Dr Danny Sullivan

MBBS MBioeth MHlthMedLaw AFRACMA FRCPsych FRANZCP
Consultant Forensic Psychiatrist

17 September 2017

PSYCHIATRIC REPORT
In confidence

Tracey Howe
Senior Solicitor
Crown Solicitor's Office
GPO Box 25
Sydney 2001

Dear Ms Howe

Re: **Inquest into death of Anthony CAWSEY**
Your Ref: **T12 201700011**

Background

[1] I have prepared a psychiatric report at your request. I understand that Mr Cawsey was stabbed on 26 September 2009 in Centennial Park, and died. Moses Kellie was a person of interest and was at one stage charged with the murder of Mr Cawsey. You have asked me to determine whether Mr Kellie's presentations were consistent with mental illness and whether that "affected Mr Kellie's cognition or his ability to answer questions responsively, truthfully or reliably". You have also asked me to review the materials (documents and video recordings) and consider whether these demonstrated that Mr Kellie suffered mental illness.

[2] In preparing this report I have reviewed the following materials:
- Letter of request dated 9 August 2017
- Brief to Expert
- ERISP interviews

[3] I work as a Consultant Forensic Psychiatrist. My medical degree is from the University of Melbourne. I hold two Masters degrees, in Medical Law (Melbourne) and Bioethics (Monash). I am a Fellow of the Royal Australian and New Zealand College of Psychiatrists, Fellow of the Royal College of Psychiatrists (UK) and Associate Fellow in the Royal Australasian College of Medical Administrators. In addition, I am an Accredited Member of the Faculty of Forensic Psychiatry of the RANZCP. My current employment is at the Victorian Institute of Forensic Mental Health (Forensicare), where I am Executive Director of Clinical Services. I have experience in forensic community, prison and hospital settings, and practical knowledge of disability, child protection and non-government sectors. I hold honorary academic positions at the University of Melbourne, and Swinburne University: I am active in research, teaching and publishing academic articles, and remain engaged in clinical practice. In 2013 I was appointed to the Expert Advisory Committee of the Victorian Law Reform Commission for the review of the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997*. My curriculum vitae is available on request.

[4] I acknowledge for the purpose of Rule 31.23 of the *Uniform Civil Procedure Rules 2005* that I have read the expert witness code of conduct in Schedule 7 to the Rules, and I agree to be bound by it. I have attached a copy of my curriculum vitae.

[redacted] [redacted]

Information obtained from the coroner's brief of evidence

Background.

[5] I have assumed the facts you provided in your letter of request dated 9 August 2017. This detailed that Mr Cawsey was believed to have died on 26 September 2009, between 0500 and 0600 in Centennial Park, Sydney. The cause of death was reportedly stabbing. I understand that Moses Kellie was identified as the sole person of interest. At that time I understand he was a homeless man living in Centennial Park campsites. Your letter informed me that no forensic evidence supported the contention that Mr Kellie killed Mr Cawsey.

[6] You reported Mr Kellie was charged on 6 October 2015, with reliance on tendency and coincidence evidence and "purported admissions made by Mr Kellie during a series of police interviews and statements". You related that on 7 September 2016, the Director of Public Prosecutions discontinued the prosecution of Mr Kellie for the murder of Mr Cawsey. I understand that Mr Kellie is now in immigration detention awaiting deportation.

[7] You provided background information about Mr Kellie including his prior criminal history. You noted that on 21 February 2011 he was convicted of assault occasioning actual bodily harm of a prisoner at Metropolitan Reception and Remand Centre and received 12 months' imprisonment with a nonparole period of nine months. You further noted that during this period of incarceration he was convicted of armed robbery with wounding and sentenced to five years' imprisonment with a non-parole period of three years and nine months, which ended on 18 October 2015. With his visa cancelled, he was taken into immigration detention at the expiration of his sentence.

Psychiatric and psychological reports

[8] A psychiatric report of Dr J Adams dated 15 June 2011 noted that Mr Kellie described auditory hallucinations commencing in 2003; her reported being prescribed psychiatric medication but did not take it. He gave a history of cannabis, alcohol and methamphetamine use before his incarceration. Dr Adams, noting some collateral information not being available, considered "his account was in keeping with symptoms of a psychotic disorder."

[9] A psychological assessment of Dr J Jacmon dated 8 November 2010, described post-traumatic stress disorder, depression and anxiety and borderline IQ.

[10] Dr T Clark, a forensic psychiatrist, in 2011 considered Mr Kellie had a schizophrenic illness. However the basis of his opinion is unclear.

Statements

[11] The **statement of** I361 noted that on 23 September 2009, at approximately 4:10 am while walking along Anzac Parade, Moore Park, he was unexpectedly assaulted by an African man who said "Why did you say what you said to me before down the street". He then fled.

[12] The relevance of this statement is that it potentially indicates the African male was experiencing auditory hallucinations which he imputed to I361 In the subsequent statement provided on 30 May 2016, I361 noted that these events were preceded by earlier interaction where he heard "a male voice was yelling 'why are you looking at me? You look at me'". He repeated this a number of times as well as saying other things.

[13] The **statement of** I357, sister of Mr Kellie, disputed numbers of claims made by Mr Kellie about his background. Of relevance, she denied that he had had contact with mental health services in Sierra Leone, and denied that their father had schizophrenia.

Mental health in custody – from correctional records

[14] Mental health issues were noted. Correctional clinicians reported that on screening at Goulburn Correctional Centre on 20 January 2010, he described a previous incident of self-harm while intoxicated in 2004 but had no other psychiatric concerns. He disclosed no medical or psychological issues except daily cannabis use.

[15] On 9 April 2010 it was noted that Mr Kellie was verbally abusive to others, apparently in order to be sent to the MPU.

[16] On 18 June 2010 he was described as defiant during strip searching on escort to court; force was used by correctional staff.

[17] On 22 June 2010, a psychologist assessed him and noted issues with anger and sleep.

[18] Consultant psychiatrist Dr G Elliott on 21 July 2010, noted "incipient psychotic symptoms, some resolving with cessation of substances and some culturally based" and he was prescribed a low dose of an antipsychotic medication.

[19] One week later he had ceased olanzapine (*Zyprexa*, an antipsychotic medication) as he felt that this disturbed his sleep and made him anxious. He was transferred to the Mental Health Screening Unit (MHSU) for assessment.

[20] He was reviewed through September and October 2010 by a psychologist, noting "he was compliant with medication, experienced reduced auditory hallucinations and ongoing anxiety". In October 2010 he described having slashed his arms in 2008 and 2009 in response to auditory hallucinations, but had never harmed himself when not hearing voices. He reported self-referral to mental health services in 2006 and for six to seven months took an unspecified medication, which he reported helped. He described that prior to incarceration he had injected amphetamines and drank alcohol, which he associated with fighting.

[21] On 30 October 2010, Mr Kellie was reported to have threatened to hang himself using a blanket and clothes, described hearing voices telling him to kill himself, and was placed under observations related to this. However, subsequently it was noted that he acknowledged making these threats for secondary gain.

[22] In November 2010 he was seen by psychologists and mental health nurses and was placed in an observation cell, and was taking olanzapine 15 mg and reported auditory hallucinations, impaired sleep, and was considered at high risk of self-harm. He was noted to have issues with conflict with other inmates and "breaches of internal discipline for fighting, intimidation and failed urine tests". He had commenced a violent offender treatment program but was suspended after a fight with another inmate, but subsequently resumed this and completed it.

[23] On 1 December 2010 a psychologist noted that he reported having previously been on clozapine (*Clopine* or *Clozaril*, the most effective antipsychotic medication) in the past, experiencing ongoing auditory hallucinations and being prescribed antipsychotic medication for this. He described past deliberate self-harm.

[24] On 28 January 2011 he described that his medication had been changed about one month beforehand, to quetiapine (*Seroquel*, an antipsychotic medication).

[25] On 30 March 2011 he described surviving while homeless by stealing. He reported that schizophrenia was diagnosed in custody and he had not taken medication for mental health issues prior to 2010. It was confirmed that he was taking 1000mg of quetiapine (a high dose).

[26] On 4 May 2011 he described thought broadcasting and ideas of reference to a psychologist.

[27] On 23 May 2011 he reported having ceased psychiatric medication in the community due to adverse effects.

[28] On 22 August 2011 he reported many years of hallucinations but no diagnosis until 2010.

[29] File notes in October and November 2011 noted repeated concerns about fighting with cellmates and other prisoners. He was segregated.

[30] In December 2011 he denied having mental illness, stating he said so to help his court case.

[31] On 9 January 2012 he self-harmed superficially scratching himself. On 10 January 2012 he described "spinning out" and reported having unilaterally ceased his medication but had recommenced hit. He reported having been sexually assaulted in the shower but this was considered highly unlikely due to the level of supervision in the Segregation Unit.

[32] On 27 February 2012 he described that he falsely told Dr Adams he had injected drugs "thinking that having been on drugs will help with his case."

[33] On 7 December 2012 it was noted that he was taking quetiapine and risperidone (*Risperdal*, an antipsychotic). He reported that earlier in 2012 his fighting was due to harassment and use of cannabis. A further note docuemtned a discussion with a mental health nurse who "Confirmed diagnosed with schizophrenia in 2008 whilst at Silverwater. CC" with an exacerbation in September 2012. At that stage he was taking quetiapine 4500mg and risperidone 2mg and was considered stable in mental state.

[34] On 1 March 2013 there were concerns about his personal hygiene and he was verbally abusive to correctional staff. It was described he had not been taking medication for a month.

[35] On 22 September 2013 he was noted to have stockpiled 46 risperidone (*Risperdal*, an antipsychotic) pills.

[36] On 17 October 2013 he was noted to have kept hidden 26 quetiapine tablets which he claimed he kept "in case he ran out of medication."

[37] On 23 December 2013 Mr Kellie was suspended from a violence program for fighting.

[38] On 8 January 2014 he reported to a psychologist the concern that others could read his mind. He reported ongoing auditory hallucinations.

[39] On 9 February 2014 a request form indicated that "for the past six months I've been using drugs. I want to get on the methadone."

[40] Review by a psychologist on 7 January 2015 noted a history of "feelings of paranoia and fear, suspicion that others were reading his mind, referential phenomena and auditory hallucinations." It was reported that upon being informed of visa cancellation he experienced a "PTSD symptomatology, in particular auditory voices and flashbacks about his earlier traumatic experiences in Sierra Leone."

[41] A Community Corrections staff member also interviewed Mr Kellie on 7 January 2015. She noted that he described negative auditory hallucinations, concerns that the television was reading his mind, and "flashbacks." He reported that at the time of the offence (armed robbery) he had paranoia that the victim was following him, and had consumed 30 cans of beer and $50 of cannabis.

[42] In January 2015 there was mention of him diverting his prescribed medications and of a dirty urine drug screen.

[43] In April 2015 it was noted that he was found with "a jail made fit" (injecting apparatus) and was charged with misconduct.

ERISP interviews

[44] I have reviewed five video interviews: dated 16 October 2009; 17 October 2009; 17 January 2010; 20 July 2010; and 6 October 2010. In addition there was an audio recording of a search on 17 October 2009; a video recording of a walk-through of the area with Mr Kellie on 26 October 2009; and a video recording of a forensic procedure on 17 October 2009. I have reviewed these but do not consider they reveal any information of relevance to the potential diagnosis of mental illness in Mr Kellie.

[45] On the **interview on 16 October 2009**, Mr Kellie presents as an African male, calm in demeanour and cooperative to interview. He shows no deficits in attention, orientation or concentration. He pays attention to each person speaking in turn. His speech is heavily accented but fluent, normal in rate and volume and demonstrates no abnormalities of expression, and although sometimes he answers questions with "okay" when he may not comprehend fully, there is no overt intimation of significant impairment of understanding. On occasion he asks to have a question repeated, for instance at 23.11 hours. His mood is markedly restricted in range. There is no incongruence of affect. There is no clear indication of delusional ideas. There is no indication that he is experiencing auditory hallucinations, and no discussion of self-harm. He appears to be of average intellect. At times he expresses concerns about "gangsters", although this cannot be clearly differentiated as delusional. The context of the discussion is in his carrying a knife. He describes, however, that when the police arrive he acknowledges a knife may be a concern and makes efforts to conceal it.

[46] The summary of the interview is that he although he may have exhibited delusional beliefs about gangsters, these appeared contextually appropriate and were not clearly or overtly delusional.

[47] On **17 October 2009 Mr Kellie was interviewed** about the murder of Mr Cawsey. He presented in clothes provided by police after they had seized his clothing. He was cooperative to interview and maintained good eye contact with interviewing police. At times he appeared restless but this was unremarkable. His mood was restricted in range but not incongruent. Speech, accented, was normal in expression and his comprehension seemed adequate. No delusional beliefs were evident, nor behaviour suggesting auditory hallucinations.

[48] At a further **interview on 17 January 2010**, he reported interaction with the alleged man at "a gay spot... he greeted me". At 12.09 Mr Kellie notes "he started talking to me". He further disclosed that "I met with him" and stated "not interested in gay sex".

[49] At 12.12 he reported that "he approached me first". At 12.13 there was a leading question.

[50] He continued to focus upon "gay sex". He considered that the person was "pretending" to be speaking on a mobile phone and was actually watching him.

[51] At 12.32 he noted that he had ceased Centrelink payments and was relying on foraging and scavenging.

[52] It is possible that Mr Kellie was speaking about different events rather than his assault on [redacted] **I359**

[53] His mental state was unremarkable. There was no clear intimation of delusional beliefs. He noted some focus upon gay sex but this seemed reality-based. There was no indication of preoccupation with this theme or of emotional arousal or anger when discussing the topic.

[54] He considered that the person speaking on the phone may have been pretending. This may be evidence of paranoid delusions (the concern that others were misrepresenting themselves) but Mr Kellie made no statements which would confirm that he was experiencing auditory hallucinations or other psychotic phenomena.

[55] On **30 July 2010, Mr Kellie was interviewed** in Silverwater Correctional Centre. This was about an assault on 3 June at Parklea Prison. He showed limited understanding of the word *inducement* but appeared to understand following an explanation. He described the incident as occurring following an argument over who was using the television. He described being subject to racist and sexual comments but it did not seem that these emanated from to hallucinations or persecutory delusional beliefs.

[56] At the time of the interview Mr Kellie was wearing prison overalls, was clean-shaven and had shortish hair. He was cooperative to interview. Much of the interview was consumed with him writing a statement. His speech was accented, normal in rate and volume and without unusual words. There were no overt delusions evident and no indication of hallucinations either being experienced or reported.

[57] On **6 October 2015, Mr Kellie was interviewed** at Wagga Wagga for around one hour. Also present was a support person, Gail Manderson. Mr Kellie denied that he was in his campsite at the same time as the murder of Mr Cawsey. He indicated to police that he thought they were confusing the armed robbery, to which he had pleaded guilty, and the murder. He reported a diagnosis of schizophrenia which he said had only been made in prison.

[58] At this interview, Mr Kellie was wearing a prison tracksuit. He had long dreadlocks and appeared heavier in the face than previously. His range of facial movement was restricted. He was slightly more animated when the discussions were around allegations that he had been involved in the murder. His eye contact was reasonable and appropriate. He appeared to maintain attention throughout the interview. There were no abnormalities of speech apart from his heavy accent. He reported some paranoia but did not characterise this further, and it was unclear whether this was reality-based given his homelessness at the time. He did not provide further detail of a diagnosis of schizophrenia apart from linking it to the experience of paranoia. There was nothing in the interview to suggest that Mr Kellie was experiencing hallucinations or that delusional beliefs influenced his statements.

Opinion and Recommendations

[59] Moses Kellie, born [redacted] 1985 in Sierra Leone, came to Australia as a refugee and was later investigated for the murder of Anthony Cawsey. You have asked me to explore evidence that he suffered a mental illness.

Do the police interviews disclose the existence of a mental illness?

[60] In each police interview conducted, there was no clear evidence of mental illness. He appeared oriented and alert. His answers were cogent and appropriate. There was no indication that at the times of the interviews he was experiencing auditory hallucinations or other perceptual abnormalities. His statements and demeanour did not suggest that he was suspicious or held grandiose ideas. His cognitive abilities and intellect did not appear in any way compromised. I have noted possible indications of psychotic symptoms:

- 16 October 2009 – reference to carrying a knife to protect against "gangsters";
- 17 January 2010 – suspicion that the victim was pretending to speak on a mobile phone;
- 30 July 2010 – concern that his cellmate had uttered racist and sexual comments;
- 6 October 2015 – reference to past "paranoia" prior to incarceration

[61] On close consideration, I do not believe that these references in fact represented clear evidence of psychotic symptoms. I do not consider that there was any mental illness apparent or disclosed at these interviews, except in the interview of 6 October 2015. On that occasion Mr Kellie discussed being diagnosed with schizophrenia in custody. However he did not describe any particular features of this apart from "paranoia" and there were no other statements or behaviours suggesting any features of mental illness.

Did Mr Kellie's behaviour in custody disclose the existence of a mental illness?

[62] Mr Kellie recurrently described symptoms of psychosis to clinicians including psychologists, psychiatrists, and nurses. He was treated with antipsychotic medication and reported attenuation of symptoms. However, apart from self-report, there is no other clear evidence of mental illness, and the other possibility remains that Mr Kellie feigned or embellished symptoms to obtain medication or for other secondary gain. His assessments were based upon recurrent outpatient-based assessment rather than observation in a hospital or clinical unit setting. On at least two occasions, he acknowledged being untruthful about his history because he considered this would help his court case.

[63] The following observations about his behaviour in custody are noted:

a. Mr Kellie reported varying amounts of preceding substance abuse including alcohol, cannabis, and methamphetamine. It is not clear from the materials that his self-reports were consistent. While in custody he failed urine drug screens and engaged in substance use, although details of the failed urine drug screens were not provided. There was variously mention of cannabis, heroin, buprenorphine and methamphetamine use. He acknowledged lying to an assessing psychiatrist about substance use to assist his court case.

b. Symptoms disclosed to clinicians included auditory hallucinations, thought interference, suspiciousness and paranoia. These rely on self-report but there were no entries suggesting behavioural manifestations which supported his self-report. There are no diagnostic tests which can confirm the presence of reported symptoms, although their presence may be supported by behavioural observations and abnormalities in demeanour. In addition his reports of the duration of symptoms varied significantly.

c. His reports of preceding mental illness were inconsistent and implausible. His sister disputed these. He acknowledged having lied about past mental illness to assist his court case.

d. There is no information suggesting that his report of previous public mental health service contacts in the community (possibly in Blacktown) resulted in a search for corroborating information. Treatment with clozapine leaves a paper trail which can be verified (Pharmaceutical Benefits Scheme or clozapine monitoring scheme documentation), as does contact with mental health services in the community.

e. He was found to have stockpiled medication and to have diverted medication. This could have been either for his own use, to self-harm, or to trade with others. Quetiapine in particular is frequently traded in prison and in the community for money or other benefits.

f. He reported past self-harm inconsistently; and when he threatened or engaged in minor self-harm it appeared to be for instrumental reasons, generally to support him being moved elsewhere in the correctional system or to obtain a single cell.

g. He was noted often to engage in fighting or assaults on others, although from what can be gleaned from the records, there is no indication of psychotic motivations for his violence. Rather, assaults seem to have been instrumental in achieving a change in his location or removal from a cellmate, related to problems with his anger, due to drug use, or associated with prosaic and reality-based conflict or perceptions of racism.

[64] On this basis I cannot be confident that Mr Kellie does clearly suffer from a psychotic illness. The possibilities are that he has a genuine psychotic illness; or that he has feigned psychosis for various secondary gains, including sentencing advantages, benefits within the correctional system, and/or obtaining sedative medication.

[65] There is also some documentation about post-traumatic stress disorder and associated symptomatology. However I note that Mr Kellie's sister disputed some of the background he recounted. Thus it is possible that the requisite exposure to a significant stressor, which underpins the diagnosis, is not made out. Collateral information from his sister certainly supports some exposure to conflict in Sierra Leone when he was a child, and having to flee the country. However it is not clear what traumatic events Mr Kellie witnessed or was exposed to. Once more, the provenance of his symptoms relies upon self-report and there is no clear behavioural evidence of post-traumatic stress disorder.

[66] On this basis I cannot be confident that Mr Kellie clearly suffers from post-traumatic stress disorder.

[67] Mr Kellie has provided inconsistent information about past substance use. Collateral information in the form of urine drug screen results will be evidence of his use of various substances in prison. His reports of heavy cannabis and alcohol use might be supported by collateral information from outreach workers or homeless services who recollect Mr Kellie. It seems likely that he has had some substance use problems but their magnitude cannot be determined. Nevertheless, Mr Kellie did not appear intoxicated during the various ERISP interviews.

[68] Given the uncertainty about whether Mr Kellie had any confirmed mental illness, and based upon observing the ERISP interviews, I cannot find evidence for any clear impediment to his cognitive abilities or his ability to answer questions responsively, truthfully, or reliably.

[69] I hope this report has been of assistance to the Coroner.

Yours sincerely

Dr Danny Sullivan
Consultant Forensic Psychiatrist
Executive Director of Clinical Services, Forensicare
Honorary Senior Fellow – Uni of Melbourne; Adjunct Research Fellow, Swinburne Uni

Appendix 1: Index to Brief of Evidence
Appendix 2: Curriculum Vitae