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AFFIDAVIT OF PETER O'BRIEN, 23 SEPTEMBER 2013

COURT DETAILS	
Court	Supreme Court of New South Wales
Division	Common law division
List	Administrative law list
Registry	Sydney 2013 | 288415

TITLE OF PROCEEDINGS	
Plaintiff	**Saeed Dezfouli** (by his tutor, Brett Collins)
Defendant	**Mental Health Review Tribunal**
Second Defendant	**Justice Health**

FILING DETAILS	
Filed for	**Saeed Dezfouli**, (by his Tutor, Brett Collins) plaintiff
Legal representative	Peter O'Brien, O'Brien Solicitors
Contact name and telephone	Peter O'Brien (02) 9261 4281

AFFIDAVIT

Name	Peter O'Brien
Address	Suit 504/265 Castlereagh Street, Sydney, NSW 2000
Occupation	Solicitor
Date	23 September 2013

I affirm:

1 I am the solicitor of Saeed Dezfouli, the plaintiff in these proceedings.

2 On 12 September 2013 an application was made, on behalf of the plaintiff, before the Mental Health Review Tribunal that the treatment regime of Mr Saeed Dezfouli not include the forced administration of anti-psychotic medication via depot injection.

3 The application for review of Mr Dezfouli's case was made under section 46 and 47(1)(a) of the *Mental Health (Forensic Provisions) Act 1900*.

4 In making the application on behalf of the plaintiff, I relied on the report of Dr Bell (Annexed and marked with letter A) and Dr Lucire (Annexed and marked with letter B). The Justice Health treating team relied on the report of Dr Pulley (Annexed and marked with letter C).

5 Our appeal is based on the following points:

(i) That the Mental Health Review Tribunal applied an incorrect test when determining our application to exclude the forced administration of anti-psychotic medication via depot injection from Mr Dezfouli's treatment regime.

(ii) The Tribunal's decision was based on the determination that only in "exceptional cases" would they consider not adopting the view of a competent treating team in deciding the appropriate medication. I provide a transcribed excerpt of the decision made by the Tribunal on 12 September 2013 (Annexed and marked with letter D).

(iii) There is nothing in the *Mental Health (Forensic Provisions) Act 1990* that stipulates that the test to be applied be so restrictive.

(iv) As such, the test applied on 12 September 2013 by the Mental Health Review Tribunal was unnecessarily restrictive and onerous.

6. There are no documented incidents of aggression or violence from Mr Dezfouli since 1996, apart from one instance in May 2009 where he threatened to throw a jug of urine on a Justice Health staff member in response to being forcibly injected at that time.

7. In relation to the injunction being sought, the treating team have indicated that Mr Dezfouli is currently receiving anti-psychotic medication orally. As far as I am aware he has been compliant with that medication regime.

6 In relation to the necessity for the order to be made, Justice Health have indicated that the treating team intend to begin to forcibly inject Mr Dezfouli with anti-psychotic medication on 26 September 2013.

AFFIRMED at SYDNEY

Signature of deponent

Name of witness STEWART O'CONNELL

Address of witness 265 CASTLEREAGH ST, SYDNEY 2000

Capacity of witness [~~#Justice of the peace~~ #Solicitor ~~#Barrister #Commissioner for affidavits #Notary public~~]

And as a witness, I certify the following matters concerning the person who made this affidavit (the **deponent**):

1 ✓ ~~#I saw the face of the deponent. [OR, delete whichever option is inapplicable]~~
~~#I did not see the face of the deponent because the deponent was wearing a face covering, but I am satisfied that the deponent had a special justification for not removing the covering.*~~

2 ✓ #I have known the deponent for at least 12 months. [OR, delete whichever option is inapplicable]
~~#I have confirmed the deponent's identity using the following identification document:~~

Identification document relied on (may be original or certified copy)†

Signature of witness

Note: The deponent and witness must sign each page of the affidavit. See UCPR 35.7B.

[* The only "special justification" for not removing a face covering is a legitimate medical reason (at April 2012).]

[† "Identification documents" include current driver licence, proof of age card, Medicare card, credit card, Centrelink pension card, Veterans Affairs entitlement card, student identity card, citizenship certificate, birth certificate, passport or see Oaths Regulation 2011 or JP Ruling 003 - Confirming identity for NSW statutory declarations and affidavits, footnote 3.]

This and the following 15 pages is the annexure "A" to the affidavit marked of Peter O'Brien affirmed on 23/9/13 before me

Dr. David S. Bell
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27 August 2013

Mr. Peter O'Brien
O'Brien Solicitors
PO Box 20073
WORLD SQUARE NSW 2002

Dear Mr. O'Brien

Re: Saeed DEZFOULI
Your Ref: Letter dated 20 August 2013

1. I saw Mr.Dezfouli, age 54 years, on 6 June 2013 at the forensic hospital attached to the Long Bay Jail at your request. I have reviewed a range of documents handed to me by Mr.Dezfouli at the jail. They begin chronologically with replies to his letters from senators (all female) and an officer of the US Department of Justice on behalf of the President in 1998. They are simple formal letters taking note of his concerns about a pending court case. The next (undated, but presumably made in 2002) is part of a statement prepared by police. It begins on what seems to be the second page referring to an investigation in which a detective Wilson purchased a petrol tin from a service station. It goes on to refer to letters apparently written by Mr.Dezfouli addressed to various members of the New South Wales and Federal Parliaments. His file contains reports from Dr.Paul E. Mullen to Dr.Tony Mastroianni, reports from Dr.Mastroianni, various reports of various nurses about the presentation and behaviour of Mr.Dezfouli in the prison hospitals, a decision of the Administrative Decisions Tribunal on 21 July 2008 and what amounts to a confession to Mr.O'Brien written by Mr.Dezfouli on 13 May 2013.

2. I viewed some of the clinical file at the hospital, limited to what I could read in the time available, and a report of 21 March 2012 from Dr.Yolande Lucire to O'Brien Solicitors. I attended together with Dr.Lucire at the jail and we were given the opportunity to speak to Mr.Dezfouli as long as we needed, which was about two hours.

3. Recently your letter added a Determination of the Mental Health Review Tribunal signed by the Deputy President, Harold Sperling QC, on 29 July 2013 and a report from Dr.Rafe Pulley.

4. At the time of the interview I explained to the patient the nature of your request, my expertise and the purpose of the examination, in particular that it was not for treatment. I pointed out that the examination would be the basis of a report, which would be sent to you and therefore any matters discussed with me would not be confidential. I certify that I have read and agree to be bound by the codes of conduct required of expert witnesses by the Federal Court of Australia and by the Supreme Court and District Court of New South Wales, in particular 31.32 of the *Uniform Civil Procedure Rules* 2005 (NSW). To the best of my ability, this report has been prepared in accordance with the relevant codes and rules.

REVIEW OF DOCUMENTS

Please note that the detailed review of the documents was undertaken after the interview and clinical assessment.

5. I see no need to discuss in detail most of the documents handed to me by Mr.Dezfouli. The first report by Professor Mullen in May 2005 refers to the visit that he made to see Mr. Dezfouli in the Long Bay Prison Hospital. It seems that Professor Mullen spent an hour with Mr.Dezfouli, but to have any conversation at all he had to promise that he would not provide a report. In his opinion Mr.Dezfouli presented as an articulate and intelligent man. He showed a normal range of emotional responses and some sensitivity to the feelings of Professor Mullen. On this basis Professor Mullen concluded that the diagnosis of chronic paranoid schizophrenia in this case is "somewhat unlikely."

6. Professor Mullen reported again in July 2006 after what may have been another interview, but is not stated so expressly in this report. As Mr.Dezfouli had decided by this time that he would resign his Australian citizenship and seek repatriation to Iran, I assume it did follow another interview. Professor Mullen assessed the plan as rational, if not unrealistically hopeful.

7. Mr.Dezfouli recognised that the fire he set caused the death of a woman, with whom he had worked. He would not accept responsibility for her death. He still saw it all in the perspective of his intention to publicise his grievances. Professor Mullen judged the attitude to be the result of a personality disorder, which he summed up as "a cautious calculating temperament associated with obsessional traits and marked rigidities." It made sense in the patient's conviction "of having been subjected to gross injustice and a malicious organised campaign of mistreatment."

8. **Comment:** As I understand the issues in dispute at present, the treating staff regard the patient as harbouring intractable delusions brought about by a mental illness, paranoid schizophrenia, whereas the patient now maintains that he had told lies deliberately rather than express delusions. The latter formulation does not fit the rationale Professor Mullen advanced. Rather the conviction Mullen described fits paranoid schizophrenia.

9. It seems that Mr.Dezfouli accepted his action justified his conviction for manslaughter. Professor Mullen had the view that the patient's fixation on publicising his grievances was responsible for the mistaken conclusion before his trial that he was unfit to plead. Professor Mullen saw the patient as caught up in his pursuit of justice. Nothing will distract Mr.Dezfouli from this quest. Professor Mullen recommended bringing him to trial, which would result in a finite sentence.

10. **Comment:** As Mr.Dezfouli is still in a prison hospital some seven years after Professor Mullen advanced this formulation, clearly those treating the patient have a different view. It all rather depends on what may be argued belongs to a justified sense of justice as distinct from a delusion or over-valued idea. The latter borders on delusion. The boundary between it and delusion is not definable. From the practical point of view the problem facing a court is to decide whether there is any practical difference between it and delusion. The same problem faces the psychiatrist.

11. The reports from nurses around this time represent Mr.Dezfouli as cooperative, but fixated on his various ideas about injustice and the "corrupt" management he endured. All of the reports

have the constant theme that the patient kept his distance from most staff. He had good rapport with few. In April 2006 two nurses came to the conclusion that on the basis of their interaction with the patient they found it very difficult to assess whether he had delusional thoughts. In the four years they knew of his stay in hospital he persistently refused to talk to his treating doctor about his behaviour. In that time he had complaints of pain in the chest and he had developed diabetes.

12. **Comment:** Mr. Dezfouli has been given large amounts of neuroleptic medication since entering the prison hospital. The practical issue in dispute hinges on whether anybody benefits from this treatment. I will return to the central aspect of mental function below. The appearance of diabetes in particular coupled with cardiac disorder indicates that the patient has developed the "metabolic syndrome" which shortens the life of those subjected to this type of treatment by some 15 years or more.

13. In May 2006 at the Prince of Wales Hospital Mr.Dezfouli underwent cardiac angioplasty. He had a range of risk factors such as hypercholesterolaemia and hypertension. He smoked and undertook little exercise. He refused medications for his heart trouble.

14. In August 2006 Dr.Mastroianni reported to the Mental Health Review Tribunal that in the opinion of the treating doctors the patient was fit to plead. He stated that the treating team shared the opinion of Professor Mullen.

15. **Comment:** I have difficulty reconciling views Dr.Mastroianni expressed later to the Tribunal with this report. Professor Mullen did not diagnose this patient as having schizophrenia.

16. In August 2006 Mr.Dezfouli went on a hunger strike limiting his intake to fluids. He resented the fact that he was tagged as mentally ill after an assessment of no more than three minutes undertaken by a prison psychiatrist. He ceased his hunger strike on what he claimed to be advice from the Iranian Embassy.

17. In May 2008 two nurses reported in much the same fashion as in the past noting the patient's preoccupation with his view of the injustice he suffered. He had no trust in his treating doctors. He remained capable of pressing his case and managing his finances. In their view he had been fully compliant with medication. As a reflection on his mental capacity, he took pride in being unbeatable at scrabble.

18. The decision of the Tribunal in July 2008 had to do with the allegation of sexual harassment by the patient against a prison officer. It seems that the patient underwent a strip body search during which the officer touched him between the legs. He claims that afterwards the officers involved trashed his cell. A letter written by the patient addressed to many authorities alleged that he had been sexually harassed and sexually assaulted a number of times. A letter to others included the allegation that a number of his bones were broken by prison officers. The Decision refers to a report from a nurse Castle, who thought that the allegations "would appear to be accurate".

19. A report from two forensic psychiatrists stated that the patient had not voiced any delusions and had not posed any significant management problem. The manager of security had attended when the incident of sexual assault allegedly occurred. He saw nothing that would support the allegations. The document given to me does not contain the wording of the final decision. I get

the impression that it concluded his allegations did not contain any substance and fit more the stated intention of the patient to manipulate the system.

20. Dr.Lucire was asked in 2012 to give an opinion on whether Mr.Dezfouli has schizophrenia or some other psychiatric illness such as a disorder of personality. She was also asked to assess whether he had disorder resulting from excessive medication. Her examination of the files revealed that at one state Mr.Dezfouli was prescribed 30mg of Zyprexa daily, well above the maximum recommended by the manufacturer. She pointed out that the half life of the drug is longer than 24 hours, which means that given continuously in a high dose (that is above 10 mg daily) the level in the body continues to rise until it reaches a toxic level. At that level it produces effects that can resemble mental illness such as a schizophrenic psychosis.

21. **Comment:** I can confirm that olanzapine (trade name Zyprexa) does have a long half life, which poses the risk that taken in a high dose the drug continues to accumulate until it impairs mental function. I can confirm that the manufacturer for good reason regards 20 mg daily as the maximum dose for anybody. I know that many psychiatrists do not know these facts and in consequence prescribe excessive amounts. I can confirm that good reason exists to believe that the high doses damage brain as well producing the metabolic syndrome.

22. The clinical notes that Dr. Lucire perused contained records of the patient's refusal to speak to his psychiatrist and of his belief that they were meddling with him and his brain cells. He also spoke of his ideas about Mr.John Howard, when he was prime minister. Dr.Lucire concluded that the various statements were not evidence of mental illness nor were the poison pen letters he had written. She pointed out that he had given a false history of what he had done at various times in his past life. He had not revealed anything of his upbringing that brought him to become what she saw as a paranoid, antisocial "drama queen". Having found no evidence of psychosis, Dr.Lucire concluded that he is fit to plead. Some of his statements had a self-aggrandising quality in keeping with his "narcissistic, antisocial and paranoid" personality disorder.

23. The review Dr.Lucire undertook of the notes uncovers entries that describe what is likely to be akathisia brought on by the excessively high dosage of medication he was receiving. She points out that the clinical notes do not show any sign that this abnormality was recognised by the treating doctors. His therapist added a drug, clopixol, which is notorious for its ability to induce akathisia. The hospital progress notes document his increasing complaints but do not connect the worsening to the increasing medication.

24. Mr.Dezfouli's letter of May 2013 begins with the admission that in 2002 he had pleaded not guilty to the charges. He alleges that in April 2003 Dr.S.Allnutt spoke to him for only three minutes. Of course that took place mainly because Mr.Dezfouli refused to talk to him. On this basis Dr.Allnutt concluded that he was unfit to stand trial. Mr. Dezfouli goes on to refer to the opinion of Professor Mullen and Dr.Mastroianni as well as various nurses. He refers to the laws, which in his view should lead to his release.

25. **Comment:** This document does not contain any evidence of schizophrenic thought disorder. Nor do any of the other documents I have reviewed, including the clinical notes. If a perusal of all of them, no doubt an arduous task, fails to reveal any verbatim account of thought disorder, I would maintain that no proof of it exists in this case.

26. I was able to review clinical notes of the hospital from April 2010 up to August 2011. In 2010 he stated that he was willing to play the game in order to move through the prison system. He held that he did not have mental illness. Dr.Christopher Bench concluded that Mr.Dezfouli lacks insight and willingness to comply with treatment. He opposed transfer of the patient to the Morisset Hospital.

27. **Comment:** Sadly this assessment lacks the information to back up the conclusions or establish their validity. Substantiation requires that the psychiatrist provide adequate instances of the words actually used by the patient to justify the conclusion. What Dr.Bench does quote could well be correct and does not include evidence of unmistakable psychopathology.

28. Many notes indicate the cooperation of the patient in ward affairs. They establish that he behaved well. On 13 July 2011 he is recorded as participating in the group discussion of "What is mental illness?" He seemed understanding and gave in discussion appropriate examples of behaviour. He is recorded as tending to dominate the group discussion at times, but was easily redirected (the nurses to whom I spoke at the jail all stated that he had behaved in an exemplary manner).

29. A day later he stated his intention to return to Iran to care for his mother, then age 72 years. He claimed that his siblings in America will not go back to Iran to care for her.

30. **Comment:** This entry conflicts with the history he gave to me of how his brothers were actually living in the USA at the time and that they had brought their mother to live there with them years before. One or other of his statements, perhaps even both, certainly have to be lies. They do not have the character of delusions, but that does not exclude the possibility that he could be both an inveterate liar as well as deluded.

31. On 19 July 2011 he was started on the Clopixol. Seven days later he complained of restlessness in his legs. The following day for the first time he spontaneously volunteered "sincere remorse for his index offence." About two weeks later he explained that he had committed his "index offence" as a protest against the Afghanistan War. He gave as his explanation of why he had not said so then that he was afraid of being labelled a terrorist.

32. **Comment:** The lies had become so convoluted at this time that they ceased to be logical. A demonstration against something makes no sense unless openly declared.

33. In August 2012 he attended a mental health education and relaxation group where he learned that depression could be causing his tiredness.

34. **Comment:** He would appear to be gleaning from the groups more excuses for his conduct. This seems to me simply manipulative behaviour in keeping with a personality disorder.

35. Annexure A to the Review of Mr.Dezfouli by the Mental Health Review Tribunal on 27 June 2013 details the background to the unresolved conflict of views about his care. By July 2009, when Dr.Westmore submitted a report, the patient had embarked on 14 or so Supreme Court writs as well as complaints to the Anti-Discrimination Board. In November 2010 Johnson J determined among other decisions that the plaintiff's compulsory medication by injection cease.

In November 2010 Dr.Westmore advised that the treating team should decide the mode of treatment depending on the patient's clinical status, which he could not determine.

36. **Comment:** Dr.Westmore holds that the treating team could arrive at an assessment, which he himself could not make. By what means could his peers do what he could not manage? After all he was the respected consultant in choice as well as in reputation. I will argue that no person could do any better than Dr.Westmore.

37. A nursing report stated that the patient had shown some improvement in his oppositional behaviour, but he "rather likes to be called a terrorist". A "multidisciplinary report of 18 September 2011" summarised data that indicated the patient had improved, but remained "proud of his index offence as a form of protest." He did not discuss "any of his previously well documented persecutory delusions." The team concluded he is mentally ill and that he had improved on Zuclopenthixol even though he still had "ongoing persecutory delusions."

38. **Comment:** After such a long time at treating the patient his therapists have tried and found wanting the very treatment that they wish to reinstate now. If the patient does have schizophrenia, it has the form of an obdurate well-encapsulated delusional system that does not respond to treatment of any kind, does not produce any further mental change and is not likely to remit.

39. Dr.Lucire held in a report of March 2012 that the patient has "a cluster B personality disorder" and that at times that he was given very large doses of neuroleptic he was affected by their toxic effects. In April 2012 a prison medical officer, Dr.Dhansay recorded that the patient remained proud of his offence, that he continued to regard Justice Health as corrupt and that he remained delusional. He listed the physical ailments of the patient as hypertension, impaired glucose tolerance, hyperlipidaemia, increased body mass index and sedentary life style.

40. **Comment:** Dr.Dhansay mentions one likely cause, the patient's reluctance to exercise, without any mention of the metabolic syndrome caused by the medication. His omission reflects the bias that therapists exert in their advice to the Tribunal, which may need to curb their desire to treat in order to safeguard the welfare of those they treat.

41. The nursing notes recorded that the patient had shown no overt psychosis over the past 6 months and that he had remained polite, approachable, calm and soft spoken. Dr.Mastroianni regarded him as knowing what not to say in order to not appear mentally ill. The review considered the assertions of Dr.Lucire that other explanations held for his letters and beliefs such as the qualities of anger, maliciousness, gross narcissism and histrionic traits or medication-induced akathisia. She recommended the parenteral medication be replaced by oral Clopixol. To Dr.Pulley the patient dismissed assertions he had made in letters the past as "lies rather than delusions."

42. **Comment:** I gain the impression that the patient began using the argument that he had lied only after Dr.Lucire recognised some of his lies and used them as an argument that lying rather than delusion explained his conduct. The alternative of lies presents as great an obstacle to reliable assessment as delusions. Similarly so all the other qualities that Dr.Lucire posits. That Dr.Westmore admits he cannot assess this patient's mental state reliably could well apply to all involved in the assessment of Mr.Dezfouli.

43. At page 26 of the review the Tribunal stated the issue facing it as "whether persisting in the current path with antipsychotic medications was going to help Mr.Dezfouli or not." Dr.Mastroianni held that as long as "numerous opinions" held that the patient had a mental illness "it would not be clinically indicated to cease medication." Later he clarified the "opinions" as belonging to the doctors who had treated Mr.Dezfouli. They have "no uncertainty diagnostically."

44. **Comment:** Happy be those who have no uncertainty. As long as they remain in this state and believe that the patient has paranoid schizophrenia, in their view they have to medicate him. The issue the Tribunal faced of whether medication was going to help the patient or not becomes immaterial. The fact that medication does not modify encapsulated psychosis, possibly demonstrated repeatedly already in this case, is disregarded. Even the issue of physical harm to body or brain becomes irrelevant. Here the Tribunal is confronted by a whole body of long-standing psychiatric dogma in conflict with the new current concern that the old views, unsupported by sound science, lead to psychiatrists mindlessly damaging body and mind of patients consigned to compulsory care. Possibly the principle of Bolam supports the old view. Certainly Dr.Lucire's criticism of the current approach by many psychiatrists indicates that she also sees the prevailing view of the profession goes against her view.

45. The Tribunal carefully tackled the issue, beginning with the question of whether failure of a medication-free trial period might not overcome the impasse by persuading the patient "to accept the merits of medication." Dr.Mastroianni held that it posed the risk that "his mental state would gradually deteriorate."

46. **Comment:** Dr.Lucire produced details of the science behind her account of the damaging effects of medication, but those opposing her make assertions without substantiation. I doubt that Dr.Mastroianni could find any well done reliable study to support his assertion. At present a large and increasing number of studies establish the harm that persistent medication produces, not just physically with the metabolic syndrome but on the cognitive functions of the brain. The ideal approach to treatment appears to be a titration of the dose to the pharmacogenetic vulnerability of the patient followed by early dose reduction or discontinuation. Compared to the maintenance therapy Dr.Mastroianni proposes, the latter achieves twice the recovery rate and better function (Wunderlink et al: JAMA Psychiatry, 3 July 2013).

47. Dr.Pulley stated that Mr.Dezfouli had "never a period of treatment on a high dose of an antipsychotic medication as would be indicated by his present delusions."

48. **Comment:** I have the impression that Mr.Dezfouli has at least taken olanzapine 30 mg daily. The manufacturer recommends a maximum dose is 10 mg daily. I also have the impression that he has been given other medications such as risperidone, some parenterally, at and possibly above recommended maximum dosage.

INTERVIEW WITH PATIENT

49. Mr.Dezfouli gave a sensible account in a cooperative manner. He remained pleasant and cooperative during interchanges in which I challenged his veracity. He took in good humour the clear accusations that Dr.Lucire and I made about his lying in the past. He did not assert in

my presence any mission for justice. In respect of any past assertion he made about securing justice, he skirted around the key issues he needed to explain. He had normal affective responses and did not show any impairment of capacity to achieve rapport with Dr.Lucire or myself. He did not show sign of abnormal anxiety or affect such as depression.

50. **Comment:** His manner does not rule out the encapsulated paranoia of schizophrenia seen in older people, but makes the diagnosis unlikely.

51. He set fire to an office, in which he had worked as an interpreter, at its front door on 18 January 2002. When he was arrested he was cautioned to remain silent. He alleges that warning guided his subsequent conduct. He was charged with involuntary manslaughter and has been in jail since 18 February 2002. He was found not guilty on the grounds of mental illness in 2004. He was being treated with large doses of risperidone, when he was judged as being unfit to stand trial.

52. In a boastful manner he claimed that he knew the system, which he could manipulate. He has studied the law. I pointed out to him that his knowledge of the law is at the rudimentary level of a bush lawyer. He agreed. Confronted by Dr.Lucire about matters he has alleged in the past, he admitted that he had lied. She ventilated one, the fact that the universities in Iran were closed at the time that he claimed to have been a student there. He admitted that he had finished high school only before he left in 1977 to go to the Philippines. He still maintained that he had lived for four years and studied political science. He obtained a good pass before he came to Australia in December 1983. He had various jobs until he became a court interpreter for the Ethnic Affairs Commission in 1986.

53. In 1990 he went to the USA on a visitor's visa. His mother was a permanent resident and his brother had become a citizen. He gained entry through an application under family reunion measures. He was given the status of temporary resident, which would entitle him to become a permanent resident and citizen after seven years. It had not come to that when he left.

54. He had set up a driving and traffic school in Orange County of California. By 1998 it was no longer profitable. He decided to close it. He asked the Department of Motor Vehicles to collect his documents. Two armed investigation officers arrived. They refused to give him a receipt for his documents. He refused to let them take the documents away. They grabbed the papers. He locked the entrance door. They flashed a gun at him, pushed him to the ground, punched him and arrested him for "false imprisonment" of them. He counter-charged with trespass, assault and battery and illegal seizure. He lost his case and they succeeded with their charges of resisting arrest, false imprisonment and refusing to surrender documents. He spent one month in jail.

55. To this day he has the conviction that the judge and prosecuting attorney teamed up against him. The judge refused to allow witnesses he called to be heard. He wrote letters to the President of the USA. He sought publicity about "unconstitutional" treatment. I put it to him that he had created his own problems. He would not accept that. He explained the law in California as justifying his action. His manner of reasoning focuses on some small matters he can justify to the exclusion of seeing the main issues involved. I pointed this out to him, but he still demurred.

56. **Comment:** This issue is no longer of assistance to him and no longer relevant to the situation he may be trying to manipulate in Australia. Nevertheless, he holds to it

rigidly. On the other hand, his arguments do not amount to delusion. They do not contain any false belief not explained by culture, including the current sense of entitlement so rife in modern life. His attitude amounts to an over-valued idea in the setting of a personality disorder, which could well match the formulation advanced by Professor Mullen and Dr.Lucire. Of course the presence of a personality disorder does not exclude delusion or schizophrenia. Indeed schizophrenia usually occurs in the setting of a lifelong personality disorder of one kind or another. The critical element in this assessment at the time we saw him would appear to be the absence of any clear indicator of delusion or schizophrenia.

57. In his defence he pointed out that in the USA he obtained favourable responses from various people including a senator sympathetic to his case.

58. **Comment:** The responses that he showed me from the senators in the USA do not amount to support from an informed legislator. Again his interpretation of them fits the view of a person with an over-valued idea rather than a clear establishment of a case for delusion.

59. He approached the Australian Consul for assistance to overcome his grievance. He said that he had been set up and framed. The Consul refused to help. An officer flashed the Yellow Pages at him and told him to find a lawyer in it. He took offence and left. He wrote letters to the Australian Ambassador in Washington and sent two faxes to John Howard but got no response. I pointed out to him that a Consul has a limited capacity to contest the law of another country, giving as an example the current situation of Julian Lassange. He knows of that situation, but could not see the parallel. It seems to me that he has an exaggerated sense of entitlement.

60. As a result of his sentence he has lost any opportunity to get a green card in the USA. He left for New Zealand in September 1999. He stayed there eight months, during which time he "travelled." He did not want to stay in New Zealand. "It was too small." At the time it was in recession and he could not obtain work. He returned to Australia in May 2000 and joined a panel of casual interpreters. Because Mr.Howard had not responded to his letter he still has a grudge against the Government. It failed to help a citizen overseas. It deprived him of that. They just rejected him. It has affected his whole life.

61. Six months after his return he wrote some letters to the media about Howard attempting to murder him. He made up the allegations "to fuck with him." He wanted to hurt Howard. He was "pissed off." In the USA he had had a house and a relationship. I discussed openly with Dr.Lucire whether his actions come from a cultural attitude. He agreed, saying that Iranians are known to be trouble makers. They are always messing with other countries. He had been a Shiite before he converted to Budhism. He went back to the early history of the Shiite sect in Iran after the death of Mohamed.

62. He continued sending letters. He wrote to the police stating that if his allegations were not investigated, he would set a government office on fire. He believed that then they would have to investigate. As they took no notice, he felt obliged for the sake of keeping face to carry through his threat.

63. He set the fire in the foyer at the front entrance of the offices on a Friday believing that all the staff would have gone home by then. The woman who died was still on the telephone talking to a relative. Somebody came out of the offices, saying that there were other people inside. He

took off his shirt to use as a mask in order to try and get them out. He could not. The security doors were locked He did not have a tag to open them. Three inside broke the glass to get out. Three were overcome by smoke, of whom only two recovered.

64. The police came. He told them that he did it. They arrested him and sent him to Silverwater Jail. There he was assessed by Dr.Ahmed on 21 January 2002. He believed that he had the right to be silent, another reference to Miranda. Then another doctor saw him. A week later he was given the first lot of medication, 100mg Acuphase together with Cogentin. "It messed me up." He could not think straight. His tongue became swollen, he could not eat and he lay in bed for the next four days. He thought that the medication was deliberate punishment for not complying with their wishes.

65. **Comment:** He describes some of the distressing side effects of neuroleptic medication such as dystonia. In regard to his interpretation of its use as punishment, we need to keep in mind that the Soviet government in the USSR used this type of drug to punish and discourage dissidents. The person on the receiving end has no doubt about the unpleasant nature of the effects.

66. He asked to go back to the clinic. He abused them and called them corrupt. He was transferred to the Long Bay Hospital, where he admitted that he was depressed. He had known the woman who died. He asked for an interpreter as a way of playing for time. He had difficulty sitting still. People looked weird. "The light in their eyes." A very frightening experience. He tried not to disclose any information that could be used against him. He was judged as paranoid.

67. **Comment:** His inability to sit still and his fear of others indicate that the medication had induced the toxic effect known as akathisia.

68. He was put on olanzapine, which he refused. He was then put on Clopixol, which also messed him up. He was described as homicidal. He recalls being very aggressive at the time. "I had to move. I could not sit still." He had suicidal thoughts. Eventually he agreed to take the olanzapine, but remained a mess. He was unclear in his thoughts. He told me that he was hallucinating, but to questioning he denied having any visual sensations at that time. He had a lot of energy and mind thoughts.

69. In January 2003 he was sent to the subacute ward. At his trial in March he represented himself, refusing legal aid. He regards the people in it as hopeless. "I've worked with them." Before the trial Dr.Allnutt assessed him. Although Mr.Dezfouli refused to talk to him, Dr.Allnutt managed to write nine pages of a report concluding that he was unfit to plead. At the time he was on 30mg of Olanzapine daily.

70. **Comment:** I agree that 30mg of Olanzapine given for some time is likely to end in a toxic confusional state. Its effects could have made him unfit to plead.

71. The court found him unfit to be tried. A year later he attended a special hearing at which the murder charge was reduced to manslaughter and he was found not guilty on the grounds of mental illness. He has been in a mental hospital ever since. At the time we saw him he was on 6mg daily of Paliperidone as well as his cardiac medication. At the interview with us he appeared to be functioning well, but he has noticed that his mind wanders when he watches television and in general he cannot concentrate well. He has cramps in his stomach. He showed no sign of akathisia during the assessment

72. I returned to the question of his attitude towards the Government. He still maintained that he made allegations to publicise his grievance. "Howard didn't take the bait. He's smart." I asked questions about his past experience on medication. He had been on the Clopixol injections for three years, during which time he was a mess, aggressive, touchy, intolerant and wanting to pick a fight. Other patients got under his skin. He retreated to his room. He did not attack other patients or staff. His medication was changed from the Clopixol to Paliperidone 3mg daily until October 2012, when it was increased to 6mg daily. On the higher dose his concentration was more impaired, his mind wandered more and he had more cramps in his stomach (upper abdomen).

73. He admitted that from 2004 until 2009 he managed to evade taking tablets given to him. In that time he was being given Abilify by mouth. He recalls that in that time he was not restless and felt settled, clear in his mind, alert and without cramps. He recalled his next problem occurring in March 2009, when smoking was suddenly forbidden. At that time in the Clovelly ward he was consuming more that 20 cigarettes per day. He refers to the experience as "cold turkey." He became edgy, touchy, impatient and grumpy. He thought that the staff regarded him as having a relapse of his psychosis. He was put on Clopixol again.

74. While still on Clopixol in 2002 he had his first "anxiety attack." During an attack he feels panic, that he is dying, cannot breathe, his heart racing and eyesight blurry and he develops pins and needles in the fingers and thighs. His calves become stiff. The best remedy is to lie down. He kept on getting worse in the sense that the attacks became more frequent. He had weekly trips to the Prince of Wales Hospital. All the investigations at that time showed no abnormality. He was told it was due to stress. The attacks ceased after he was taken off the drug given at the time, injectible Risperidone.

75. **Comment:** Although some symptoms he has had while on high doses of neuroleptic medication could reflect excessive accumulation of the drug in his body and toxic effects, these attacks of panic were not due to that cause. Referred to as panic attacks in the DSM, they are due to overbreathing. In this case the symptoms are so typical that I have no doubt this was the cause. Should he become subject to them again the simple remedy is to pay attention to his breathing habits and retrain them.

Background:

76. He developed diabetes in 2008. In 2011 he was put on metformin. He is now being monitored with random blood tests.

77. **Comment:** Diabetes is one of the long term ill effects of neuroleptic medication, particularly olanzapine .

78. His father died at age 76 years of a heart attack. He was the principal of a high school, a strict and controlling man. His mother migrated to the USA in 1985, brought over by her eldest son, who had travelled to Spain and from there to Mexico. He crossed the border into the USA illegally. He owns a restaurant.

79. The patient has four siblings in all. Three of his brothers live in the USA where they run businesses. A sister still lives in Iran. She had worked as an accountant. He does not admit to any mental illness in the family.

80. He claims to have been a good student and to have come top of his class in Year 11. He was offered a scholarship to complete school in 1978, after which he "rested for a year." In that time he hung around with friends and got involved with them throwing rocks at the Parliament in June 1979. The group were arrested but all denied charges and were released after one day. He left the country for the Philippines in November 1979.

81. He began drinking alcohol in the Philippines, but has never done so to excess. He began smoking tobacco in 1979. He learned to drive in 1978. His only encounters with police were due to speeding three times in 10 years.

82. He had a normal sexual life, but on Clopixol could not have an erection. He has had unwanted erections on other medication. He has no recall of the time that he was on high doses of olanzapine. He has seen the clinical records kept in the hospital jail over that time. He believes those entries were fabricated and were not true.

83. He began forging visas while living in the Philippines. He did this because Iran brought Hezbollah into Manila to attack the Iranian students there at the time that they were demonstrating about events in Iran. For himself he forged a New Zealand visa in 1983 so that he could board the plane that passed through Australia. He destroyed his passport in the plane and asked for asylum when he arrived in Sydney. He was sent to Villawood and obtained a bridging visa in 26 days. He believes he was handled so favourably then because the Iran/Iraq war was on.

OPINION

84. The key issue for some appears to be whether Mr.Dezfouli is correct in asserting that he is fit to plead. The medical question at issue appears to be whether he has schizophrenia bringing about delusions that make him unfit to plead as well as a danger to society. From the record and the limited time that I have had to observe Mr.Dezfouli I cannot detect any diagnostic feature that would establish the diagnosis of schizophrenia in his case. I gather from reports that also neither Professor Mullen, Dr.Westmore nor Dr.Lucire could detect signs of Mr.Dezfouli having schizophrenia. At least at one stage a report from Dr.Mastrioanni indicates that he as a treating doctor of Mr.Dezfouli and the rest of the team that had the same responsibility agree with Professor Mullen. As independent assessors and at least some of the patient's therapists share the same opinion, the question of the correct diagnosis certainly remains open to doubt.

85. The patient describes effects of drugs given to him in terms that could mean at various times he was impaired mentally by them. The dosage levels have been very high even for a person who does not have sensitivity to their effects. The high dosage alone could well have produced impairment of mental function that resembles schizophrenia. In addition and quite separately the patient has had the hyperventilation disorder, which he describes as having occurred for a limited period of about two years from 2002 until 2004. Mr.Dezfouli attributes this to the effects of Risperidone, an attribution which I regard as unlikely. I gather that this issue is no longer relevant to the deliberations of the Tribunal.

86. The matter of a toxic reaction could be understood better were we to know the pharmacogenetic vulnerability of Mr.Dezfouli. A relatively simple assay of his pharmacogenetics can establish whether this is so, but I think a vulnerability unlikely. He showed no sign of medication effects at the time I assessed him. The observations do not dismiss the possibility of neuroleptic

CURRICULUM VITAE

My qualifications are

Bachelor of Medicine (M.B.), Bachelor of Surgery (B.S.), Bachelor of Medical Science (B.Sc.(Med.)) and Diploma of Psychological Medicine (D.P.M.), all from the University of Sydney, the last obtained in 1959, Fellow of the Royal Australian and New Zealand College of Psychiatrists (F.R.A.N.Z.C.P.) and Fellow of the Royal College of Psychiatrists (F.R.C.Psych.).

My Appointments are

Honorary Psychiatrist to the St.Vincent's Hospital, Sydney and Emeritus Editor of the Australian Journal of Forensic Sciences.

My experience in general psychiatry commenced in 1956, I have held specialist qualification in psychiatry since 1959, been in private practice since 1971, taught as a Clinical Lecturer in the University of New South Wales School of Psychiatry and been gazetted as a Medical Referee to the Commonwealth Government Employees Compensation Tribunal.

My clinical and research experience in the fields of brain damage and epilepsy commenced in 1956, when I undertook a survey of epilepsy in the psychiatric hospitals of New South Wales. I was awarded a World Health Organization Travelling Fellowship and appointed Clinical Assistant to Dr.Eliot Slater at the National Hospital for Nervous and Neurological Diseases, Queen Square, London, during 1961 and 1962. From 1963 I worked as liaison psychiatrist with the Division of Neurology and Neurosurgery at the St.Vincent's Hospital, Sydney. I commenced medico-legal work in 1972.

From 1963 to 1970 I held the post of Psychiatrist in Charge of the Psychiatric Research Unit, Sydney, which provided the neurological and neurosurgical service for the psychiatric hospitals of New South Wales as well as an extensive research programme in neuropsychiatry, drug addiction and animal behaviour. My responsibility extended to the EEG laboratories of the Health Department of New South Wales and in particular the EEG department of the Psychiatric Research Unit and the electrophysiological recording from the brain undertaken in its neurosurgical operating theatre. For about 13 years from 1971 I ran the methadone clinic at the St.Vincent's Hospital and for some years the group therapy programme for alcoholics at the Alanbrook Hospital. I have taught as a Clinical Lecturer of the School of Psychiatry in the University of New South Wales and on an occasional basis at the Universities of Sydney and New South Wales and in the course of Forensic Psychiatry of the Institute of Psychiatry.

I served as a Director of the Foundation for Research and Treatment of Alcoholism and Drug Dependence of New South Wales, a Director of the Australian Foundation on Alcoholism and Drug Dependence and a Member of the World Health Organization Panel of Experts on Drug Dependence from 1970 to 1980. I was foundation President of the New South Wales Society for Medical and Biological Engineering, Editor of the Australian Journal of Alcoholism and Drug Dependence, Editor of the Australian Journal of Forensic Sciences, and a member of the Editorial Boards of the International Journal of The Addictions and of Drug and Alcohol Dependence. I have held office on the councils of the Public Medical Officers' Association of New South Wales and the Section of Psychiatry in the Australian Medical Association.

I have lectured overseas at the invitation of the International Bureau for Epilepsy, the British Council for Rehabilitation of the Disabled, the British Bureau for Epilepsy, the International Council for Alcoholism and Addictions, the World Health Organisation and Academia Eurasiana Neurochirurgica. From a total of more than 200 personal publications a selected list of original work in general psychiatry, drug addiction and areas pertinent to the assessment of brain damage is appended.

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This and the following 9 pages is the annexure marked "B" to the affidavit of Peter O'Brien affirmed on 23.9.13 before me

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11 September 2013

Mental Health Review Tribunal
PO Box 2019
Boronia Park NSW 2111

Dear Sir/Madam,

I have been asked by Peter O'Brien and Brett Collins for a supplementary report updating my last one,

Re: Saeed Dezfouli

I am aware that Mr Dezfouli had read my last report.

I am also aware that my last report is not on his file.

Indeed, it has been replaced by an entirely false and defamatory report in the Sun Herald, one subject to defamation proceedings.

I am commenting as the prison staff have made this report part of their patient's medical record. I think there is a law against spreading defamatory material

I should like to point out now that I am not a hired gun. Hired guns do don't blow the whistle on drug company frauds and risk their livelihoods by doing so.

Nor was I ordered into treatment by the Medical Board.

Nor is there anything "unusual," as suggested by Mr Fenely, in what I say about drugs and their side effects. My so-called 'unusual' ideas come from the fact that I read Product Information created both in USA and Australia and I have kept up

with development in reports of clincial trials and licensing documents. That, I would have thought, was my duty as a doctor.

There should be nothing "unusual" about that, except the fact that I do read these documents. That my ideas are "unusual" is also, as I told Mr Fenely, the subject of defamation proceedings.

This should be obvious to anyone who reads the cited material.

Everything that I have said comes from Product Information (PI).

It mostly comes from US Product Information (PI) available on the website of the United States Food and Drug Administration (US FDA). I use that because Australian Product Information (PI) is grossly inadequate.

It also comes out of Public Health Advisories.

It also emerges from my own education in psychiatry.

The first week that I started my training near London in 1965, I was advised

> "Do not replace a schizophrenic illness with a neuroleptic psychosis".

Neuroleptic psychosis includes akathisia, which was called "a bizarre psychosis" by van Putten who first differentiated akathisia from the dyskinesia in 1975. It is also classified under the rubric of Adverse Effects of Medication and Psychoactive Substance Induced Disorders in ICD 10.

One can replace normality with a drug-induced psychosis.

Schizophrenia is not an adverse effect of a substance or medication but a notion that it is seems to be at the base of the cases I see and publish about. The notion that a mental illness has been "uncovered" is also at the base of the suicides and homicides committed under mental health care and the huge increases in demand and costs of Mental Health services.

Psychiatrists should be up in arms against drug companies who miseducated them and should not be not attacking whistleblowers.

My knowledge of side effects of drugs and fraudulent promotion is backed by extensive knowledge of litigation under the False Claims Act in the United States. Fraud is also going on in China at the moment and in various other countries and is being litigated under United States Foreign Corrupt Practices Act. All this information is available on the Internet. I hope such litigation will soon be possible here. This was reported in my last report.

I accompanied Dr David Bell. I took notes.

On this occasion, I listened as Mr Dezfouli tried to rationalise his letter writing which started in the United States. He seemed to be trying to persuade Dr Bell that he wrote those letters because he was upset at the treatment that he had from the Australian Consul in USA

On the occasion when I first saw him, he had rationalised his letter writing as a protest against the Iraq war. His letter writing antedated the Iraq war by a full two years.

As Mr Dezfouli knew he had been rumbled on his fake political "protest" and imprisonment and torture story, he had another go at accounting for several missing years of his life.

Mr Dezfouli said that he spent this time in the Philippines, studying political science. However, he could not tell me the name of the university or its address or the names of any theoreticians he may have studied.

Be that as it may, he said he was supported by his family and, again, he claimed to be an altruistic political activist engaged with Amnesty International.

This was a second claim of political activism (the first being throwing stones at the Iranian Parliament) and somewhat self aggrandizing as well.

He said that he had been a forger of passports for refugees. I do not believe that Amnesty International does that). I found this inconsistent with the claimed Amnesty connection.

Be that as it may, he told me that he also forged a passport for himself on which he travelled in to New Zealand for six months but New Zealand was too quiet for him so he came to Australia where he destroyed his passport in the airport toilet and applied for refugee status.

Either my notes are unclear or Mr Dezfouli's story telling was not too well prepared but I remain unsure from my own records whether the trip to New Zealand happened on the way back from the United States or on the way to Australia from the Philippines or both.

Either way, it was unconvincing.

He seems to have been in New Zealand for 6 or 8 months on $4,000 savings in USA and another $4,000, the source of which was unclear or 'my parents".

On one occasion, it seemed to be his savings from the United States which I found a little improbable.

I believe there are four years of his life that are unaccounted for. It would be interesting to know if he attracted any adverse reports in the Philippines or in New Zealand.

So he arrived in Australia as a fake refugee on false documents which, by this account, he destroyed.

Again, I said to him "Why on earth were you writing all those stupid letters?" and he said

> "To fuck with Mr Howard."

The letters are narratives. They refer to many ideas and involve many people. They change from one letter to another, different behaviours involving different people and in my view different self-aggrandising lies.

A delusion, on the other hand, is a fixed belief impervious to reason that does not change.

In order to say he had a delusion, it would be necessary to differentiate a single idea in a pack of confabulations or lies and call it a delusion.

At the last hearing I attended, understood that prison psychiatrists were trying to make a case that he had once had a delusion, one that he wouldn't talk about but they were sure it was there.

I have not been permitted access to the transcript to confirm what was said.

I am not sure that anybody really thinks any more that he has schizophrenia or had schizophrenia. There is no convincing documentation of schizophrenia at a time he was not medicated.

A diagnosis of neuroleptic psychosis under the influence of Risperdal (risperidone), Zyprexa (olanzapine), or Acuphase (zuclopenthixol) does not count towards a diagnosis of schizophrenia.

Symptoms caused by medication or substance are a specific exclusion for making the diagnosis or the diagnosis of delusional disorder.

He certainly didn't have schizophrenia when he was writing the letters. He had no impairment. He was working as a court interpreter, living with friends, writing his ridiculous letters and arranging his citizenship papers.

In order to persuade me that he had Delusional Disorder, his treating doctor would have to tell me which one of his nonsensical tales he believes was a delusion or meets the criteria of a delusion.

None of the antipsychotics he had been taking are licensed for delusional disorder, however they are licensed for schizophrenia and related psychosis. So I suppose one could argue that delusional disorder was a related psychosis.

However, it is impossible to argue that neuroleptic-induced akathisia and neuroleptic-induced psychotic symptoms (see lists in Product Information (PI) for all the drugs) are related disorders to schizophrenia.

That would be like arguing that diabetes mellitus and diabetes insipidus manifest with the same symptom (polyuria) so are "related disorders" and therefore should be treated similarly.

This is what the DSM seems to do. It describes "disorders" by their symptoms and no causes and this combines with the pharmaceutical industry information which then provides remedies for symptoms. Causation and psychopathology do not appear in the DSM.

The mode of onset of his behaviours is nothing like schizophrenia or delusional disorder.

He had been arrested and told not to talk to anyone.

He knew he had done it and wanted to plead guilty and he knew his rights in the United States. It seems that psychiatrists took exception to the fact that he didn't want to discuss his problems and labelled him "uncooperative" and suspected he was hiding something, specifically that he was hiding delusions or a delusion.

He went to see the clinic because he had a sore arm and he was referred to a psychiatrist. He was angry about that. Dr Tran thought there was an "implicit threat" in his anger and ordered a double dose of Acuphase (zuclopenthixol) 100 mg by injection.

When I was a forensic psychiatrist working in the prison (1983-1996) treating behaviours with antipsychotic drugs would have been illegal.

There are many other ways of dealing with angry people in prisons and elsewhere. There are safe cells. There is an offer of Valium (diazepam) or a sleeping pill so they get a good night's sleep. They can be just left to cool off.

But to use a neuroleptic, which may have serious side effects, was simply not ethically available to psychiatrists of my generation.

After he became delirious on Zyprexa (olanzapine), and violently homicidal on 30 mg/day a dose 50% above Eli Lilly's safe level, see Product Information (PI) he was deemed to be mentally ill.

Olanzapine wasn't the only drug being given at the time.

Being intoxicated by alcohol, medicinal drugs or illicit substances is not being mentally ill in any logical jurisdiction,

He was forced/coerced to use a mental illness defence.

He had made it clear that he didn't want to use a mental illness defence.

He mercifully he has amnesia for the period on olanzapine. See product information amnesia is a listed side effect on USA.

Zyprexa is licensed for the treatment of schizophrenia and bipolar illness. It is not licensed for the treatment of drug-induced psychosis.

Zyprexa actually has the following as listed psychiatric side effects (not in the body, but mental) in American PI. (APPROVED AGREED-UPON LABELLING)

> Abnormal dreams, aggressiveness, agitation, akathisia 27% rate on 15 mg/day, akinesia, , alcohol misuse, altered mental status tardive dyskinesia, amnesia, antisocial reaction, anxiety, apathy, articulation impairment, ataxia, choreoathetosis, coma, confusion, COSTART (Non aggressive objectionable behaviour), death, delirium, delusions,

dementia, depersonalization, depression, dizziness, dreams, emotional lability, , encephalopathy, euphoria, extrapyramidal symptoms, hallucinations, hostility, hyperkinesia, incoordination, insomnia, intentional injury, libido decreased, libido increased, manic reaction, motor and cognitive impairment, nervousness, neuroleptic malignant syndrome, obsessive compulsive, paranoid reaction, personality disorder, phobias, reduced level of consciousness ranging from sedation to coma, schizophrenic reaction, seizures, sleep disorder, somatization, speech disorder, stimulant misuse, stupor, stuttering, suicide attempt, tardive dyskinesia, thinking abnormal, tobacco misuse, tremor, vertigo and withdrawal reaction.

AUSTRALIAN Product Information for Zyprexa 2003 UPDATED 2005

•ADVERSE REACTIONS

•***Nervous system*** – _Very common (≥ _10%): somnolence. Common (≥ _1% and < 10%): dizziness; akathisia

•Australian Product information says it has lower rates of akathisia.
•27% is a lot higher than old drugs.

Note there were five schizophrenia trials at this time but only two short six week trials are cited in the document as 'establishing efficacy".

In premarketing trials involving more than 3100 patients and/or normal subjects, accidental or intentional acute over dosage of olanzapine was identified in 67 patients. That is an overdose rate of 2161/100,000, and this causes a privatized profit and socialized cost model of health care delivery. Prescribers in neither USA or Australia are being told the 50% of clincial trial subjects did not compete ten weeks and out of the remaining 2607, 22 died and 12 died by suicide, this makes death, a one in 108 occurrence a 'common' event and suicide at 1 in 217 subjects makes it "uncommon" but catastrophic.

Mr Dezfouli accepted the defence and this landed him in the prison hospital for longer than he would have served for felony murder.

My understanding during the years 1983-1993 when I was a consutant to Corrections Health, was that a mental illness defence was a defence and was optional. It couldn't be forced on anyone.

He could just be made "unfit to plea, until treatment (or its withdrawal) made him better, that was all.

When a person became fit to plead he could be tried. He was not unfit to plead before he was given neuroleptics only after he got angry. However, I understand that has been dealt with by the Supreme Court on evidence then available which might not have included the side effects of Zyprexa.

On Risperdal (risperidone) or more likely Zyprexa (olanzapine), he developed diabetes. Eli Lilly would pay him damages for that if he were allowed to see a compensation lawyer.

He is now supposed to be taking Invega (paliperidone) which is the first metabolite of risperidone, a drug to which he responded very badly and on which he developed heart problems. The details are in my last report.

Invega (paliperidone) was promoted initially as a drug that did not need CYP450 2D6, to be metabolised.

A drug not metabolised by CYP450 2D6 is the Holy Grail of psychopharmacology.

It is the first metabolite of risperidone and psychoactive. It is the same drug as risperidone but produced for ever-greening of the patent. Invega is repeating a failed treatment that harmed him in the first place.

I cite US product information as Australian is inadequate as is all Australian Product Information.

Invega Product information from website of US FDA

CONTRAINDICATIONS

Known hypersensitivity to paliperidone, risperidone, or to any components in the formulation.

(4) ---WARNINGS AND PRECAUTIONS_*Cerebrovascular Adverse Reactions:* An increased incidence of cerebrovascular adverse reactions (e.g. stroke, transient ischemic attack, including fatalities) has been seen in elderly patients with dementia- related psychoses treated with atypical antipsychotics. (5.2)

• _*Neuroleptic Malignant Syndrome:* Manage with immediate discontinuation of drug and close monitoring. (5.3) • _*QT Prolongation:* Increase in QT interval, avoid use with drugs that also increase QT interval and in patients with risk factors for prolonged QT interval. (5.4)

• _*Tardive Dyskinesia:* Discontinue drug if clinically appropriate. (5.5)

• _*Metabolic Changes:* Atypical antipsychotic drugs have been associated with metabolic changes that may increase cardiovascular/ cerebrovascular risk. These metabolic changes include hyperglycemias, dyslipidemia, and weight gain. (5.6)

o *Hyperglycemia and Diabetes Mellitus:* Monitor patients for symptoms of hyperglycemia including polydipsia, polyuria, polyphagia, and weakness. Monitor glucose regularly in patients with diabetes or at risk for diabetes. (5.6)

Dyslipidemia: Undesirable alterations have been observed in patients treated with atypical antipsychotics. (5.6) o *Weight Gain:* Significant weight gain has been reported. Monitor weight gain. (5.6)

• _*Hyperprolactinemia:* Prolactin elevations occur and persist during chronic administration. (5.7) • _*Gastrointestinal Narrowing:* Obstructive symptoms may result in patients with gastrointestinal disease. (5.8)

• _*Orthostatic Hypotension and Syncope:* Use with caution in patients with known cardiovascular or cerebrovascular disease and patients predisposed to hypotension. (5.9)

• _*Leukopenia, Neutropenia, and Agranulocytosis:* has been reported with antipsychotics, including INVEGA®. Patients with a history of a clinically significant low white blood cell count (WBC) or a drug-induced leukopenia/neutropenia should have their complete blood count (CBC) monitored frequently during the first few months of therapy and discontinuation of INVEGA® should be considered at the first sign of a clinically significant decline in WBC in the absence of other causative factors. (5.10)

•_*Potential for Cognitive and Motor Impairment:* Use caution when operating machinery. (5.11)

• _*Seizures:* Use cautiously in patients with a history of seizures or with conditions that lower the seizure threshold. (5.12) • _*Suicide:* Closely supervise high-risk patients. (5.14)

INVEGA® is an atypical antipsychotic agent indicated for Treatment of schizophrenia (1.1)

• _Adults: Efficacy was established in three 6-week trials and one maintenance trial. (14.1)

Australian Product information is found on TGA website lists a single

CONTRAINDICATIONS

Invega _(paliperidone) is contraindicated in patients with a known hypersensitivity to paliperidone, risperidone, or to any components in the INVEGAâ _formulation.

However, I have also described in my last report how a lower metabolite of Invega does need 2D6 and that the Product Information (PI) for Invega (paliperidone) is clearly labelled that it was not suitable for use in people who have been sensitive to Risperdal (risperidone) and Mr. Dezfouli certainly has been sensitive to Risperdal (risperidone).

He now has similar problems. Side effects may be building up. I don't know if he is taking it. I wouldn't be sure as he tells a lot of lies. I cannot see any reason for giving it let alone enforcing it. Indeed, he should be allowed at his own discretion to reduce the dose to nothing and see how he goes.

It seem that even if Mr Dezfouli did suffer from schizophrenia, Invega would not be a suitable drug for him and his genotype which shows diminished CYP450 metabolism would contraindicate Invega.

Again, I cast no aspersions on the treaters. They know not what they do.

They are educated by the Royal Australian and New Zealand College of Psychiatrists (RANZCP), and by clinical practice guidelines that fail to mention side effects, and by seriously defective Product Information (PI).

As I said in my last report, and I quote again here, Mr Dezfouli will have his life expectancy shortened by 15-25 years because of treatment with neuroleptics. Here are the references:

Healy D, Harris, R, Tranter R, et al. Lifetime suicide rates in treated schizophrenia: 1875–1924 and 1994–1998 cohorts compared. *Br J Psychiatry*. 2006;188:223–228.

Lawrence D, Jablensky AV, Holman CD, Pinder TJ. Mortality in Western Australian psychiatric patients. *Soc Psychiatry Psychiatr Epidemiol.* 2000;35(8):341–347.

Saha S, Chant D, McGrath J. A systematic review of mortality in schizophrenia: is the differential mortality gap worsening over time? *Arch Gen Psychiatry*. 2007;64(10):1123–1113.

Colton CW, Manderscheid RW. Congruencies in increased mortality rates, years of potential life lost, and causes of death among public mental health clients in eight states. *Pre Chronic Dis.* 2006;3(2)A42.

Burgess P, Pirkis J, Jolley D, Whiteford H, Saxena S. Do nations' mental health policies, programs and legislation influence their suicide rates? An ecological study of 100 countries. *Aus N Z J Psychiatry*. 2004;38(11–12):933–939.

Every author suggests it is not the socially constructed diagnosis of serious mental illness but the medication that shortens life by affecting the body.

This is hardly reasonable treatment for such an insecure diagnosis.

He remains fit to plead and fit to stand trial.

Yours sincerely,

Dr Yolande Lucire
Consultant Psychiatrist

NSW GOVERNMENT Health
Justice Health &
Forensic Mental Health Network

This is the following 4 pages is the annexure marked "C" to the affidavit of Pete O'Brien affirmed on 23.9.13 before me

3 September 2013

Mental Health Review Tribunal
PO Box 2019
BORONIA PARK NSW 2111
Fax No: 9879 6811

MENTAL HEALTH REVIEW TRIBUNAL REPORT

Name:	**Saeed Sayaf DEZFOULI**
DOB:	**4 December 1958**
MRN:	**701035**
Legal Status:	**Section 39**
Date of MHRT Hearing:	**12 September 2013**

INTRODUCTION

This report is prepared in relation to Mr Dezfouli's New South Wales Mental Health Review Tribunal (MHRT) hearing under the provisions of Section 46 of the NSW Mental Health (Forensic Provisions) Act 1990 scheduled for 12 September 2013.

This report is written in my capacity as Mr Dezfouli's current treating psychiatry consultant in Dee Why Ward, the Forensic Hospital, and is to be read in conjunction with previous MHRT reports.

BACKGROUND INFORMATION

Mr Dezfouli's background history, based on previous MHRT reports is briefly summarised here. For a more detailed description, see report by Dr Pulley dated 4 December 2012.

Mr Dezfouli is a 53-year-old man who is an inpatient of Dee Why Ward, The Forensic Hospital. He is a Forensic Patient, having been found not guilty by reason of mental illness at a special hearing on 18 March 2004 for index offences of *manslaughter* and *maliciously damage property.* The index offences were committed on 18 January 2002. He was found unfit for trial on 12 April 2003.

Prior to the index offence, over the course of one year, Mr Dezfouli sent a number of letters to a variety of public figures and media outlets accusing the prime minister John Howard of attempting to murder him and issuing assassination orders for Mr Dezfouli on the television. The letters repeatedly refer to Mr Dezfouli being under surveillance by "Stingers", and contain claims that he was being persecuted because the US Democrats blamed him for losing the 2000 US Presidential Elections. Some letters included a threat to either self-immolate or blow up a government building if his demands were not met, although the exact nature of his demands was not clear. The letters were thought disordered and contained highly denigrating language to describe Mr John Howard.

On 18 January 2002 Mr Dezfouli set fire to the Ethnic Affairs Commission building, resulting in the death of one person by smoke inhalation. Mr Dezfouli was taken into custody at the scene of the index offence and immediately confessed to burning the offices. When asked why, he referred the interviewers to the letters described in the above paragraph.

Mr Dezfouli was received to prison on 19 January 2002. Dr Ahmed, a psychiatrist, found that Mr Dezfouli had a complex and elaborate persecutory delusional system. His impression was that Mr Dezfouli had paranoid schizophrenia. Mr Dezfouli presented as hostile, stating he wanted nothing to do with the doctors because they were "part of the game" and "meddling" with his "brain cells".

Mr Dezfouli was transferred to the Long Bay Gaol Hospital and remained there until 24 March 2009. During this time he was treated with zuclopenthixol depot, oral olanzapine up to 20mg daily, then risperidone depot 25mg fortnightly then aripiprazole 30mg. There were extended periods during the time in Long Bay Hospital during which Mr Dezfouli would refuse to speak with his treating clinicians. Mr Dezfouli was able to cause considerable conflict between staff members treating him.

There have been a number of documented occasions during Mr Dezfouli's incarceration when he has made threats to harm others:-

- In May 2002 he made threats to blow up the gaol if he had the opportunity and later that month made threats to attack nursing and medical staff if released, and threats to pursue individual doctors if his demands were not met after his release from prison;
- In September 2002 he threatened to target individual doctors if his intended lawsuit against corrections health was unsuccessful and his demands were not met after his release;
- In September 2004 he threatened to kill Dr Allnutt to his face, and told a nurse that if he saw Dr Allnutt again he would bash him;
- In January 2006 the Australian Federal Police notified the treating team that Mr Dezfoli had written threatening letters to John Howard;
- In 2006 the NSW Police Force notified the treating team that the Community Relations Commission (Mr Dezfouli's former workplace) had received a letter from Mr Dezfouli in which he threatened to "shit on" an individual who he claimed locked the fire exit door where the index offence was committed;
- In September 2006, according to the NSW Police Force, a letter was received at the Community Relations Commission in which Mr Dezfouli stated that he intended to have sex with a staff member at CRC on release.

Mr Dezfouli undertook hunger strikes on two occasions. In 2005 Mr Dezfouli was diagnosed with Coronary Artery Disease and treated with angioplasty.

On 24 March 2009 Mr Dezfouli was transferred to Clovelly Ward in the Forensic Hospital. He was irritable and suspicious and refused any interview of reasonable length with his treating doctors. He initiated a brief hunger strike. In May 2009 depot Zuclopenthixol was commenced with physical restraint required after he refused an increase in the dose of Aripiprazole and the addition of Sodium Valproate as a mood stabiliser. He refused all medications, including cardiac medications in protest, and complained of chest pain. Over the next six months there was gradual improvement in Mr Dezfouli's engagement and rapport with the treating team. He became less hostile. He was referred to Morisset Hospital, but this referral was rejected in April 2010 on the basis of poor insight and lack of engagement.

Mr Dezfouli was transferred to Dee Why ward on 10 May 2011 and then to Eloura on 6 July 2011. During this time he showed gradual improvement in his engagement with his treating team. In late 2011 he was participating well in the Eloura ward routine, though the presence of long standing delusions about civil liberties and ideas of reference from letters from US senators was noted.

Due to his complaints of side effects on Zuclopenthixol, a trial of Paliperidone was considered. Whilst this was being considered, Mr Dezfouli refused to accept the depot, or

any medication, and was transferred to Dee Why ward on 8 May 2012. Mr Dezfouli said he did this to be transferred away from his treating psychiatrist, Dr Mastroianni, whom he believed to be "corrupt and incompetent". On Dee Why ward, Mr Dezfouli agreed to commence on paliperidone tablets, initially at 3mg daily. He accepted an increase of dose to 6mg daily only as an alternative to depot medication. Mr Dezfouli complained of side effects from this medication of stiffness and a pressure in his head, however there were no objective signs of side effects. Following the Mental Health Review Tribunal Hearing on 6 December 2012, Mr Dezfouli refused any interview with his treating psychiatrist.

Mr Dezfouli wrote a letter to US President Barak Obama on 6 January 2013, requesting that the President facilitate finding and sending Mr Dezfouli copies of his previous letters to US Senators in the early 2000s, which contained his discussion of the issues which he states are 'allegedly' delusional.

From early 2013 Mr Dezfouli made a series of complaints about his treating team and his treating psychiatrist. He complained to the Health Care Complaints Commission regarding medication side effects and proposed medication increases. In February 2013 communication was received from the Anti-Discrimination Board of New South Wales that Mr Dezfouli had lodged a complaint that Dr Pulley had discriminated against him on the basis of race. Specific allegations that Mr Dezfouli made included that Dr Pulley said to him words to the effect of "people like you come to Australia to commit crimes".

In March 2013, in interview with Dr Colquhoun, Mr Dezfouli outlined that he planned to refuse cardiac medication if placed on depot medication and that his death would "shed light on Justice Health". He said that he never believed the contents of the
letters that he sent prior to the index offence were true and that he sent them just to get media attention because he felt that the Australian government did not help him when he was arrested in the United States. He said that when the letters were not published he realised that 'the press' was under the control of Rupert Murdoch.

In May 2013 Mr Dezfouli informed the treating team that he believed that he could be released on the basis that he was now fit for trial and requested that the treating team comment on fitness in the report for the coming tribunal hearing. During this interview he expressed a view that unlike other Forensic Patients he was "abducted" from the criminal justice system into the forensic system. He would not acknowledge how the letters that he provided to his treating team at the time of the index offences could be reasonably interpreted as evidence of a mental illness. He refused to disclose why he thought he had been "abducted".

PROGRESS SINCE LAST TRIBUNAL HEARING ON 27 JUNE 2013

In accordance with the second opinion from Associate Professor Kimberlie Dean, wafer forms of medications were considered as an alternative to depot medication. Mr Dezfouli refused olanzapine and risperidone wafers, citing metabolic side effects of olanzapine and headaches and pressure in his head when previously prescribed risperidone. He was willing to try asenapine wafers, however this was not considered appropriate after the team found that there was an issue with oral bioavailability that might undermine the goal of monitoring compliance. On 1 August 2013 Mr Dezfouli was formally notified of the plan to recommence treatment by long acting depot injection by Dr Adrian Keller, Clinical Director of the Forensic Hospital, and Dr Pulley. He was given a choice between depot paliperidone and depot zuclopenthixol injections. He declined to indicate a preference. He indicated that he expected to be released when he was found fit to stand trial and allowed to plead guilty to his charges and that he did not intend to cooperate with any treatment in the meantime. He also indicated that if depot medication was recommenced, he would cease all cardiac medications in protest.

Between 27 June 2013 and 21 August 2013 Mr Dezfouli has written 12 letters to various politicians including Kevin Rudd, Jillian Skinner, Kevin Humphries and Tony Abbott. In the same period of time he has written 6 letters to various agencies of complaint including the Antidiscrimination Board of New South Wales, the Health Care Complaints Commission and the NSW Ombudsman.

On 16 July 2013 the Dr Pulley received a complaint that Mr Dezfouli had made to the Antidiscrimination Board of NSW In May 2013 that Dr Pulley had decided to initiate depot medication in order to punish Mr Dezfouli for making his previous complaint.

The treating team were notified on 20 August 2013 that Mr Dezfouli made a complaint to the Antidiscrimination Board that Justice Health were preventing him from donating a kidney because of his psychiatric disability. This complaint appears to relate to a conversation that Mr Dezfouli had on 8 April 2013 with his registrar at the time, Dr Cheryl Colquhoun, in which he indicated that he wished to donate a kidney. Dr Colquhoun documented at the time that she advised him that he would require compatibility testing, and that he should seek clarification as to what testing would be required, and this should then be discussed with his consultant. Mr Dezfouli indicated that he thought that the request would have to involve the upper strata of management as it had "never been done in the history of Justice Health". Mr Dezfouli mentioned this conversation to a nurse on 7 July 2013 but did not notify his treating team of his wish to proceed.

On 12 July 2013 Mr Dezfouli expressed disappointment that a catering staff member accused him of verbal abuse. The notes indicate that nursing staff present believed that Mr Dezfouli was trying to help the situation.

On 13 July 2013 Mr Dezfouli refused to have routine physical observations for metabolic monitoring in protest at the "system". On 19 July Mr Dezfouli told his nurse that he would like to "screw up" Justice Health because he did not like "their ways". He alleged that Justice Health denied him the opportunity to donate a kidney. He said that he wanted to give back to humanity because he had taken an innocent life.

Mr Dezfouli declined an interview with Dr Pulley on 25 July 2013 because he believed he was receiving "confinement not treatment". On 29 July 2013 Mr Dezfouli refused to participate in a mental state examination with his nurse in protest at his treatment.

On 10 August 2013 Mr Dezfouli refused to have a urine drug screen.

On 14 August 2013 Mr Dezfouli was seen by Anthony Arestakesians, a counsellor from the Transcultural Mental Health Centre. Mr Arestakesians indicated that he would send a report to the treating team.

On 20 August 2013 Mr Dezfouli refused to accompany the treating team to an interview room. The choice of depot medication was reiterated to him. He declined to indicate a preference as he believed that his fitness for trial should take precedence. Later that day he told his care-coordinator that he was offended that his medical team spoke to him in a common area and that he considered that it breached his right to privacy and confidentiality. He indicated that he intended to make a complaint to the HCCC.

On 27 August 2013 Mr Dezfouli stated "you are playing mind games with me" to his nurse for the shift after he was asked to direct his request for photocopying to his care coordinator.

On 29 August 2013 Mr Dezfouli refused to be interviewed by Dr Pulley.

MEDICAL ISSUES

Mr Dezfouli was diagnosed with probable beta thalassaemia minor causing mild hypochromic microcytic anaemia by Dr Chow, general practitioner, on 18 June 2013. No further investigation was indicated. He was also diagnosed with eczema affecting his upper chest and prescribed hydrocortisone cream.

CURRENT MEDICATIONS

Paliperidone PO 6mg at night
Rabeprazole PO 10mg twice a day
Vitamin D PO 1000 units in the morning
Fish Oil PO 3g twice a day
Hydrocortisone cream 1% topical to rash twice a day
Perindopril PO 2.5mg twice a day
Aspirin PO 100mg at night
Metoprolol PO 50mg twice a day
Simvastatin PO 20mg at night
Metformin PO 250mg twice a day

MENTAL STATE EXAMINATION ON 29 AUGUST 2013

Mr Dezfouli appeared as a dishevelled overweight, bearded man of stated years wearing grey track suit and a white polo shirt. He was sitting comfortably prior to approach, however on approach he was hostile to the interviewer and refused any interview. There was no evidence of abnormal psychomotor activity. He did not appear to be agitated. His speech was normal in rate and rhythm, although only observed briefly. It is not possible to comment on thought form or content given the brief interaction.

OPINION

Diagnosis

Axis I

Mr Dezfouli suffers from a chronic paranoid psychotic illness. The most likely diagnosis is chronic paranoid schizophrenia, with a differential diagnosis of delusional disorder. The bizarre nature of the delusions that he has experienced, for example that he influenced the outcome of US presidential elections, the fact that he was thought disordered early in his incarceration, and the evidence that he has experienced some psychosocial decline from a previously high baseline all suggest that the diagnosis of schizophrenia is more likely.

Mr Dezfouli's claims that the letters that the treating team maintain demonstrate delusions were a "game" contradicts past events. He handed the letters to police at the time of the index offence and mental health staff early in his incarceration, telling them that the letters explained the reason he committed the offence. He expressed persecutory delusions about John Howard in interviews in the early part of his incarceration. He sent a highly threatening letter to John Howard in 2006. In conversations with Dr Pulley in 2012 Mr Dezfouli expressed ongoing delusions of reference from letters he received from US senators – he made a bizarre interpretation of the word "global warming" from an unrelated letter he received from Senator Barbara Boxer in response to his correspondence to mean that his case was "too hot to handle". He refuses to discuss exactly what took place in the United States that he claims the Australian Government should have assisted him with. He has written to Barack Obama requesting that Mr Obama help him recover correspondence that Mr Dezfouli believes will vindicate his story. His current pattern of behaviour and statements he makes regarding the system being "corrupt" and being "abducted" from the criminal justice system are consistent with an ongoing delusional system of a persecutory nature. In

in the future. His ongoing persecutory beliefs provide a continuing motivation to engage in similar behaviour in the future, and he demonstrates this by his ongoing harassment of the treating team through vexatious complaints.

There has been a decline in his mental health since cessation of depot medication. This has increased his hostility and increases the risk of aggressive behaviour or making threats of a similar nature to that which has occurred in the past.

Medicolegal Opinion

In regards to s74(a) of the *NSW Mental Health (Forensic Provisions) Act* 1990, it is our opinion that Mr Dezfouli suffers from a mental illness as defined by the *NSW Mental Health Act* 2007, namely chronic schizophrenia. His illness has been characterized by ongoing persecutory delusions and a history of bizarre delusions. In regards to s74(c) of the *NSW Mental Health (Forensic Provisions) Act* 1990 Mr Dezfouli 's illness is a continuing condition that is likely to worsen without supervision and treatment within a high secure setting.

In regards to s74(b) of the *NSW Mental Health (Forensic Provisions) Act* 1990, it is our opinion that there are reasonable grounds for believing that care, treatment and control of Mr Dezfouli is necessary for his own protection from serious harm and the protection of others from serious harm.

In regards to s43(a) of the *NSW Mental Health (Forensic Provisions) Act* 1990 in our opinion, on the balance of probabilities, the safety of the public is likely to be seriously endangered by Mr Dezfouli's release or transfer into a less restrictive environment. In regard to s43(b) of the Act, in our opinion there is no less restrictive placement option available that is consistent with safe and effective care. In regards to section 47 of the Act, we recommend continued detention in the Forensic Hospital.

MANAGEMENT PLAN

Treatment

- We propose recommencement of depot medication for the following reasons:-
    - Mr Dezfouli's clinical condition improved when depot zuclopenthixol was commenced in 2009, and then deteriorated following its cessation in 2012.
    - Mr Dezfouli demonstrates such poor insight and hostile attitudes to treatment that it is likely that he is not fully compliant with oral antipsychotic treatment as prescribed at present.
    - It is highly unlikely that Mr Dezfouli would take medication if not closely supervised, therefore being on a long acting injectable medication would be a prerequisite for any progression beyond the Forensic Hospital to an environment where he might be granted leave.
    - Allowing Mr Dezfouli's mental state to continue to deteriorate places staff at risk of harm from threats or aggressive behaviour (for example in 2009 he filled a urine bottle and threatened to throw it at staff).
    - In his current state any negotiation for treatment or monitoring of Mr Dezfouli's progress is impossible as he refuses interviews with his treating team.
- Regarding the choice of depot medication, as Mr Dezfouli refuses to enter into any discussion of this issue, refuses metabolic monitoring for side effects and threatens to stop his cardiac medications, we are of the opinion that depot zuclopenthixol is the safer alternative as it has less potential for metabolic side effects. Furthermore zuclopenthixol has already been demonstrated to have greater efficacy as compared to the current medication regime.

Placement

- We suggest Mr Dezfouli remain in the Dee Why Ward of the Forensic Hospital.

Restrictions

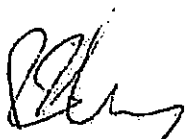
- Mr Dezfouli has unescorted ground access.
- Care should be taken to monitor to whom Mr Dezfouli sends letters, as there is a potential for recurrence of sending of threats via mail.

Implementation

- The treatment plan will be implemented by the Multidisciplinary Team.

Monitoring

- Routine metabolic monitoring.
- Daily review of mental state by nursing staff.
- At least fortnightly review with psychiatrist or registrar.



Dr Rafe Pulley
Consultant Psychiatrist

This is the annexure marked "D" to the affidavit of Pete O'Brien affirmed on 23.9.13 before me

MENTAL HEALTH REVIEW TRIBUNAL DECISION

Name: Saeed Sayaf DEZFOULI

Legal Status: Section 39

Date of MHRT Hearing: 12 September 2013

Presided over by: The Hon. Helen Morgan, Dr. Peter Klug and Meredith Martin

Transcript from 2:05:00

The Hon. Helen Morgan:

> "The Tribunal has been greatly assisted by the reports and the oral evidence given in this matter and by the submissions made on Mr. Dezfouli's legal representatives. The tribunal is of the view however, that this is essentially a matter for the treating team to decide the appropriate medication. In the Tribunal's view it is only in exceptional cases that the Tribunal would step in and make orders as to the medication to be given or not given to a patient who is under the everyday care of a competent treating team. The tribunal does not regard this to be such a case and accordingly declines to make any order. Is there anything further that is required under s 46? Nothing further, well thank you very much for your attendance."