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, Stephen Raymond Carey, Coroner, having investigated a death of Mr D

Find, pursuant to Section 28(1) of the Coroners Act 1995, that:

(a) The identity of the deceased is Mr D;

(b) Mr D died in the circumstances set out in this finding;

(c) Mr D died as a result of multiple fatal injuries following a fall from height onto rocks;

(d) Mr D died in July 2014 in northern Tasmania;

(e) Mr D was born in Continental Europe and was aged 57 years at the time of his death;

(f) Mr D was married and was employed at the date of death; and

(g) No other person contributed to the cause of death of Mr D.

Circumstances surrounding the death:

Mr D came to Australia with his family when he was approximately 4 years old. After completing tertiary education he was then engaged for a number of years as a groundsman/gardener in the Canberra area, concluding with a period of approximately 13 years whilst he was the head gardener and caretaker at the British High Commission in Canberra. During this time he married his wife and they had three children.

Mr D and his family then moved to Tasmania where he studied fisheries at the Australian Maritime College and then, after concluding an honours project, he commenced employment in or about 1998. He remained employed with the same employer until his death.

Although Mr D was described as always being a worrier, his mental health condition appears to have deteriorated in the approximate 12 month period leading up to his death. He expressed concerns about physical complaints relating to aging, some frustrations at his work and family issues, in particular relating to one of his sons. In early 2014, the son was arrested for the third time in relation to drink driving. Mr D was worried about the possibility that his son may be sent to prison upon conviction and he believed that his son's offending conduct reflected poorly upon him as a father. Mr D's son was determined to address his issues by ceasing the consumption of alcohol and Mr D decided to also cease consumption of alcohol in order to support his son. Up until that time Mr D had been a heavy user of alcohol. He only consumed alcohol at home and the family believed this was in the form of self-medication in respect of Mr D's attempts to deal with his worries and concerns.

Mr D was reluctant to discuss his mental health issues but at a consultation with his general practitioner, Dr Annamalai, he burst into tears and outlined to the doctor issues that were impacting upon him at that time. He was prescribed anti-depressant medication, which was noted as significant by the family as Mr D, up until that time, had always spoken of not needing medication, believing that exercise and healthy lifestyle were all that were needed to combat depression. However, Mr D did not persist with this medication as he did not like the way it made him feel. At a consultation with his general practitioner in June 2014, it was noted that he was in the process of withdrawing from alcohol, he described himself as agitated, feeling down and was having suicidal thoughts. He was prescribed Diazepam and Thiamin to manage the alcohol issues.

Following this, at the suggestion of his wife, Mr D attended a yoga ashram retreat in New South Wales, in an endeavour to address his ongoing issues. On the return flight home after this, he suffered a panic attack and apparently he was in a worse state upon his return than he had been before attending the retreat.

Mr D returned to work after a period of recreational leave and then sick leave required as a result of his mental health condition. Mr D, as part of his employment, stayed at accommodation provided by his employer where he was performing his work duties. On this evening, he attempted to asphyxiate himself. On the following day, he drove to his employer's office and, upon the return journey to his accommodation, he was involved in a motor vehicle accident. This required him to attend hospital, following which he returned to his home.

In July 2014, he attended his general practitioner in company with his wife. He reported no change in his symptoms and at that time had been away from work for 4 days, suffering insomnia and poor eating. He also reported thoughts of self-harm and confirmed that he was not supportive of taking anti-depressants. Apparently there had been further

difficulties with his son and he stated that he felt he was a burden to his family. He was referred to the Launceston General Hospital and following a mental health assessment he was admitted for inpatient care which occurred over the subsequent 5 days. It was at this time that he advised his wife about the previous attempt to end his life.

A report was received dated 30 September 2014 from Dr Ben Elijah, Clinical Director, Mental Health Services North, in respect of the inpatient stay by Mr D. In the letter of referral from his treating general practitioner, it is reported that Mr D had been unable to work due to anxiety and depressive symptoms and that these had been worsening over some 6 weeks. Dr Annamalai also referred to the prescribing of anti-depressant medication but also that Mr D had been noncompliant. When Mr D was assessed at the Emergency Department of Launceston General Hospital in July 2014, he was noted to have had suicidal thoughts, depressive symptoms, alcohol issues and noncompliance with prescribed anti-depressants. There were stressors relating to his son's third drinking driving charge with attendant insurance and financial issues, difficulty coping with a return to work and the recent motor vehicle accident when he was driving his work vehicle. He was referred for review by the Crisis Assessment Team. Upon that review, his recent mental health history was noted but also that there was a strong family history of mental disorder, including bi-polar affective disorder in a sister who had taken her own life, the deaths by suicide of a grandfather and uncle. The review concluded that Mr D had features of a major depressive illness with a concerning undisclosed recent suicide attempt against a background of strong family history of depression, deaths by suicide and past significant alcohol use. He had been noncompliant with prescribed medication and his presentation had worsened but he appeared receptive to taking prescribed medication.

Following a discussion with the on-call consultant, Dr Ulla Jonsson, it was decided that given the severity of symptoms and suicidal ideation, with impaired judgement about the nature and intensity of his illness, that Mr D be admitted under an assessment order to the Northside Psychiatric Inpatient Unit. A notation was made about category 2 observations, visual sightings at 15 minute intervals (with anti-depressant agent Escitalopram to be commenced). Additional prescribed medications were given to treat his insomnia and to manage his anxiety and agitation.

He was reviewed by the on-call consultant, Dr Jonsson, and the assessment was confirmed that he was suffering a major depressive episode with melancholic features triggered by significant psycho-social stressors and a biological predisposition. Mr D agreed to remain in hospital as a voluntary patient and the assessment order was not confirmed. A subsequent review by Dr Franco Giarraputo also in July confirmed a major depressive episode with associated recent suicide attempt and guilty ruminations. At that time, however, there was a clearing of suicidal ideation, no plan or intent and a willingness to accept treatment and management plan suggestions. It was felt at that time that there were a number of

strengths countering the impact of Mr D’s medical mental health status, including a supportive family, good employment history, ongoing interests in activities, willingness to seek help and a reasonable insight into his situation. He was still noted to have strong risk factors due to the family history and his recent attempt to end his life but he was at that time remorseful, keen and receptive of help. The plan at that stage was to arrange for Mr D to consult his general practitioner about a mental health plan to access a psychologist for cognitive behaviour therapy and upon discharge there would be follow-up in the community by the Crisis Team. Over the subsequent days Mr D was noted as largely settled and compliant with ward routine; however there were still episodes of anxiety.

Mr D was reviewed again by Dr Giarraputo in the presence of his wife and an allocated nurse. The illness and its effects on the couple were discussed as was the current treatment, education about the disorder and degree of progress. Mr D was not keen to take the option of overnight leave prior to discharge and preferred to go home at the time of his discharge. His wife was allowed to talk about the difficulties for her in relation to his recent illness and behaviours but the couple were clear about the strength of their marriage. It was discussed that Mr D’s treatment would continue to be optimised and that he would have community follow-up with a Crisis Team and that he would need to access targeted cognitive behavioural therapy to help him with his mood. In the last entry at discharge he was described as settled, polite and appropriate, with good dietary intake and interaction with staff. During the period prior to his leave he had been on unescorted leave from the ward with no issues and he was taken home by his wife. The Northside discharge care plan was faxed to his treating general practitioner, the state-wide Helpline phone triage service and the Community Mental Health Team. The care plan was a follow-up by the Crisis Assessment Team, his general practitioner and for a mental health plan so as to access a psychologist.

In July 2014 Mr D was contacted by the Crisis Assessment Team Management and he advised that he was to see his general practitioner that day to organise a mental health plan so as to access a psychologist as suggested. He reported that he was happy to be home, that he had good support and that there was no acute stress. A follow up telephone call was made four days later, which went to a message bank. Later that day he was contacted again and reported a gradual improvement, that he was sleeping well and that the initial sedation from the medication was clearing. He reported to be gradually improving and feeling more positive. The issue of appointing a case manager for him at the Community Mental Health Clinic was discussed; however Mr D was unsure of the value and felt that he would not require or utilise a case manager. He said he was stable at home, had a good relationship with his general practitioner and was allowing another week to assess the effects of the new medication. No concerns or risk issues were raised, nor were they apparent. It was organised to contact him again in 2 days’ time.

Several days later an attempt was made to contact Mr D in the morning but it was diverted to a message bank. A further call in the afternoon to Mr D's mobile and landline both went to message banks.

Mr D responded to a call on the following day and said that he was going well and improving daily. No acute concerns were expressed or evident. He advised that he was to see his general practitioner later in July and also had an appointment with a psychologist. He intimated that he did not want further calls from the Crisis Team as he was going well and had adequate support.

At a discussion at a multi-disciplinary team meeting, the case was closed.

However, Mrs D reports that Mr D spent that particular week or so pottering around the house, looking unhappy and continued mentioning that he was a burden. On the day of Mr D's death, Mrs D and her son travelled to Launceston at about 9:00am. Mr D was invited but did not wish to accompany them. Mrs D returned home with their sons at about 3:30pm. She noted that her husband's car was not at the home, and this concerned her, especially when she found a concerning note on the dining room table. She then left the home to search for her husband noting that he had not taken his wallet or phone with him. It was about 4:45pm when she left her home and travelled to a local lookout as her husband had mentioned previously that if he had a stroke she was to take him to that location and push him off the cliff. On those occasions he said this "*half-jokingly*" but her husband had worried about having a stroke given that this had occurred to his father. When she arrived at the local lookout she found her husband's car, she ran to the lookout, climbed over the fence to get to the cliff face, crawled to the edge and looked down and saw what she thought was her husband's body resting on the rocks below. She returned to her home, collected her son and tried to find a good torch before returning and endeavoured to find a means to get to the area where she thought her husband's body was. After failed attempts, at the suggestion of her son, police were contacted. Police were contacted at 7:07pm and at 8:13pm police reached Mr D's body, confirmed he was deceased and arrangements were made for the attendance of CIB and forensic personnel.

The police investigation identifies that Mr D had driven his motor vehicle to the car park at the lookout and he has then walked a distance of approximately 270m along an established walking track to the lookout. The lookout is effectively fenced. The section of steel fencing is located immediately at the lookout. This is boarded by additional timber posts and rail fencing. Additional wire fencing effectively corrals visitors to the lookout to prevent them from accidentally venturing over the edge of the cliff. Prominent signage warns of "*Dangerous cliffs. Remain within fenced areas*".

It is believed that Mr D climbed over the safety barrier and walked to the edge of the lookout. Once there he has fallen down the sheer cliff face to impact on rocky ledges and boulders below. It is clear that the impact most likely resulted in instantaneous death.

Mr D had a note in his pocket, alluding to the loss of his job.

As to this, Mr D's employment supervisor advises that the circumstances of the motor vehicle accident Mr D had in the work vehicle were that the employer intended to investigate the accident and, given that Mr D had taken the vehicle without lodging the correct paperwork, it was possible he may have received counselling in that regard but, it was the supervisor's view that this would not have adversely affected his employment status. The initial information from the police was that the motor vehicle accident was just an accident and that Mr D did not have alcohol in his blood at the time. It was the supervisor's view that, at worst, he would have received counselling in regards to submitting the correct paperwork but he would not have lost his employment position. The supervisor recalls in his last conversation by telephone with Mr D, he advised him that there would need to be an investigation of the motor vehicle accident but stated that they wished him to return to work when he was able to do so. Mr D was assured that he was a valued member and that they wanted him back to work. He says he advised Mr D he could return to work whenever he wanted but that he could take as much time as he needed to work through the issues that were impacting upon him. The supervisor felt that Mr D was stressed throughout this conversation, and Mr D rang back about half an hour later stating how he wanted his job, he thought he would be losing his job, but the supervisor assured him he would definitely not lose his job and could return whenever he liked. He says he reassured Mr D that the investigation was merely a procedure that had to occur. He concludes that he had "*never seen Mr D like this, he never really had issues at work*".

Comments and Recommendations:

This is yet another tragic incident where a person whose ability to make rational decisions has been adversely affected by their mental health state. Unfortunately, although Mr D had received appropriate intervention in an endeavour to address his mental health issues, he appears to have been reluctant to fully engage in this intervention. However in this case it does appear that the follow up support was prematurely ceased based upon the positive feedback from Mr D as to his condition. This feedback apparently did not accurately reflect the mental health status of Mr D as described by his wife. I would recommend that confirmation of a patient's self-reported mental health status be confirmed by a carer, a family member or some other person able to independently comment upon and verify the description given by the patient.

In concluding, I convey my sincere condolences to the family of Mr D.

Dated: 29 January 2016 at Hobart in the state of Tasmania.

Stephen Raymond Carey
Coroner