MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

# Record of Investigation into Death (Without Inquest)

*Coroners Act* 1995
*Coroners Rules* 2006
*Rule* 11

I, Olivia McTaggart, Coroner, having investigated the death of David Lester Townsend

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

a) The identity of the deceased is David Lester Townsend;
b) Mr Townsend died as a result of a gunshot wound of the head inflicted by himself with the intention of ending his life;
c) The cause of death was partial contact range gunshot wound of the head; and
d) Mr Townsend died on 25 September 2017 at Berriedale, Tasmania.

In making the above findings I have had regard to the evidence gained in the comprehensive investigation into Mr Townsend's death. The evidence includes:

- Tasmania Police Report of Death;
- Identification and life extinct affidavits;
- Opinion of the State Forensic Pathologist regarding cause of death;
- Toxicological evidence regarding analysis of Mr Townsend's post-mortem blood sample;
- Medical records from Mr Townsend's general practitioner;
- Affidavit of Donna Reed, Mr Townsend's case manager;
- Affidavit of David McDougall, Mr Townsend's treating psychiatrist;
- Affidavit of Megan Townsend, daughter of Mr Townsend;
- Affidavit of Rodney Cross, housemate of Mr Townsend;
- Affidavit of Norman Beaumont, who located Mr Townsend deceased;
- Affidavit of Senior Constable Simon Taylor of the ballistics team;
- Affidavits of Senior Constable John North and Constable Nicholas Monk of Forensic Services, together with photographs;

- Affidavits of Detective Sergeant Michael Foster and Detective Senior Constable Kirby Direen of the Criminal Investigation Branch;
- Affidavits of Sergeant Ricky Bain, Sergeant Jennifer Wood and Constable Alisha-Lee Anderson - attending and investigating officers;
- Guardianship and Administration Tribunal Order for Administration in respect of Mr Townsend;
- Sample of Mr Townsend's handwriting;
- Notes written by Mr Townsend before his death;
- Mr Townsend's record of prior convictions;
- Fact sheet of medical reporting requirements prepared by Firearm Services;
- Guardianship and Administration Board hearing record; and
- Information from Firearms Services.

**Background**

Mr David Lester Townsend was born in Hobart on 9 November 1947. He was aged 69 years at the time of his death and lived alone in his own home in Berriedale. In about 1968 he married Cherylene Thompson. There are two adult children of the marriage, Megan Townsend and Drew Townsend. In about 1982, Mr Townsend and Ms Thompson separated, with Ms Thompson subsequently remarrying.

Mr Townsend grew up in New Norfolk in a very large family. He was a builder by trade and worked as a Senior Purchasing Officer in the Housing Department for 27 years. He was retired at the time of his death. The evidence indicates that he abused alcohol for many years. His alcoholism is reflected in his record of criminal convictions, containing numerous drink-driving offences and offences involving violence and destruction of property. His daughter described Mr Townsend as being extremely violent towards his wife and children. Even after his separation, Ms Thompson was required to seek and obtain restraint orders against Mr Townsend to protect her and her husband. Mr Townsend's criminal history also extends to multiple breaches of such restraining orders, for which several sentences of imprisonment were imposed.

Mr Townsend had a long history of physical illness and mental health conditions. His general practitioner's records indicate that, at the time of his death, he suffered from chronic kidney

disease, hypertension, Type II diabetes, obesity, chronic dermatitis, chronic shoulder pain, gout, bipolar affective disorder and depression.

**Mr Townsend's mental health**

Mr Townsend had a lengthy psychiatric history. He was diagnosed with bipolar disorder in 2009 and was treated and medicated for the condition. He was referred to the Glenorchy and Northern Adult Community Mental Health Service ("the Service") at that time and received ongoing support from that organisation. Despite treatment, the condition caused him serious difficulties in his functioning. He suffered from suicidal ideation, expressing often that he would take his life using means of high lethality. Relevantly, he would tell his treating health professionals that he intended to die by shooting himself.

Dr David McDougall, psychiatrist, took over Mr Townsend's treatment from December 2015 until the time of his death. Mr Townsend was also supported by case managers from the Service. Ms Donna Reed was his case manager from March 2017 until the time of his death. As his case manager, she conducted regular home visits, centre-based appointments, and telephone discussions with Mr Townsend.

Throughout the course of his treatment with Dr McDougall, Mr Townsend's compliance with his medication was sporadic. His illness and mood would fluctuate from time to time. He would often be significantly depressed and suicidal in his thoughts. However, there is no evidence of actual suicide attempts. He suffered from deep feelings of loneliness and would not take care of himself. In 2017 he required regular respite stays at an inpatient mental health facility and, about two months before his death, he had a lengthy hospitalisation as an inpatient, which is described below.

**Events and treatment prior to death**

Three years prior to his death, Mr Townsend began a relationship with Annabelle Pestano, who lived in the Philippines. They communicated regularly by text messages and in May 2017 he flew to the Philippines to meet her three children and spend time with them.

Throughout his relationship with Ms Pestano he sent to her money on a regular basis. It seems that he may have sent her large amounts of money. Upon his return from the Philippines, he

commenced planning to bring Ms Pestano and her children to Australia and live with him. As this was not possible, Mr Townsend then considered moving to the Philippines himself.

After returning to Tasmania, Mr Townsend became severely mentally unwell, with depressed mood and suicidal ideation, and was not capable of rational thought. In furtherance of his relationship with Ms Pestano, he commenced to sell his furniture and belongings and planned to sell his house. It appears that he may have intended to give her all or part of the proceeds.

On 30 June 2017 Mr Townsend was admitted to his usual mental health respite facility due to an exacerbation of his mental illness. He had not taken his medication for approximately one month. During his stay there, he was described as having very low mood and eating very little. He was discharged on 4 July 2017, expressing that he needed to go to hospital.

On 6 July 2017 Mr Townsend had a telephone appointment with Dr McDougall. He admitted to having suicidal thoughts as he felt lonely and being physically away from Ms Pestano was unbearable to him. He expressed thoughts about hanging himself with a rope but said he probably would not have the courage to go ahead with it.

On 18 July 2017 Mr Townsend's case manager, Ms Reed, received a message from him stating that his life was not worth living if he could not be with Ms Pestano in the Philippines. When Ms Reed visited him at his home, he was in a dishevelled state and his home was in disarray because he was arranging to sell his belongings to be with her.

On 20 July 2017 Mr Townsend was admitted to the Royal Hobart Hospital Department of Psychiatry (DOP). Dr McDougall assessed Mr Townsend just before his hospitalisation that day and, in relation to his ongoing high suicide risk, asked Mr Townsend whether he owned a gun. Mr Townsend replied that he did not own any guns but he believed he could borrow one from a friend. He declined to provide Dr McDougall the names of any friends who could provide him with a gun. In his referral letter to the treating doctors at the hospital, Dr McDougall stated that he was concerned about Mr Townsend's suicide risk and that Mr Townsend said that he had access to firearms.

At his presentation at DOP later that day, Mr Townsend told the psychiatric emergency nurse that he had been off all his medications for about five weeks. He said that he wrecked his house by trying to sell everything and felt that he "might as well shoot himself".

On 21 July 2017 the specialist psychiatrist at the DOP, Dr Anila Rao, reviewed Mr Townsend. Mr Townsend said that he felt safe in hospital and was scared to go home. He said that although he had suicidal thoughts, he had not previously attempted suicide as he was too scared to hang himself. He said that he believed he would die if he did not take his medication for a long period of time.

On 24 July 2017, when Dr Rao reviewed Mr Townsend in hospital, he expressed to her that he was in *"total depressive agony"*. He indicated that he was hearing voices about how to get guns but said he would not do so. He continued expressing suicidal ideation as he felt helpless about the whole situation.

Mr Townsend's mental state improved greatly over the next few days and he ceased expressing suicidal ideation. He was discharged from the DOP on 27 July 2017 and that evening he was admitted to Mistral Place, a public mental health inpatient facility.

On 1 August 2017, upon the advice of Dr McDougall, Ms Reed made an application to the Guardianship and Administration Board (GAB) requesting for a Guardianship Order to prevent Mr Townsend selling his belongings and losing a substantial proportion of his accumulated assets, thus placing himself in serious financial difficulties. It was also the opinion of Dr McDougall that Mr Townsend's risk of suicide would escalate if he lost all of his assets.

Throughout his stay at Mistral Place, the staff noted that Mr Townsend was in a depressive state and kept to himself. On 15 August 2017, he sent Ms Reed several messages expressing his anger after finding out about the application made to the GAB, even after Dr McDougall explained to him the purpose of the application. He was due to be discharged on 17 August with the arrangement that Ms Reed would collect him from Mistral Place. However, Mr Townsend was still angry with Ms Reed and left without waiting for her.

**Circumstances of death**

The hearing of the application to the GAB was listed on 8 September 2017. Mr Townsend was informed that he should attend but refused to do so. The hearing proceeded, with the GAB being satisfied that Mr Townsend was unable, by reason of his mental illness, to make reasonable judgements in respect of his estate and was in need of an administrator. The GAB ordered that the Public Trustee be appointed as administrator of his estate for a period of 12 months.

On 12 September 2017 Mr Townsend was informed by Ms Joanne McGinniss of the Public Trustee about the decision made at his hearing. He became extremely angry and told Ms McGinniss that he would put a brick through Ms Reed's car window. He also told her that he would shoot Dr McDougall if he had a gun. These threatening statements were conveyed to Ms Reed and Dr McDougall two days later.

On 14 September 2017, Mr Townsend sent Ms McGinniss multiple text messages continuing to express his anger at Dr McDougall and Ms Reed. He believed his life had been made worse by Dr McDougall and that Dr McDougall and Ms Reed were motivated by ill-intent and revenge towards him. Ms Reed and Dr McDougall subsequently refrained from contacting him in an attempt to calm him down. Another case manager was appointed for him instead of Ms Reed.

On 18 September 2019 Mr Townsend sent a message to Ms McGinniss reiterating his anger at Ms Reed and Dr McDougall, stating that they had made his life "unliveable" and that he was broke.

On 25 September 2017 Mr Townsend was last seen by a friend, Mr Rodney Cross, and also his current housemate, both of whom had spent time with him that morning at his residence. He was noted to be in reasonable spirits with nothing out of the ordinary in his communications. Mr Townsend left the residence at 11.15am. Mr Cross stated that Mr Townsend did not appear to carry anything with him. He said that he had never known Mr Townsend to own or carry a gun.

The evidence in the investigation allows me to find that Mr Townsend drove his vehicle, a blue Proton Jumbuck utility, registration E18GW, a short distance to the foreshore of Alcorso Drive in Berriedale. He then walked no further than 200 metres to a small embankment. At this time he had possession of a Sportco .22 calibre bolt action repeating rifle. He then seated himself in an upright position and gripped the firearm barrel in his left hand. The stock of the rifle had been removed. It appeared that he used nearby branches to pull the trigger by hooking the trigger around a branch and then pulling the firearm towards himself.

At 11.30am Mr Norman Beaumont was walking past the embankment when he saw something near the water's edge. At first he believed the firearm to be a walking stick but upon peering over the embankment, he observed a male body slumped against the embankment with blood flowing from his head. Mr Beaumont flagged down the attention of another passer-by who called the police and ambulance. When police officers and paramedics arrived, they confirmed

that the male was deceased. He was subsequently identified as David Lester Townsend by his daughter, Megan Townsend.

A full autopsy was conducted by forensic pathologist, Dr Christopher Lawrence. Dr Lawrence concluded, based on autopsy findings and toxicological examination, that, in his opinion, the cause of Mr Townsend's death was due to a partial contact range gunshot wound of the head consistent with suicide.

A full investigation into his death subsequently took place. A handwritten note was found by the police officers on the front passenger seat of his vehicle which he left unlocked. The note indicated anger towards Ms Reed and Dr McDougall and stated that the last three months had been "awful". The notes also directed that further reasons would be found in his bedside table. Upon searching his house, attending officers found it in a state of disarray. There were notes in his bedside table, which I am satisfied were written by Mr Townsend. The notes clearly contemplated his death and gave several reasons for him taking such action. These reasons included the actions of Dr McDougall and Ms Reed, the involvement of the Public Trustee, his poor physical health, his poor financial situation and inability to upkeep his house. There was no firearms or ammunition located in the house.

Mr Townsend was not the holder of a firearms licence. The rifle used to take his own life was an older style rifle, was not registered and had not been reported missing. I cannot determine its origin. Megan Townsend said that her father owned guns when she was a child but she did not recall him having possession of any firearm later in his life. After Mr Townsend's death, Mr Cross heard from another person that Mr Townsend owned a gun that he kept in three pieces in his car. This may have been the case, but there is little value in investigating the issue of who may have been aware of Mr Townsend's possession of the gun.

I am satisfied that there were no suspicious circumstances surrounding Mr Townsend's death and that he, alone, deliberately took action to end his life using a rifle that he had likely had in his possession for a very long period of time. The marked deterioration in his mental health upon his return from the Philippines caused him to be in a most distressed and suicidal state of mind and unable to make rational decisions. His beliefs about Dr McDougall and Ms Reed, two professional persons who considerably supported him, are evidence of his irrationality. His unhappiness with the GAB order, resulting in a loss of control of his finances, appeared to have contributed to his decision.

**Comments**

In this investigation, I have considered whether Dr McDougall had an obligation under section 148 of the *Firearms Act* 1996 to make a report to police in respect of Mr Townsend's threats of firearm usage, either in respect of suicide or homicide. That provision requires a medical practitioner (and other specified classes of persons) to make a report if he or she reasonably believes that a patient is likely to possess or use a firearm, and that such possession or use would be unsafe for the patient or another person as a result of the patient's mental or physical condition, or because the patient would be a threat to public safety.

In considering this issue, I have received submissions from counsel for Dr McDougall, Ms Gretel Chen. Ms Chen submitted that there were insufficient facts in existence for Dr McDougall to hold a reasonable belief that Mr Townsend was likely to possess or use a firearm.

I note that when Dr McDougall and Dr Rao both questioned Mr Townsend separately about his access to firearms, Mr Townsend denied possessing firearms. He told Dr McDougall at the commencement of his hospitalisation that he could borrow a firearm but gave no further details. He told the psychiatric nurse upon his admission to hospital that he had access to firearms and planned to shoot himself. However, he subsequently told Dr Rao on 24 July that he did not have access to firearms.

Dr McDougall diagnosed Mr Townsend as suffering a bipolar mixed episode, demonstrating evidence of mood elevation and depression at the same time. He said that this state put Mr Townsend at a high suicide risk, in addition to his existing risk factors which included a history of high lethality suicidal ideation, a diagnosis of bipolar disorder and a family history of suicide.

Dr McDougall was of the belief, however, that Mr Townsend's suicide risk would reduce once he was established on appropriate medication and treated for his bipolar mixed episode as a hospital inpatient. He also took the step of instigating the application to the GAB with a view to reducing his suicide risk by protecting Mr Townsend from financial ruin. In light of the dissipation of his assets and Mr Townsend's inability to make reasonable decisions with respect to his finances, Dr McDougall's action was thoughtful and appropriate. Finally, when Dr McDougall reviewed Mr Townsend while still an inpatient on 14 August 2017, he assessed his mixed episode as having resolved, which put him into a lower category of suicide risk.

After his discharge, Dr McDougall did not see Mr Townsend, although he provided evidence at the GAB hearing on 8 September 2017. On 14 September 2017 Dr McDougall became aware that Mr Townsend had told Ms McGinness of the Public Trustee that he (Mr Townsend) would shoot him. Dr McDougall did not have personal contact with Mr Townsend after 14 August 2017.

In all of the circumstances, I am satisfied that Dr McDougall did not hold a reasonable belief, upon the information he had, that Mr Townsend was likely to possess or use a firearm, this being a precondition for mandatory reporting to police under section 148 of the *Firearms Act*. Mr Townsend had denied to Dr McDougall that he possessed a firearm and did not give any convincing account about how he could borrow one. It is unclear whether Dr McDougall was aware that Mr Townsend had told Dr Rao that he did not have access to firearms. Mr Townsend's statement that he would shoot Dr McDougall was not received directly by Dr McDougall and did not entail any further information about Mr Townsend's access to firearms. Dr McDougall was entitled to interpret that statement only as a manifestation of Mr Townsend's continuing anger at the imposition of the order, particularly in light of his previously good therapeutic relationship with Mr Townsend and the lack of evidence that Mr Townsend had access to a gun.

I am further satisfied that Mr Townsend received dedicated and high-quality care from his treating mental health professionals both as an inpatient and within the community. Unfortunately, Mr Townsend remained very unwell and his death could not have been reasonably prevented by any person.

The circumstances of Mr Townsend's death are not such as to require me to make any recommendations pursuant to Section 28 of the *Coroners Act* 1995.

I convey my sincere condolences to the family and loved ones of Mr Townsend.

**Dated:** 25 January 2021 at Hobart Coroners Court in the State of Tasmania.

**Olivia McTaggart**
**Coroner**