common in psychiatric patients and stated that the treating team relies on patient and family reports to become aware of non-compliance.[41] Dr Rudolph stated that NWMH endeavour not to act coercively in relation to taking medication in order to aid the therapeutic relationship. Dr Rudolph further stated that scripting is usually managed via medical reviews and was not the role of a clinical review meeting or non-medical staff. Prescriptions are recorded in the medical record and it is a requirement for a consultant psychiatrist and/or psychiatric registrar to review that information to check whether further prescriptions are required.[42]

19. There was evidence that Ms O'Dowd enquired into Katica's compliance on several occasions, which was appropriate, and Katica indicated that she was compliant, although this was unlikely to be true on the more recent occasions. Given the general issues with compliance that were acknowledged by Dr Rudolph and the RANZCP and Orygen guidelines in combination with the specific issues with compliance noted in Katica's medical record, it would be reasonable to monitor her compliance by remaining aware of when her

[41] Statement of Dr Devapriya Rudolph dated 3 March 2022, 8
[42] Ibid

prescription would run out. This would also be consistent with RANZCP and Orygen guidelines which suggest frequent reviews of compliance and addressing any barriers to compliance. Monitoring access to medication via the prescriptions provided can be considered another form of reviewing compliance and raising discussions around future prescriptions when the previous prescription is due to run out and would address a potential barrier to compliance. This is especially the case in circumstances where there was no plan to cease risperidone and therefore appropriate oversight of compliance would be appropriate. Clinicians being aware of when a patient's prescription is due to run out cannot be considered coercive and it cannot be concluded that this would have adversely affected the therapeutic relationship.

20. While it was appropriate to work collaboratively with Katica and allow her to take lower than the recommended dose, this would indicate an increased need to monitor her compliance, mental state and risks. Katica was a voluntary patient and could not be forced to take or increase her medications. Her engagement and compliance with treatment was a significant factor in her remaining a voluntary patient. If Katica was known to be non-compliant and adequate assessments of her mental state and risks occurred, a more accurate view of her presentation may have been formed which may (or may not) have led to alternative therapeutic options being explored.

The adequacy of NMWH's clinical review meetings held before the fatal incident

21. In his statement to the Court, Dr Rudolph stated that the purpose of clinical review meetings is for psychiatrists and senior clinical staff to provide input into patient care and treatment, for the team to review the patient's presentation and develop short term treatment plans, discuss barriers to implementation of a previously formulated plan and to provide a safeguard and quality assurance around treatment plans.[43]

22. The available evidence indicates that Katica was discussed at a clinical review meeting on 30 November 2020 and a plan was made to reduce the frequency of contact with her from every two days to every three days[44]. Clinical review meetings on 3 and 7 December 2020

[43] Ibid, 4
[44] Consultant psychiatrist Dr Lokesh Sekharan was present at this clinical review meeting.

identified that Katica missed a scheduled psychiatric registrar review on 3 December 2020 but did not identify that Katica had not been contacted every three days.

23. On 8 December 2020, Dr Das documented a plan for reviews every 1-2 weeks to provide psychoeducation in preparation for increasing Katica's medication and this did not occur. Katica was discussed at a clinical review meeting on 4 January 2021, at which time she had not been seen face-to-face or telehealth for four weeks and no psychoeducation had been recorded. It was noted that she was avoidant and possibly masking some symptoms, however it was not identified that she had not been seen for four weeks, that phone contacts were brief or that psychoeducation had not been recorded.

24. A plan was documented at the 4 January 2020 clinical review meeting to liaise with Katica's husband and treating GP, however no attempts were made over the following 10 days (until the day of the fatal incident) to contact Katica's husband or GP. Previous clinical review meetings documented Katica's reluctance to involve her husband and reports that they were separating[45], however did not document the lack of contact with Katica's GP. While a NWMH internal review identified lack of contact with Katica's husband and GP as an issue, it was not identified that the clinical review meetings failed to detect this during Katica's period of treatment.

25. NWMH identified during their internal review that Katica had not been reviewed by a consultant psychiatrist during the eight weeks that she was engaged with their service. Clinical review meetings were an opportunity to identify and rectify this oversight, however there was no evidence that this was identified during the multiple clinical review meetings at which Katica was discussed.

Whether first episode psychosis guidelines were considered in the treatment provided to Katica by NMWH clinicians

26. The NWMH internal review identified that first episode psychosis is less common in a consumer of Katica's age, that she was ineligible for specialist first episode psychosis treatment available to younger consumers from Orygen Youth Health, and that the published

[45] Mrs Perinovic's belief that she and Mr Perinovic were separating appeared to be delusional.

guidelines on treatment for first episode psychosis are heavily oriented to young people and do not take into account the different factors affecting older people experiencing first episode psychosis.[46]

27. The *Royal Australian and New Zealand College of Psychiatrists Clinical Practice Guidelines for the Management of Schizophrenia and Related Disorders* (**RANZCP Guideline)** provides guidance for all psychotic disorders including first episode psychosis, and the guidance provided for first episode psychosis is not specific to young people. This guideline notes that the onset of psychotic illness for females shows a peak between ages 15 and 30 with a second smaller peak between ages 45 and 50 with a hypothesis that the bimodal distribution of onset in females is related to oestrogen production providing protection against psychosis (and thus an increased risk of psychosis during the perimenopausal reduction of oestrogen). As identified by NWMH, the Orygen Youth Health *Australian Clinical Guidelines for Early Psychosis* (**Orygen Guideline**) are focused on younger patients. This is appropriate given the remit of Orygen Youth Health and the availability of the RANZCP Guideline for older patients experiencing first episode psychosis. Nevertheless, the guidance provided by the Orygen Guideline remains relevant for older onset first-episode psychosis.

28. Both the RANZCP Guideline and the Orygen Guideline highlight the need for early intervention and access to treatment in order to ensure the safety of the patient, reduce duration of the untreated psychosis, preserve and restore function and reduce disability associated with the psychotic illness. A comprehensive and systematic biopsychosocial approach is promoted, whereby the person's mental illness is treated alongside medical assessment of any potential physiological causes or contributors (including substance use) and addressing any social issues which may be impacting the person's presentation and/or level of functioning. Both guidelines promote a patient-centred and collaborative approach to treatment which includes carers and families.

29. Specifically, regarding treatment of the psychotic symptoms, both the RANZCP Guideline and Orygen Guideline promote the use of combined pharmacological and non-

[46] Coronial Brief, Appendix N – North West Mental Health [sic] Review - Conclusions, 1569

pharmacological approaches. The RANZCP Guideline provides (and cites) the exact same medication guideline as the Orygen Guideline. Non-pharmacological treatment promoted by both guidelines include psychoeducation, personal goal setting and attainment (particularly around employment, education and social functioning), cognitive behavioural therapy and motivational interviewing. Both guidelines specifically discuss the importance of psychoeducation, the improved outcomes and adherence to treatment resulting from psychoeducation and include recommendations specific to providing psychoeducation[47].

30. Both the Orygen Guideline and the RANZCP Guideline provide guidance around treatment non-adherence, with both noting high levels of non-adherence to medication amongst people with first episode psychosis and psychotic disorders. The Orygen Guideline notes risk factors for non-adherence that clinicians should be alert to and suggests use of problem solving, addressing side effects, motivational interviewing and direct instruction to improve adherence. The RANZP Guideline suggests careful and ongoing medication monitoring in the early stages of illness, along with a willingness to decrease medication dosages to promote improved long-term outcomes.

31. The Orygen Guideline provides additional recommendations specific to the treatment provided by public mental health services that is not provided by the RANZCP Guideline. Those relevant to Katica include:

- Risk assessment should be undertaken and documented at each visit, and should include routine assessment of depressive symptoms, hopelessness, suicidal intent, the effect of returning insight, and the role of psychotic features on mood;

- Where possible, informants (particularly referrers, but also other key members of the young person's social networks) should be drawn upon as valuable sources of information about

[47] *Royal Australian and New Zealand College of Psychiatrists Clinical Practice Guidelines for the Management of Schizophrenia and Related Disorders*, "psychoeducation should be available" (page 26); Orygen Youth Health *Australian Clinical Guidelines for Early Psychosis*, "Recommendations 3.4.7.1 Psychoeducation should be provided for young people with early psychosis and their families, 3.4.7.2 The case manager and treating doctor are responsible for ensuring access to psychoeducation, 3.4.7.3 The material should be appropriate for young people and for early psychosis, 3.4.7.4 Psychoeducation and support should be provided for the client and family on an initial, continuing and 'as needed' basis through individual work, group programs and consumer support groups or a family participation program" (page 17).

the trajectory and nature of the young person's difficulties. Assessment should also consider needs of the family, their knowledge of psychosis, the impact of psychosis on the family, and their strengths and coping resources;

- All clients should be seen by a doctor within 48 hours after entry to the service;
- All clients should be seen by a consultant psychiatrist within one week after entry to the service;
- All clients should be seen at least twice weekly in the acute phase by the acute treating team, or case manager, and a doctor;
- All families should be seen or contacted at least weekly in the acute phase by the acute treating team or case manager;
- Adherence should be monitored and explicitly addressed where necessary;
- Treatment response and adherence should be regularly reviewed. All clients should be seen at least weekly by a case manager and at least fortnightly by a doctor in the early recovery phase;
- All families should be seen or contacted at least fortnightly during the early recovery phase; and
- Family attendance and involvement should be reviewed as part of the clinical review process.

32. While the Orygen Guideline are specific to young people, all these treatment recommendations would be reasonable for an older patient with onset first episode psychosis. The above listed recommendations appear to have been mostly overlooked in Katica's treatment with NWMH.

33. Katica's ineligibility for specialist first episode psychosis treatment via Orygen Youth Health was reasonable and likely did not contribute to the suboptimal treatment provided by NWMH. It is within the remit and expertise of every public mental health service to provide

specialist treatment for first episode psychosis, regardless of the age of onset. While Orygen Youth Health provide training and resources for clinicians and conduct research into youth psychosis, they are not the specialist service for treating youth psychosis. Like every public mental health service, Orygen Youth Health provides specialist mental health services for people who meet their age and location criteria, specifically those aged 15-25 who reside in western and north-western regions of metropolitan Melbourne. Those who do not meet this criteria are eligible for other, more appropriate public mental health services suited to their age and/or location. Given both Katica's age and location, she was most appropriate for treatment by NWMH.

Lack of communication between NWMH and Katica's treating GP

34. The NWMH internal review identified a lack of communication with Katica's family and GP. However, it did not specifically indicate the impact that this had on Katica's treatment.

35. It is likely that the lack of collateral information from Katica's family, particularly her husband, contributed to an underappreciation of the severity of her symptoms and therefore an underappreciation of her level of risk. Statements provided by Tomislav indicated that he was aware Katica's mental state was declining approaching the fatal incident. Had active attempts been made to obtain collateral information, the mental state assessments and risk assessments completed by NWMH would have been more reliable. Similarly, the lack of contact with Katica's GP likely contributed to NWMH being unaware that Katica had taken an overdose of risperidone, and the NWMH internal review concluded that had this information been known, this likely would have altered the treatment plan.

36. The available evidence suggests that along with a lack of collateral information, there was limited psychoeducation recorded. Information from both statements of Tomislav and his brief contacts with NWMH in the early stages of Katica's treatment indicate that he had a limited understanding of Katica's presentation and how to respond to Katica. This is understandable in circumstances of first episode psychosis where carers may not have experienced similar situations in the past, and this increases the importance of psychoeducation for families and carers of people experiencing first episode psychosis. Had Tomislav been well engaged with Katica's treating team, had an understanding of her illness

and how and when to escalate to the treating team, there would be an increased likelihood that Tomislav would alert NWMH that his wife's mental state was worse than they understood it to be. This may have also prompted Tomislav to be more alert to Katica's medication compliance and access to a sufficient supply of medications, and thus increased the likelihood that this would be brought to the attention of NWMH.

37. Dr Das documented on 8 December 2020 "e*mphasise [sic] on need for involving family > if agreed then family sessions*". No attempts were documented after this date to discuss with Katica the involvement of her family in treatment or organise family sessions. Ms O'Dowd documented on 21 December 2021 a plan to ask Katica's permission to speak with her husband[48], however there was no evidence that she did so during the two subsequent phone calls prior to the fatal incident. Similarly, Dr Fong documented during a clinical review meeting on 4 January 2021 that liaison with Katica's husband and GP was required, and that she was suspected of being avoidant and/or having "*hidden sx [symptoms*]"[49]. Despite this notation there were no documented attempts to contact Tomislav or Dr Rahman over the following 10 days before the fatal incident, including after Katica missed a psychiatrist appointment on 11 January 2021.

38. Suspecting that Katica was avoidant or that her mental state was worse than it appeared would indicate the need for collateral information in a timely manner. While Katica had expressed early in her episode of care that she was reluctant to involve her husband, the medical record indicated that Katica had delusions around her husband leaving her and that she often expressed initial reluctance to recommendations of NWMH clinicians before agreeing to their recommendations. In such circumstances, it would be reasonable for NWMH to have ongoing discussions with Katica about her husband's involvement in treatment, especially as treatment became effective and she gained insight. This would have also been in line with the *Royal Australian and New Zealand College of Psychiatrists Clinical Practice Guidelines for the Management of Schizophrenia and Related Disorders* and the Orygen Youth Health "*Australian Clinical Guidelines for Early Psychosis"*.

[48] Coronial Brief, Appendix F – Medical Records (NorthWestern Health) – Perinovic, Katica, 955.

[49] Coronial Brief, Appendix F – Medical Records (NorthWestern Health) – Perinovic, Katica, 953.

Concerns with the treatment provided by Katica's GP

39. Katica last saw Dr Rahman on 17 December 2020 for review following an overdose of risperidone tablets. Dr Rahman documented that Katica took 14 risperidone tablets as she was unable to sleep. Katica denied thoughts of harming herself. She reported feeling well and that Tomislav would control the medications from that point forward.

40. There appears to be no evidence that Dr Rahman enquired with Mrs or Tomislav whether NWMH was aware or that he communicated this to NWMH himself. In a statement to the Court, Dr Rahman confirmed that he advised Mr and Katica to communicate with NWMH regarding the overdose but there is no record of this in his clinical notes.[50]

41. Dr Rahman was aware that Katica was receiving treatment from NWMH as evidenced by his referral to NWMH on 17 November 2020 and his multiple entries in the medical record referring to her engagement with a mental health service. The NWMH internal review identified that they were not aware that Katica took an overdose until after her death and this information likely would have changed the risk assessment if it were known and possibly led to a Child Protection report.[51]

42. Dr Rahman's explanation of why he did not consider it necessary for NWMH to be informed of the overdose appeared to centre around the apparent lack of suicidal intent. However, Dr Rahman's statement appeared to show little consideration to other indicators of mental ill-health that would be relevant to the monitoring and treatment provided by NWMH. Dr Rahman stated that it was his opinion that Katica may have taken the overdose with the intent to sleep, numb her feelings or seek attention from Tomislav in the context of relationship difficulties.[52] Sleep disturbance and difficulty coping with emotions are both indicators of mental ill-health.

43. If Katica was struggling with these symptoms and she responded by taking 14 risperidone tablets (seven times her daily dose), the presence of these symptoms and her maladaptive response would be relevant to the mental health treatment that she was receiving and to the

[50] *Statement provided to the Court by Dr Abid-ur Rahman dated 24 June 2022,* 3
[51] Coronial Brief, Appendix N – North West Mental Health [sic] Review - Conclusions, 1569
[52] *Statement provided to the Court by Dr Abid-ur Rahman dated 24 June 2022,* 3

level of risk monitoring required. It would have been reasonable for Dr Rahman to ensure that NWMH were aware of this relevant information.

44. Furthermore, Dr Rahman stated that he provided a further prescription for risperidone to Mr and Katica (to be monitored by Tomislav) as the overdose would have meant that she ran out of medication.[53] NWMH had provided the previous prescription and there is no evidence that the service had requested that Dr Rahman take over prescribing[54]. Dr Rahman providing a prescription for risperidone was directly relevant to the treatment that NWMH was providing to Katica.

Improvements to clinical practice and recommendations implemented by NWMH since the fatal incident

45. NWMH conducted an internal review of their practices and Katica's treatment leading to the fatal incident. A copy of the report was included with the coronial brief prepared by DS Farrell, the report[55] confirms that recommendations were made to improve clinical practice including:

(a) Face-to-face assessments should be prioritised, particularly for consumers new to the treating team. Where phone assessments are used, they should be backed up with collateral information from families. Procedures should be updated to reflect this, and education provided to clinical staff. Compliance to be assessed by documentation audit within 9 months.

(b) Family engagement should be renewed regularly, and particularly when there is a change of treating teams. Home assessments should be an essential part of the management of new consumers wherever possible. Referrers and general practitioners should be updated about the progress of the referral, and when there is a transfer to a different treating team. Procedures should be updated to reflect this, and education

[53] Ibid.

[54] It appeared that NWMH planned to continue prescribing in the short-term as they were attempting to optimise her dose.

[55] Coronial Brief, Appendix N – North West Mental Health [sic] Review - Conclusions, 1569

provided to clinical staff. Compliance to be assessed by documentation audit within 9 months.

(c) Definition of supervision for families to be established (The definition must step out specific actions requested of the family or carer). Compliance to be assessed by documentation audit within 9 months.

(d) Treatment of first episode Psychosis should follow Australian Clinical Guidelines for Early Psychosis, 2nd Edition) and deviation from the guidelines should be approved and documented by the treating consultant.

(e) The stream guidelines need to be updated to reflect the requirements of first episode psychosis treatment, including at least twice weekly follow up for the acute phase, and at least weekly for the early recovery phase. Risk assessment should be updated weekly during these phases. Compliance to be assessed by documentation audit within 9 months.

(f) The risk assessment protocols should be reviewed to ensure they incorporate risk factors associated with filicide and ensure that there is a robust assessment of risk to children particularly in maternal psychosis.

46. NWMH have confirmed that the following actions have been completed as of the date of this finding:

(a) A new guideline titled, "Best practice principles for choosing a mode of contact" has been developed. The guideline highlights the need for staff to consider key principles of quality and safety as well as recognise the unique risks and potential unintended consequences of virtual and/or over the phone care. The guideline further provides, "*When seeing a consumer who is new to the service or at the start of a new episode of care, the first appointment should be in person whenever possible*", and that in person appointments are to occur at least once every eight weeks with telehealth appointments occurring in between.

(b) A review has been undertaken concerning the rates of family contact by the service within seven days of engagement. Based on the information gathered, work is currently being done to develop measures to improve family engagement. There is now a process to regularly audit the rate of family contact by the service within the first seven days which is done twice yearly.

(c) There is a new "*family inclusion officer*" position created to support family engagement in community mental health settings. This role will involve the clinician working with families to assess and support home-based consumer supervision, including the assessment of familiar psychosocial factors that might support or obstruct the appropriateness of any intervention.

(d) North West Area Mental Health service have developed new measures to conduct family meetings and support other clinicians seeing families through the "*Family Work Champions*" initiative. A Family Strategy Steering Committee meets monthly and includes representatives from each program within the service alongside consumers and carers to ensure staff actively engage family members and significant others in a consumer's assessment, treatment and care.

(e) There is a safety plan standardisation project underway, which will examine the issue of supervision within community settings. This work is being undertaken by Orygen, which is the youth services arm of NWMH, however the results will be applicable to all NWMH services.

(f) The North West Area Mental Health service has updated procedures regarding minimum contact guidelines to include minimum requirements for contacting consumers presenting with first episode psychosis. NWMH confirmed their intention to write to the Royal Australian and New Zealand College of Psychiatrists to encourage the development of adult first episode psychosis guidelines at a national level.

(g) NWMH has completed a review of its Clinical Risk Assessment and Management guideline forms. The guideline has been updated and a bulletin was issued to all clinical staff to assist in understanding the importance of identifying risk for consumers with

first episode psychosis. The updated guideline will also assist with identifying vulnerable and at-risk children to prevent imminent harm.

47. I note that several of the changes made by NWMH appear to be a positive step forward in addressing the risks highlighted in this matter and are positive reforms that will work to improve patient safety moving forward.

48. As noted above, NWMH now require that missed appointments are rescheduled for the same or the next day. If a patient is unable to be contacted, then the nominated person will be contacted. Given the number of appointments that Katica missed, it is likely that this would have resulted in more assertive attempts by NWMH to make contact with her and clinicians having more contact with Tomislav and thus his awareness would have likely increased regarding his wife's lack of engagement.

49. The other significant improvement outlined by NWMH is in the introduction of the Minimum Contact guideline. According to this guideline first episode psychosis treatment now requires two contacts per week (one face-to-face and one phone call) for the first three months. This is quite comprehensive and takes into consideration the risks associated with first episode psychosis (including risks of harm to self, harm to others, non-compliance and premature disengagement).

50. Non-compliance and early disengagement are particularly prevalent risks for first episode psychosis, which increase the risk of relapse and hospitalisation. With each subsequent episode, people with a psychotic illness tend to experience more severe symptoms, longer duration of episodes, a longer period until resolution of symptoms and require higher doses of medication.[56] Therefore, comprehensive early intervention is vital and can significantly improve the trajectory and reduce the impact of their life-long illness. The Minimum Contacts guideline also includes a table for clinicians, which makes it easy for clinicians to know what is required. This will hopefully improve compliance with the policy, which is important as compliance with policies was an issue that was identified in this case.

[56] Paolo Fusar-Poli, Patrick D. McGorry and John M. Kane, *Improving outcomes of first episode psychosis: an overview* (21 September 2017), available online at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5608829/

51. NWMH and the North West Area Mental Health service have transitioned to Northern Health with disaggregation occurring on 1 July 2022. NWMH confirm that all mental health related policies, procedures, guidelines, forms and clinical risk bulletins will be carried across. I commend NWMH for implementing the above changes to their practices and I am satisfied that these changes address the substantive issues raised in my investigation.

RECOMMENDATIONS

Pursuant to section 72(2) of the *Coroners Act 2008*, I make the following recommendation connected with the death:

1. With the aim of promoting public health and safety and preventing like deaths, I recommend that the **Royal Australian and New Zealand College of Psychiatrists** review and update the *Clinical Practice Guidelines for the Management of Schizophrenia and Related Disorders* to improve best practice in clinical care provided to patients diagnosed with First Episode Psychosis in community mental health practices and in light of the circumstances of Katica and her children's deaths.

FINDINGS

1. I find that Matthew Perinovic born 6 June 2017 died on 14 January 2021 at 4 Burgess Street, Tullamarine, Victoria.

2. I accept and adopt the cause of death as ascribed by Forensic Pathologist, Dr Heinrich Bouwer and I find that Matthew died from multiple stab wounds to the back.

3. I am not able to determine all of the contributing factors leading Katica to end her own life and that of her children. However, in the absence of any other intervening significant event, I find that Katica was suffering from First Episode Psychosis and was not compliant with her risperidone prescription in the lead up to the fatal incident.

4. I find no causal link between NorthWestern Mental Health and Dr Abid-ur Rahman's treatment of Katica and her decision to take her own life and that of her children. I do find

that the mental health treatment that was provided to Katica to be suboptimal in the circumstances.

5. I acknowledge and accept appropriate restorative and preventatives measures have been taken by NorthWestern Mental Health since the fatal incident.

6. I am unable to say with any degree of certainty that Matthew's death was preventable. However, I find that there were missed opportunities to intervene in the course of events preceding and leading to Matthew's death.

PUBLICATION OF FINDING

To enable compliance with section 73(1) of the *Coroners Act 2008* (Vic), I direct that the Findings be published on the internet.

DISTRIBUTION OF FINDING

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

Mr Chen Yang, Paul Vale Criminal Law, Lawyers for Mr Tomislav Perinovic

Ms Samantha Downes, Landers & Rogers, Lawyers for NorthWestern Mental Health

Ms Shashi Silva, Sparke Helmore Lawyers, Lawyers for Dr Abid-ur Rahman

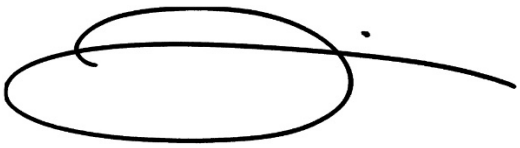
Dr Devapriya Rudolph, NorthWestern Mental Health

Mr Andrew Peters, Chief Executive Officer, Royal Australian and New Zealand College of Psychiatrists

Dr Neil Coventry, Chief Psychiatrist, Office of the Chief Psychiatrist

Detective Sergeant Luke Farrell, Coroner's Investigator, Victoria Police

Signature:



AUDREY JAMIESON

CORONER

Date: 15 November 2022

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an inquest. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.
