CORONERS ACT, 2003

SOUTH  *AUSTRALIA*

FINDING OF INQUEST

An Inquest taken on behalf of our Sovereign Lady the Queen at Adelaide in the State of South Australia, on the 7th and 8th days of March 2006 and the 22nd day of June 2006, by the Coroner's Court of the said State, constituted of Elizabeth Ann Sheppard, a Coroner for the said State, into the death of Christopher Simon Merritt.

The said Court finds that Christopher Simon Merritt aged 24 years, late of 16 Moor Crescent, Hallett Cove, South Australia died at Flinders Medical Centre, Flinders Drive, Bedford Park, South Australia on the 15th day of July 2003 as a result of a .22 calibre gunshot wound to the head. The said Court finds that the circumstances of his death were as follows:

1. Sequence of events on 15 July 2003

1.1. On the morning of 15 July 2003 Christopher Merritt reluctantly got out of bed at around 7.00 am after having an argument with his father. Although Christopher had lived independently in the past, in July 2003, he was living at home with his parents. There had been a family dinner the night before which Christopher appeared to enjoy. Following the dinner he went off with some friends and stayed out late. Christopher had a good job as a mechanic with the Adelaide City Council and his father was worried that if he turned up late for work or was not in a fit state, he might lose the job. The last words uttered to his son were shouted in anger, as follows:

> 'Well you can bugger off out of the house and not come back.'

According to Christopher's father, Douglas Merritt, he and his son got along really well sometimes, but that at other times they were "at each others' throats" (T137, 149, 151).

1.2. Christopher Merritt was a young man who had struggled with personal issues including failed relationships with women. It is clear in hindsight that he had developed a tendency to become depressed, largely as a reaction to some of these challenging personal circumstances (Exhibit C17a).

1.3. Dr Owen Watson had been the family's general practitioner for at least 20 years. Dr Watson had treated Christopher in December 2002 when he was recovering from a serious bout of 'Q' Fever, contracted whilst working in New South Wales. According to Dr Watson, Christopher had become quite unwell and it took some time for him to recover (T60). The contents of Dr Watson's medical records for Christopher reveal that in September 2002, he was struggling with feelings of depression. A letter dated 23 September 2002 from Social Worker Norm Sidebotham reported Christopher's progress in his rehabilitation program which was instituted following the episode of 'Q' Fever. He noted that Christopher reported feeling depressed and lacking in motivation. Another letter contained within Dr Watson's file is one written by Christopher's mother Ngaire Merritt. This letter is undated but it sets out Mrs Merritt's concerns about Christopher's mood swings following the episode of 'Q' Fever. In this letter, Mrs Merritt requested Dr Watson's assistance as follows:

> 'I would be most grateful of any suggestions on how to help Chris. We just want our happy Chris back, not a young man with a chip on his shoulder.'
> (Exhibit C15)

1.4. On 30 June 2003, two weeks before his death, Christopher consulted Dr Watson. When Christopher presented at Dr Watson's surgery in Oaklands Park, he turned up without warning and waited for about half an hour before he was seen. In a short statement provided on 16 July 2003, Dr Watson summarised the consultation as follows:

> 'I have been treating Christopher Merritt for approximately 13 years since 1990. On the 30th June 2003, Chris attended at my office without an appointment. During the consultation Chris appeared teary and depressed and informed me that he had driven straight to the surgery after driving his car about 190 kph along the Southern Expressway with a thought that he might run into something.
>
> I prescribed the anti-depressant Cipramil to him and told him to make an appointment to see me ten days later as it takes approximately ten days for this medication to take effect. I did not consider him at this stage to be a danger to himself. I believed that he was behaving in a reckless manner due to some personal problems he was experiencing in his life.
>
> During the 13 years I have been treating Chris, with the exception of the last occasion I saw him, he has not displayed any signs of suffering from a mental or depressive illness

> and I am surprised by his actions to end his own life.'
> (Exhibit C15a)

1.5. Dr Watson did not elaborate any further about the nature of the problem that triggered this episode and he made no note about it. His notes of the consultation were brief as follows:

> 'Tearful, wakes overnight, suicide ideation (today doing 190kph and thinking about running into something)
> Motivation- poor.
> Depression
> Cipramil
> Off Work Certificate
> Rx: 28 – Cipramil (Tablets) 20 mg'
> (Exhibit C15d)

1.6. Dr Watson gave evidence at the Inquest during which he acknowledged that the notes recorded of this session with Christopher were inadequate. He explained that his keyboard skills were limited and he was still familiarising himself with the computerised record system operating at the Oaklands Park Practice which he had joined some four weeks earlier. According to Dr Watson, he was disappointed with the brevity of his record and he found it difficult to recollect any detail other than two factors which stood out in his mind, 'the presentation and the final conclusion'. He explained that there was a stark contrast between Christopher's initial presentation and the state he was in by the time he left his surgery as follows:

> 'Probably the only reason I remember those is because they are quite starkly opposite. He presented with this reckless driving episode where he had driven very fast and in a sort of carefree manner. He'd had some suicidal thoughts as I remember and I remember my final thought as being quite contrary to that and he wasn't suicidal. So I remember that only I'm sure because of the contrast in presentation to the conclusion.' (T64)

1.7. Dr Watson explained that by the end of the consultation, he felt confident enough about his mental state to allow him to drive home. He decided that Christopher was not at real risk of suicide even when he pressed him and tried to discover if he was depressed (T66). Dr Watson emphasised in evidence that at the end of his consultation with Christopher he felt very comfortable that he was not suicidal. When questioned about what significance he attached to Christopher's tearfulness during that consultation he explained that he felt that it was a reaction 'to some acute event and it wasn't an ongoing problem'. He was asked by counsel, Mr Lindsay:

> 'Q. Are you able to say whether you explored what that acute event might have been.

A. I would like to think absolutely I did, but I'm afraid I didn't record it. I don't remember it being anything outside of normal life sort of experiences.' (T67)

Dr Watson explained that whilst he thought Christopher had a depressive illness, it was very mild and that prescribing an antidepressant was a reasonable thing to do. He claimed that he would have expected to follow him up in ten days but made no note of this. Christopher did not return to see Dr Watson for follow-up.

2. Period between Dr Watson's assessment and 15 July 2003

2.1. There was a suggestion towards the end of the Inquest when Douglas Merritt gave evidence, that the driving behaviour that led Christopher to consult Dr Watson in fact occurred the day before, which is 29 June 2003. Douglas Merritt suggested that having discussed this issue with his wife before the Inquest, they now consider that Christopher saw Dr Watson only after Mrs Merritt questioned Christopher about his mood and learnt about this episode of reckless driving. Mr Merritt claims that after disclosing this on 29 June, Christopher was urged by his parents to see Dr Watson to discuss the issue. Ultimately I find that the potential discrepancy on this point does not have any significant bearing upon the outcome.

2.2. Douglas Merritt explained that he and his wife knew that their son had been to see Dr Watson on 30 June because they could see that Christopher had been prescribed antidepressant medication. Mr Merritt was unable to say whether or not Christopher took any of the medication. Douglas Merritt explained that during this period following the consult with Dr Watson, Christopher seemed fairly happy and settled, however on the morning of 15 July 2003, the situation suddenly changed (T138). The last encounter with his son featured shouting and an argument because Christopher would not get out of bed. Both father and son were angry. I readily acknowledge how difficult it must have been for Mr Merritt to speak about what occurred that morning. It took a lot of courage to give such a frank account of what was said. Douglas Merritt claimed that he heard Christopher leave the house very soon after this episode, although he did not see him leave and therefore could not say whether or not Christopher was carrying anything with him.

2.3. Christopher did not go to work that morning. He drove his vehicle from Hallett Cove towards Victor Harbor. By about 10:20 am he had parked his vehicle at the Bluff at Encounter Bay. There were a number of other vehicles in the vicinity. He did not

park in the designated parking area, but instead in a position closer to the edge of the bluff, facing the sea. Witnesses are said to have noticed the vehicle and to have heard two loud bangs. The male driver of the vehicle was seen to be slumped over, in the driver's seat, with his head moving about. On closer inspection, he seemed to be alive, but was unresponsive. It was obvious that the young man had shot himself. Ambulance and police were called and Christopher Merritt was taken initially to the South Coast Hospital and then he was airlifted to Flinders Medical Centre (FMC). Unfortunately Christopher's injuries proved fatal and he was pronounced deceased at 7:30 pm (Exhibits C5a, C6a, C7a, C8a and C12a).

3. **Post Mortem**

3.1. A post mortem examination was conducted by Dr John Gilbert, a forensic pathologist at the Forensic Science Centre on 17 July 2003. Dr Gilbert's examination revealed fatal injuries to Christopher's skull and brain caused by a gunshot to the right temple. Additionally, Dr Gilbert observed shotgun pellets around the base of the skull and in the upper oropharynx where he noted submucosal bruising, but no significant penetration of tissues. A deposit of black soot was noted over the radial aspect of Christopher's left index finger. Dr Gilbert made the following observations in his report:

> 'Death was due to a .22 calibre gunshot wound to the head. The shot was inflicted at contact range to the right anterior temple. The projectile passed from right to left in a more or less horizontal plane and passed slightly posteriorly at an approximate angle of between 5 and 10 degrees to the coronal plane. It entered the skull at the right posterolateral aspect of the frontal bone and then passed through the right and left frontal lobes. The projectile impacted the inner aspect of the left posterolateral aspect of the frontal bone raising a portion of skull bone but no further injury was produced. There was therefore no exit wound.
>
> There was also evidence of minor shotgun pellet injury to the upper oropharynx. Numerous 2.5 mm diameter shotgun pellets were identified within blood clot at the rear of the mouth and in the posterior nasopharynx but there was minimal tissue injury associated with their presence. A few pellets were also identified within the gastric contents consistent with swallowing of the pellets and a clinical chest X-ray indicated that a few pellets had also been inhaled into the lungs.
>
> Information received after the autopsy indicated the finding of a damaged 12 gauge shotgun cartridge containing #6 birdshot at the scene of the shooting along with a .22 calibre bolt action repeating rifle with a shortened barrel and the shoulder stock sawn off, .22 LR ammunition (Winchester, hollow point, copper plated) and a spent .22 LR cartridge. The nature of the damage to the shotgun cartridge suggested that the deceased had fired the rifle through the base of the shotgun cartridge, presumably while the latter

> was within his mouth. This resulted in only minor pellet injury to the oropharynx insufficient to cause incapacitation. It appears that following infliction of this injury, the deceased placed the muzzle of the rifle in contact with his right temple and discharged the weapon a second time inflicting the fatal brain injuries.
>
> The .22 calibre projectile from the first shot was not present in the body at autopsy nor was it visible in any of the x-rays taken at Victor Harbor or at Flinders Medical Centre. It had evidently not penetrated any of the oral or pharyngeal structures. Assuming that it did not lodge in the shotgun cartridge, it was presumably lost due to falling from or being spat from the deceased's mouth.'
> (Exhibit C2a, pp5-6)

3.2. I accept the conclusions expressed by Dr Gilbert as to the cause of death. I find that Christopher initially tried to detonate a 12 gauge shotgun cartridge in his mouth by firing a .22 round through its base. The cartridge did not detonate during that activity which explains the relatively minor pellet injuries to the back of the throat. I find that the fatal injuries were self-inflicted by Christopher Merritt whilst seated in his vehicle at the Bluff.

3.3. Further macropscopic and microscopic examination of the brain was conducted by Dr Barbara Koszyga and Professor Peter Blumbergs. The conclusion reached during this examination was that the missile track extended from the right inferior frontal to the lateral left frontal lobe. Extensive subarachnoid haemorrhage and brain stem injury was also observed. I accept the opinions expressed by Dr Koszyga and Professor Blumbergs in their report (Exhibit C3a).

4. Toxicology

A sample of Christopher Merritt's blood was analysed for traces of alcohol and common drugs by Forensic Scientist Heather Felgate. No alcohol was detected, but a small level of tetrahydrocannabinol and nor 9 carboxy-THC was detected, indicating some consumption of cannabis in the days leading to Christopher's death. The blood screen for common drugs did not disclose the presence of Citalopram, which suggests that the medication prescribed by Dr Watson on 30 June 2003 was not being taken (Exhibit C4a, T125).

5. Police observations of Christopher Merritt's vehicle

Detective Darren Flynn from Victor Harbor CIB attended the Bluff shortly after the shooting, together with other police and ambulance officers. When Detective Flynn

arrived, ambulance officers were treating Christopher prior to his transfer to hospital. A sawn off .22 bolt action rifle was removed from the driver's side floor of Christopher Merritt's vehicle by Constable Nichele. Constable Nichele cleared the weapon and located a spent cartridge in the breach. Detective Flynn saw numerous lead pellets in the driver's seat which he later established were shotgun pellets. There were keys in the ignition with the ignition setting turned off. A mobile phone was on the dash in front of the steering wheel with the screen displaying the message 'I'm sorry'. Detective Flynn saw a large quantity of .22 ammunition and numerous empty ammunition boxes throughout the vehicle. He located an empty .22 cartridge on the floor of the driver's side. On the passenger seat he saw an empty cash box which contained lead pellets resting on top of a black canvas bag. This bag contained a riflescope. Inside the bag was written 'Doug 0408 797 098'. In evidence, Douglas Merritt explained that this was one of his bags which he used on a regular basis and which he had seen about a day or two before his son's death (T152-153). On the floor in front of the front passenger seat, was located a spent shotgun cartridge next to some burnt electoral registration papers. This cartridge had a hole through 'the primer stage of the cartridge', consistent with a .22 round penetrating its base. An inspection of the rear seats disclosed more .22 live ammunition strewn on the seats and the floor (Exhibit C12a). Detective Flynn also located a porcelain 'bong' which could have been used for the consumption of cannabis.

6. Examination of the weapon and ammunition seized from Christopher Merritt's vehicle

6.1. The items seized from Christopher's vehicle were examined by Senior Constable Lawrence who has been a member of the Ballistics and Armoury section of the South Australian Police Force since 1976. He has also accumulated expertise in the examination and testing of firearms and ammunition and the microscopic comparison of cartridge cases and projectiles. He concluded that the firearm retrieved from the vehicle was functioning correctly and would not have discharged accidentally through knocking or rough handling. Senior Constable Lawrence described his assessment of the weapon as follows:

> 'I examined this item and found it to be a Sportco bolt action repeating rifle, serial number RN623, in calibre 22 Long Rifle. The barrel had been cut down to a length of 175mm and the shoulder stock had been cut off behind the pistol grip, giving the firearm an overall length of 413mm. The firearm had a weight of 1.28 kilograms. There were

smears of what appeared to be blood on the stock, barrel, and receiver. With the firearm was a ten round detachable box magazine, containing five live rounds of Winchester brand .22 Long Rifle, hollow point ammunition.

I subjected the firearm to a series of standard safety tests, which exceeded the required standard, and found that the firearm would not discharge when subjected to knocks and bumps as could be encountered during rough handling. The safety catch was in good working order and the firearm was fitted with an effective trigger guard. The trigger would support a maximum weight of 2.1 kg before it would cause the firearm to discharge. I test fired the firearm and found that it functioned correctly in all respects. During this test firing I collected spent cartridge cases for later use during microscopic comparisons.'
(Exhibit C11a, pp3-4)

6.2. Other items seized from the vehicle

In addition, the following items seized from Christopher's vehicle were examined by Senior Constable Lawrence:

- Item 'WIK 5' containing twenty seven (27) shot size number 6 lead shotgun pellets.
- Item 'WIK 6' containing fourteen (14) shot size number 6 lead shotgun pellets.
- Item 'WIK 7' being a spent Winchester brand .22 Long Rifle cartridge case. Microscopic tests showed this cartridge could have been fired from the Sportco rifle (serial RN623), but could not be conclusively identified to, or eliminated from it.
- Item 'WIK 8' containing an empty gold Winchester brand ammunition packet for 22 Long Rifle hollow point ammunition, an empty grey Winchester brand ammunition packet for 22 Long Rifle hollow point, four (4) live round of IMI brand 22 Long Rifle ammunition with lead round nose projectiles, Twenty live rounds of Winchester brand 22 Long Rifle ammunition with hollow point projectiles.
- Item 'WIK 9' being a plastic 12 gauge shotgun wad. It had propellant powder, and what appeared to be blood adhering to it. There was a hole in the base of the wad which would not be present if it had been fired from a shotgun in the normal way.
- Item 'WIK 10' containing an empty IMI brand ammunition box which would normally contain 22 Long Rifle ammunition, five (5) live rounds of IMI brand 22 Long Rifle ammunition with lead round nose projectiles, one live round of Winchester brand 22 Long Rifle ammunition, with a hollow point projectile.
- Item 'WIK 11' containing thirty one (31) live rounds of IMI brand 22 Long Rifle ammunition with lead round nose projectiles and two (2) shot size number 6 lead shotgun pellets.
- Item 'WIK 12' containing thirty one (31) live rounds of Winchester brand 22 Long Rifle ammunition with hollow point projectiles.
- Item 'WIK 13' containing a Nikko-Stirling brand 'Tiara' 4x28 telescopic sight,

with mounts attached. This sight could be affixed to the Sportco rifle.

- Item 'WIK 14' containing ten (10) live rounds of IMI brand 22 Long Rifle ammunition with lead round nose projectiles, fifty three (53) live rounds of Winchester brand 22 Long Rifle ammunition with hollow point projectiles, two hollow point projectiles, most likely from Winchester brand 22 Long Rifle ammunition and a spent Winchester brand 22 Long Rifle cartridge case. Microscopic tests showed this cartridge could have been fired from the Sportco rifle (serial RN623), but could not be conclusively identified to, or eliminated from it.
- Item 'WIK 15' being a Browning brand 12 gauge cartridge case. It was marked as containing shot size number 6. The plastic side walls were split, and the primer in the head of the cartridge case had been perforated and inwards. There was what appeared to be blood on the cartridge case.
  (Exhibit C11a)

According to Senior Constable Lawrence, he would anticipate seeing damage of this type, if the head of the cartridge case were struck with a .22 calibre projectile, which was unsupported in a firearm chamber. Senior Constable Lawrence had these further comments to make in relation to Item WIK 15:

> 'Re Item 'WIK15' - In the past I have conducted tests whereby I fired a 22 Long Rifle round at the base of a 12 gauge shotgun round. The observed result was that the 12 gauge cartridge case burst along the side walls, and the pellets and wad were ejected with very little force. Much of the propellant powder remained unburnt. The 12 gauge wad inside the cartridge case was perforated by 22 Long Rifle projectile. Cartridges which are allowed to discharge while confined in a firearm chamber or barrel, develop very little pressure inside the cartridge case, and thus the ejected pellets present little hazard.
> (Exhibit C11a)

I accept the observations and comments made by Senior Constable Lawrence concerning the items seized from Christopher Merritt's vehicle.

7. Douglas Merritt's knowledge of the firearm and ammunition

7.1. When Douglas Merritt was first spoken to by police about the weapon on 15 July 2003 following his son's death, he stated that he did not know how his son came to be in possession of a firearm. He also claimed that Christopher had never owned a firearm and that there were no firearms in their home (Exhibit C1a). Shortly before the commencement of the Inquest in February 2006, Douglas Merritt provided a further statement in which he disclosed that the rifle that was used by his son on the day of his death was indeed a dismantled shortened rifle kept at his house. He stated that the rifle had belonged to his father but after he was diagnosed with dementia, it

was taken away from him and kept hidden in a box in a cupboard in an upstairs attic room. He stated that it was not common knowledge in his family that he had the rifle (Exhibit C1b).

7.2. When Mr Merritt was questioned about the weapon during the Inquest, he explained the situation as follows:

> 'We used to live at a farm up Wistow way, so firearms and that were part of our life up there. When the farm was sold, all the firearms were really sold off except for a 22 that was damaged and dad had that and they were living at Marino. Dad began to get a bit funny and a bit of dementia and he took it out in his little workshop one day and he sawed the handle off it into a pistol and cut the barrel down and made it into like a little sawn-off 22 and my mum wasn't very happy about this and with dad's state of mind she said 'Look what your dad's done to this gun' and I said 'Dad you can't do that', I said 'I'll take it', so I took it away 'cos mum was worried about it and I had it in pieces, the bolt action wasn't in it, the magazine was somewhere else and I had a little cubbyhole at home upstairs and buried it in the back of the cupboard and as far as I knew no-one else knew about it, but Chris had obviously been up there and he obviously knew about it. At the time all this happened I said I didn't know anything about it and I really didn't because it wasn't till afterwards that I found out what weapon was used, because they were talking about shotgun cartridges - well I never had a shotgun and we didn't have shotgun cartridges in the house, but when I found out a little bit more information I began to realise that the one that was at home must've been the weapon, particularly when I found that I couldn't find it anymore, and when this statement, the affidavit came through, before the inquest here and I read what was on it, then I thought I'd better at least set the record straight as to what happened there.' (T139-140)

7.3. Mr Merritt explained that Christopher knew how to handle firearms at the time of his death. According to Douglas Merritt, his son became familiar with them through family activities around Wistow and also from Christopher's participation in camps organised by police and the army (T140). Douglas Merritt claimed that the last time he saw the rifle, it was wrapped in a rag in the cupboard, some months or even a year before his son's death (T141). Mr Merritt maintained that because he didn't see Christopher leave on the morning of his death, it was possible that he made his way to the attic room without Douglas Merritt being aware of it. He conceded that his son would have known how to access the room even if it had been locked. When asked why he kept the weapon in the house rather than disposing of it, Douglas Merritt was unable to explain this, but he emphasised how much he regretted it (T152). I have no doubt about that. Douglas Merritt also stated that there was no ammunition with the weapon as far as he knew and that there was no other ammunition elsewhere in the house or anywhere on his property (T141). There is no evidence which establishes

directly whether Christopher came into possession of the weapon and the ammunition immediately prior to setting off for Victor Harbor on 15 July 2003, or whether he had them in his possession previously. The presence of a rifle scope in a black canvas bag belonging to Douglas, last seen only days before Christopher's death, tends to suggest that the rifle was also housed in the bag when Christopher left home that morning.

7.4. The quantity of ammunition and the variety of items seized from Christopher's vehicle on 15 July 2003, tends to suggest that it was the remains of a collection of ammunition held over a period of time. In the circumstances I find that it is likely to have come from the Merritt family home at Hallett Cove.

8. History of self-harming behaviour

8.1. Douglas Merritt explained in evidence that his son had experienced previous episodes of self-harming behaviour which resulted in him being taken to the Flinders Medical Centre (FMC). He found it difficult to recall the circumstances of these presentations except for the last one where his son admitted to his parents that he had taken a quantity of Temazepam. According to Douglas Merritt, Dr Watson was not consulted in relation to any of these episodes of self-harming behaviour where Christopher attended the FMC. Mr Merritt was critical of the way in which the medical staff at the FMC assessed his son following the overdose of Temazepam. He regarded the assessment made by the medical practitioners as somewhat cursory in nature. Mr Merritt conceded that he himself had struggled with depression over the years, probably because of his service in Vietnam. He referred to some unsatisfactory attempts to get help from the FMC Accident and Emergency Department concerning his own issues (T154). I consider that it is quite likely that these experiences have predisposed Douglas Merritt to form a rather sceptical attitude to psychiatric services provided through the Accident and Emergency Department of the FMC.

8.2. The FMC medical records for Christopher Merritt revealed that he presented to the Accident and Emergency Department on three separate occasions after ingesting harmful substances. In June 1993, when aged 14 years, he is said to have ingested six Panadeine Forte tablets. The medical records reveal that Christopher left the hospital before he was formally released and he was advised to see his medical practitioner the following morning (Exhibit C14). It is not known whether Christopher acted on this advice.

8.3. On 21 November 1994, Christopher again presented to the Accident and Emergency Department, accompanied by his parents, after ingesting about 30ml of pyrethrum. He was said to have stated that he wanted to die after breaking up with his girlfriend. Christopher was now 16 years old. His parents participated in an interview with their son conducted by a nurse from the Child Adolescent Mental Health Service (CAMHS). Before Christopher's release from the Accident and Emergency Department, a follow-up appointment was made with CAMHS one week later. Douglas Merritt explained in evidence that he believed the follow-up was not very helpful and it did not involve Dr Watson. The FMC records for Christopher contain an entry by the nurse in which the interview and outcome is summarised. The entry refers to a history of aggression and an acknowledgment by Christopher that he felt depressed and wanted assistance.

8.4. The next presentation recorded at the FMC is 12 February 2003 at 11:20 pm regarding an overdose of Temazepam following the break-up of the relationship with his fiancé. His fiancé was said to be pregnant at the time and Christopher was also struggling to deal with a claim for financial compensation from an ex-girlfriend. The medical records of this presentation reveal that an RMO in the Emergency Department examined Christopher and noted his examination and assessment comprehensively in two pages of handwritten entries. The RMO assessed Christopher as suffering from 'overdose with suicidal ideation' and noted that he now wanted counselling and had seen a general practitioner the previous day who had offered to arrange counselling. It is not known who this general practitioner is. It was not Dr Watson. There is no documented information available about what arrangements may or may not have been made. Unlike the earlier presentations in 1993 and 1994 Dr Watson is nominated in the medical notes as Christopher's General Practitioner on 12 February 2003. Dr Watson's contact details and facsimile number for his Morphett Vale Practice are also documented.

8.5. Psychiatric Registrar, Dr Warhurst examined Christopher the following morning on 13 February 2003. He also documented his examination and assessment comprehensively in the medical records in six pages of handwritten entries. Dr Warhurst did not give evidence at the Inquest.

8.6. According to the notes attributed to Dr Warhurst, he concluded that Christopher did not suffer from a major depressive disorder, but instead had a "situational crisis with

impulsive overdose". Christopher's parents were present during the assessment and were involved in the final discharge plan. Dr Warhurst recommended that Christopher see a counsellor through the Service for Dependents of Vietnam Veterans via Douglas Merritt's contacts. It was further documented that Christopher and his family would seek help from their general practitioner and the Assessment and Crisis Intervention Service (ACIS), if his depressive symptoms persisted or worsened, at which time, antidepressants might be considered (Exhibit C14). According to Douglas Merritt, he tried to engage his son in the counselling services offered to Vietnam Veterans and their children, but Christopher declined to take up the offer. I say more about the way in which Christopher was assessed at the FMC subsequently.

9. Specialist Review of presentations by Christopher Merritt for attempted self harm

9.1. Dr Tony Davis is an experienced psychiatrist who was asked to review the available material concerning Christopher's death and his previous medical history and to provide a report concerning the adequacy of Dr Watson's consultation on 30 June 2003, together with the adequacy of the FMC presentations. Dr Davis freely acknowledged the difficulties encountered by medical practitioners when dealing with young patients who express suicidal thoughts. According to Dr Davis, decisions must be made about the seriousness of the threat posed at the particular time and whether the person ought be detained for their own safety under the provisions of the Mental Health Act. According to Dr Davis, the three presentations to the Flinders Medical Centre, together with the presentation to Dr Watson on 30 June 2003 suggested that Christopher had "a significant propensity for depression, which was largely reactive to difficult interpersonal circumstances" (Exhibit C17a). In his view, the most significant presentation at the FMC was on 12 February 2003 regarding overdose of Temazepam. Dr Davis summarised the effect of Dr Warhurst's assessment by reference to his entries in the medical records as follows:

> 'He indicated that Christopher had been depressed for one and a half weeks or so following the break-up of a relationship with his fiancé. She was pregnant at the time. He was also dealing with a complex issue involving an ex-girlfriend, who was seeking some form of financial compensation. Christopher reported a variety of symptoms indicative of a reactive depressive state. This culminated in an overdose of medication, having thought about this for two and a half hours or so prior to the event. The case notes indicate that Christopher was in part trying to make his fiancé feel guilty about his situation, and was stated to be *"glad it didn't work and wasn't successful"*. He did not

> report any long-standing suicidal ideation or symptoms suggestive of a major depressive disorder. He referred to a degree of depression in relation to the 'Q' fever episode, but no lasting symptoms. He did report sleep disturbance from late December 2002 onwards.
>
> Dr Warhurst documented the fact that Christopher had *"hopes and plans for the future",* and that he had maintained a number of activities and interests. He did not document any psychotic symptoms or suggestion of other major psychiatric disturbance. There was reference to a history of suicide in one uncle. He did not report any alcohol abuse or dependence, and acknowledged some regular cannabis use.
>
> Dr Warhurst concluded that Christopher had a *"situational crisis with impulsive overdose".* He offered a differential diagnosis of dysthymia and adjustment disorder with depressed mood. He considered that there was no evidence of major depression and that there was no indication for admission to a hospital or use of antidepressant medication at that stage. He considered that Christopher was not a suicide risk at that stage'
> (Exhibit C17a, p2)

9.2. According to Dr Davis the assessment documented by Dr Warhurst was "thorough and thoughtful". He regarded the conclusions reached by Dr Warhurst as reasonable. He considered that the discussion with Christopher and his parents and the management plan adopted was also appropriate.

9.3. Dr Davis also reviewed the records of Christopher's presentation to Dr Watson on 30 June 2003. He took into account what Dr Watson said in his first statement about this consultation. He formed the view that Dr Watson's notes failed to provide a detailed summary of the mental state assessment that might have been made and failed to detail the extent of Christopher's suicidal ideation.

9.4. According to Dr Davis, when Christopher presented to Dr Watson reporting reckless driving, this should have suggested 'a degree of considerable impulsivity and risk-taking behaviour, that may well have been a manifestation of significant suicidal intent'. In Dr Davis' view, a more intensive follow-up plan was required than that adopted by Dr Watson. Arrangements for follow-up by a Community Mental Health Service or alternatively a referral to a psychiatrist would have been appropriate. Dr Davis elaborated as follows:

> 'While Dr Watson stated that he did not consider Mr Merritt to be a danger to himself at that stage, I consider that the presentation of an agitated, depressive state and the report of extreme risk taking behaviour suggested otherwise, and a need for a more assertive intervention. This may have enabled Mr Merritt to work through his situational difficulties and deal with what I presume were overwhelming suicidal impulses in the context of another reactive depressive state.'

However Dr Davis did not identify in the material available to him a history suggestive of a major depressive disorder or other severe psychiatric illness which

would have warranted intensive psychiatric treatment. Dr Davis summarised his opinion as follows:

> 'I consider it is likely that Mr Merritt had a degree of personality vulnerability to rejection and loss and, therefore, experienced difficulties with the break-up of intimate relationships. It seems that these episodes triggered reactive depressive states, which tended to stabilise with the passage of time and psychological adjustment to the fact of separation.'
> (Exhibit C17a)

9.5. When asked to comment upon the decision to prescribe Cipramil, Dr Davis expressed the following view:

> 'Well, I think again this seems to have been an acute onset depressive state from what I've read. There is a place for anti-depressants in such situations. Not always and they don't always work because you're dealing with a reactive state rather than a prolonged depressive state that the drugs are particularly helpful for. But it's a reasonable thing to do I think if you're worried and you might say well I'll cover my bets on that front to try and deal with the depressive element as I can with tablets and hopefully pursue other things.' (T109-110)

9.6. In an interview with Senior Constable Paul Gross, conducted on 15 November 2004, Dr Watson was given an opportunity of commenting upon the opinions expressed by Dr Davis in his report in which he suggested that a more assertive follow-up plan would have been appropriate after the consultation on 30 June 2003. According to Dr Watson, when he read Dr Davis' report reviewing the presentations to the FMC it was the first time that he learned anything about those previous presentations. Dr Watson acknowledged the criticism that his notes of the consult did not offer a detailed summary of the mental state assessment and the extent of suicidal ideation expressed by Christopher. He explained that he was frustrated that he did not record what occurred and stated that he would normally have recorded more. He elaborated as follows:

> 'The fact I didn't makes me really, it just confirms what I recall of the conversation, I wasn't particularly concerned while chatting, there was cordial exchange, I'd like to think I did ask him those sorts of things, but I can't remember and I didn't record it unfortunately. But my notes do not reflect, I agree, I agree with him. I didn't, I really just did not pick him as being a serious threat, it was a very big surprise to me.'
> (Exhibit C15b, p3)

Dr Watson explained that he would have arranged a more intensive follow-up if he had a more serious view of Christopher's condition. He explained the situation as follows:

> 'I mean I would've arranged it if I seriously considered he was a threat. I just didn't think so, on reflection that was a poor error or poor judgement call.'
> (Exhibit C15b, p4)

Overall, Dr Watson stated that he agreed with the criticisms made by Dr Davis in his report (Exhibit C15b).

9.7. It was subsequently pointed out to Dr Davis before the Inquest, that at the time of Christopher's presentation on 30 June 2003, Dr Watson was unaware of the previous presentations to the FMC. Dr Davis was asked to consider whether this might have influenced Dr Watson to regard this presentation as a "one off episode" rather than forming part of a pattern of reckless and impulsive behaviour. Dr Davis read the transcript of the interview in which Dr Watson highlighted the fact that he did not have all of the relevant material that he might have had for his appraisal of Christopher's suicide risks on 30 June 2003. Notwithstanding this additional information about Dr Watson's limited knowledge at the relevant time, Dr Davis remained of the same opinion that the follow-up by Dr Watson should have been more assertive and that his assessment "underestimated the seriousness of the crisis that Mr Merritt confronted at that point in time." (Exhibit C15b, C17b)

9.8. When Dr Watson gave evidence on this topic at the Inquest, he retreated from the concessions made during the interview with Senior Constable Gross that he had exercised poor judgment during the consult with Christopher. He explained that on reflection, had he been aware of the information concerning the three previous presentations at the FMC, he would not have altered his assessment of the situation on 30 June 2003 (T75).

9.9. When asked by his counsel what difference the extra information might have made to his actions that day, Dr Watson gave the following answer:

> 'I have now pondered this for a long time. At the end of the consultation process I was certainly of no concern that he was, at that stage, suicidal. I also thought his depressive illness was fairly mild. I don't think that letter would have changed my conclusion. How I would have acted is difficult because I now know of course that Chris committed suicide two or three weeks later. Forgetting just for the moment the suicide thing I feel now at the time the way I would have preferred to have treated Chris was not really the antidepressant. I think I alluded to that earlier. I think the ACIS number, 'follow-up if you have another crisis' was probably a better way to go. I suspect that's what I would have done, that is, encouraged him to seek help if he had another crisis and I think that's the way I would have dealt with his problem.'

9.10. An additional statement signed by Dr Watson on the same day he gave evidence at Inquest, was introduced into evidence to supplement Dr Watson's oral testimony. Dr Watson claimed in this statement, that he would not have referred Christopher to Assessment and Crisis Intervention Service (ACIS) because he did not present as a sufficiently serious problem. He elaborated as follows:

> 'In retrospect, I do not know whether that would have made any difference. Even if I had reinforced going to ACIS, or returning to me, I doubt he would have done so on the occasion of his suicide.'
> (Exhibit C15d)

9.11. Having considered Dr Watson's evidence on this topic, I have no confidence that he would have emphasised counselling or arranged more vigorous follow up if he had been aware of Christopher's history at FMC.

10. What information was available to Dr Watson as of 30 June 2003

10.1. Dr Watson's notes concerning his consults with Christopher Merritt, were seized under a Coroners Warrant on 6 February 2004 as part of the investigation into Christopher's death. Amongst the small collection of documents in Dr Watson's file was a three-page document which referred to Christopher's presentation to the FMC on 12 February 2003. The first page is an unhelpful computer generated cover sheet carrying the description 'ED Discharge Summary', which is said to be a document generated as part of an audit process undertaken at the hospital. This page bears the initials of Dr Watson. Dr Watson conceded in evidence that he must have seen the document before it was placed into Christopher's file, but he had no memory of receiving it or reading it (T62).

10.2. The next two pages are photocopies of the first two pages of handwritten notes made by the RMO in the Emergency Department at FMC on 12 February 2003. I find that these two pages of handwritten notes contain enough information for an experienced general practitioner such as Dr Watson to learn that Christopher had presented to FMC on 12 February 2003 after taking an overdose of Temazepam and that Christopher felt suicidal regarding problems concerning his ex-fiancé. The notes also covered the fact that Christopher was to be monitored in the Emergency Department and have a psychiatric review that evening or next morning (Exhibit C15).

10.3. For some reason, Officer Paul Gross did not realise when he interviewed Dr Watson in November 2004, that the three pages of discharge documents were in Dr Watson's file, even though the file had been seized some nine months earlier. When Senior Constable Gross went back to Dr Watson to discuss the document on 21 February 2005, Dr Watson explained that he was not aware of the document in the file because it had been placed at the back of the file. He explained that he would have expected the document, given its date, to have been filed by staff at the front of the file. In evidence, Dr Watson stated that when this document was pointed out to him, he was completely surprised by it and he was certain that he did not see it when he assessed Christopher on 30 June 2003 (T62, T72).

10.4. Dr Watson explained that he had previously worked at a practice in Morphett Vale with three other doctors but was forced to close the practice when the other full-time doctors left and he was unable to find replacements. With approximately 10,000 patients to service, he struggled to cope and was assisted by one other part-time doctor for a while. He decided to abandon the practice and to join a new one at Oaklands Park. According to Dr Watson, in about March 2003, he put arrangements in place to close the Morphett Vale practice and to transfer all of his patient files to the Marion Domain Medical Centre. He arranged for all mail for the old practice to be held at the post office and he provided a list of patients to be notified of the changes to staff at the new practice.

10.5. Dr Watson explained that he decided to take advantage of the changeover in his practice by having a two-month break, but during this time he and his secretary regularly went through the material being forwarded to the post office. He explained that there was a very large amount of material to go through and he initialled the documents to indicate that he had been made aware of them. Dr Watson claimed that he kept the documents in a box and arranged for them to be filed by clerical staff at the new practice after he commenced there on 2 June 2003 (T72, T84).

10.6. According to Dr Watson, when he commenced at the Marion Domain Centre at Oaklands Park, he was obliged to use a new computerised record system. All old patient hard copy files were retained, but all new consults were recorded electronically. Dr Watson explained that the system operating at Oaklands Park, did not enable patients to make appointments. They were required to wait in turn. He estimated that Christopher may have waited for half an hour to see him. In evidence,

Dr Watson was questioned about whether or not he would have had the hard copy file for Christopher with him when he saw him on 30 June 2003. Dr Watson responded that 'I would like to think I had the file' (T64). He conceded however that it was possible that he did not have it (T96). Dr Watson explained that the changeover between practices was a relatively 'chaotic' period and that things did not go smoothly.

10.7. As far as the three page document from the FMC is concerned, Dr Watson suggested that it was unlikely that it would have been in his file, when he saw Christopher because in his experience, documents such as that take at least three weeks to make their way to general practitioners. Dr Watson suggested that it would not have been received and filed while he was still practising at Morphett Vale.

10.8. Evidence was called from the Director of the Emergency Department at FMC, Dr Diane King, who explained the procedures for the provision of information to general practitioners following presentations such as that occurring with Christopher Merritt in February 2003. According to Dr King, because Christopher was not admitted to the hospital, no formal discharge summary would have been prepared. Because Christopher was classified as a 'short stay' patient in the Accident and Emergency Department, the procedure followed at that time involved a portion of the doctor's hand written entries being photocopied and attached to a covering sheet which was posted to the relevant general practitioner, normally within about three days of presentation at the Emergency Department. Dr King examined the three-page document located in Dr Watson's file concerning the presentation on the 12 February 2003 and identified it as an example of the type of document that would have been sent to the general practitioner and would have been received within a few days of 18 February 2003 (T50). Whilst Dr Watson claimed that it is unlikely that he received these documents at his old practice, I am prepared to accept on the basis of the evidence from Dr King, that the three-page document was received at Dr Watson's practice at Morphett Vale before he ceased working there. Because Dr Watson was under extraordinary pressure towards the end of his time at Morphett Vale, I would not be surprised if the documents were quickly noted without taking in any detail and were left for staff to file. The evidence does not enable me to determine whether the document was in Christopher's file on 30 June 2003. If there is fault in incorporating this important document into Christopher's file in a timely

fashion, then it is explicable by virtue of the 'chaos' which surrounded Dr Watson's final period at Morphett Vale and his efforts to keep up with the mail generated from the Morphett Vale Practice in the period between March and June 2003, when he was trying to have a break.

10.9. In addition to the three-page discharge summary, a small slip of paper referring to the same presentation in February 2003 at the FMC made its way at some point into Dr Watson's hard copy file. Dr King explained in evidence that this was the type of document generated automatically from the FMC by a clerical officer simply to alert general practitioners to the fact that one of their patients had presented to the hospital. She explained that it was routinely faxed to the general practitioner after midnight on the day the patient presented (T18). Dr King explained that in Christopher Merritt's case, the document recorded his presentation at the FMC on 12 February 2003 at 7:33 pm for a 'situational crisis' and that he was discharged home on 13 February 2003 at 12:22 pm. The slip of paper found in Dr Watson's file, also carried his initials. Dr Watson acknowledged that he would have seen the document, but not surprisingly, given the number of patients he had been dealing with at the time, he had no recollection of it and was not sure what significance he would have attached to it. Dr Watson acknowledged that it would have been received at his Morphett Vale practice while he was still working there (T20).

10.10. There was some discussion in evidence with Dr King, concerning the quality of information that was provided to general practitioners by way of these computer generated slips of paper, together with the additional material concerning 'short stay' patients at the FMC in the Accident and Emergency Department. I say more about this topic later in these findings.

11. Revised opinion of Dr Davis concerning Dr Watson's consult on 30 June 2003

11.1. In Dr Watson's statement provided during the course of his evidence he set out in more detail the type of assessment that he considers that he would have made of Christopher when he saw him on 30 June 2003. Whilst Dr Watson freely acknowledged that his notes were inadequate and he had difficulty recalling details of the assessment, he sought to reconstruct what he believed would have happened based upon his usual practice. The following is an extract from the twelve page statement:

> 'I believe, following my usual practise, I would have explored the matters I recorded.

> In relation to the topic of tearfulness, I believe I would have, as usual, explored frequency, context, changed behaviour etc. I would probably have started by asking questions about his work to stimulate that discussion.
>
> In relation to the sleep issues, I believe I would have looked for patterns of sleeplessness, changes, how it related to energy and spontaneity etc.
>
> In relation to suicidal ideation, I believe I would have discussed his thoughts, the strength of them, whether they were ongoing, whether he had made plans, whether he had them before etc.
>
> I can recall discussing the driving with him and concluding that it was impulsive behaviour. I believe I tried to explore what if anything lay behind the impulsive behaviour and my recollection is that there was nothing revealed.
>
> I did not perform a Mental State Examination, but an informal Mental State Examination always happens as a part of a consultation of that nature. I am always assessing demeanour, dress, state or agitation etc. I would conduct a formal Mental State Examination if I suspected psychosis.
>
> I have a distinct memory that at the end of my conversation with Christopher I assessed his functioning as relatively normal. He was by then, calm and responsive. I remember feeling that I could not really work out why he was seeing me, because it did not add up to the state he reported before he saw me. There was no crisis or particular situation or element I could identify. Whatever it was that had upset him was not specific or continuing or outside general life experiences. I did not believe he was a danger to himself or others.'
>
> (Exhibit C15d)

11.2. This statement, which was clearly produced in response to Dr Davis' criticisms, was provided to Dr Davis to enable him to consider whether this version of events caused him to alter his opinion about the adequacy of Dr Watson's management of Christopher on 30 June 2003. Having reflected on the additional statement and the thrust of the evidence provided by Dr Watson during the Inquest, Dr Davis maintained his view that a more prompt follow up was indicated. When asked if the presentation warranted referral to a psychiatrist, Dr Davis gave the following answer:

> 'Well, I thought on the data I had initially especially in view of the reckless driving that this man needed to be, just followed up more swiftly be it by the practice or a community service or a psychiatrist. I didn't feel strongly it had to be a psychiatrist having understood that there was not an ongoing agitated depression or psychotic state or overt suicidal state.' (T110)

By prompt follow up, Dr Davis stated that there should have been follow up within one week. Dr Davis maintained that there should have been better notation and considered that it would have been appropriate to engage with Christopher's parents. Dr Davis summarised his qualified opinion as follows:

> 'But as I say, the impulsivity issue is such that it may well have settled and it may be that two weeks later there was another crisis. And you can't even the best (sic) even if he was contained in hospital, it doesn't necessarily mean we'd prevent that outcome. But you do your best to put a safety net around people. So my point probably would have been a more rapid follow up either back at that clinic or at one of the mental health clinics. And just as you were talking, given his link with the family, maybe engaging his parents to alert them and say 'right, you need to be watching'.' (T124-125)

11.3. I accept the qualified opinions expressed by Dr Davis concerning the adequacy of Dr Watson's assessment and handling of Christopher on 30 June 2003. Whilst I have some reservations about how much one can rely upon Dr Watson's reconstructed version of events, I am prepared to accept that Dr Watson's assessment was more comprehensive than his very brief notes suggest.

12. Could Christopher Merritt's death have been avoided?

12.1. According to Dr Davis if a more assertive intervention plan had been instituted by Dr Watson it may have enabled Christopher to work through his "situational difficulties" (C17a). The evidence concerning Christopher's various presentations of threatened self-harm to the FMC illustrates an ongoing pattern of behaviour. The first three episodes concerning Panadeine, Pyrethrum and Temazepam were reasonably regarded as a relatively low risk. However, the subsequent presentation to Dr Watson was potentially a much more serious sign. I find that it is regrettable that the issue that led to this impulsive, potentially dangerous behaviour was not documented or followed up with any formal plan for ongoing medical support or counselling. Mr and Mrs Merritt were clearly concerned for their son's welfare but had limited success in getting him to seek help and engage in counselling. Yet the episode concerning overdose of Temazepam suggests that when Christopher was examined by the medical practitioners at FMC, he was willing to engage and provide information about the episode and how it was triggered. Whilst it appears reasonable for Dr Warhurst at the FMC to release Christopher into the care of his parents, in the knowledge that they were aware of his self-harming behaviour, the same cannot be said about the presentation to Dr Watson. Dr Watson acknowledged in evidence that he had a very good relationship with Christopher's parents and if he had thought of it, he could have gained Christopher's permission to consult with his parents and involve them in providing some form of safety net following his consult on 30 June 2003. But given the previous unsuccessful attempts to help their son, one could never be confident that this would have altered the outcome.

12.2. Medical practitioners are not able to force reluctant patients to make or attend follow up appointments, engage in counselling, or to follow advice given. They have enough difficulty dealing with those who come willingly to see them. I find however that when Christopher Merritt did finally make contact with Dr Watson, it was incumbent upon the practitioner to ensure that he had his records before him and that he perused them at least in a fashion that enabled him to identify any relevant history of depression. If he had done this, the discharge documents from the FMC for February 2003 would have become apparent, assuming they had been filed by that time. Additionally Dr Watson should have been able to remind himself that Christopher had previously struggled with feelings of depression following his bout of 'Q' Fever. By not reflecting on all of the available information, Dr Watson was inclined to view Christopher's reckless driving behaviour as a 'one off' episode which quickly resolved. I find that if he was aware of the previous presentation in February 2003 which resulted in Christopher being assessed by a psychiatric registrar, he may have questioned Christopher more carefully about his impulsive self-harming behaviour and may have learned about previous episodes of self-harm. Had he done so, Dr Watson may have realised that a disturbing pattern was developing featuring impulsive reactions to personal stressors. I find that if he was aware of the additional information, Dr Watson may have adopted a more serious view of Christopher's behaviour, despite his claim in evidence to the contrary.

12.3. It appears that no-one had successfully managed to direct Christopher into any form of counselling which may have given him strategies to deal differently with his personal problems and situational crises. Because he was never regarded as having a serious depressive illness, and because he appeared to settle down quickly between episodes of impulsive behaviour, he slipped through the 'safety net'. The fact that he did not take the Cipramil prescribed by Dr Watson tends to confirm his reluctance to follow advice when given. Even if Dr Watson had taken a more serious view of Christopher's condition and had instituted a more formal plan for follow up, one could never be confident that Christopher would have co-operated with the plan.

12.4. It is acknowledged that general practitioners have limited choices when dealing with patients such as Christopher Merritt. The choices are dictated largely by whether or not the patient is regarded as acutely suicidal. If Dr Watson had access to a social worker or psychologist conveniently linked to his practice, he may have been able to

seize the opportunity when Christopher was in his surgery to immediately arrange a session to provide some valuable counselling or a referral to another appropriate agency. Allied health workers such as psychologists, social workers and nurses may provide valuable support in this regard, where patients who have contemplated suicide, are not classified as acutely suicidal, but the general practitioner nevertheless feels uneasy about letting them leave the clinic alone. The advantage in having this type of support would be that the nurse or social worker for example, could contact patients to encourage compliance with follow up strategies. Whilst ACIS is a potential resource for some patients, the organisation is known to be under pressure (T100). A more immediate and accessible option ought to be available for general practitioners in Dr Watson's situation. Some support for this concept has been articulated by the Federal Minister for Health, Tony Abbott, during the 8th Annual Health Congress, in an article published in the Medical Observer Weekly, 10 March 2006 entitled "Share the GP load: Abbott backs allied health workers".

13. Access to a lethal weapon

By the time of Christopher Merritt's tragic death, it must have been obvious to his parents that he had a number of episodes of depression featuring impulsive self-harming behaviour, which required medical intervention. They must also have realised that he was resistant to attempts to intervene and to engage in counselling services. It was therefore particularly important that they take reasonable steps to minimise any opportunity for their son to engage in self-harming activities. If it was Mrs Merritt who persuaded her son to see Dr Watson after he revealed that he had been driving recklessly and at high speed on or before 30 June, 2003, then she acted appropriately in the circumstances. Mr and Mrs Merritt realised that Dr Watson had prescribed anti-depressants for their son. In these circumstances, if Mr Merritt had thought about it, he would have realised that a lethal weapon in the home would pose a potential danger for Christopher or someone else. Douglas Merritt knew that the weapon was in the house. He should have realised that his son would be capable of using it once he found it. No doubt Douglas Merritt will be plagued with feelings of regret about this for the rest of his life. This tragic death should also serve as a sobering lesson for all those who have weapons in their homes, regardless of their intended purpose or efforts made to secure them.

14. Provision of discharge summaries by the Flinders Medical Centre

Dr King explained that if Christopher had presented to the FMC today he would have been admitted to the Emergency Extended Care Unit and when he was discharged, a formal discharge summary would be prepared and provided to the treating general practitioner. This is a welcome improvement. It is incumbent upon general practitioners to ensure that upon receipt of these documents, they are filed or processed in a timely fashion in such a way as to enable them to refer to the documents when they next see the patient (T32).

15. Recommendation

In accordance with the provisions of Section 25 (2) of the Coroner's Act 2003, the following recommendation is made in anticipation that it might prevent or reduce the likelihood of or recurrence of an event, similar to the event, the subject of this Inquest.

1. That the Minister for Health consider ways in which allied health professionals might be encouraged to work closely with general practitioners with a view to providing social and psychological support to those patients requiring it.

Key Words: Gunshot wound; Head injury; Hospital treatment; Psychiatric/Mental illness; Self-inflicted injury

In witness whereof the said Coroner has hereunto set and subscribed her hand and

Seal the 22nd day of June, 2006.

Coroner