CORONERS ACT, 1975 AS AMENDED

SOUTH  *AUSTRALIA*

FINDING OF INQUEST

An Inquest taken on behalf of our Sovereign Lady the Queen at Mount Gambier in the State of South Australia, on the 5th, 6th, and 27th days of May, 2003, before Wayne Cromwell Chivell, a Coroner for the said State, concerning the death of Wayne John Gillies.

I, the said Coroner, find that, Wayne John Gillies aged 45 years, late of Lot 118 Ascot Way, Mount Gambier died at Dismal Swamp, South Australia on the 4th day of April, 2000 as a result of a bullet wound to the head.

1. Introduction

1.1. At about 1:20pm on Tuesday 4 April 2000, Mr Dirk Stevens, a local farmer, was driving along Three Chain Road at Dismal Swamp when he saw a white utility parked on a driveway to a paddock on the eastern side of the road. He then saw a male person lying on his back on the ground at the southern side of the utility with blood on his head.

1.2. Mr Stevens stopped his car and approached the man lying on the ground. He saw a rifle laying on the man's body, with the top of the rifle at about chest level. The man had sustained terrible head injuries. He was still gasping. Mr Stevens rolled him into the coma position and then went back to his car and called for help on his CB radio.

1.3. Mr Stevens went back to the man and did what he could to administer first-aid.

1.4. At about 1:30pm, Mr Trevor McCrae arrived on the scene and helped Mr Stevens. At about 1:35pm the man stopped breathing.

1.5. Uniformed police officers arrived at about 1:40pm. Detective Senior Constable Kurt Slaven of Mount Gambier Investigations Unit attended the scene at about 1:56pm and

identified the deceased person as Mr Wayne John Gillies. Detective Slaven knew Mr Gillies on a social basis and had seen him only two days before (Exhibit C1a).

1.6. Detective Slaven found a note on the front seat of Mr Gillies' vehicle, apparently written by him. The note clearly indicates that Mr Gillies intended to take his own life. Having regard to the circumstances in which he was found, the background circumstances, which I will shortly discuss, and the contents of the note, I have no hesitation in finding that Mr Gillies died by his own hand, with the intention of taking his own life.

1.7. The body was eventually conveyed to the Mount Gambier Hospital where Dr Humen formally pronounced life extinct (Exhibit C2a).

2. Cause of Death

2.1. A post mortem examination of the body of the deceased was performed by Dr Andrew Sharard, Pathologist, on 6 April 2000. Dr Sharard diagnosed the cause of death as a bullet wound to the head (Exhibit C3a, p1). I accept Dr Sharard's opinion about that and find that the cause of death was as he described. Dr Sharard noted a rounded bullet entry wound through the hard palate of the mouth with profuse bleeding, and another wound over the crown of the head associated with a stellate fracture of the skull. He also noted a severe laceration of the brain along the bullet track with profuse haemorrhage and disruption of brain substance.

2.2. In his correlation, Dr Sharard stated:

> 'The autopsy finding together with the circumstances of death as related are consistent with self infliction of a bullet wound.' (Exhibit C3a, p1)

2.3. A toxicological analysis of Mr Gillies' blood was performed by Mr P D Felgate, Forensic Scientist on 24 January 2001. Mr Felgate noted that the serum contained:

> 'a) approximately 0.5 mg diazepam/L (therapeutic concentration)
> b) approximately 0.2 mg nordiazepam/L (therapeutic concentration)
> Venlafaxine (Efexor) was not detected in the serum.' (Exhibit C4a)

3. Events of 4 April 2000

3.1. Mr Gillies' widow, Ms Kerry Pedlar, said that Mr Gillies had seemed anxious and depressed from the time he woke that morning. He went to work at about 7:20am.

3.2. Mr Gillies telephoned the clinic of his general practitioner, Dr Catherine Pye, at about 9:30am that morning and left a message with her receptionist asking her to ring him when she had a moment. Dr Pye detected no urgency in the request. She did not have the opportunity to telephone him prior to his death.

3.3. At about 10:30am, Mr Gillies telephoned his wife and told her:

> '(his boss' wife) had accused him of something and he had to have a meeting with his boss and his wife later in the morning. He said that he was accused of doing something wrong. He also told me that he wasn't feeling good. I asked him what he was going to do and he said he was just going to keep hanging in there.' (Exhibit C8a, p2)

3.4. Mr Colin Townsend, the Managing Director of the Company which employed Mr Gillies, said:

> 'At about 10.30am I called him into my office and we discussed the need to have a system connected with the workings of the company in place by the end of the week or by at least next week. The conversation became a little heated but it was no more than a boss talking to an employee about the need for company objectives to be met.' (Exhibit C5a)

3.5. I have no evidence before me of any accusation made by Mr Townsend's wife in relation to Mr Gillies. I am unable to determine whether he was referring to the incident described by Mr Townsend in his telephone call to his wife or whether two incidents happened at work that morning. For my present purposes, I do not consider it necessary to investigate this aspect of the matter further, since the merits of whatever happened at work that morning are not central to the issues of the cause and circumstances of Mr Gillies' death. It is sufficient for my purposes to record that at least one incident happened at work which played upon Mr Gillies mind, rightly or wrongly, and which probably caused him to act as he did.

3.6. Mr Gillies left his workplace at 12:30pm. Nothing is known of his movements until his body was found at 1:20pm at Dismal Swamp, which is about 15 kilometres away, in a different direction from his home address. It is not possible to determine whether he brought the rifle with him that morning to work, or whether he went home and collected it before driving to Dismal Swamp. His wife was at work that day, and did not see him after 7:20am. She made several attempts to contact him later in the morning, but was unsuccessful.

3.7. At the time of his death, Mr Gillies was the holder of a firearms licence, number 25952V, and he had one firearm registered to him, a BRNO .22 calibre bolt-action

rifle, serial number 08683. Although no note was made of the details of the rifle seized at the scene, apart from the fact that it was a BRNO .22, the evidence suggests that the particular rifle was eventually examined by Mr Peter Lawrence of the South Australia Police Ballistics Section on 10 April 2000, and he identified the rifle as number 08683. From this evidence, I am satisfied that the rifle which inflicted the fatal injuries upon Mr Gillies was in fact his own rifle (see the statements of Senior Constable Lawrence Exhibit C10a and Sergeant Riach Exhibit C12a).

4. Medical/Psychiatric Treatment

4.1. The evidence suggests that Mr Gillies had episodes of depression in 1992 and 1998, and again in 1999. The antidepressant medication Efexor was first prescribed in February 1999. On 23 February 1999 it was noted by his then general practitioner that this had resulted in some improvement.

4.2. There was no record of Mr Gillies having sought treatment in relation to depression again until 25 January 2000 when he attended upon Dr Catherine Pye for the first time. Dr Pye knew Mr Gillies because she had treated his wife previously, but she had not treated him.

4.3. Dr Pye took a history from Mr Gillies and noted his symptoms which included that he was anxious, fidgety, had low concentration, he was not eating, he was restless and tearful. She diagnosed that he was anxious and depressed.

4.4. Dr Pye said that she asked Mr Gillies if he had been having suicidal thoughts and he admitted that he had. She asked him if he had a gun, and he replied that he did, that it was in pieces, and that he was thinking of giving it to a friend who owned a gun shop. Dr Pye said that she told Mr Gillies that she thought that was a good idea and encouraged him to do so. She said that he 'guaranteed' that he would (T17 and T49).

4.5. Dr Pye continued Mr Gillies medication with Efexor (even though she was concerned that some of his symptoms may have been side effects from the medication), offered him general advice, and gave him information about how to obtain counselling and emergency treatment if necessary.

4.6. Dr Pye said that in her opinion Mr Gillies was not suicidal on that occasion (T18).

4.7. Dr Pye next saw Mr Gillies on 7 February 2000 when she noted some improvement. She wrote another prescription for Efexor, and in fact increased the dose to 75mgs

daily. She made no note of a discussion of suicide on that occasion. She asked him about the gun, and he admitted that he did not give it away to a friend. Instead, he said that he had dismantled the gun into pieces and had hidden them around the house. Dr Pye said that she was surprised that he had not given it away as he said he would, but did not consider suicide an issue at that point, having regard to the improvement in his condition (T50).

4.8. Mr Gillies consulted Dr Pye again on 17 March 2000. He told her that he had been having a busy week, which had been going well except for a problem at work several days earlier when an interstate delivery had not gone according to plan. Mr Gillies' symptoms of anxiety and panic attacks had returned, and he was waking at 4:00am and unable to sleep after that. She discussed some relaxation techniques with Mr Gillies, and noted that there was some 'cognitive distortion' in relation to his reaction to the problem at work, in the sense that he seemed to be needlessly blaming himself for what had occurred (T23).

4.9. Dr Pye said that she had no recollection of whether the issue of suicide was discussed on that occasion.

4.10. Mr Gillies next saw Dr Pye on Thursday 30 March 2000, having made an urgent appointment to see her that day. She found that his mental state had deteriorated even further. He was anxious and tearful, he had lost weight, was sleeping poorly, and he had poor energy levels.

4.11. When Dr Pye asked him about suicide, Mr Gillies said that he had been having these thoughts two days earlier, he described them as 'continual thoughts', and he had only managed to control them by looking at a photograph of his wife and children and reminding himself how important they were to him.

4.12. Dr Pye decided to arrange a telemedicine conference with a psychiatrist from the Rural and Remote Mental Health Service. She sent a referral form by facsimile requesting an assessment of Mr Gillies. As to particular questions/issues requiring specific attention, Dr Pye wrote:

> 'Do we continue same medication – increase this medication or is he experiencing side effects of medication and need to change.' (part of Exhibit C13b)

4.13. Even though Mr Gillies was so obviously suicidal on 28 February 2000, and Dr Pye was so concerned about him on 20 March 2000 that she arranged the teleconference

the next day, Dr Pye was reassured that Mr Gilles would not harm himself on 30 March 2000 (T52). I must say that I find this surprising.

4.14. Dr Pincombe's involvement

A telemedicine conference took place by video link between the Mount Gambier Hospital and the Glenside Hospital on 31 March 2000. The consultant psychiatrist at Glenside who performed the assessment was Dr Kerry Pincombe, an experienced psychiatrist.

4.15. Dr Pincombe took commendably detailed notes of the consultation, which lasted an hour or so. Her findings were consistent with those of Dr Pye the day before.

4.16. In a report to Ms Pedlar's solicitors, Dr Pincombe said:

> 'Wayne described decreased sleep with middle wakening and early morning wakening, anxiety during the day with limited symptoms, panic attacks, diurnal mood variation in the setting of a depressed mood with some anhedonia and poor appetite with a loss of some 5kgs in two months. He described his mood as not only depressed but also tearful and labile and stated his energy was low. He began experiencing suicidal thoughts, which were quite strong in January, had settled to some degree but had been returning for the past week.
>
> He stated he had no current plans, although a few days ago he had formed plans and said that this varied on a day to day basis. Wayne was also experiencing moderately decreased memory, decrease in libido, diarrhoea for the past three days and increase in his psoriasis for the past week. He had become less interested in going out socially although he was still able to cope with this. He was unable to see a future, but stated he went from one day to the next, rather than looking further ahead.' (part of Exhibit C14)

4.17. In the same report, Dr Pincombe summarised her diagnosis as follows:

> 'I felt that Mr Gillies was suffering from a major depressive episode, most likely an exacerbation of an unresolved episode which had begun the year before, with worsening of symptoms and mood in the setting of work and social issues, stated by the patient to be predominantly work problems at the time of the interview. I felt there were also some obsessional traits evident. I was concerned that the Efexor was likely to be contributing to the insomnia and agitation.
>
> My suggestions to Dr Pye were that she decrease the Efexor gradually to nil, followed by 2 to 3 days washout and then a trail of Luvox or Cipramil. I suggested to Mr Gillies that he take time off from work, of at least two weeks duration, and that if he had difficulties during the medication changeover time, commonly a time of worsening symptoms as medication is withdrawn, that he look at admission either locally or down in town. Mr Gillies was very reluctant even to consider time off work, as he felt that it would make his position at work more difficult. At the time of interview Mr Gillies also assured Dr Pye and myself that the gun he owned was no longer available to him.' (Exhibit C14)

4.18. In relation to that last statement of Dr Pincombe's, it appears that there was some misunderstanding during the course of the telemedicine session. Dr Pye told me that she had asked Mr Gillies the day before about the gun (although she made no note of this in Exhibit C13b), and he told her that the gun was still in pieces in his house (T50). Dr Pincombe appeared to be under the impression that Mr Gillies had taken the gun to pieces and given the pieces away to a friend (T80). Whatever the details, Dr Pincombe was clearly under the mistaken impression that the gun was no longer available to him.

4.19. Dr Pincombe told me that it was her assessment that Mr Gillies was not actively suicidal on 31 March 2000, and that he was not at high risk of suicide generally (T72). Again, I find this surprising in view of the instability of Mr Gillies' illness and the fact that he was actively suicidal only three days earlier.

4.20. Following the telemedicine conference, Dr Pye said that she wrote out a prescription for Luvox which Mr Gillies collected from her surgery on 3 April 2000. It would appear that Mr Gillies stopped taking Efexor around this time, since none of that medication was found in his blood according to the toxicology analysis of blood taken after his death (exhibit C4a). This would suggest that he had not taken the medication for 24 hours or more prior to his death. As Dr Pincombe observed, it appears that Mr Gillies did take the Valium she suggested during the 'washout' period.

4.21. As I have already indicated, Mr Gillies telephoned Dr Pye on the morning of 4 April 2000, but she was unable to return his call by the time he died.

5. Issues arising at the inquest

5.1. I heard evidence from Dr Tony Davis, a psychiatrist with long experience in clinical psychiatry. Dr Davis examined all of the documentation available, and provided me with comprehensive reports (Exhibit C15 and C15a).

5.2. Dr Davis agreed, on the evidence before Drs Pye and Pincombe, that Mr Gillies was suffering from a major depressive disorder, of a moderate degree of severity. He noted that Mr Gillies had a history of major depression going back to 1992, with recurrences and/or exacerbations periodically. Dr Davis told me that he thought Mr Gillies' depression was both endogenous, in the sense that it was due to hereditary or constitutional factors, and that it also had reactive features whereby he would suffer

exacerbations as a result of external stressors such as relationship issues and/or work stresses (T110).

5.3. Dr Davis noted that Mr Gillies condition had been unstable and variable since January 2000 when he first consulted Dr Pye. It was a serious concern on 25 January 2000, had improved on 7 February, had deteriorated on 17 March, apparently as a result of a workplace difficulty, and had deteriorated even further on 30 March 2000 when he sought the urgent appointment with Dr Pye. Although Mr Gillies sought to reassure both Dr Pye and Dr Pincombe that he had no present plans to suicide, it should not have been overlooked that he was experiencing suicidal thoughts only days earlier, and had only been able to gain control over them by the use of an external resource in the form of a photograph of his wife and children. Dr Davis thought that Mr Gillies' statement that he would get rid of the gun carried with it the implicit acknowledgement that he had associated the gun with his suicidal thoughts at some stage during the process (T107).

5.4. Dr Davis was prepared to accept that Mr Gillies was not suicidal on the occasions on which Dr Pye and Dr Pincombe saw him, but he said that Mr Gillies' condition was inherently unstable, and that the potential for suicide was always present. His condition was liable to exacerbation at any time as a reaction to circumstances he may have been confronted with (T110).

5.5. Dr Davis also pointed out that Mr Gillies was especially vulnerable during the period when the change of medication was taking place. Dr Pincombe had correctly acknowledged this by suggesting that Mr Gillies should take some time off work and go into hospital so that his condition could be monitored. Mr Gillies steadfastly refused to do so, on the basis that he could not afford the time off work (T68). It was indeed during this washout period that Mr Gillies took his own life. Dr Pye had been reassured by Mr Gillies that he would always contact her if he found himself in that position. Tragically, he was unable to do so.

6. Section 20A of the Firearms Act 1977

6.1. Section 20A of the Firearms Act 1977 reads as follows:

> 20A. (1) Where a prescribed person has reasonable cause to believe that-
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> (a) a person whom he or she has seen in his or her professional capacity is suffering from a physical or mental illness, disability or deficiency that is likely to make the

possession of a firearm by the person unsafe for the person or any other person; and

(b) that person holds or intends applying for a firearms licence or possesses or has the intention of possessing a firearm;

the prescribed person has a duty to inform the Registrar in writing of the person's name and address, the nature of the illness, disability or deficiency and the reason why, in the opinion of the prescribed person, it is or would be unsafe for the person to have possession of a firearm.

6.2. Both Dr Pye and Dr Pincombe told me that they did not inform the Registrar in accordance with that section, because they did not believe that Mr Gillies' mental illness was likely to make his possession of the firearm unsafe. They said that on no occasion did they consider Mr Gillies to be actively suicidal (Dr Pye T52-53 and Dr Pincombe T71-72, T78).

6.3. Both Dr Pye and Dr Pincombe seem to have taken the view that their obligation to inform the Registrar pursuant to Section 20A only arises where the person is actively suicidal, and constitutes a danger to him or herself or others. This is the situation contemplated by Section 12 of the Mental Health Act. That section reads as follows:

12. (1) If, after examining a person, a medical practitioner is satisfied:

(a) that the person has a mental illness that requires medical treatment; and

(b) that such treatment is available in an approved treatment centre; and

(c) that the person should be admitted as a patient and detained in an approved treatment centre in the interests of his or her own health and safety or for the protection of other persons,

the medical practitioner may make an order for the immediate admission and detention of the person in an approved treatment centre.

6.4. The use of the word 'immediate' in that section is particularly important. It would not be enough to justify detention under that section if the patient's condition is unstable and, although his or her health and safety is not at risk at the time of the consultation, it may, at some indeterminate time in the future, become so. The act of detention would not be authorised until the patient was actually in that condition, and immediate detention was called for.

6.5. The Firearms Act, on the other hand, refers to the mental illness being 'likely to make the possession of a firearm unsafe', refers to a situation where a person 'holds or intends applying for a firearms licence', and the opinion of the practitioner is that it 'is or would be unsafe' for the person to have possession of a firearm.

6.6. That section clearly contemplates that the practitioner should have regard to the patient's overall condition, and that although the patient may not be actively suicidal, there is a substantial risk that he may become suicidal in the course of the illness, and the possession of a gun constitutes an ongoing threat to the safety of the patient or another person. In my opinion, the obligation to report pursuant to the Firearms Act is much wider, and calls for a judgement about the risk that the patient's condition may deteriorate, and his or her ongoing possession of a gun may become unsafe during the course of such deterioration.

6.7. Dr Davis agreed that there is some confusion in the medical profession about this. Obviously there is no confusion when the patient is detainable – clearly he would fit the criteria in the Mental Health Act as well. However, the obligation to report pursuant to the Firearms Act is at a 'lower order', and an assessment of the ongoing risk is called for (T151).

6.8. I find, based on the opinion of Dr Davis, which I accept, that Mr Gillies clearly fitted these criteria.

6.9. <u>The death audit</u>

Mr Gillies death was subjected to a review, described as a 'death audit', by a committee consisting of Professor Ross Kalucy, the Clinical Director of the Southern Division of the Mental Health Service, Dr Fiona Hawker, the Director of Telepsychiatry of the Rural and Remote Mental Health Service and Dr Pincombe. Dr Pye also participated in the meeting by way of a videoconferencing link.

6.10. The report (part of exhibit C14) outlines Dr Pye's dealings with Mr Gillies and refers to Dr Pincombe's telemedicine assessment on 31 March 2000. It contains a number of factual inaccuracies which Mr Ryan, counsel for his widow, pointed out.

6.11. I do not propose to examine the details of the review here. It is clearly a valuable exercise for the purposes of the South Australian Mental Health Service that such tragic events are reviewed and improvements made if necessary.

6.12. However, it is necessary to review the comments made by the review panel about the question of notification pursuant to the Firearms Act. The report states:

> 'Notification of the Police would have meant that not only would his gun have been removed but his licence would have been revoked and both these actions would have

been major embarrassments and stress to Mr Gillies which in turn would have made him more vulnerable.' (part of Exhibit C14)

6.13. The same argument was presented to me in an inquest into the deaths of John Anthony Corani and Claire Leslie Corani (Inquest No. 20/1997). The argument has not improved with the passage of the years. If the possession of a firearm by a person suffering from a mental illness is unsafe for that person or any other person, then the doctor's legal obligation is to notify, whether that causes embarrassment and stress to the patient or not.

6.14. In fairness to both Dr Pye and Dr Pincombe, they both accept this view. It is therefore necessary for me to emphasise that their decisions were based upon their assessments of Mr Gillies' condition, and not the reason put forward by the review panel.

7. Conclusions

7.1. Having regard to the totality of the evidence in this matter, I conclude as follows:

1. The treatment of Mr Gillies' psychiatric condition by Dr Pye and Dr Pincombe was appropriate. Indeed, Dr Pye impressed me as a caring and compassionate practitioner who took a close interest in Mr Gillies' condition, and the initiative she showed in organising the telemedicine conference after his presentation to her on 30 March 2000 is to be commended.

2. The assessment performed by Dr Pincombe during the telemedicine conference was thorough and well documented, and her diagnosis and treatment plan were appropriate, and in accordance with high professional standards.

3. The conclusions reached by Drs Pye and Pincombe that no notification should be made pursuant to Section 20A of the Firearms Act 1977 were erroneous. In my view they took an unduly narrow view of their obligations pursuant to that section. The section calls upon a practitioner to form a judgement about the ongoing risk that the patient's condition may render the possession of a firearm unsafe.

8. Recommendations

8.1. I have already considered the provisions of the Firearms Act in the finding of Corani (Inquest number 20/97). In that finding, I recommended that:

> '(1) Amending Section 20A(1) of the Firearms Act by deleting "reasonable cause to believe" and inserting in lieu thereof "reasonable cause to suspect"; and/or
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> (2) Inserting a provision in either the Firearms Act 1977 or the Mental Health Act, 1993, to the effect that, in the event that any person is detained pursuant to the Mental Health Act 1993, a report should be made by a responsible person to the Registrar of Firearms.'

8.2. It may be that if those amendments had been made, Drs Pye and Pincombe might have found it easier to justify a report on the basis of a reasonable suspicion rather than a reasonable belief. I therefore recommend, pursuant to Section 25(2) of the Coroner's Act, that the recommendations I made in Corani receive further consideration by the Attorney-General.

8.3. I have referred in these findings to the wider scope of the reporting obligation on a medical practitioner pursuant to the Firearms Act, compared with the obligation to detain pursuant to the Mental Health Act.

8.4. As I did in Corani, I recommend that the medical profession be reminded of these obligations by the appropriate agency, whether that be one or more of the following agencies:

- The Minister of Health;
- The Department of Human Services;
- The Medical Board or South Australia;
- or a combination.

Key Words: Suicide Risk - Assessment of; Gunshot Wound; Psychiatric/Mental Illness

In witness whereof the said Coroner has hereunto set and subscribed his hand and Seal the 27th day of May, 2003.

Coroner