THIS IS AN OFFICIAL REPORT OF THE MENTAL HEALTH REVIEW TRIBUNAL PROCEEDINGS IN RELATION TO MR BARNABY FANSHAW AUTHORISED BY THE PRESIDENT OF THE TRIBUNAL ON 20 JULY 2017

Mental Health Review Tribunal

This is an edited version of the Tribunal's decision. The patient has been allocated a pseudonym for the purposes of this Official Report

Forensic Review:	Barnaby Fanshaw 1st Review	
s44 First review following finding of not guilty by reason of mental illness *Mental Health (Forensic Provisions) Act 1990*		
Date:	27 March 2015	
Location:	Metropolitan Remand and Reception Centre	
Panel:	Daniel Howard SC	President
	Enrico Parmegiani	Psychiatrist
	John Haigh	Other Member
Application:	N/A	
Decision:	Order for transfer to the Forensic Hospital when a bed becomes available for care and treatment; in the meantime to be detained in a Correctional Centre for care and treatment with a recommendation that this be in the Hamden Unit at the Metropolitan Remand and Reception Centre as long as is clinically required.	

This is the first review of Mr Barnaby Fanshaw who is currently detained in the Metropolitan Remand and Reception Centre (MRRC) on an order of the Supreme Court. Mr Fanshaw's treating team did not provide a Notice of Intent seeking changes to the current arrangements for detention.

BACKGROUND

Mr Fanshaw was found not guilty by reason of mental illness on a charge of murder and was ordered to be detained. .

TRIBUNAL REQUIREMENTS

The Tribunal is required under section 44(1) of the *Mental Health (Forensic Provisions) Act 1990* (the Act) to review a person's case as soon as practicable after a person is found not guilty of an offence by reason of mental illness and is ordered to be detained in a mental health facility or other place.

Pursuant to section 44(2) of the Act, the Tribunal must, after reviewing a person's case, make an order :

(a) as to the person's care, detention and treatment, or

(b) as to the person's release (either unconditionally or subject to conditions).

The *Mental Health (Forensic Provisions) Act 1990* has special evidentiary requirements in relation to leave or release which must be satisfied before the Tribunal can grant leave or release. In view of this, the Tribunal requires notice of applications for leave or release to ensure that the necessary evidence is available. This process also enables the Tribunal to provide notice of such applications to the Minister for Health, the Attorney General, and any registered victims who are entitled to make submissions concerning any proposed leave or release. No notice of an application for leave or release was provided to the Tribunal prior to this review.

Without limiting any other matters the Tribunal may consider, the Tribunal must consider the principles of care and treatment under section 68 of the *Mental Health Act 2007* as well as the following matters under section 74 of the *Mental Health (Forensic Provisions) Act 1990* when determining what order to make:

(a) whether the person is suffering from a mental illness or other mental condition,

(b) whether there are reasonable grounds for believing that care, treatment or control of the person is necessary for the person's own protection from serious harm or the protection of others from serious harm,

(c) the continuing condition of the person, including any likely deterioration in the person's condition, and the likely effects of any such deterioration,

(d) …….

(e) …….

DOCUMENTARY EVIDENCE

The Tribunal considered the documents presented to the Tribunal.

ATTENDEES

Mr Fanshaw attended the hearing accompanied by his lawyer, Mr Ross Hudson. Also in attendance were:

- Treating Psychiatrist by telephone;
- Clinical Nurse Consultant;
- Tribunal staff member by videolink, MHRT; and,
- Registered Victim by videolink.

PRESENT CIRCUMSTANCES

The Tribunal was provided with a report prepared by Mr Fanshaw's treating psychiatrist at the MRRC,

The Tribunal was also provided with the psychiatric reports that were before Justice X in the Supreme Court proceedings in which Mr Fanshaw was found not guilty of the offence of murder on the grounds of mental illness. These include a report by Forensic Psychiatrist B, a report of Forensic Psychiatrist C and reports Forensic Psychiatrist A.

In relation to the reports that were before Justice X, Forensic Psychiatrist B was of the view that Mr Fanshaw was suffering from a major depressive illness with psychotic symptoms prior to and at the time of the offence. He also raised the possibility that, whilst there was insufficient evidence to confirm the presence of a sleep disorder, this might warrant further investigation.

Forensic Psychiatrist C also expressed the opinion that Mr Fanshaw had a diagnosis of major depressive episode with psychotic features, based on the history given by Mr Fanshaw of the full syndrome of severe depression accompanied by perceptual disturbances and mood congruent delusional beliefs, the history of a typical pattern of treatment for the disorder, including for a previous similar episode and aspects of Mr Fanshaw's presentation during his interview.

Forensic Psychiatrist A expressed the opinion in his report that Mr Fanshaw was suffering from a major depressive disorder with psychotic symptoms at the time of the index offence. He noted that Mr Fanshaw reported that, at the time of the incident, he heard voices, specifically his partner's voice, telling him to hit her. At page 10 of his report, Forensic Psychiatrist A noted that Mr Fanshaw had described the onset of his psychotic symptoms. He believed that the previous owners of the house in which he resided had sold the house because a baby had died in the pool. He also believed that the bathroom was leaking and he became aware of a pungent smell, which he said established the fact, in his mind, that the bathroom was leaking. He saw a psychologist and consulted the staff at his local hospital. The doctor had wanted him to see a psychiatrist, but could not get an appointment and unfortunately the index offence occurred before he received psychiatric care.

Forensic Psychiatrist A notes in his report that Mr Fanshaw appears to have first become seriously unwell from a psychiatric perspective, in 2007. At that time he was thought to have developed a brief psychotic episode. Forensic Psychiatrist A notes that, for some reason, this condition was not treated with medication

and, according to Mr Fanshaw's history taken by Forensic Psychiatrist A, the illness resolved over a period of seven months.

In his report Mr Fanshaw's treating psychiatrist notes that the doctors who prepared court reports had unanimously been of the opinion that Mr Fanshaw was suffering from a major depressive disorder with psychotic features. Mr Fanshaw's treating psychiatrist also notes that Mr Fanshaw was reportedly experiencing a relapse of his illness, featured by a severe disturbance of his mood, the delusional belief that his partner was going to kill him, passivity phenomenon and auditory hallucinations.

Mr Fanshaw's treating psychiatrist also took a history from Mr Fanshaw in relation to his account of the index offence, although this was only brief as Mr Fanshaw became tearful and was distressed discussing details in relation to the index offence. According to this history, Mr Fanshaw reported he had become increasingly depressed in the context of having purchased a new home which he believed had numerous faults. He reported that there were broken tiles around the pool and that he could smell something rotten, which he believed to be leaking water collecting under the floorboards. He also reported the belief that a baby had drowned in the pool. Mr Fanshaw reported that he had been sleeping poorly and had awakened in the early hours on the day of the offence. He told his treating psychiatrist that he threw himself against the wall to get distressing thoughts *"out of his head*". He reported that he developed a sudden and intense belief that his partner was going to harm him. His next recollection was pulling a knife out of his partner's chest. Mr Fanshaw attempted suicide by stabbing himself in the chest, leg and abdomen, once he realised what he had done. He reportedly went to lay next to the victim and he said that he saw his own hand going through the victim's purse pulling out items one by one. Mr Fanshaw reported that he was looking at his hand as though it was not his own. He pulled the phone out of the purse and called the police.

According to his treating psychiatrist's report, Mr Fanshaw reported that he had experienced a relapse of his depressive condition over the 12 months leading up to the index offence. He stated that he had seen a GP and commenced on an anti-depressant (Fluvoxamine) and had also seen a clinical psychologist for counselling. He had been reviewed by a Community Mental Health Service and a mental health nurse at a Hospital.

Mr Fanshaw's treating psychiatrist notes that, according to collateral history, Mr Fanshaw had experienced deterioration in his mental state from September 2013, featured by a relapse of anxiety and depressive disorder. This appears to have occurred in the context of work and financial stress, according to his treating psychiatrist report. Mr Fanshaw had been experiencing anxiety, agitation, feelings of helplessness and lost a

significant amount of weight. He experienced the belief that when he opened the car door, the wind would stop blowing. He was noted to be fidgety, agitated and referring obsessively to problems with his new home. He also became pre-occupied with the assertion that he had been sexually assaulted as a child.

Mr Fanshaw's treating psychiatrist notes in his report that, following the index offence, Mr Fanshaw was asked why he had stabbed the deceased and he replied "*I don't know".* He was also noted to state "*It was like I wasn't there".* He also expressed a number of bizarre and thought disordered statements such as "*this was how it started. I got hypnotised by a priest … paedophile by that woman"* and *"too many brainwashes for me, they are all friends, now brain washers … everywhere too late to be re-programmed again."* He was also reported to say "*I thought she was going to kill me over the speakers; the speakers were the paedophile; I felt a connection between the priest paedophile and speakers [sic]. I thought Jennifer (the victim) was going to cut my head off; I'm frightened I might hurt someone … "*.

His treating psychiatrist notes that at Long Bay Hospital, Mr Fanshaw was observed to be disorganised in thought form, incongruous in affect and experiencing auditory hallucinations of his daughter's voice. He was diagnosed with psychotic disorder and depressive symptoms.

Under the heading "Progress in custody" his treating psychiatrist notes in his report that, following his presentation into custody, Mr Fanshaw continued to experience severe symptoms of depression and psychotic features, specifically agitation, nihilistic delusions and auditory hallucinations. At one time he contemplated suicide and attempted to fashion a noose. He also experienced an unrecognised voice talking to him from outside his cell door. He was commenced on the antidepressant Sertraline and antipsychotic medication Olanzapine to assist with his sleep. He continued to experience low mood and ruminated about the offence, according to his treating psychiatrist's report.

Mr Fanshaw's treating psychiatrist further notes that, since presenting to Silverwater MRRC, Mr Fanshaw continued to experience low mood and feelings of hopelessness, and experienced daily suicidal ideation, but had no plan or intent in relation to this. However, he denied experiencing further psychotic symptoms (such as delusional guilt, nihilistic delusions or ongoing auditory hallucinations). He was also profoundly remorseful for his behaviour and was easily brought to tears discussing the offence.

The treating psychiatrist notes that Mr Fanshaw's antidepressant medication was changed to Venlafaxine and his antipsychotic medication was changed to Seroquel (due to weight gain). Over the ensuing weeks, Mr Fanshaw's depression improved and his energy levels improved. He was also sleeping better. He reports

that his energy is 80% improved and his concentration difficulties have resolved. Nevertheless, his treating psychiatrist notes that Mr Fanshaw experiences occasions of low mood and tearfulness. His treating psychiatrist states that Mr Fanshaw's circumstances and grief reaction to the tragic events appear to be perpetuating some ongoing depressive features. Mr Fanshaw has been seeing a clinical psychologist for help with these issues.

In relation to past psychiatric history, his treating psychiatrist notes Mr Fanshaw reported a past episode of psychotic depression in 2006 in the context of increased work load pressure and workplace disputes. His sleep pattern had deteriorated and he felt paranoid, believing that something was going to happen to him and he was worried that "*an organised attack was coming from the supermarkets".* He believed that he was being targeted and being tracked by mobile phones and that the police or the government may have been involved. He saw a GP at the time and was given medication but he could not recall what this was. He also saw a psychologist every fortnight for a number of months and gradually improved and returned to work. Mr Fanshaw also reported to his treating psychiatrist that he experienced a mild relapse of depression in the context of marital difficulties. At that time he was prescribed Fluoxetine.

His treating psychiatrist notes that Mr Fanshaw had a further relapse of his depressive disorder in 2012 with deteriorating sleep, poor energy levels, low appetite and poor concentration and motivation. He again was referred to his psychologist and reported a resolution of his symptoms. Mr Fanshaw told his treating psychiatrist that he had not attempted suicide prior to the index event nor had he previously seen a psychiatrist or had any psychiatric admission.

In relation to Mr Fanshaw's developmental and family history, his treating psychiatrist notes that there is a suggestion that Mr Fanshaw was sexually abused at the age of 13. He reported as having serious asthma requiring multiple hospital admissions and long periods off school. He also reported being bullied at school and found it difficult interacting with peers and preferring solitary activities. He obtained a boilermaker and welding apprenticeship and worked for Public Works in Sydney. He subsequently worked for the Australian Defence Industry, Garden Island Dockyard and the Australian Metal Workers Union. He has had two serious relationships, the first being with his wife whom he married in 1984. He met his second partner (the victim of the index offence) in his workplace in approximately 2000 and commenced a relationship in 2004. They were engaged for two years prior to the index offence. There was no reported history of domestic violence or threats.

In relation to his prior drug and alcohol history, his treating psychiatrist notes that Mr Fanshaw does not have a significant substance use disorder history. He smoked cannabis at the age of 17. He is not a regular user of alcohol.

His treating psychiatrist notes Mr Fanshaw's current medications include Quetiapine, Venlafaxine amongst other medications.

Mr Fanshaw's treating psychiatrist conducted a mental state examination referred to in his report. He noted Mr Fanshaw to be generally composed but tearful when speaking about the index offence. He was slightly anxious but did not present any psychomotor abnormality. He rated his mood as "OK" and 7/10. He did not express any formal though disorder or any delusional material. He struggles with feelings of moral culpability and guilt. He denied experiencing any recent ideas of self-harm or suicide. He did not appear to be experiencing any cognitively disturbances.

His treating psychiatrist states in his report that Mr Fanshaw has a diagnosis of recurrent major depressive disorder (severe) with psychotic features, characterised by a pervasive low mood with diurnal mood variation and disturbances of sleep, appetite, energy level, concentration and motivation. His psychotic experiences have consisted of bizarre, nihilistic and paranoid delusions and auditory hallucinations. His relapses in the past have occurred in the context of relationship and financial stressors. His treating psychiatrist notes that, despite the severity of Mr Fanshaw's illness he appears to have had relatively limited treatment in the community leading up to the index offence. There does not appear to be any complicating history of substance use.

His treating psychiatrist notes that Mr Fanshaw currently presents with ongoing residual symptoms of depression in the absence of psychosis. He is undergoing further medication adjustment and psychological therapy to target these remaining symptoms.

His treating psychiatrist notes in his report that Mr Fanshaw is on a waiting list for the Forensic Hospital, which he considers to be the most appropriate treatment facility for Mr Fanshaw's condition. In the meantime he will require ongoing monitoring. He will also need to undergo a general psychiatric rehabilitation including psychoeducation and illness management strategies, according to his treating psychiatrist's report. In the meantime, his treating psychiatrist considers it appropriate that Mr Fanshaw remain in a correctional facility until a bed becomes available at the Forensic Hospital.

At the hearing of the review, his treating psychiatrist told the Tribunal that Mr Fanshaw had been profoundly unwell and had taken a while to respond to treatment. However, he has made significant improvement and his mood has improved. He has some ongoing depressive features although he is improving and is able to derive some pleasure from activities such as playing cards. He continues to experience profound grief and guilt for the index offence. His medication is being adjusted. He is also seeing a psychologist.

Mr Fanshaw's treating psychiatrist was asked whether he had a view in relation to Forensic Psychiatrist B' suggestion as to the possibility of a sleep disorder being involved. His treating psychiatrist stated that his view was that this was remote and unlikely and he did not consider that a sleep study was required at this time. He raised the possibility that Mr Fanshaw may have sleep apnoea.

The Clinical Nurse Consultant noted that there was a significant delay for places at the Forensic Hospital but confirmed that Mr Fanshaw would be able to have appropriate clinical interventions whilst waiting for a place at the Forensic Hospital.

Mr Fanshaw told the Tribunal that he remains anxious about what had happened. He thought that it would be "*really good*" to go to the Forensic Hospital. He stated that his memory has improved and that his medications had been helpful to him. Mr Fanshaw stated that he had been gainfully employed for most of his life. He believed he had seen a psychiatrist in the past in Parramatta at some time in his past.

His treating psychiatrist told the Tribunal that he hopes that Mr Fanshaw will be able to obtain a sweeper's position whilst he is being detained at the MRRC. He does not consider Mr Fanshaw to be well enough to be in the main part of the prison and considers that the Unit is the appropriate place for him at this time.

Mr Hudson, representing Mr Fanshaw, asked his treating psychiatrist whether he expected a positive recovery for Mr Fanshaw. Mr Fanshaw's treating psychiatrist responded that he did expect a positive recovery. He noted Mr Fanshaw was generally improving and he expects this to continue. He believes that psychological therapy will be helpful to assist Mr Fanshaw to manage the grief and guilt that he is experiencing and he noted that the psychologist at the MRRC does a weekly ward round.

DETERMINATION

This has been a helpful review and the Tribunal has been provided with a considerable amount of background information relating to Mr Fanshaw. The Tribunal notes that he is making good progress although he still has significant negative symptoms for which he is being treated with appropriate medication

and also psychological therapy. His mood has improved and his treating psychiatrist is confident of ongoing progress.

The Tribunal is satisfied that there are reasonable grounds for believing that care, treatment or control of Mr Fanshaw is necessary for his own protection from serious harm or the protection of others from serious harm. Mr Fanshaw's treating psychiatrist has given a diagnosis of recurrent major depressive disorder (severe) with psychotic features, for Mr Fanshaw. Whilst there has been a significant improvement in symptoms, there are ongoing residual symptoms of depression in the absence of psychosis. His treating psychiatrist notes Mr Fanshaw will require ongoing monitoring of his mental state, medication supervision and regular psychological interventions and that he will need to undergo a general psychiatric rehabilitation, including psychoeducation and illness management strategies. The Tribunal agrees with Mr Fanshaw's treating psychiatrist that the appropriate placement for Mr Fanshaw will be the Forensic Hospital, when a bed becomes available. In the meantime, the Tribunal notes that Mr Fanshaw has been improving and has been well managed at the MRRC.

In the circumstances, the Tribunal determines that Mr Fanshaw should be transferred to the Forensic Hospital when a bed becomes available, and will make an order accordingly. In the meantime, it will be appropriate for Mr Fanshaw to remain in a correctional centre and the Tribunal further recommends that he be detained at the Unit of the MRRC for care and treatment, pending his transfer and detention at the Forensic Hospital for care and treatment.

Signed:

Professor Daniel Howard SC
President
Dated this day: 8 July 2015