MAGISTRATES COURT of TASMANIA

CORONIAL DIVISION

Record of Investigation into Death (Without Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

(These findings have been de-identified in relation to the name of the deceased, family, friends and others by direction of the Coroner pursuant to s. 57(1)(c) of the Coroners Act 1995.)

I, Rod Chandler, Coroner, having investigated the death of Miss N

Find:

(a) Miss N died in October 2009 at Burnie in Tasmania.

(b) Miss N was aged 20 years at the time of her death.

(c) Miss N was a single person.

(d) Miss N died as a result of injury caused by hanging.

(e) No person contributed to the cause of Miss N's death.

Circumstances

1. Miss N was the eldest of four children. The family lived in the west and northwest of Tasmania. During her school years Miss N performed very well academically, in sport and in other areas.

2. Miss N displayed some early but mild signs of compulsive obsessive behaviour. However, as she became older her symptoms became worse. When she reached grade 8 or 9 she began exercising excessively and she developed an eating disorder. She was referred to a child psychologist. Nevertheless, the effects of the disorder became more pronounced over the next couple of years. In April 2005 Miss N's mother took her to the Bronte Centre in Melbourne for advice. Initially the financial demands of admission were too great, but because her weight was dangerously low she was, with the assistance of others, able to attend for a period. The program and the follow-up therapy were to positive effect and Miss N made good progress. However, the course of this treatment imposed considerable emotional and financial strain on her family. The relationship between Mr and Mrs N deteriorated.

3. Miss N returned to school and obtained part-time work. However, by the beginning of 2006 her eating disorder returned. Another 8 week admission to the Bronte Centre was

completed, again with financial assistance from others. Again it had positive effect and Miss N seemed to manage well at college although the family relationships remained difficult.

4. In 2008 Miss N commenced a relationship with a boy which turned out to be unsatisfactory. In November 2008, while studying for exams, Miss N took an overdose of medication she found at home. She was taken to hospital and although initially reluctant, was admitted and monitored for a day or two.

5. Following that episode Miss N was referred to a psychologist in Burnie. She was able to complete her exams at the end of 2008 and in early 2009 she started another relationship. Her relationship with her mother became more distant and she spent less time at home. Her mother found her a flat but did not approve when her boyfriend moved in because their relationship was problematic.

6. Just after Miss N's birthday, in 2009 she separated from her boyfriend and found out she was pregnant. She underwent a termination. She was in contact with her parents who were trying to support her but her life was chaotic. She had problems with finances and was abusing alcohol. In 2009, after an argument with her boyfriend and while drunk, she threatened suicide in the presence of her mother. Later the same night she took an overdose of her brother's Ritalin and other substances. She was taken to hospital unwillingly. She was treated and admitted for about 3 days. The apparent plan was for Miss N to receive follow up treatment at the Parkside Clinic.

7. Mrs N made unsuccessful inquiries about further treatment. Then in early October 2009 Miss N found a full time job in Devonport, which she enjoyed and her mood seemed to markedly improve. At this time she was living in Burnie.

8. In 2009 Miss N went to the Beach Hotel in Burnie to celebrate the birthday of a friend. She became drunk and then angered by the presence of her former boyfriend. They argued and she became upset. One of her friends took her home and stayed to keep an eye on her until 11.30 am the following day. On that day Mrs N arrived at about 8.00 am. She described Miss N as stressed, still affected by alcohol and *"as if she was racing, talking really fast about what happened the night before."* She offered to take her to her home but Miss N declined and Mrs N left.

9. At about 1.30 pm Mrs N received a text message from one of her daughter's friends to the effect that he had received a 'goodbye message' from her. Unable to contact her daughter by phone Mrs N returned to her house. She arrived at around 2.00 pm. She found her daughter had hung herself. Mrs N lifted her daughter down, called "000" and commenced CPR. The police attended and assisted with resuscitation attempts until ambulance officers arrived. The ambulance officers made further attempts to resuscitate Miss N but were unsuccessful.

The coronial investigation

10. The primary focus of an investigation is to seek out and record the facts concerning the death of a person. It is a fact-finding exercise of an inquisitorial nature. The facts which are relevant are those which may enable findings about the matters the Act requires the coroner to, if possible, determine. It is not the function of an investigation to attribute any

moral or legal responsibility or liability for a death or to hint at blame. It is not a means of apportioning guilt. A coroner is to determine facts. The facts, once determined, will speak for themselves and it is for others to, if necessary, draw legal conclusions.

11. The coronial investigation was initially conducted with the assistance of Tasmania Police. The investigating officer interviewed and took statements from a considerable number of Miss N's family members and friends and, of course, investigated the scene where Miss N was found. There is no evidence suggesting the physical involvement of another person in the cause of Miss N's death.

12. The investigation has also involved examination of the medical records of the North West Regional Hospital and reports from Dr Jennifer Tudehope as the Clinical Director of Mental Health Services North West and from Dr A B Owen the current Acting Clinical Director of North West Mental Health Services. The reports indicate:

    - Miss N's early contact with Child and Adolescent Mental Health Service was from February to May 2005.

    - Following her discharge from hospital in November 2008 an appointment was made for Miss N to attend the Adult Outpatient department on 24 November. She attended with her mother and was reportedly uncooperative. Nevertheless, Miss N did later attend a psychologist at the department who had experience in the treatment of eating disorders. She began a course of treatment and was reportedly making good progress. However, the psychologist fell ill and the treatment ended.

    - In May 2009 a decision was taken for Miss N to be referred back to her general practitioner with the suggestion that she arrange referral to a private psychologist. Miss N was advised of this decision by letter when she could not be contacted by phone.

    - There was a short delay in arranging follow-up treatment for Miss N following her discharge from hospital in late August 2009. However, in September 2009 she attended an appointment at the Parkside Clinic. The record of that attendance states:

      "Miss N reports a recent break-up with partner, she also has recently terminated a pregnancy which when speaking about becomes teary. Sleep good, energy level good. Miss N is motivated to attend her part time job in aid [sic] to save money and pay debt back to her parents. She recently attended a personal trainers training centre in Victoria which she wants to study with when she has sufficient funds to pay for the course. .Miss N reports to have good family support & a few close friends. She denies any suicidal ideation, plans or means. . .Miss N identified that in crisis situations she is impulsive and this is when she disengages from seeking appropriate support from family & friends."

    - A management plan was then made for the Clinic to provide support to Miss N for up to a month while attempts were made to link her with private psychological services. Thereafter two unsuccessful attempts were made to contact Miss N by phone, the last being in late September 2009. It seems clear that no arrangement was settled for Miss N to see a private psychologist.

13. The circumstances surrounding Miss N's death raised a query upon the availability and adequacy of treatment services on the North West Coast for adults suffering from eating and adjustment disorders. Upon this issue I am advised by Dr Owen as follows:

"The CAMHS (Child & Adolescent Mental Health Service) operates in Burnie & Devonport and has several staff with considerable expertise & experience in the treatment of eating disorders. They work on a family-based model and operate in tandem. Before acceptance for treatment there is a requirement for medical clearance by a paediatrician and possible admission to the paediatric ward at the North West Regional Hospital (NWRH) if medically unwell. Under-18 year-olds with eating disorders seem to me to be comparatively well provided for in the North West public sector.

There are no public adult services specifically for this group in the North West. Those judged to be medically acute are admitted briefly to a medical ward and then possibly to the adult psychiatric ward. Some with life-threatening anorexia are transferred to the Austin Hospital in Melbourne if this can be arranged. Most are discharged into the community, some to be followed up in the private sector, others – like Miss N – to the ACMHS (Adult Community Mental Health Services) from where they may be referred on to the private sector. I understand there are no ACMHS staff specifically trained in working with people with eating disorders, possibly because of chronic understaffing and relatively high staff turnover rates. In other words, adults with eating disorders do not seem to be well-catered for in the public sector apart from acute treatment. There is a recovery support group which is open to public sector patients which meets monthly at Ulverstone."

Discussion

14. I have set out the events leading up to Miss N's death in some detail to illustrate the persistent and determined attempts made by Mrs N from about 2003 up to Miss N's death to obtain medical, psychological and psychiatric treatment for her. The course of events demonstrates the extraordinary difficulty for a parent in managing the complex issues which arise from the condition from which Miss N suffered. Such conditions sometimes resolve but on other occasions do not, even with the benefit of expert and intensive assistance coupled with family support.

15. Dr Owen's acknowledgement that the North West Coast of Tasmania does not currently have in place a service to support and treat adults suffering from eating disorders is matter of real concern. It puts patients resident in the area, and I suspect on the West Coast, at a serious disadvantage in having their illness successfully treated. It leads me to **recommend** that the State's health authorities explore the viability of remedying this serious shortcoming in medical services.

Comments & Recommendations

16. I have decided not to hold an inquest into Miss N's death. The investigation has sufficiently disclosed her identity, the time, place, relevant circumstances concerning her death and the particulars needed to register her death under the *Births, Deaths and Marriages Registration Act 1999*. No other person contributed to the cause of death within the meaning of that term in the *Coroners Act 1995*. I do not consider that an inquest is likely to elicit any further significant and relevant information concerning the issues that I am

required to determine. There is no need in this case to make other comment or recommendation.

I convey my sincere condolences to Miss N's family.

Dated 9 August 2013 at Hobart in the State of Tasmania.

Rod Chandler
Coroner