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)

I, Simon Cooper, Coroner, having investigated the death of Mr S

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

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

(b) Mr S died as a result of an action taken by him alone, with the intention of ending his own life;

(c) The cause of Mr S's death was asphyxia;

(d) Mr S died in bushland in Southern Tasmania;

(e) Mr S was born on mainland Australia and was aged 58 years at the time of his death; he was in a *de facto* relationship and recently retired.

In making these findings, I have had regard to the material provided to me as a consequence of the comprehensive investigation in relation to Mr S's death. That material included a police subject report, the police report of death to coroner, affidavits dealing with identification and the declaration of life extinct, an affidavit from the forensic pathologist who conducted the autopsy, the results of toxicological analysis carried out at the laboratory of Forensic Science Service Tasmania on samples taken from Mr S's body at autopsy, medical records from both the Royal Hobart Hospital and Mr S's general practitioner, and affidavits and photographs from investigating police. Perhaps most importantly I have had regard to the affidavits of those close to Mr S.

It is clear, and I find, that Mr S was suffering depression in the lead up to, and at the time of, his death. He consulted with his general practitioner and a diagnosis of depression was made, and medications to assist with that condition (and sleep) were prescribed to him. Advice was given to Mr S with respect to actions he needed to take in the event that he was actively suicidal. At the time he consulted with his general practitioner, Mr S indicated he had no suicide plan and was not actively suicidal, although he was experiencing occasional suicidal thoughts.

The next day Mr S was taken to the Royal Hobart Hospital by his partner at his own request. In the Department of Emergency Medicine he was triaged and assessed by a medical practitioner. The notes of that medical practitioner indicate that there was sufficient evidence for there to be real concerns about Mr S's safety. He was admitted to the Royal Hobart Hospital, but due to a shortage of beds in the mental health unit of the hospital, he was required to spend the evening in the Department of Emergency Medicine. In addition to the medications prescribed by his general practitioner, diazepam was provided to Mr S.

The next day at about 9.30am, Mr S was assessed by a psychiatrist. It was noted that he was a moderate suicide risk, and that he was to be admitted properly to the Royal Hobart Hospital. The psychiatrist, after discussion between Mr S and his partner, allowed Mr S to return home with his partner so he could shower and prepare some clothes, then return to the hospital by 4.00pm that day. The request came from Mr S and his partner, and was agreed to by the psychiatrist. A consideration was, it would appear, that the Department of Emergency Medicine is an inappropriate environment for a depressed or anxious patient (such as Mr S). Arrangements were made for the psychiatrist to review Mr S the following day.

After Mr S and his partner returned home, the evidence is that while his partner was in the shower Mr S walked away from their home and made his way to nearby bushland. There, very sadly, he took his own life. His body was located the next day by police using a scent dog. It was clear that he was deceased, and no efforts of first aid were carried out. The lividity described as being present on the lower parts of Mr S's body together with the fact that his body was cold and exhibiting signs of *rigor mortis* all indicate that he had been deceased for an extended period of time.

All of these factors lead me to conclude that Mr S took his own life shortly after he walked away from his home the previous morning.

The results of the autopsy and toxicological analysis showed no signs of alcohol or drugs being present in Mr S's body at the time of his death. The forensic pathologist who conducted the autopsy, Dr Donald McGillivray Ritchey, expressed the opinion that the cause of Mr S's death was asphyxia. I accept this opinion.

It is clear that Mr S was suffering from mental illness at the time of his death. Had sufficient beds been available in the mental health ward of the Royal Hobart Hospital then doubtless he would have been admitted and it is likely that he would not have taken his life. Self-evidently the Department of Emergency Medicine at the Royal Hobart Hospital is no place for anyone suffering from depression, anxiety, suicidal ideation and indeed any mental health issue.

Comments and Recommendations

I **comment** that it is a matter of real concern that, at the time of Mr S's death, insufficient beds were available in the mental health ward at the Royal Hobart Hospital.

I convey my sincere condolences to Mr S's family and loved ones on their very sad loss.

Dated 21 November 2016 at Hobart in the State of Tasmania.

Simon Cooper
Coroner