CITATION: *Inquest into the death of Aaron Nathan Stagg* [2011] NTMC 041	
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Darwin
FILE NO(s):	D0040/2010
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HEARING DATE(s):	6 and 7 September 2011
FINDING OF:	Mr Greg Cavanagh SM
CATCHWORDS:	**Death by Hanging, Self-inflicted, Mental Health Issues, Treatment and Care**

REPRESENTATION:

Counsel:

Assisting:	Jodi Truman
Department of Health	Tom Anderson

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IN THE CORONERS COURT
AT DARWIN IN THE NORTHERN
TERRITORY OF AUSTRALIA

No. D0040/2010

In the matter of an Inquest into the death of
AARON NATHAN STAGG
ON 5 MARCH 2010
AT PARKLAND, HAYDON CRESCENT, ROSEBERY IN THE NORTHERN TERRITORY OF AUSTRALIA

FINDINGS

Mr Greg Cavanagh SM

Introduction

1. Aaron Nathan Stagg ("Mr Stagg") was a Caucasian male born on 7 April 1981 in Alice Springs, in the Northern Territory of Australia. Mr Stagg was found by police hanging from play equipment in a children's playground at the corner of Haydon Crescent and Forrest Parade in Rosebery, Palmerston. He died sometime between 11.00pm on 4 March 2010 (the last time he was seen) and 5.00am on 5 March 2010 (the time when he was found by police).

2. This death was reportable to me pursuant to s12 of the *Coroners Act* ("the Act"). There is evidence, later referred to in these reasons, which satisfied me to the required standard that Mr Stagg took his own life.

3. Pursuant to s34 of the Act, I am required to make the following findings if possible:

> "(1) A Coroner investigating:
>
> a. A death shall, if possible, find:
>
> (i) The identity of the deceased person.
>
> (ii) The time and place of death.
>
> (iii) The cause of death.

(iv) Particulars required to register the death under the *Births Deaths and Marriages Registration Act*".

4. Section 34(2) of the Act operates to extend my function such that I may comment on a matter including public health or safety connected with the death being investigated. Additionally, I may make recommendations pursuant to section 35 as follows:

> "(1) A Coroner may report to the Attorney General on a death or disaster investigated by the Coroner.
>
> (2) A Coroner may make recommendations to the Attorney General on a matter, including public health or safety or the administration of justice connected with a death or disaster investigated by the Coroner.
>
> (3) A Coroner shall report to the Commissioner of police and Director of Public Prosecutions appointed under the Director of Public Prosecutions Act if the Coroner believes that a crime may have been committed in connection with a death or disaster investigated by the Coroner"

5. Counsel assisting me at this Inquest was Ms Jodi Truman. Mr Tom Anderson was granted leave to appear on behalf of the Department of Health. I thank each Counsel for their assistance in this matter. It is noted that Mrs Phylis Stagg, the mother of the deceased, Mr David Stagg, his father, and Steven and Carly, the brother and sister of the deceased, were in attendance at the Inquest. I am aware from the evidence before me, particularly that of Mrs Stagg, that the circumstances of this death have caused significant distress to the family who have a number of concerns related to the assistance that was offered to the deceased by Top End Mental Health Services ("TEMHS") and the NT Aged and Disability Program. These were matters that I considered carefully throughout this inquest.

6. Seven (7) witnesses were called to give evidence at the Inquest. Those persons were:

   a. Detective Senior Constable Kate MacMichael, the officer in charge of the coronial investigation;

   b. Phylis Stagg, the mother of the deceased;

   c. Richard Ashburner, Community Mental Health Nurse employed by TEMHS at the relevant times;

   d. Stephen Carrigg, Community Mental Health Nurse employed by TEMHS at the relevant times;

   e. Dr Ohn Kyaw, Consultant Psychiatrist employed by TEMHS at the relevant time;

   f. Robyn Westerman, Acting Director of Aged and Disability Services; and

   g. Bronwyn Hendry, Director of Mental Health Service.

7. A brief of evidence containing statements from family members, medical staff, St John Ambulance personnel, and police, together with numerous other reports, photographs, and police documentation was tendered at the inquest (exhibit 1). The deceased's various medical files and reports held with various service agencies was also tendered in evidence (exhibit 2). Public confidence in coronial investigations demands that when police (who act on behalf of the Coroner) investigate deaths, that they do so to the highest standard. I would like to thank Detective Senior Constable Kate MacMichael for her investigation.

Formal Findings

8. On the basis of the tendered material and oral evidence received at this Inquest I am able to make the following formal findings in relation to the death of Aaron Nathan Stagg, as required by the Act:

   i. The identity of the deceased person was Aaron Nathan Stagg who was born on 7 April 1981 in Alice Springs, in the Northern Territory of Australia.

   ii. The time and place of his death was sometime between 11.00pm on 4 March 2010 and 5.00am on 5 March 2010 3.25pm at the corner of Haydon Crescent and Forrest Parade in Rosebery, Palmerston.

   iii. The cause of death was hanging.

   iv. Particulars required to register the death:

      a. The deceased was a male.

      b. The deceased's name was Aaron Nathan Stagg.

      c. The deceased was of Caucasian descent.

      d. The death was reported to the Coroner.

      e. The cause of death was confirmed by post mortem examination carried out by Dr Nigel Buxton.

      f. The deceased's mother was Phylis Ann Stagg and his father was David John Stagg.

      g. The deceased lived at unit 160, 21 Cavanagh Street, Darwin in the Northern Territory of Australia.

      h. The deceased was unemployed at the time of his death.

Circumstances Surrounding the Death

Background

9. Aaron Nathan Stagg was the eldest child to Phylis and David Stagg. He was born in Alice Springs in the Northern Territory and lived most of his life in Alice Springs before moving to Darwin in about 2007. Mr Stagg lived with his siblings for a period of time and then eventually moved to a unit in the city. This is where he was living on his own before he died. I heard evidence that whist the deceased was a very well loved and supported member of the family, he did have difficulties in his relationships with his family save and except his mother who appears to have been the only person able to calm Mr Stagg when he would become enraged or distressed.

10. It was clear from the evidence before me that by the age of four years Mr Stagg became very difficult to handle. The statement tendered into evidence from his mother sets out that as a child, Mr Stagg would often have tantrums and was shy from cameras which would cause him panic attacks. He was assessed for pre-school but did not pass the motor sensory skills test. From that point forward it appears that he had problems coping within the main stream school system.

11. When his brother Steven was born, Mr Stagg's parents noted that Steven also appeared to have similar difficulties. As a result, both Mr Stagg and his brother were referred to the Adelaide Children's Hospital for a neurological assessment. Mrs Stagg stated that no formal diagnosis was made or given to her at that stage; however I had tendered into evidence before me a number of reports contained in the medical records which highlight Mr Stagg as suffering from what was described then as a congenital language disorder.

12. As Mr Stagg grew older he appears to have become more difficult to handle. His mother would engage him and assist in pacifying him when things would seem to go wrong with friendships and relationships. Mr Stagg continued to have problems with his social interactions and started to withdraw himself

from everyone as time went on. At the age of seventeen (17) years Mr Stagg decided to drop out of Year 11. He was observed to have closed down and had withdrawn from everyone except one friend. Eventually he was convinced by his parents to return to school and he completed Year 11, but in year 12 his mother described him as becoming negative again and he only graduated in his Art component.

13. After Mr Stagg finished school he went on to complete a Diploma in Arts and had a number of jobs including delivery driver, supermarket assistant and security officer. It appears however that Mr Stagg's difficulties in social interaction and communication often resulted in him becoming marginalised from his fellow employees, which then resulted in him leaving his employment. These difficulties often left Mr Stagg feeling unhappy and angry.

Mental Health Intervention and Other Agency Intervention

14. On the materials tendered before me it appears that the first occasion that an attempt was made to obtain some mental health assistance was in June 2006. At that time contact was made with the Centralian Mental Health Services by Mr Stagg's mother. This was after Mr Stagg had damaged some property during a rage. An appointment was made for Mr Stagg to be assessed by a psychiatric registrar, however when Mr Stagg arrived for the appointment, he is recorded as leaving as soon as he saw the "mental health" sign. Mr Stagg's mother nevertheless continued with the appointment and sought advice.

15. The contemporaneous records from Centralian Mental Health Services (exhibit 2) note Mrs Stagg subsequently made telephone contact with the service and advised that she had decided to try "another avenue" with Mr Stagg and that she did not think he was in need of psychiatric assistance at that time.

16. As set out previously, eventually Mr Stagg's siblings moved to Darwin and in about 2007 his parents encouraged him to move to Darwin so he could be closer to his siblings. I received evidence that Mr Stagg's parents drove him to Darwin, got him established and rented a unit for him. It appears that not long after his arrival Mr Stagg obtained employment as a taxi driver.

17. Unfortunately, shortly thereafter it appears that Mr Stagg and his brother started to struggle living with one another and it became clear that Mr Stagg's issues were increasing. There were incidents involving physical attacks by Mr Stagg on his brother and it was decided by Mr Stagg's parents that they should move him into his own unit, which they purchased for him in the city of Darwin. This is where Mr Stagg was living at the time of his death.

18. Following his relocation to the city, Mr Stagg kept in daily telephone contact with his mother; however it appears that eventually this became Mr Stagg's only human contact and he had no relationship with anybody else. By all accounts it appears he quickly became a very sad and lonely person.

19. Then in November 2008 Mr Stagg had an argument with a passenger in his taxi. He eventually pulled the passenger out of his taxi and threw them to the ground. As a result, Mr Stagg was initially charged with aggravated assault, but was finally dealt with on a charge of "cause substantial annoyance". This was Mr Stagg's first involvement with the justice system and he was placed on an 18 month good behaviour bond with no conviction recorded. It became apparent that Mr Stagg's behaviours were changing and escalating and he was becoming unpredictable.

20. In December 2008 Mr Stagg had an outburst whilst at home and all other family members, except his mother, had to leave for their safety. Mrs Stagg remained and calmed her son down. From this outburst it became clear to his mother that Mr Stagg needed help outside the family and they could no

longer deal with him on their own. As a result, Mrs Stagg made contact with the TEMHS On Call Team on 29 December 2008, seeking support.

21. Mrs Stagg's phone call was taken by one of the community mental health nurses who recorded the call in the TEMHS progress notes. Those notes were tendered into evidence (exhibit 2) and record that Mrs Stagg stated she believed her son was at risk of harming himself or others and that she had discovered a cross bow belonging to him. As a result the nurse discussed the matter with Dr San Pedro, a psychiatric registrar at TEMHS, who formed a preliminary opinion that Mr Stagg may not have been suffering from a mental illness, but was having problems with anger management. Mrs Stagg was re-contacted and encouraged to bring Mr Stagg into the Tamarind Centre for assessment. Mrs Stagg was also advised to contact Police if she felt her son was a risk to himself and/or others.

22. It appears from the progress notes that when police were mentioned, Mrs Stagg became very unhappy about involving them and was reluctant to bring her son into Tamarind Centre for assessment. The phone call then ended. I note that during the course of her oral evidence Mrs Stagg referred to her son's concerns about police, and also her own concerns about police and their abilities to interact effectively and appropriately with persons suffering from mental health issues. I note that Mrs Stagg specifically referred to the death of "a person at the hospital" who was in the custody of police and suffering from a mental illness. I take this to be a reference to the death of Mr Robert Plasto-Lehner, and note the very significant concerns that the report of his death appeared to cause Mrs Stagg.

23. The TEMHS progress notes show that because of the concern raised regarding a cross bow; the nurse discussed the call with Dr Rob Parker, the Director of Psychiatry, who recommended contact be made with police. Notations were made by police, but no formal action was taken by them at that time as no offences had been committed.

24. Mrs Stagg later made telephone contact again with TEMHS and described her concerns at her son's increasing frustration with his inability to obtain "reasonable" employment and her desire to get him some assistance with social skills and anger management. As a result, contact details were provided for Somerville Services, Autism NT and also Amity.

25. The notes also record that an offer was made for Mr Stagg to attend at the Tamarind Centre for assessment. After this conversation on 30 December 2008, Mr Stagg in fact attended with his mother as a "walk in" and was assessed by a Community Mental Health Nurse. He was then referred to the Adult Team for further assessment.

26. As a result, Mr Stagg was seen by psychiatric registrar, Dr San Pedro on 31 December 2008 and 5 January 2009, at which time he was diagnosed as likely suffering from Autism Spectrum Disorder with a differential diagnosis of chronic psychosis. Mr Stagg was prescribed Risperidone to assist with his aggression and a decision was made for there to be a period of case management to ascertain:

    26.1 whether there was any underlying mental illness,

    26.2 for tests to be carried out for the presence of any organic features, and

    26.3 for a second opinion to be obtained.

27. This second opinion was conducted by Consultant Psychiatrist, Dr David Cutts, on 14 January 2009. Again the diagnosis made was that Mr Stagg was likely to be suffering from a Pervasive Developmental Disorder, which was likely to be high functioning Asperger's Syndrome. It was considered that a psychotic illness was unlikely as there was no evidence of formed delusions or perceptual disturbances. It was considered that Mr Stagg would benefit most from psychological support because of his anger issues and, therefore, a referral was to be made to NT Aged and Disability Services for them to coordinate such support.

28. Despite the likely diagnosis of high functioning Asperger's Syndrome, a plan was nevertheless made for Mr Stagg to have a Computerised Axial Tomography ("CAT") scan of his head and an electroencephalogram ("EEG") as part of the organic screen testing.

29. It was also during this appointment that Dr Cutts explained to Mr Stagg and his mother that adult Pervasive Development Disorders were not of themselves a focus of treatment at TEMHS, but that they would complete their investigations to be sure there were no underlying issues and to assist with referrals. This was recorded in the notes as having been agreed and understood by Aaron and his mother.

30. An On Call Team Clinical Meeting then occurred on 15 January 2009 at which time Mr Stagg's case was discussed. A plan was prepared for Mr Stagg to be referred to a psychologist for anger management through NT Aged and Disability Services. Mr Stagg was also assigned a case manager, namely Mr Steve Carrigg. It appears from the notes that from this time on, Mr Stagg was in regular contact with TEMHS until about mid-May 2009.

31. Aaron saw his case worker regularly and would undertake appointments with him not just at the Tamarind Centre but also at his home and public places such as the Cool Spot. Mr Carrigg gave evidence before me that he used these sorts of causal "outside" appointments as a tool to get to the heart of Mr Stagg's difficulties in a "less confronting environment" than the one that could be perceived at the Tamarind Centre.

32. It is also recorded in the progress notes that during this period there were occasions where Mr Stagg expressed suicidal and homicidal ideation and would, as a result, be formally psychiatrically assessed. During these assessments Mr Stagg would identify his frustrations with his life and make clear that he had no plans to take any action. It was clear from the evidence that these thoughts were not fixed at any time. In addition to the weekly contact with his case worker, Mr Stagg was also trialled on anti-psychotic

medication as well as anti-depressant medication. Despite these medications being administered there was no reported discernable difference following their administration and no evidence of any overt psychotic symptoms.

33. In addition to the case management and observation conducted by TEMHS, assistance was also given with referral to Amity Counselling for anger management. The records of Amity Counselling were also tendered into evidence (as part of exhibit 2) and show that appointments occurred with Amity between 31 March and 20 September 2009. Unfortunately Mr Stagg's attendance waned over the period of July to September 2009 with Mr Stagg often not attending and reporting frustration at having his appointments rescheduled. Eventually Mr Stagg was discharged from the service.

34. On 7 April 2009 Mr Stagg was also referred by Mr Carrigg, to the NT Aged and Disability Program, Darwin Urban Disability Team. The reasons for this referral were recorded in the referral letter as being to assist Mr Stagg with communication and community access/employment opportunities. The records of NT Aged and Disability Service were also tendered into evidence (exhibit 2) and show that the Darwin Urban Disability Team considered the referral on 14 April 2009. Thereafter they sought further information from Mr Carrigg to determine whether Mr Stagg met the Aged and Disability Program's eligibility criteria.

35. I received evidence from Ms Westerman that the eligibility criteria for disability services in the Northern Territory is determined by the relevant legislation, namely the *Disability Services Act*, and the funding agreement between the NT and Commonwealth Government, called the "National Disability Agreement". Ms Westerman stated that an individual may be eligible for disability services if they:

35.1 Live in the NT;

35.2 Are covered by agreements with other jurisdictions (such as the Portability Agreement);

35.3 Have a disability as defined in the *Disability Services Act* which results in a substantial reduction in the person's capacity to function and require continuing support services; or

35.4 Present with a developmental delay (within the developmental period).

36. Ms Westerman gave evidence that under the *Disability Services Act*, "disability" means a disability:

"(a) which is attributable to an intellectual, sensory, physical or psychiatric impairment or a combination of those impairments;

(b) which is permanent or likely to be permanent;

(c) which results in:

(i) a substantially reduced capacity of the person for communication, learning or mobility; and

(ii) the need for continuing support services; and

(d) which may or may not be of a chronic episodic nature."

37. Upon receipt of the request for further information, material was sent by Mr Carrigg to the Urban Disability Team confirming that Mr Stagg had:

> "… A diagnosis of Pervasive Developmental Disorder, Asperger's Syndrome with evidence of lifelong difficulties with social relations, odd use of language, narrowed interests, few friends and difficulties with anger and depressive symptoms".

38. I heard evidence that following receipt of this information, a decision was made by the Darwin Urban Disability Team that they would not accept the referral from TEMHS for the following reasons:

38.1 There was an absence of what was referred to as "disability criteria";

38.2 TEMHS was already providing case management as the lead agency; and

38.3 Eligibility for Behaviour Education with NT Aged and Disability required the presence of an intellectual disability; as people without an intellectual disability were able to access mainstream counselling services and cognitive behavioural therapies.

39. These reasons for the refusal to accept the referral were considered further in the evidence before me. I will address these matters and their adequacy, later in these reasons.

40. As a result, a letter was sent by the Darwin Urban Disability Team to Mr Carrigg on 29 April 2009 advising him that the referral had not been accepted and giving referral information to Autism NT to assist with counselling and support, with recommendations to also Centrelink and CRS Australia to assist with employment options. It appears on the evidence that Centrelink was already involved with Mr Stagg by this time with the assistance of TEMHS.

41. In June 2009 Mr Carrigg also referred Mr Stagg to a psychologist in the Adult Mental Health Team, namely Yolanda Adams, for input into his communication and self-esteem issues. Whilst Ms Adams and Mr Stagg had one session together the further sessions did not occur after some re-scheduling. It is clear from the evidence that Mr Stagg never coped well when his appointments were re-scheduled with any agency and would disengage quickly with the service. Eventually Ms Adams moved interstate and it appears that another psychologist was not immediately available as a replacement. Again Mr Stagg lost contact.

42. On 2 July 2009 contact was made by Mr Stagg's case worker with CRS Australia. CRS was previously known as the Commonwealth Rehabilitation

Service. I received evidence that it is a leading provider of disability employment and assessment services in Australia. As a result of the contact made by Mr Carrigg, Mr Stagg attended CRS on 9 July 2009 and was assessed to be referred to the Vocational Rehabilitation Services ("VRS") who could provide him with a more intense long term program. Their records were also tendered into evidence (exhibit 2) and show that shortly after the referral was made to VRS, Mr Stagg stopped attending appointments and his case was also closed with CRS Australia.

43. Coincidentally it was in early July 2009 that Mr Stagg began to disconnect from TEMHS as well. He did not return calls made to him by his case worker or attend appointments. Between July and September 2009 numerous attempts were made to communicate with Mr Stagg by Mr Carrigg, but to no avail. A decision was therefore made that because of his disengagement, TEMHS would close his case. This also coincided with Mr Carrigg leaving the service to go interstate.

44. Before closing their file, a formal letter was posted to Mr Stagg advising him that his case would be closed due to nil engagement by him. When this was received, Mr Stagg made contact with Mr Carrigg and re-engagement occurred. Mr Stagg attended an appointment with Mr Carrigg on 18 September 2009 and was observed by Mr Carrigg as showing no change in his clinical presentation. The impression remained of Pervasive Developmental Disorder with no psychotic or depressive features. Mr Stagg also informed Mr Carrigg that he had stopped taking his medication for some time and subjectively described himself as "needing to work things out for myself". The cessation of medication appeared to also have made no change.

45. Mr Carrigg gave evidence before me that no immediate risk issues were identified by him and that Mr Stagg had advised him that he would consider further psychological support if he ever felt that he was becoming

increasingly angry, frustrated or thinking negatively. He was encouraged by Mr Carrigg to do so, but also to seek support to address his socialisation issues. It appeared from the evidence of Mr Carrigg that whilst he had concerns for Mr Stagg's future, there was no basis for any further continued involvement by TEMHS and Mr Stagg's case was closed.

46. On 1 October 2009 Mr Stagg attended at the Tamarind Centre and was seen by psychologist Vince Champion. At that time Mr Stagg stated that he had been referred by the court following his finding of guilt for causing substantial annoyance (i.e. the incident earlier referred to involving a passenger in his taxi). After further discussion with Mr Stagg it appeared that in fact the Magistrate had merely indicated to Mr Stagg that he should consider anger management counselling. As a result, Mr Champion began to discuss what was available, however Mr Stagg stated that he was not interested in such counselling and "did not want to do the homework involved". No further action was therefore taken and Mr Stagg left.

47. Despite this disengagement by Mr Stagg, I received evidence that in December 2009 Mr Stagg's mother made contact with Employee Assistance Services Australia ("EASA") through her own employment. As a result, arrangements were made for Mr Stagg to have some counselling in Darwin. I received evidence that Mrs Stagg had considered there had been a regression in her son's mental state and that he was threatening self-harm and harm to others. Therefore she had made contact with EASA.

48. Consequent upon these arrangements, Mr Stagg was seen by a counsellor, namely Anuja Daniel, on 16 December 2009. Ms Daniel noted that Mr Stagg appeared paranoid and depressed with very little sleep occurring. As a result a referral was made to see a psychologist. From this referral, Mr Stagg was seen by psychologist Vince Champion on 19 December 2009. As noted above, Mr Champion had been the same psychologist to see Mr Stagg for the last time at the Tamarind Centre on 1 October 2009.

49. The notes of EASA (also part of exhibit 2) record the session with Mr Champion as being difficult because Mr Stagg did not want his mother to be present and "did not believe there was anything wrong with him". Mr Champion however noted in the records:

> "Clear paranoid delusional thinking patterns involving broad conspiracies in all areas of Aaron's life".

Mr Champion therefore considered that Mr Stagg was suffering from

> "A combination of Asperger's type poor social functioning and paranoid psychosis, with depressive features as a secondary condition".

50. I received evidence via Mr Champion's statement to police (part of exhibit 1) that Mr Stagg was not interested in taking any further medication and Mr Champion therefore considered the prospects of any "voluntary treatment" to be "poor". Nevertheless Mr Champion stated that because of what he considered to be "likely symptoms of psychosis" and "chronic risk factors" in terms of thoughts of self harm and harming others, he recommended that Mr Stagg return to the Tamarind Centre for a new assessment. Mr Champion stated that he explored the risks of self harm and harm to others with Mr Stagg and determined that there was no "acute" risk as there were no current thoughts or plans to harm himself or anyone else.

<u>Mr Stagg's final involvement with Top End Mental Health Services (TEMHS)</u>

51. Contact was again made by Mrs Stagg with the On Call Team on 21 December 2009. Because of this contact, Mr Richard Ashburner (community mental health nurse) conducted a review of the file held for Mr Stagg. Mr Ashburner gave evidence that after having conducted his review, he made contact with Mr Stagg on 22 December 2009. The notes record that

when contact was made with Mr Stagg, he advised that he did not wish to have a psychiatric review and wished to wait to speak with Mr Champion again. I received evidence that Mr Champion had in fact gone on leave for two weeks over the Christmas period. Mr Ashburner then made offers of social skill services, to which Mr Stagg is recorded as stating that he "wasn't interested" and also commenting that although he was aware that Mr Champion "thought he had delusions", he believed that he in fact suffered from PTSD and it was simply taking "him and mum a long time to adjust".

52. Mr Ashburner stated that he considered Mr Stagg to be speaking clearly, coherently and giving prompt responses and that Mr Stagg gave him authority to advise his mother that they had spoken. Mr Ashburner gave evidence that he spoke with Mrs Stagg and at that time she advised him that her son had made threats of killing himself and harming others and she was concerned. Mr Ashburner stated that he encouraged Mrs Stagg to speak with the police about her concerns, but that she expressed reluctance as Mr Stagg was on a good behaviour bond and she was concerned any report might result in him going to gaol. Mr Ashburner subsequently contacted police about her concerns and requested they communicate with Mrs Stagg to try and allay her fears.

53. Because Mr Stagg stated he wished to wait for Mr Champion's return, it was not until early January 2010 that contact was attempted once again with Mr Stagg. A number of attempts were made by Mr Champion to speak with Mr Stagg in January 2010, but to no avail. Attempts at home visits were then made by Mr Champion, but again no contact was made. Eventually contact occurred on 24 February 2010, at which time Mr Champion arranged for Mr Stagg to attend for an assessment with consultant psychiatrist, namely Dr Ohn Kyaw.

54. I received evidence that this assessment occurred on 2 March 2010 with Mr Champion also present. Both Mr Champion and Dr Kyaw provided detailed

statements as to Mr Stagg's appearance and behaviour during that consultation. It was noted by Dr Kyaw that Mr Stagg had "delusional ideas, persecutory in nature". Mr Stagg stated that he believed people were against him and would sometimes notice people on the street behaving strangely and indicating as if giving signals to themselves. Mr Stagg also stated that he heard voices of people talking about him and telling themselves to harm him. In particular Mr Stagg described an occasion on Australia Day 2010, when he thought of driving into a crowd, but did not do so as he was afraid of the consequences of being in prison. Mr Stagg is recorded in the notes as "trying to overcome this fear".

55. Dr Kyaw gave evidence that after the interview his working diagnosis was:

- "Asperger's Syndrome (long term);
- Psychosis –paranoid schizophrenic disorder, probably gradually and slowly developing for years associated with the above condition;
- No evidence of major depressive disorder;
- No evidence of abuse of drugs or alcohol;
- Risk – from the conversation and assessment outcome I have noted the suicidal and homicidal risk if he did not receive treatment for psychotic symptoms. He was not thinking or planning to harm himself or others all the time and on the day of interview".

56. Mr Champion also noted that Mr Stagg "expressed chronic thoughts of suicide" and that he was:

> "… at *chronic* risk of harming himself or others. However, Aaron stated during this interview that he had no current plans to act on these thoughts. Therefore, there was no evidence of the presence of any *acute* risk requiring immediate, involuntary, intervention".

57. Dr Kyaw gave evidence that he considered Mr Stagg should be admitted to hospital and suggested it should be the day of their interview (i.e. 2 March 2010). When this suggestion was made, Mr Stagg stated that he would be willing to admit himself to hospital, but he needed to clean his residence up firstly and wished to do some cleaning and washing in order to take clean clothes with him. A discussion occurred between Dr Kyaw and Mr Champion where it was decided that Mr Stagg's requests were reasonable and an arrangement was made for him to be collected the following day at 10 am by Mr Champion and taken to the hospital. It was noted by both Mr Champion and Dr Kyaw that during this time Mr Stagg was not angry, agitated or showing signs of thought disorganisation. This decision to postpone admission, once it was considered necessary, is a matter that I will address further in these reasons.

58. On 3 March 2010, Mr Stagg telephoned Mr Champion and advised that he had "changed his mind" and no longer wished to go to Cowdy Ward. Mr Stagg is recorded as stating that he did not believe the medication would assist him, he was concerned he would not be able to sleep at Cowdy, and therefore concerned he would be unable to cope. Mr Stagg is also recorded as stating he believed there was a connection between the public health system and public education system where he stated he had experienced bullying as a child.

59. Mr Champion stated that the more contact he had with Mr Stagg "the more of his delusional belief system he was revealing". In an attempt to keep Mr Stagg engaged with the service, Mr Champion offered him an appointment for Monday 8 March 2010 which was accepted, however Mr Champion told Mr Stagg that he would need to check with Dr Kyaw as to what was occurring. Mr Champion stated that at this time Mr Stagg stated that he had no thoughts or plans to harm himself or others, and Mr Champion assessed him as calm and lucid.

60. Mr Champion then made contact with Dr Kyaw. Dr Kyaw stated that he considered Mr Stagg should be admitted involuntarily as he believed Mr Stagg required treatment and such treatment should occur in hospital in order for Mr Stagg to be monitored and the medication observed. As a result, Dr Kyaw began preparing the paperwork for an involuntary admission under s.34 of the *Mental Health and Related Services Act*, completing the various forms and sending them to Cowdy Ward. Because of this decision to admit Mr Stagg involuntarily, attempts were then made by Mr Champion to contact Mr Stagg on 3 March 2010, but these were unsuccessful.

61. On Thursday 4 March 2010 an Adult Green Team Clinical review meeting was held and again agreement was reached that Mr Stagg should be admitted involuntarily. Following the meeting, Mr Champion telephoned Mr Stagg at which time he answered. Mr Stagg was advised of the decision by Dr Kyaw to admit him involuntarily. Mr Champion stated that initially Mr Stagg was "calm and lucid", but he then "went on to talk about being 'locked up' for years and other bizarre paranoid delusional beliefs". Mr Champion stated that Mr Stagg then became "extremely angry and saying things I did not understand". Mr Champion tried to calm him, but then Mr Stagg began "screaming down the phone" and then terminated the call.

62. Mr Champion stated that this conversation caused him significant concern and he believed there was now "a significant acute risk and that we should act immediately". Mr Champion spoke with Mr Ashburner, and he agreed. Contact was also made with Mr Stagg's mother to advise her as to what was occurring and also determine whether Mr Stagg had been in contact. Mrs Stagg stated that she and her husband would travel from Alice Springs to Darwin the next day to assist in locating their son.

63. At 1.30pm Mr Ashburner, together with another mental health nurse, went with police to Mr Stagg's residence to take him into custody under s.34 of the *Mental Health and Related Services Act*. An approach plan was

instigated, but it was discovered that Mr Stagg's vehicle was absent from the residence. Telephone contact was also attempted to Mr Stagg's land line and mobile phone with no results. Police Communications then issued a, "be on the lookout for" ("BOLOF") over the police radio to all police units in respect of attempting to locate Mr Stagg.

64. Further discussions occurred and attempts were made to locate Mr Stagg. At 7.10pm an inter-agency briefing with NT Police and Mental Health Case workers from Tamarind Centre, was conducted and a response plan was formulated to attempt to locate Mr Stagg.

65. At 11.02pm police received a complaint informing of a Hit and Run incident outside the Arch Rivals car park in Palmerston. Subsequent investigations revealed that at around 11.00pm Mr Stagg had driven his vehicle to the vicinity of the Arch Rival Tavern in Palmerston. He drove into the back of the car park situated beside the Arch Rival Tavern. At this time there were two young females near a blue barge container which was situated over two car park bays opposite Beaurepaires. One of the females was sitting down on a curb and the other was standing nearby.

66. Mr Stagg stopped his vehicle and put his car head lights on high beam. He revved his engine two times and then drove towards the two females at a speed up to 30 kilometres, running into the two females and causing one to fall onto the bonnet of the car, then land in the garden bed. The other received cuts, scratches and bruising. Mr Stagg then reversed his vehicle and again drove towards the two females. The female who had only received cuts and bruising from the first incident reached out for the other who was still lying in the garden bed and pulled her towards herself seeking protection behind the barge container. The vehicle continued towards them and hit the side of the barge container. Mr Stagg reversed again and drove again towards the two females but instead veered away and departed the area. Police and St Johns Ambulance attended and CCTV footage was

viewed and seized by police. Police then began scouring the area for Mr Stagg and his vehicle.

67. On Friday 5 March 2010 at 3.10am a complaint was received concerning an abandoned vehicle within Mily Lily Park, Roseberry, which was parked up against a resident's fence line. Police attended and the vehicle was identified as that belonging to Mr Stagg. An extensive search of the area was conducted by police. As stated previously, at 5.00am Mr Stagg was located by NT Police members hanging from a beam on playground equipment.

Issues raised for consideration at this Inquest

68. At the commencement of this inquest, Counsel assisting outlined a number of issues that she suggested I may wish to consider and make comment upon, pursuant to my powers under s34(2) of the Act. Those issues can be summarised as follows:

1. The manner and sufficiency of the response by the NT Aged and Disability Program to the referral from TEMHS;

2. The manner and sufficiency of the response by TEMHS particularly in the few short days prior to Mr Stagg's passing;

3. Whether consideration should be given to a recommendation for the establishment of a service to provide a care coordination function for individuals with these kinds of disorders to access the services they need and to provide them with support to remain engaged with those services.

69. I will now deal with each of the above matters in turn in light of the evidence I have received during the course of this inquest.

The manner and sufficiency of the response by the NT Aged and Disability Program to the referral from TEMHS

70. As set out previously, it was following the obtaining of the second opinion from Dr Cutts as to Mr Stagg's condition, that a decision was made by TEMHS that because:

(a) Mr Stagg was most likely suffering from a Pervasive Developmental Disorder, like Asperger's Syndrome; and

(b) such disorders were not of themselves a focus of treatment at TEMHS,

that Mr Stagg would benefit most from psychological and other support that could best be co-ordinated by the NT Aged and Disability Service. Thus a referral was made by TEMHS to the NT Aged and Disability Service.

71. The eligibility criteria was set out in the evidence of Ms Westerman (as noted above) who also stated in her report (exhibit 8) at paragraph 25, that:

> "Eligibility to Northern Territory disability services is not based on diagnosis alone but is based on the person's level of function. Not everyone who meets the eligibility criteria for disability services needs, wants or receives services. Being assessed as eligible does not always equate to a person receiving a service. There is a high demand for disability services and access to services are prioritised or triaged according to need".

72. Upon receipt of the evidence related to the definition of "disability" under the *Disability Services Act*, I considered there was a real argument that Mr Stagg fell within that definition given:

72.1 His possible intellectual impairment;

72.2 That was permanent;

72.3 Resulting in

72.3.1 his reduced capacity in communication; and

72.3.2 need for continuing support services,

72.4 Which may or may not have been chronic, episodic in nature

73. However, Ms Westerman also pointed out (at paragraph 26) that the DSM IV TR defining diagnostic characteristics of Asperger's Syndrome are:

"(a) no clinically significant delay in language; and

(b) no clinically significant delay in cognitive or intellectual development".

74. Consistent with the above, it was clear from the evidence before me that at that time Mr Stagg appeared to be an intelligent young man whose real difficulty appeared to be his inability to communicate effectively with others and his frustration at being unable to develop relationships as a consequence. Significantly, even Mr Carrigg's original referral to NT Aged and Disability on 7 April 2009 identified the reasons for referral as being to obtain assistance for:

(a) Communication; and

(b) Community access/employment opportunities.

With the outcome to be that Mr Stagg's social skills be improved and developed "so he can enjoy social outings and gain employment of his choosing".

75. Ms Westerman noted that the "core functions" of disability services in the NT are (at paragraph 27):

> "…to provide services to those clients who have a moderate to severe intellectual or physical disability. Services provided are mostly aimed at addressing client's essential or basic needs such as:
>
> a. providing assistance for people with personal care such as toileting, showering, dressing;

b. assistance for people who are non-verbal and or unable to communicate their needs, through developing a sign system or prescribing a communication aid; and

c. assistance with mobility such as accessing specialised wheelchairs, walking aids etc."

It is clear that Mr Stagg did not require any such services as a result of his Asperger's Syndrome.

76. Ms Westerman went on at paragraphs 28 and 29:

> "28. Services funded by the disability services program are also geared towards people who have moderate to severe disability. A large proportion of disability services funding goes to Non-Government Organisations to provide supported accommodation services to people who are severely disabled and unable to live independently and perform their own self-care tasks. People with a comparatively high level of function, such as those with Asperger's Syndrome, frequently choose to disengage with disability services as they do not believe that they have a disability and they do not connect with those people who have moderate to severe physical and / or intellectual disabilities as they frequently have a higher level of functioning, inconsistent with other service recipients of the Disability services.
>
> 29. The professional staff employed within the disability program are qualified, experienced and skilled in providing services to people with moderate to severe disabilities. The professional staff of the disability program are predominantly physiotherapists, speech pathologists and occupational therapists. There are some generic allied health positions working as wheelchair consultants and Disability Case Managers and Coordinators. Two Behaviour Educator positions within the Disability Team are generic allied health positions that work predominantly with care givers and disability support workers of people with moderate to severe intellectual disability whose behaviour is challenging and jeopardising their educational, supported workplace or supported accommodation placement."

Again, I note that in terms of Mr Stagg, he did at times "disengage" with service providers and it is clear that he did not consider himself to be suffering from a disability. Further, the staff employed at the service, are

not the kind of service providers that it appears would have been of greatest assistance in Mr Stagg's circumstances.

77. In terms of the kinds of intervention needed for an adult suffering from Asperger's Syndrome, Ms Westerman went on at paragraph 30 to note:

> "The intervention required for an adult with Asperger's Syndrome needs to be provided by a professional who is skilled in psycho social interventions, such as cognitive behavioural therapy. This is a specialty area of psychology. There are no psychology positions or social work positions within the Disability Team to provide psycho-social interventions for clients requiring this form of assistance. The current staffing mix and core functions of the disability program means that it is currently unable to provide high level, specialised psycho-social services. It is also a risk to have staff, who are not qualified or skilled in the area, providing this service."

78. It was certainly clear from the evidence of Ms Westerman that following a review of Mr Stagg's circumstances, she considered the refusal of the referral from TEMHS by NT Aged and Disability to have been appropriate. After having considered the evidence, I agree. It is clear that Mr Stagg did not require disability specific services as offered by NT Aged and Disability Services, and that the type of service that he did need, i.e. in the nature of psycho-social interventions, was not one offered by NT Aged and Disability.

79. I therefore do not consider there was anything inappropriate or insufficient in the response by the NT Aged and Disability Services Program in their refusal to accept the referral of Mr Stagg.

The manner and sufficiency of the response by TEMHS particularly in the few short days prior to Mr Stagg's passing

80. Upon reflection of the evidence I consider this issue should be considered in terms of the two relevant time periods:

80.1 The response from TEMHS when contact was first made with them on 29 December 2008 until they closed their file on or about 18 September 2009 ("the first response period"); and

80.2 The response from TEMHS when contact was "re-made" on 21 December 2009 until Mr Stagg's death on 5 March 2010 ("the second response period").

First Response Period

81. I considered closely and carefully the evidence received as to the response by TEMHS during this first period. I was particularly impressed with the evidence of Mr Steve Carrigg. There was no doubt in my mind that Mr Carrigg was particularly concerned for Mr Stagg, however he was constrained by the eligibility criterions and frameworks established for TEMHS. That is not a criticism of TEMHS; it is simply a statement of fact that they have eligibility criterions that must be met before service can be provided. This is the case with any service provider around the country.

82. Despite those criteria not having been met during the first contact period, TEMHS continued to provide case management for a period so as to make sure that there was no underlying mental illness that may have been impacting upon Mr Stagg. As detailed earlier, this resulted in Mr Stagg having weekly contact with Mr Carrigg, assistance with referral to other agencies (that eventually Mr Stagg disengaged with), and trial of anti-psychotic and anti-depressant medications (which made no discernable difference).

83. I note that Mrs Stagg made some criticism of the meetings with Mr Stagg taking place "at the Cool Spot" and her view that "playing chess" wasn't helping her son. I note that Mrs Stagg also considered that "not enough time" was being spent in assessing Mr Stagg. In terms of these matters, I disagree.

84. As stated previously, Mr Carrigg was an impressive witness. I note that he has been a mental health nurse since 1992. It is clear he has a great deal of experience and knowledge in mental health services. Mr Carrigg gave

evidence that he carefully considered how best to manage Mr Stagg and formed the view that to get a true and accurate assessment, it was necessary to observe Mr Stagg outside of the Tamarind Centre (see tp. 28.4):

> "For me, as a mental health nurse, I initially try and establish some rapport and trust with people. I think it is imperative that that happen, because there are some people in our line of work who we try and engage who may not be - may be guarded or may not be telling us everything that's going on for them and that is not that unusual in itself. So I think it's important that we just don't have a, you know, strictly formal meetings necessarily within the buildings at the Tamarind Centre. For me it was about establishing some rapport and trust and continuing to assess and observe what was happening for Aaron over an extended period of time, rather than just perhaps a one-off assessment."

And further (tp. 28.6):

> "What sort of things did you do to try and establish that rapport and trust and observation just outside of the four walls of the Tamarind Centre?---Look, my initial meeting with Aaron was to try and get a sense of what was happening. I also took on board the history that I had received from others, including his family, and I decided that perhaps for someone like Aaron, one of the best ways to try and engage him would not necessarily be at the Tamarind Centre. He expressed an interest in playing chess. I used to play chess. I thought it might be one way that we could get together and meet outside the clinical confines of the Tamarind Centre and I could get a bit more of a chance to observe and assess what was happening for Aaron. So we went down to the Cool Spot in Fanny Bay on a couple of occasions to do that. I bought him lunch a couple of times. We sat and chatted and really it's important for him to be able to trust the person that he's talking with. I got the sense with Aaron - because of not just his diagnosis of pervasive developmental disorder but he'd struggled with friendships and social interactions since he was a young boy and that's not unusual for people with his syndrome or condition, if you like. So there was this sense of - he - I felt he had a sense of suspicion about others, about, you know, being able to trust other people. So I think, from my point of view, trying to establish that trust was going to be critical as far as observing what was happening and assessing what was happening for Aaron."

Also at tp.29.9:

> "Okay. And whilst you're having these meetings and playing chess and those sorts of things, are you also conducting the observations that you talked about with his Honour in terms of trying to establish whether there was an underlying psychosis or other condition?---That was the primary goal. I mean, my goal in doing those sorts of activities is to continue observation and assessment. You know, I didn't do it for my enjoyment. I did it to try and establish some rapport and continue to observe what was happening. I think it's a good opportunity to, in a non-confronting environment for someone like Aaron to talk about what was happening for him in his life. Also to check out his concentration and to see if there's other things that he talks about that might have suggested to me that he had an ongoing or underlying psychosis or depression."

85. In terms of the timing and length of such appointments, Mr Carrigg gave evidence that this varied and that he was aware at all times during his assessments and observations of Mr Stagg that there are some people who can keep things together for a certain period but that eventually they will break down (see tp. 30.5):

> "One of the concerns that has been raised as well, Mr Carrigg is that perhaps that time wasn't sufficient enough to allow there to be this breakdown of a facade that Aaron may have been putting up, trying to put his best face forward, I suppose. Are you cognisant of those sorts of things when you're meeting with a patient and were you in relation to Aaron?---In my line of work, there are some people who, within five minutes of them walking through the door you know pretty well, what's going on for them because they don't have the ability, if you like, or capacity to keep a lid on it or be guarded and put on a good front. For some people they can hold it together for certain periods of time and eventually the underlying thoughts, symptoms and signs of their condition emerge or declare themselves and it's something we're always or certainly I'm always wary of when I'm trying to do an accurate assessment and that is why I felt that, particularly with Aaron, I couldn't do that assessment in 60 minutes in an office environment. I, for that very reason, decided that case management was probably the best option for him so I could continue to assess his situation but also try and link him in with other agencies who might be able to help him socially, with frustration and anger management, because that was an obvious issue, and try and offer some support through the legal process, which he was also going through at the time.

One of the things that Mrs Stagg has raised with me particularly, and she's not - the family is not represented during the course of these proceedings so I'm trying to ensure that all the relevant information is coming out. But one of the things that she's raise particular is that perhaps Aaron was showing signs that maybe were more of their being a psychosis or a mental illness to her in the family rather than to the experts or the professional staff like you. For example, Mrs Stagg has particularly highlighted that when Aaron had his ankle broken, he went home and he cut off the cast immediately. She's also talked about incidents where there were very, very serious - she referred to it as an attack by Aaron on his brother and those sorts of things. Whether, in fact, Aaron was very good at hiding what was going on to the professional people but very poor with his family, were you ever aware of those sorts of things and taking them into account when you were assessing Aaron?---I was very much aware of Aaron's mother's concerns about that and I suppose I can say Aaron did describe many suspicious or paranoid ideas, particularly about conspiracies, particularly about what I termed as quite a long-standing, perceived sense of injustice. One thing I didn't pick up with Aaron's presentation was the presence of what we'd call auditory hallucinations, such as a command type hallucinations or a voice telling him - talking about him or telling him to do things or what we also would term formal thought disorder, where his topic of conversation is very difficult to follow. So I would agree that there was some odd thoughts of a paranoid nature but at the same time I sort of challenged him on some of those and on occasions I did challenge him he didn't seem to be 100 per cent fixed, so I wouldn't have called it at that stage delusional intensity. People with delusions and most commonly the people we see with acute psychosis or schizophrenia, for example, have delusions which you can argue until you're blue in the face and you'll never change their mind. I find with Aaron that I could present him with perhaps a statement counteracting his claim of, for example, if he slept on one side he might not wake up in the morning and he could tell you that, oh, yeah, okay, well, maybe it's a little bit irrational. So, look, I still, I guess, felt that for Aaron he probably had a low threshold for developing an acute psychosis and in many ways that would have made my job, my work, a whole lot easier really with regard to what sort of treatment path we went down but during my contact with him I never felt that he was certainly floridly psychotic and there was no way that I would have been able to utilise the Mental Health Act to enforce involuntary treatment at that stage. He was coming in voluntarily. He was accepting of my appointments. I never ever felt that he was threatening or intimidating toward me. I was aware of the issues at home when he was living in Nightcliff and I had actually met with his brother on one occasion who came in to

describe to me his concerns about Aaron as well and some of the things he was saying and doing".

86. As is clear from the above, Mr Carrigg acknowledged that at times Mr Stagg did express "paranoid ideas" but there were no hallucinations and when challenged, Mr Stagg was not fixed in his ideas and therefore there were no fixed delusions as required in order to fit the criteria for a diagnosis of mental illness. Mr Carrigg did state however that he considered Mr Stagg had a low threshold for developing acute psychosis but during his periods of contact with him there were no times when he considered Mr Stagg to have been floridly psychotic, and therefore he was unable to use admission under the *Mental Health and Related Services Act.*

87. In terms of the closure of the file, I note that there was a criticism inferred in the evidence that Mr Stagg's file should never have been closed with TEMHS. In this regard I note the following relevant evidence (tp. 32.3):

> "And you then met with him, as I understand it, on the 21st of September 2009?---Yes, I was - at that stage I was leaving the Northern Territory and he did - I can't remember if he called me or just came in to see me. It's probably in my notes here somewhere but he did come in and at that stage I must say that he was - I mean, as I said before he was never - I never ever felt threatened or intimidated by Aaron but he was - he was bring and chatty and he was actually appreciative of some of the attempts to help him that I'd made and I sort of encouraged him - strongly encouraged him to continue to get some psychological support because whilst at that point in time I didn't feel he was floridly psychotic or even clinically depressed, he obviously had some very clear underlying problems that I felt and advised him to get some help for. I thought it would have been beneficial if he continued to get some psychological support."

And further at (tp. 32.7):

> "Perhaps if I can assist you, sir, the records that his Honour has received is that he certainly indicated that if he felt the need to do so he would and he was very grateful to you for the assistance you've

given. Does that assist you in your recollection?---Yeah, look, there's - I couldn't force him at that stage. In all honesty there were many other people who were accessing the service who would have been closer to more assertive treatment and by that I mean involuntary treatment at that particular point in time for Aaron. I can't make comment on what happened a few months later but certainly when I last saw him there was no way in the world I was ever going to be able to utilise the Mental Health Act. All I could do was strongly encourage him to continue to get psychological support and he declined the offer at that point.

And you've just indicated to his Honour that at that stage at that last meeting it was certainly your opinion that Aaron wasn't psychotic, he wasn't depressed but it would be beneficial for him to receive psychological support?---Yeah. Yes. The issue of an underlying psychosis was always in the back of my mind with Aaron but nothing had changed on my last meeting with him. I, in fact, felt that he was brighter than usual. He still had the ongoing court case issues and he had been having some contact with his legal representatives about that but he came in, he was smiling, he was chatty and I think he just actually wanted to come in and say, I guess, just thanks for your efforts. I knew it was going to be a bit of a difficult period for him because I felt anyway that I had managed to establish some rapport with Aaron, even with the rescheduling of an appointment that he felt personally probably aggrieved by. I'm only sort of, I guess, assuming a bit there but I felt that we'd actually managed to establish a reasonably good therapeutic relationship and felt - I think he felt comfortable in my presence anyway."

88. I accept the evidence given by Mr Carrigg and have no criticism to make whatsoever of the assistance he provided to Mr Stagg. Nor do I have any criticism of the decisions made by TEMHS during this period. It is clear that Mr Stagg did not meet their criterion for assistance at that time, however despite that, a determination was made to be absolutely sure that there were no underlying mental health issues that were being masked by the Asperger's Syndrome. That was a sensible, considerate and pro-active approach to have taken.

Second Response Period

89. As outlined earlier, it was as a result of the referral to EASA that Mr Stagg was assessed by Mr Champion on 19 December 2009. Coincidentally, Mr Champion had last seen Mr Stagg in October 2009. It was during this second assessment however that for the first time Mr Stagg was noted as having "clear paranoid delusional thinking" and that the very real concern was that Mr Stagg was suffering from "paranoid psychosis with depressive features as a secondary condition". This was the first time that any such recordings had been made in relation to Mr Stagg.

90. It was as a result of this assessment that a referral was made back to TEMHS and that contact was re-made within three days Mr Ashburner on 22 December 2009. I consider this time frame to have been reasonable, particularly given it involved Mr Ashburner conducting a review of the file held by TEMHS in relation to Mr Stagg.

91. When contact was made however with Mr Stagg by Mr Ashburner it is clear that Mr Stagg wanted to speak with, and have the assistance of, Mr Champion. I note that during the course of the evidence a number of witnesses spoke of the real and significant need to attempt to engage with individuals in a manner that will encourage future engagement by them with the service and allow a relationship of trust to develop in order to encourage the disclosure of information relevant to their mental health. Also raised was the need to ensure compliance with the policy of the *Mental Health and Related Services Act* of ensuring that:

> "a person who has a mental illness receives the best possible care and treatment in the least restrictive and least intrusive environment enabling the care and treatment to be effectively given" (see section 8 in this regard).

92. Upon his return from leave it is clear from the notes tendered before me that Mr Champion made all reasonable attempts to contact Mr Stagg in a timely manner, including actual home visits. That eventually occurred on 24 February 2010 whereupon arrangements were made for assessment by a

consultant psychiatrist on 2 March 2010. I do not consider any of these periods to have been unreasonable in the circumstances.

93. When that assessment did occur with Dr Kyaw, I note that Mr Champion also attended. At that time a decision was made that admission should occur. As noted above, although it was considered by Dr Kyaw that Mr Stagg was experiencing psychotic symptoms, with secondary depression and fear, Mr Stagg stated that he was willing to be admitted into Cowdy Ward for treatment. Mr Stagg's only request was that he be able to get his house in order and obtain some clothes for the purpose of the admission. This was not an unreasonable request, particularly when considered in light of the "least restrictive" policy of the provision of mental health care and treatment. I therefore find that it was not unreasonable for that request to be acceded to. This is particularly so in light of the fact that Mr Stagg was assessed at that time as lucid and calm and not an "acute" risk of self harm or harm to others.

94. Unfortunately however, that state did not remain the case for Mr Stagg. By the following day he no longer wished to be voluntarily admitted and was becoming angry and aggressive. His level of risk therefore changed significantly, both in terms of himself and to others. It is very easy to be wise in hindsight and argue that the opportunity should have been taken to have admitted Mr Stagg on 2 March 2010, when he was in agreement. However I find that the staff with the relevant experience and expertise (namely Dr Kyaw and Mr Champion) considered the matter carefully at the time and formed the view that in the hope of being able to engage Mr Stagg effectively and in the best way possible in future, his request for time to get his affairs in order should be agreed with.

95. What occurred thereafter in terms of the attempts to locate Mr Stagg and to arrange for his admission to Cowdy Ward on an involuntary basis was done promptly. I consider all reasonable attempts were made to communicate

with him and establish his location, but they were to no avail. It is not clear where Mr Stagg went in that period prior to him driving into the two females in Palmerston. It is unfortunate in the extreme that he was unable to be located prior to that time, but I consider that all that could be done to try and locate him, was done.

96. I note that following Mr Stagg's death, a Critical Incident Review was conducted by the Department of Health. As stated in a number of other inquests, I am pleased that the Department has conducted its own review and sought to find ways of improving systems or avoiding similar deaths in future. That is very important and not something that should simply wait to occur as a result of the outcome of one of my inquests. That review formed part of the report tendered from Ms Bronwyn Hendry (exhibit 7).

97. The review made four recommendations:

97.1 Documentation. It is noted that instances were found where some attempted contacts or actions with Mr Stagg were not well documented and as a result all mental health practitioners have been required to complete a national training module. I do not intend to say anything further on this issue and consider it has been adequately addressed;

97.2 Communication between Mental Health Services and Police. A single instance of unsatisfactory communication between mental health service staff and police appears to have occurred in relation to the circumstances concerning Mr Stagg. I note that the evidence is that this was described as a "momentary hindrance" and then a unit was made available by police to mental health service staff. It is clear therefore that this did not have an impact upon the outcome for Mr Stagg.

I do note however that the evidence also revealed that the revised "Protocol for Cooperative Arrangements in Mental Health Matters between the Northern Territory Police Force and the Department of Health" remains outstanding. This has now been outstanding for a considerable period of time. I once again encourage both the Department of Health and the Commissioner for the NT Police (as I have now done in a number of inquests) to attend to this Protocol and its finalisation as soon as possible.

97.3 Clinical Decision Making. The review notes that a different course of action **may** have produced a different outcome (my emphasis). However it also goes on to note, quite properly, that it is not possible to know what would have actually occurred if another course of action was pursued. As I have already endeavoured to set out within these reasons, the review also notes that:

"The clinical decisions that were taken were considered decisions by experienced clinicians, with the aim of achieving the best possible long term outcome for (Mr Stagg), as well as safeguarding the community".

I make a similar finding on the evidence before me.

97.4 Services for adults with Pervasive Developmental Disorder/Asperger's Syndrome. I intend to deal with this aspect of the review whilst considering the final issue raised for my consideration during the course of this inquest.

98. After careful consideration of all of the evidence, I do not find that there is any valid criticism that can be made in relation to the response by TEMHS staff and practitioners during the course of Mr Stagg's second contact period with their service.

Whether consideration should be given to a recommendation for the establishment of a service to provide a care coordination function for individuals with these kinds of disorders to access the services they need and to provide them with support to remain engaged with those services.

99. As outlined above, the Critical Incident Review identified that there are no specialised service system for adults with these disorders who are relatively high functioning. In addition, whilst there are mainstream programs provided that may assist, the nature of the disorder is such that individuals may have difficulty navigating the service. That appears to have been the case in relation to Mr Stagg who would quickly disengage with any service provider whenever an appointment was re-scheduled. Mrs Stagg herself noted her son's complete frustration whenever this would occur.

100. As a result, I note that the review recommended that:

> "… consideration be given to establishment of a service that can provide a care coordination function to enable individuals to access the services they need, and to provide support to the individual to remain engaged with these services".

Whilst that recommendation was made, I note that nothing further appears to have occurred.

101. In relation to services to adults with Pervasive Developmental Disorders/Asperger's Syndrome, I received evidence that the care and support of people with high functioning Asperger's Syndrome is an issue in the community services system nationally and that high functioning people with Asperger's Syndrome (like Mr Stagg) do not generally meet the eligibility criteria for disability services across the states and territories.

102. Ms Westerman helpfully set out within her report that she made contact with each state and territory government disability program to determine the services provided. Ms Westerman noted as follows:

> "33. Eligibility to the majority of interstate disability services is not based on diagnosis but on the functional impact of the diagnosis, i.e.

to what extent is a person able to engage in functional every day Activities of Daily Living. There was, however, unanimous consistency across the state and territory disability services in the prioritisation of access to services based on need, which in practice tended to exclude those people with Asperger's Syndrome with no intellectual disability.

34. There are two states that have given consideration to providing services to adults with Asperger's Syndrome through their disability service system.

35. One of these states is South Australia, which reports that it is able to provide some services to people with Asperger's Syndrome who have complex needs. However, Disability SA reports that "services were, and still are, relatively limited due to limited numbers of staff with the expertise to provide these services". Best practice in the support of adults with Asperger's Syndrome would require staff with the expertise to treat the new client group.

36. The other state, Western Australia, has strict eligibility criteria for this client group. The Western Australian Disability Services Commission reports that while an adult may be eligible, there is no automatic entitlement to services. If services are able to be provided they are limited to case coordination."

103. As can be seen from the above, there does not appear to be any specific service provider to assist adult sufferers of Asperger's Syndrome in the whole of Australia.

104. Whilst considering the issue of whether a recommendation should be made for the establishment of such a service in the Northern Territory, consideration was also given by me to the issue of prevalence of Asperger's Syndrome. Again I was assisted by the report of Ms Westerman which noted as follows:

"13. There is a variation in prevalence figures from different sources of data. However, using the Australian Government's Centrelink data the finding is that there is an estimated prevalence of Autism Spectrum Disorders across Australia of approximately 1 in 160 for children aged between 6 and 12 years.

14. Studies showing prevalence rates solely of Asperger's Syndrome are difficult to find but it is generally accepted that

> Asperger's Syndrome comprises a small proportion of the total number of people with an Autism Spectrum Disorder. The Canadian estimate of prevalence is 3 in 10,000 people. The prevalence in the Northern Territory is unknown. Not all of these people require treatment and support for their condition. The majority of young people with Asperger's Syndrome live with families or independently and generally require informal or occasional services."

105. What these figures mean in terms of adult sufferers is perhaps questionable, however given that Asperger's Syndrome cannot be cured; it is easy to translate these *approximate* figures into the adult population. As can be seen however, when considered in light of the total population in the Northern Territory, there are not large numbers of sufferers. I do not mean this as any disrespect to those who suffer from the disorder, or to their families who provide such invaluable assistance to them, however such numbers are matters that need to be considered when determining whether a recommendation should be made for Governments to consider providing the necessary funds for the establishment of such services.

106. It is in these circumstances that I have determined not to exercise my discretion to make an actual recommendation on this occasion for the establishment of a service to provide a care coordination function. I do consider that there are other service providers in the mainstream that can, and do, provide assistance, and that perhaps with the death of Mr Stagg now firmly in the minds of those service providers, they will be more determined to be more vigorous in their endeavours to keep such persons engaged. I encourage them in this regard.

Conclusion

107. Despite what I accept to be the very real distress to the family of the tragedy of the death of their son after numerous attempts by them to obtain help, I do not have any criticism to make of those service providers who were

contacted given the criterions that needed to be addressed by them when providing services.

108. I have no recommendations to make arising from this inquest.

Mr Greg Cavanagh :

Dated this 11th day of October 2011

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GREG CAVANAGH
TERRITORY CORONER