



FINDING OF INQUEST

An Inquest taken on behalf of our Sovereign Lady the Queen at Adelaide in the State of South Australia, on the 27th day of September 2018 and the 8th day of March 2019, by the Coroner's Court of the said State, constituted of Mark Frederick Johns, State Coroner, into the death of Michael David Bird.

The said Court finds that Michael David Bird aged 43 years, late of 5 Lowana Terrace, Taperoo, South Australia died at Taperoo, South Australia on the 11th day of September 2018 as a result of neck compression due to hanging. The said Court finds that the circumstances of his death were as follows:

1. Introduction and cause of death

1.1. Mr Michael David Bird was 43 years of age when he died on 11 September 2015 at his home address in Taperoo. A post-mortem was conducted by Dr John Gilbert from Forensic Science South Australia in relation to Mr Bird's death. In his report Dr Gilbert provided the cause of death as neck compression due to hanging¹, and I so find.

2. Reason for Inquest and background

2.1. Mr Bird was the subject of a home detention bail agreement at the time of his death. As Mr Bird died at his specified place of detention his was a death in custody within the meaning of that expression under the Coroners Act 2003 and this Inquest was held as required by section 21(1)(a) of that Act.

2.2. Mr Bird had a son who was born in 2001. This was from a relationship which had subsequently broken down. Mr Bird had shared custody of his son, although the details

¹ Exhibit C2a

of that are not clear. At the time of his death he was in a relationship with another woman with whom he lived. There is evidence to suggest that just prior to his death Mr Bird was in communication with a woman from a previous relationship. These communications have relevance in the context of Mr Bird's death that I shall come to in a moment.

- 2.3. Mr Bird had a history of anxiety, depression and chronic back pain for which he had been seeking treatment. His general practitioner was Dr David Wong and he also was seeing a clinical psychologist, Mark Cox and a psychiatrist, Dr Richard Thompkins. At the time of his death he was prescribed Seroquel, Quetiapine, Ativan, Pregabalin² and Duloxetine.
- 2.4. Mr Bird was involved in a motor vehicle accident in July 2014 for which he was receiving treatment for headaches and neck and shoulder pain. He sought treatment from Dr Wong for these complaints. He was also making a claim under WorkCover. Mr Bird was unemployed at the time of his death. Mr Bird had some prior criminal antecedents, including aggravated and common assault and some traffic convictions.

3. The events of 9 April 2015

- 3.1. Constable Benjamin Foreman of SAPOL³ was tasked to Mr Bird's Taperoo address on 9 April 2015. The tasking was for a man who had cut himself and was making threats of self-harm. Upon arrival Mr Bird was threatening police with two knives and making further threats to use a shotgun (but no such weapon was ever sighted, nor were any firearms seized). Mr Bird was disabled using an electronic taser and detained under the Mental Health Act 2009. He was conveyed by ambulance to the Queen Elizabeth Hospital where he was assessed and released.
- 3.2. Once returned to police custody Mr Bird was refused police bail and was brought before a Magistrate on 20 May 2015. A home detention bail report was ordered, as well as a bail inquiry report, to assess Mr Bird's suitability for bail. He was remanded to Yatala Labour Prison before being brought back before the Magistrate on 4 June 2015. Mr Bird was granted home detention bail⁴. The usual home detention conditions were imposed, as well as conditions to remain under the psychiatric care of Dr Thompkins,

² Pregabalin is an anti-epileptic medication, but can also be beneficial to persons suffering from anxiety – Mr Bird did not suffer from epilepsy

³ Exhibit C12a

⁴ Exhibit C15d, Bail Agreement

to attend not less than weekly appointments with Dr Thompkins, and to authorise Dr Thompkins to inform Community Corrections of any deterioration in Mr Bird's mental health.

- 3.3. Ms Debra James⁵ was Mr Bird's home detention case manager. She gave a chronology of contact that Mr Bird had with Community Corrections through his home detention officer. There were approximately 40 occasions of contact in the period between his release on bail and his death. These contacts related mostly to passes being provided to Mr Bird so that he could attend psychiatric appointments. There is no record of non-compliance with his bail agreement, although there are some references to devices running out of charge and his warnings in relation to this.
- 3.4. As to the psychiatric appointments, a letter dated 3 August 2015 to Mr Bird's lawyer is contained within the case notes of Dr Thompkins. In that letter Dr Thompkins notes that there have been weekly psychiatric visits and he described Mr Bird's compliance with this aspect of his bail agreement as faultless. Dr Thompkins indicated that the weekly visits with Mr Bird during this period of time had been of considerable benefit and there was cause to adjust Mr Bird's medication over the period of those visits. Dr Thompkins was of the view the Mr Bird was no longer exhibiting any anti-social behaviour and had gained psychiatric stability. He believed that Mr Bird was not a risk to himself or to others. That letter was written approximately one month prior to Mr Bird's death.
- 3.5. There is nothing in either the home detention case manager's statement or the records of Dr Thompkins to suggest that Mr Bird was showing any signs of suicide or self-harm. There is a history of alcohol abuse, however there is nothing to suggest that whilst on home detention bail Mr Bird abused alcohol, although the post-mortem report indicates alcohol in his system at the time of his death⁶. Mr Bird was the subject of usual urinalysis testing that is required on home detention bail and all were negative.
- 3.6. The case notes of Dr Thompkins reflect that Mr Bird attended his rooms for an appointment on 10 September 2015. Dr Thompkins did not record any concern in the appointment. The following day Mr Bird had a telephone conversation with Ms Benham, his ex-partner, with whom he had remained in contact. Her statement⁷

⁵ Exhibit C8

⁶ Exhibit C3a.

⁷ Exhibit C7 Toxicological analysis found .091% of alcohol in Mr Bird's blood.

reflects that a number of topics were raised, including plans that Mr Bird had for the future with inheritance money from his father. Ms Benham describes Mr Bird's mood as good and positive. There was also discussion about their respective current partners.

- 3.7. It was when Ms Benham told Mr Bird of her intentions of moving in with her current partner that she described the conversation as taking a slide and it ended shortly after Mr Bird told Ms Benham not to move in with her current partner. At the conclusion of the conversation Ms Benham received two emails from Mr Bird asking for reconciliation. Ms Benham stated that she deleted these two emails, however later that evening she received two further emails, which were not deleted; one stating, 'No one will ever love you like I always will' and the second attaching a picture of Mr Bird in his garage⁸.
- 3.8. Approximately 15 minutes later Ms Benham recalled in her statement that she received a distressed a phone call from Mr Bird's current partner informing her that Mr Bird had taken his life.
- 3.9. In her statement⁹ Mr Bird's partner, Ms Whysall, detailed that on the day of his death he had received a pass out in the morning and had gone for a motorbike ride. He also told her that he had been to the pub with his friends and had brought home some longnecks of beer. Ms Whysall suspected that Mr Bird had been speaking to his ex-partner.
- 3.10. Later in the afternoon Ms Whysall could not find Mr Bird. It was then that she noticed the garage was locked. Ms Whysall sought assistance from her neighbour who assisted with a pair of bolt cutters to gain access to the shed. He provided a statement to the Court describing cutting the padlock to the chain on the internal side of the shed to gain access.
- 3.11. He also described cutting the electrical cord that was around Mr Bird's neck. The ambulance service was called, as were police, however Mr Bird could not be resuscitated.

⁸ Annexed to Exhibit C7

⁹ Exhibit C19

3.12. The scene was examined by crime scene examiners and there were no suspicious circumstances found.

4. Conclusion

4.1. I find that Mr Bird took his own life by hanging and there was no evidence of any warning signs that Mr Bird would harm himself, certainly not from those monitoring him either psychiatrically or through Community Corrections.

5. Recommendations

5.1. I have no recommendations to make in this matter.

Key Words: Death in Custody; Suicide; Home Detention Bail

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

Seal the 8th day of March, 2019.

State Coroner