JUSTICE HEALTH
STATEWIDE SERVICE | NSW HEALTH

15 June 2011

FAXED 15/6/11

The Presiding Judge
Sydney District Court
Downing Centre, 143-147 Liverpool Street
Sydney NSW 2000

Your Honour

Strictly Confidential Psychiatric Report
RE: KELLIE, Moses
MIN: [redacted]
DOB: 5 [redacted]
COURT HEARING DATE: 17 June 2011

INTRODUCTION

This psychiatric report has been prepared following a request by Judge Finnane dated 18 April 2011.

According to information made available Mr Kellie has been charged with *robbery armed with offensive weapon cause wounding / GBH.*

I have read and agree to adhere to the principles of the Expert Witness Code of Conduct (Part 28 Rule 9C and Part 28A Rule 2).

Report of Dr Adams, Forensic Psychiatrist

CONSENT & CONFIDENTIALITY

I explained my role in assessing him for the purpose of preparing a psychiatric report. I informed Mr Kellie that any information he provided would not be confidential. I formed the opinion that Mr Kellie understood this and that he consented to continue with the interview and the preparation of a psychiatric report.

SOURCES OF INFORMATION

In the preparation of this report I have obtained information from the following sources:

Justice Health
ABN 70 194 595 506
PO Box 150 Matraville NSW 2036
Tel (02) 9700 3000 Fax (02) 9661 8409
Website www.justicehealth.nsw.gov.au

1. Interview with Mr Kellie at the Metropolitan Remand and Reception Centre on 30 April 2011.
2. Letter of request for a psychiatric report from Judge Finnane dated 18 April 2011.
3. Copy of the Indictment dated 25 August 2010.
4. Justice Health Medical File.

INFORMATION FROM CLINICAL ASSESMENT

Background Information

Mr Kellie informed me that he was 26 years of age. He described how prior to his arrest and subsequent incarceration he was homeless, sleeping in Centennial Park, for approximately seven months. He told me that he was not in a relationship, had never been married, and had no children. Mr Kellie said that he was not working prior to his incarceration and was not in receipt of any financial benefits. He told me that he had three sisters living in Blacktown, but had not any direct contact with them for approximately seven months prior to his arrest.

Mr Kellie was aware of his current charges, and told me that he was pleading guilty to part of the alleged offence but not all. Mr Kellie was aware of his next court date, and told me that he was awaiting sentencing.

Psychiatric History

Mr Kellie told me that he had never been admitted into a psychiatric hospital.

Mr Kellie believed that his first contact with mental health services was whilst he was in a refugee camp in Guinea, having fled there from Sierra Leone in approximately 1996. He told me that he saw mental health workers on an occasional basis and that he was prescribed what he believed to be psychiatric medication, but he could not be precise as to the details.

I questioned Mr Kellie as to why he saw mental health services whilst placed in a refugee camp, to which he replied, "because of what we experienced, the killings…I was traumatised". Mr Kellie gave an account of how whilst living in Sierra Leone he witnessed the murder of his mother and father by the rebels, as part of the civil war. He also noted witnessing a variety of other atrocities. He told me that soon after he experienced nightmares, "flashbacks" of the scenes of the murder, increased anxiety, and he felt "depressed" in mood.

Mr Kellie described how in approximately 2003 he began "hearing voices". He was unable to provide any clear examples of auditory perceptual abnormalities during this time, but likened them to "strange voices". Mr Kellie commented that the voices were "telling me about killing, doing something silly…do revenge" – and referred to the voices instructing him to harm both himself and others. On questioning Mr Kellie believed that the voices occurred within the internal space. He believed them to be real at the time.

He told me that they usually sounded like his sister's voice or a male voice, whom he believed to be his father. At around this time Mr Kellie described how he began believing that the television was referring to him, "gossiping" about him and also "giving me instructions". Mr Kellie noted widespread persecutory ideas and ongoing concerns with regards his safety. On direct questioning Mr Kellie described how others could "read my thoughts", but he was unable to provide any exact details.

Mr Kellie described how he travelled to Australia having obtained permanent residency status. He said that he was seen at a Blacktown Hospital by services whom he believed to be in relation to mental health, and was prescribed psychiatric medication. Mr Kellie told me that he was not compliant with this, however, as he saw no benefit from it.

Mr Kellie told me that he had no further contact with mental health services during the four years leading up to his current incarceration, nor was he prescribed psychiatric medication. Mr Kellie described his presentation during this time, "I didn't feel good at all". I asked Mr Kellie if he continued to experience the above symptomatology to which he answered, "it was part of my life every day". He described ongoing auditory perceptual abnormalities similar to those above. He told me that his mood he was "not happy at all", and he noted ongoing nightmares, flashbacks, and anxiety occurring "every day". Mr Kellie endorsed ongoing concerns with regards the television. He told me that he believed his sisters to be "plotting against me... to do bad things to me". Mr Kellie reported believing that his sisters were "trying to send me to gaol, trying to involve me with criminals". He also noted wide ranging concerns regarding his safety.

Mr Kellie gave an account of lacerating his wrists in an attempt to commit suicide on approximately five occasions whilst living in Sierra Leone, whilst feeling particularly "worthless" and experiencing "voices in my head telling me I was no good to live". Mr Kellie noted that he attempted to hang himself on "several" occasions whilst living in Marrickville. He told me that he had not engaged in any self harming behaviour or attempting to commit suicide since his incarceration, but told me that in approximately November 2010 he told staff that he was contemplating suicide.

Drug & Alcohol History

Mr Kellie reported first using illicit substances at the age of 11 years, whereupon he began smoking cannabis daily – usually up to 10 "joints" per day. He told me that he continued smoking in this pattern thereafter. He described how from the age of approximately 12 years he began to consume alcohol regularly, usually on a daily basis until intoxicated. Mr Kellie described how upon moving to Australia he ceased cannabis use and began using amphetamines and methamphetamines approximately once per week. He described using these substances for approximately six months intravenously prior to returning to cannabis use. Mr Kellie reported how his cannabis use fluctuated thereafter, dependent upon his finances. He told me that at most he would smoke cannabis three times per week.

Mr Kellie denied ever using additional illicit substances.

Mr Kellie denied using any cannabis for approximately three weeks prior to his incarceration, and told me that he had consumed no alcohol.

Mr Kellie described how cannabis use made him feel increasingly paranoid.

Mr Kellie said that he had never entered drug and alcohol rehabilitation.

Medical History

Mr Kellie described losing consciousness secondary to head injury on approximately three occasions, as a result of being assaulted. He said that he underwent investigative scans, but he was unaware of the results. Mr Kellie denied any additional significant medical history, including any history of diabetes, epilepsy, cardiac pathology, cerebrovascular accident, or hepatitis.

Family History

As already mentioned, Mr Kellie described how his mother and father were killed during the Sierra Leone Civil War, when he was approximately 11 years of age. He told me that his mother worked in the town council and his father as a miner. Mr Kellie told me that he had two brothers, one of whom was "missing in the war" and the other remained in Sierra Leone. He said he had not had any contact with his brothers since moving to Australia. Mr Kellie told me that he had three sisters, all of whom he moved to Australia with in 2006. Mr Kellie reported how his sisters suffered similar "trauma" in the civil war as he had. He told me that his father was diagnosed with schizophrenia, and that he was treated with psychiatric medication. Mr Kellie described how both his parents regularly consumed alcohol.

Personal History

Mr Kellie told me that he was born in Sierra Leone. He had no knowledge of his mother's pregnancy or delivery history, but believed that the attained his developmental milestones at appropriate stages. He denied any history of sexual abuse, but described regularly being physically abused by his father throughout his early childhood years. Mr Kellie described how following the outbreak of civil war he moved to Guinea in 1990, at the age of approximately five years. He said he and his family later returned until he was 11 years of age when his mother and father were killed.

Mr Kellie gave an account of how at the age of 11 years he fled to a Guinea refugee camp with his sisters, and remained there for approximately 10 years prior to moving to Australia. He described occasionally attending school in both Sierra Leone and Guinea, but told me that he never attained any formal qualifications. Mr Kellie described being able to read, write, and perform basic mathematics. He said that he occasionally became involved in fights as a child, but denied any significant conduct problems.

With regard to his employment history Mr Kellie described how he traded goods and food whilst living in the refugee camp, but was never employed on a full time basis. He told me that since moving to Australia he attended a migrant's English course, prior to enrolling in a nursing course at the Wesley Mission for approximately three months. He noted being employed in factory work thereafter, but told me he had not worked since approximately 2008.

Mr Kellie said he was not involved in any serious relationships whilst living in Africa, but that he had had one relationship lasting approximately six months since moving to Australia.

Recent History

Mr Kellie reported being placed at Goulburn, Parklea and most recently MRRC since his arrest. He told me that he was not initially seen by mental health services and was not prescribed psychiatric medication. He said that this altered whilst he was placed at Parklea as he was "going off"...my head was not proper...I had voices in my head, I was violent to anybody". Mr Kellie described being reviewed by mental health services, and being transferred to the Mental Health Screening Unit (MHSU, MRRC) as a result.

Mr Kellie gave an account of how whilst placed at the MHSU he was prescribed Olanzapine (an antipsychotic), and underwent regular review with mental health services. He told me that he was subsequently transferred to the Mental Health Accommodation Area in approximately November 2010.

Mr Kellie described how overall he felt "better" with regards his mental state. He commented, "the voices in my head have reduced dramatically". He described, spontaneously, how his sleep pattern had improved and his levels of paranoia lessened.

I questioned Mr Kellie with regards possible ongoing psychotic symptomatology, and he reported the following:

- Mr Kellie told me that he last heard "voices" the day prior to my assessment. He initially stated that he was unable to ascertain the exact content of the "voices", but subsequently said that he heard commands instructing him to harm both himself and others. His account was vague. He told me that they occurred within the internal space, and were usually female – sounding mostly like his sister. He told me that he was able to "overcome the voices", and remain "calm and relaxed".

- Mr Kellie described ongoing concerns in relation to the television, and told me that approximately three days prior to my assessment he believed it was referring to him.

- Mr Kellie described ongoing concerns regarding fellow inmates reading his thoughts and being able to "read my mind". He said this happened fleetingly, usually three times per week.

- Mr Kellie described feeling safe, and denied any ongoing concerns regarding his persecution.

- Mr Kellie denied any features suggestive of passivity phenomena, or perceptual abnormalities in additional sensory modalities.

Mr Kellie described how all of the above features of mental illness had reduced in both frequency and intensity since his antipsychotic medication was changed from Olanzapine to Quetiapine, and the dose was increased. He believed that all of the above features were based in mental illness and he denied believing in their reality.

Mr Kellie described his current mood as "around seven out of ten...okay". He denied any significant concerns regarding his sleep pattern, appetite, concentration, or sense of humour. He described his daily routine, encompassing exercise and playing table tennis with others. He denied recent ideas of self harm or suicide. As noted above, however, Mr Kellie endorsed fleeting ideas of wishing to commit suicide in approximately November 2010.

Mr Kellie said that he last had a nightmare or a flashback approximately three weeks ago, and said that they had decreased in frequency. He told me that he tended to feel calm, and denied any significant levels of anxiety. There was no recent evidence of panic attacks.

Mr Kellie's outlook with regards the future was positive, and he described his future plans including completing his nursing course and having increasing contact with family members.

MENTAL STATE EXAMINATION

Mr Kellie appeared moderately kempt in both his attire and grooming. He was dressed in prison greens. He was pleasant and appropriate in manner throughout the assessment, and there was no element of hostility. He sat calmly throughout the interview, and did not appear overtly anxious or agitated. At no stage did he seem to be responding to unseen external stimuli. For the majority of the interview Mr Kellie's facial expressions were restricted, but he was able to raise a laugh on one occasion. He maintained a good level of eye contact. Mr Kellie tended only to respond to the questions asked and his speech lacked spontaneity.

Mr Kellie described his mood state as "okay". Objectively he appeared flat. He denied any ideas of self harm or suicide.

Mr Kellie's thought processes were integrated, and he was clear and coherent in his account of events – with no evidence of form thought disorder. As discussed above in more detail, Mr Kellie endorsed ongoing features in keeping with referential thoughts regarding the television and thought broadcasting. There was no evidence of further delusional beliefs. Mr Kellie denied any ideas of wanting to harm others.

Mr Kellie described ongoing auditory perceptual abnormalities, which were in keeping with auditory hallucinations. No perceptual abnormalities were evident on cross-sectional examination.

Mr Kellie was orientated in terms of time, place and person. He was able to attend to a lengthy interview without difficulty. No formal neuropsychiatric testing was carried out.

With regards Mr Kellie's level of insight, he labelled his past psychiatric symptomatology as pathological in origin. He described how recent changes in his psychiatric medication had been of benefit in reducing the intensity and frequency of his psychotic symptoms. He expressed his wish to maintain compliance with both biological treatment and follow up with mental health services. On direct questioning Mr Kellie appeared to identify that illicit substance and alcohol use had had a detrimental effect on both his mental state and level of functioning. He reported his wish to remain abstinent from these in the future.

DOCUMENTATION REVIEW

I have not had the opportunity to review the Police Force Facts Sheets pertaining to Mr Kellie's current charges, nor have I reviewed Mr Kellie's criminal history. Information contained therein may be of importance in understanding Mr Kellie's presentation.

Information from Justice Health Medical File

I had the opportunity to review Mr Kellie's most recent Justice Health Medical File.

Towards the beginning of Mr Kellie's period of incarceration it does not appear that he was reviewed on a regular basis by mental health services. I note that a member of nursing staff reviewed Mr Kellie on 15 July 2010, and on mental state examination documented, "states when last watched TV received messages, states TV is communicating directly with PT (patient)...states he hears whispers at night, states not sure what is being said, intermittently lasting for one minute..."

I note that Dr Elliott (forensic psychiatrist) reviewed Mr Kellie on 21 July 2010. I note that the background history documented is broadly consistent with that gleaned from my interview. It is documented, "whispers at night. Finds his thoughts being reflected in TV programmes...describes more long standing and partly culturally based ideas re voodooism, psychic powers, and people influencing his thoughts..." It appears that psychiatric medication was first introduced following this review, namely Olanzapine (an antipsychotic) 5mg at night.

I note that Mr Kellie was transferred to the Mental Health Screening Unit on 28 July 2010, due to concerns regarding his mental state presentation. I note that Dr Nguy (Psychiatrist) reviewed him on several occasions whilst there. I note that the history Dr Nguy documented on 29 July 2010 is broadly

consistent with that gleaned from my assessment. On mental state examination it is documented, "mood depressed / dysphoric. Affect restricted. Vague persecutory ideations…no perceptual disturbance." I note that on 9 August 2010 Dr Nguy documented, "admits TV referential talking to him to – 3/12 ago when in segro…thought control – people would say what he was thinking last time a few days ago…" I note that the dose of Olanzapine was increased to 7.5mg at night at this stage.

I note that on 19 August 2010 Dr Nguy documented, "believes that he has to be hypervigilant and not trust anybody…states he still hear voices – multiple known and unknown in his head…also believes that he hears the radio / TV talking about things that he had thoughts of…" I note that the dose of Olanzapine was increased to 10mg per day at this stage.

I note that following review by Dr Nguy on 9 September 2010 Mirtazapine (an antidepressant) at a dose of 30mg per day was commenced, due to concerns regarding Mr Kellie's depressed mood and "restricted affect". I note, however, that this was ceased on 20 September 2010 due to side effects. I note that the dose of Olanzapine was also increased following this review to 20mg per day due to ongoing psychotic symptoms of "delusions of thought control and auditory hallucinations".

I note that by 7 October 2010 it appears Mr Kellie's mental state had improved and following review by Dr Nguy it is documented, "no evidence of psychosis currently. Stable." I note that the dose of Olanzapine was 20mg per day at this time.

I note that Mr Kellie was transferred to the Mental Health Accommodation Area on 17 October 2010. I note that on 30 October 2010 he was reviewed by a member of nursing staff and it is documented, "patient stated ""I have thoughts of hanging myself with my blankets and clothes, I have the thoughts today""". I note that Mr Kellie was transferred into safe cell conditions as a result. I note that Dr Elliott reviewed Mr Kellie on 3 November 2010, ""my mood changed, it got worse"" worried about court…also concerned re family – has had an argument with his sister…now denies hearing AH (auditory hallucinations) and appeared to indicate he said this only to convey his distress re court…" I note that the safe cell conditions were ceased at this stage, and Mr Kellie was transferred back to the Mental Health Accommodation Area.

I note that since his transfer to the Mental Health Accommodation Area that Dr White (Psychiatry Registrar) has reviewed Mr Kellie on several occasions. I note that on 9 December 2010 Dr White documented, "said voices are worse again. Said he hears several voices inside his head, they put him down, talk about him and talk about his thoughts…" I note that Mr Kellie's antipsychotic treatment regime was altered to Quetiapine at this stage.

I note that Dr White reviewed Mr Kellie on 10 January 2011, "reports feeling better with the Seroquel (Quetiapine). Sleeps better but also said that the voices are better, less distressing and there less often…" I note that following Dr White's reviewed Mr Kellie on 4 March 2011, it is documented, "voices

persist but now only two – three times / week, five – ten minutes at a time…several voices, talk about him and have conversations about him…"

I note that Dr White reviewed Mr Kellie on 28 March 2011, "has deteriorated a little. Said the voices are more often, happening now most evenings. Last about 30 minutes…also now having some problems with the TV. Said he is sometimes receiving messages through the TV and has to turn it off" I note that at this stage the dose of Quetiapine was increased to 1000mg per day. I note that following Dr White's review on 11 April 2011 it is documented, "reports improvement with the increase in his Seroquel. Only OCC (occasional) voices now…"

OPINION

Mr Kellie described his traumatic developmental history in Sierra Leone, witnessing the killing of his parents and a variety of atrocities during the civil war. Mr Kellie gave an account of fleeing to a Guinea refugee camp, where he suffered post traumatic features (intrusive nightmares and flashbacks, anxiety and depressed mood). Mr Kellie noted a relatively early onset of significant cannabis and alcohol use. In this context Mr Kellie described features consistent with gradually emerging psychotic symptomatology, in the form of auditory perceptual abnormalities and persecutory and referential thinking.

By his own account, the above features suggestive of mental illness continued following Mr Kellie's move to Australia as a permanent resident in 2006. Mr Kellie also noted ongoing substance use, with a short lived period of stimulant use, prior to returning to frequent cannabis and alcohol consumption.

With regards his contact with mental health services, Mr Kellie noted occasional review and prescription of psychiatric medication whilst living in Africa, but he could not be precise as to the details. He provided a history of having no continuous contact with mental health services, however, having moved to Australia.

It must be borne in mind that I have reviewed no collateral information regarding Mr Kellie's presentation prior to his arrest. In my opinion his account was in keeping with symptoms of a psychotic disorder, with associated mood disturbance and post traumatic features. He also noted continued illicit substance and alcohol use. Review of collateral information would be required to clarify his exact presentation prior to incarceration.

I did not discuss the current alleged offence with Mr Kellie in detail, as no collateral information was available at the time of my assessment and Mr Kellie said that he was pleading guilty to only part of his current charges.

It is evident that following Mr Kellie's incarceration he had no frequent contact with mental health services for approximately six months, following which he has necessitated significant input. He has been transferred to the Mental Health Screening Unit, has been reviewed by mental health staff frequently, has had trials of antipsychotic medication, and most recently has been placed

in the Mental Health Accommodation Area. Review of Mr Kellie's medical notes indicated the gradual improvement in his overall presentation and psychotic symptomatology, in the context of his assertive psychiatric management.

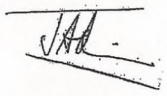
At the time of my assessment Mr Kellie provided a relatively clear and coherent account of his history. He presented as calm and not overtly agitated, but was flat in mood with a restricted affect. He appeared to be suffering residual symptoms of psychosis, and endorsed features in keeping with ongoing auditory hallucinations, referential thoughts, and thought broadcasting. Mr Kellie's overall level of insight appeared good however, and he appreciated the pathological basis of his symptoms and he described the benefits of psychiatric medication. Mr Kellie expressed his wish to remain compliant with both biological treatment and follow up with mental health staff.

With regards treatment recommendations, whilst Mr Kellie remains incarcerated his mental health needs will continue to be met by Justice Health. Given his overall improvement I concur with his current management plan, in terms of antipsychotic medication prescription, placement in the Mental Health Accommodation Area, and regular review by mental health staff. In my opinion Mr Kellie would also benefit from formal drug and alcohol rehabilitation.

Should Mr Kellie be considered for release from custody, he will require a referral to the appropriate community mental health team with a view to offering assertive follow up and ongoing prescription of psychiatric medication. Mr Kellie may benefit from placement in a supported environment, with assistance in integrating into the community and achieving stable employment. I believe that Mr Kellie would also benefit from ongoing drug and alcohol rehabilitation, and remaining abstinent from illicit substance and alcohol use.

Should Your Honour wish me to comment upon Mr Kellie's mental state at the material time of the alleged offence I would be happy to reassess him if additional collateral information is made available. Please do not hesitate to contact me should you have any further questions or require further clarification.

Yours sincerely



Dr Jonathon Adams MBChB MRCPsych FRANZCP
Forensic Psychiatrist
Visiting Medical Officer, Justice Health