MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

Record of Investigation into Death (Without Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Robert Webster, Coroner, having investigated the death of Rodney Keith Daw

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

a) The identity of the deceased is Rodney Keith Daw (Mr Daw);

b) Mr Daw died as a result of self-inflicted sharp force incisional wounds of the throat and bilateral wrists and forearms in the circumstances set out below;

c) Mr Daw's cause of death was acute blood loss;

d) Mr Daw died on 5 November 2018 at Launceston, Tasmania.

Introduction

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

- The Police Report of Death for the Coroner;
- affidavits establishing identity and life extinct;
- affidavit of Dr Rosanne Devadas, pathologist;
- Forensic Science Service Tasmania – toxicological and analytical report;
- Ambulance Tasmania (AT) electronic patient care record;
- affidavit of Mr Levi Daw;
- affidavit of Mr John Daw;
- affidavit of Mr Ross Munro;
- affidavit of Detective Senior Constable Joshua Hayes;
- affidavit of Sergeant Phillip Norton;
- affidavit of Constable James Fenton;
- affidavit of Constable Maddison Barron;
- affidavit of Mr Jared Baker;
- affidavit of Mr Timothy Watson;
- Correspondence from Mr Mike McDermott Director, Clinical Services, AT;

- affidavit of First-Class Constable Marcus Williams together with photographs;
- Mr Daw's medical records obtained from Prospect Medical Centre;
- Mr Daw's medical records obtained from Calvary St Luke's Hospital; and
- Advanced Care Directive (ACD) of Mr Daw**.**

Background

Mr Daw was born in Devonport on 12 January 1955. He was aged 63 years of age at the date of his death. He was one of three sons born to the marriage of Lyle and Loretta Daw. Mr Daw grew up in Devonport and went to both primary school and high school in Devonport. Mr Daw enjoyed swimming.

Upon completion of his formal education Mr Daw obtained employment at Edgells (Simplot) as a factory hand. He then obtained employment as a kitchen hand at a restaurant called Gillies. Mr Daw then worked at the Mersey Community Hospital as a truck driver.

Mr Daw met and subsequently married Lynette Mulligan when they were both in their early twenties. Their marriage produced two sons John and Levi. Mr Daw's marriage ended in divorce in or about 1985.

Mr Daw had regular contact with his sons after the divorce. Mr John Daw recalls outings with his father to his grandparents' home, regular trips to Hobart and being taught to swim by his father.

In approximately 1990 Mr Daw commenced a relationship with Mr Tony Newman. Mr Daw and Mr Newman resided together in Launceston. That relationship ended after 13 years. When Mr Daw moved to Launceston John and Levi used to catch the Redline bus from Devonport to spend weekends with their father. Mr Newman also had children and they all used to go camping and have picnics together.

While in Launceston Mr Newman held employment at the Launceston General Hospital initially as a truck driver and later as a ward clerk. For the last three years or so of his career he also worked in aged care. He retired at the age of 55.

Mr Daw has always had regular contact with his sons. Mr Daw's hobbies were travelling and gardening. He travelled extensively both interstate and overseas. Mr Daw was a social person who had a number of good friends who he would host at dinner parties held at his home.

After his retirement Mr Daw spent time caring for his grandchildren, whom he adored. It is obvious from reading the affidavits of Mr Daw's sons that he was a loving father and grandfather.

His good friend Mr Munro, who Mr Daw had assisted during his own difficulties, says Mr Daw valued his friends and family more than anything. He says Mr Daw's work enabled Mr Daw to do the things he really wanted to do with his family. Mr Munro says Mr Daw was a very lively, incredibly loyal and happy person.

Mr Daw's Health

Mr Daw had several medical issues in the years preceding his death including dyslipidaemia, hypertension, anxiety, and psoriatic arthritis. Mr Daw consulted two medical practitioners with respect to the psoriatic arthritis from 2007 until at least the end of 2016. Mr Daw had suffered from psoriasis since he was 16 years of age. In 2007 there was a history of at least two years of symptoms of inflammation. Degeneration of the cervical spine from C5 to C7 was evident on radiology from as early as 2007. He was referred to a number of neurosurgeons about this condition from the middle of 2015 until early 2017. A C6 – 7 discectomy and fusion was performed in March 2017. He had undergone back surgery, namely a L4-5 laminectomy, on 28 November 2017 which reduced his symptoms but a subsequent fall worsened his condition.

In 2015, he was diagnosed with depression and in March 2016 he first outlined thoughts of self-harm to his local medical practitioner. In June 2017 he was diagnosed with a medical condition. In 2018, he was having a lot of difficulties with his teeth and by September 2018 he first attempted suicide. In September 2017, he was also diagnosed with prostate cancer. Mr Daw struggled with his illnesses and the resulting health issues that went with them of which there were a number. As to the prostate cancer his urological surgeon Mr Eaton says in a report dated 10 September 2017:

"Unfortunately Rodney's histopathology has confirmed a small volume low grade prostate cancer. I have discussed the natural history of low grade prostate cancer with Rodney and have advised him that this is ***unlikely*** *to become a significant clinical issue for many years if at all and accordingly I have recommended active surveillance."* (my emphasis)

In September 2018 he was admitted to Calvary St Luke's Clinic for twenty three (23) days following two attempted suicide events of overdosing on prescription medication. He was diagnosed with an Adjustment Disorder, provided significant psychological intervention to come to terms with his medical condition diagnosis and when discharged was provided a relapse prevention plan. Upon release he was described as more positive in his outlook.

On 17 October 2018, he was informed he would require dentures due to the issues with his teeth. Levi Daw has indicated the prospect of losing his teeth hit his father particularly hard. The medical records show the dental surgery was scheduled to take place on 12 November 2018. On 18 October 2018 he reported thoughts of self-harm to his medical practitioner and was again referred to Calvary St Luke's Clinic, being admitted on 22 October 2018. He was assessed as being at low risk of self-harm and he was permitted periods of approved leave.

Levi Daw says his father was attempting to deal with all his physical and psychological health issues on his own. He would only speak to his doctors. He did tell Levi about some of his difficulties in 2017 but he only told him about his medical condition diagnosis a few weeks before his death.

Circumstances Surrounding the Death

On 5 November 2018, whilst still a patient at Calvary St Luke's Clinic, he again left those premises and went home. He was visited by his son Levi who found him in bed. Levi got him up and spent time with him. Mr Daw was due to return to the clinic and asked his son to leave.

Mr Daw went to the bathroom and lay in the bath, surrounding himself with family photographs and proceeded to cut his body. Levi was informed by Calvary St Luke's Clinic his father had not returned. He therefore attended Mr Daw's home to find him in the bath bleeding. Paramedics were called and attended. Levi told paramedics his father had an ACD and he told the paramedics to cease treatment. Levi says they complied with that request.

Investigation

(i) Ambulance Tasmania (AT)

The electronic patient care record of AT indicates the call was received at 18:12 hours and the paramedics were with Mr Daw 10 minutes later. It records the following history:

"63 YOM self-inflicted deep lacerations to bilateral cubicle fossa and wrists resulting in exsanguination. O/A met by pts son (Levi) who advised AT that pt has hx of suicidal ideation and has attempted to commit suicide before. Son advised that pt has current DNR and that pt would not wish to be resuscitated. Pt (sic) advised he did not know where to locate pts DNR and advised AT crew he did not want pt resuscitated and did not want AT to provide life-saving interventions…Pt initially GCS 7, …, moving all limbs (writhing on floor), groaning. … defibrillator pads applied, ICP backup requested….OPA about to be inserted –pts son requested that OPA be withheld and no

resuscitation efforts applied, pts son advised that without intervention pt would not survive, pt understood and agreed to withhold resus…".

(ii) Police

Mr Daw's passing was investigated by a Detective Senior Constable Hayes of the northern Criminal Investigation Branch of Tasmania Police. He was of the opinion there were no suspicious circumstances and due to Mr Daw's terminal illness[1] Mr Daw has inflicted the wounds that have resulted in his death. Detective Senior Constable Hayes had been told about the terminal illness by Sergeant Norton. Sergeant Norton attended Mr Daw's home in response to a report from AT that they had attended that residence in relation to the suicide of Mr Daw. He was advised by the paramedics from AT Mr Daw had terminal cancer[2]. After examining and considering the scene he was of the view there was nothing that caused him to believe that this death was anything but suicide. While Detective Senior Constable Hayes' view, that the outcome of this case was due to Mr Daw having a terminal illness, is probably incorrect I think, on balance, the outcome is due to Mr Daw's poor health generally and the symptoms he was experiencing as a result of the various ailments and illnesses he had. The three short messages Mr Daw left on a blackboard suggest he was struggling to cope with his failing health.

(iii) Post Mortem

Dr Devadas performed the post-mortem on 6 November 2018. Her opinion is Mr Daw's cause of death was acute blood loss due to the sharp force incisional wounds of the throat and bilateral wrists and forearms. She noted Mr Daw suffered from a mood disorder with depressive symptoms and had also contracted a medical condition. An analysis of Mr Daw's blood found it contained prescription and non-prescription drugs. The report of the forensic scientist Miriam Grist indicates there is a potential risk of an enhanced central nervous system (CNS) depression with the use of multiple CNS depressant agents; e.g. codeine, diazepam, tramadol and quetiapine. In addition there was an increased risk of serotonin syndrome occurring with the use of serotonergic agents; e.g. tramadol, citalopram and possibly codeine.

(iv) Calvary St Lukes Hospital records

In so far as the admission between 12 September and 5 October 2018 is concerned Dr Hyde reports the admission occurred following two overdoses. The history was Mr Daw

[1] His statement says he was advised Mr Daw had terminal cancer and medical condition. According to Mr Eaton his prostate cancer was "***unlikely*** *to become a significant clinical issue for many years if at all.."* and his medical condition is not necessarily terminal. (my emphasis).
[2] I infer this information was provided to the paramedics by Levi Daw.

had experienced significant dental issues in the context of his medical condition and had been struggling to come to terms with that diagnosis of that condition. He had recently ceased his antiretroviral medication and felt he was not coping. On admission he was depressed with ongoing suicidal thoughts and ambivalence about living. He was treated with medication and his mood gradually improved. There was liaison with the sexual health service to ensure Mr Daw was receiving his medical condition medication. He underwent significant psychological intervention in respect of his acceptance of the diagnosis and coming to terms with his family finding out. He underwent cognitive behaviour therapy which was beneficial. The diagnosis was major depressive disorder with a differential diagnosis of an adjustment disorder with depressed mood. At discharge Dr Hyde reports Mr Daw was more positive, brighter, more reactive and more hopeful.

Mr Daw was readmitted to Calvary St Luke's hospital on 22 October 2018. The history was his mood was low and he was not coping at home. He was anxious, agitated, restless and having some suicidal thoughts. His medication dose was increased one week prior to admission. It was increased again during this admission and his mental state settled. He engaged well with cognitive behaviour therapy. The diagnosis remained the same. The records show he was assessed as a low risk patient for the entire period of this admission. He was granted leave on 25, 26, 27, 29, 30, 31 October, 1, 2, 3 and 5 November 2018. Mention is made on 2 November 2018 of the upcoming dental appointment. A clinical risk assessment performed on 3 November 2018 notes Mr Daw was going home for the day and was meeting with his friend Ross. The history on that day includes Mr Daw's distress with respect to his teeth which were to be removed on Monday week due to periodontal disease. This was causing quite a bit of distress as Mr Daw believed his dentist had let him down. On his return from leave he requested overnight leave to his son's home which Dr Hyde supported. He returned at 17:20 hours the next day. Again he disclosed his distress about losing his teeth. He said he always had wanted to die with his own teeth. He was counselled about the benefits he should receive from the procedure. On 5 November 2018 he left the ward at 09:30 hours and was expected to be out for three hours. There were no concerns on his departure. At 13:45 hours Mr Munro is recorded as telephoning the hospital and advising Mr Daw had *"had another go"* at taking his own life. He thought Levi had called an ambulance. He was advised to ensure an ambulance was on its way and he was asked if Levi could call. Mr Munro agreed to contact Levi. Mr Daw's nurse then attempted to call Levi who promised to call back. Dr Hyde was informed and staff were directed to attempt to call Levi again and, when contacted, Levi assured staff his dad was "okay". The ambulance was requested to call the ward once information was to hand. A message was left for Mr Daw to call back after he did not answer his phone. A message was left with Levi to call back and he did. He said his father was okay but that he would call back in a couple of minutes.

That was at 13:50. An attempt was made to phone Mr Daw and Levi at 16:20 hours and messages were left. A call was received from Levi at 17:10 hours reporting that Mr Daw was fine and was currently resting in bed watching TV. When asked about a self-harm report Levi was very vague and said that Rodney was currently alone because he had come home to feed the cat but intended returning after the phone call. Levi was told staff required more information and he was asked to ensure Rodney call the Calvary clinic. Levi was also very vague when asked whether Rodney intended returning to the unit. Levi was advised if Rodney had not returned or contacted the unit within an hour police would be contacted. As no contact had been received at 18:30 hours police were contacted. A phone call was subsequently received from AT to advise Mr Daw had passed away. Ambulance personnel had attended at the request of Calvary staff.

(v) Advanced Care Directive (ACD)

This document indicates that if Mr Daw is suffering from one or more of the conditions mentioned in the schedule and he has become unable to participate effectively in decisions about his medical care and two independent physicians (one being a consultant) were of the opinion that he was unlikely to recover from illness or impairment involving severe distress or incapacity for rational existence then he directs he is not to be subjected to any medical intervention treatment aimed at prolonging or sustaining his life. Mr Daw was not suffering from any of the conditions set out in the schedule, there is no evidence he was unable to participate effectively in decisions about his medical care and there was no evidence from two independent physicians that he was unlikely to recover from illness or impairment.

(vi) Other Evidence

Mr Munro says throughout the time he knew Mr Daw he would, every now and then, say he didn't want anyone to look after him when he was older and he didn't want to become a burden. He never wanted to be someone who lost his dignity when he was older. He visited Mr Daw regularly whilst he was in Calvary St Luke's Hospital. After the first suicide attempt Mr Daw advised Mr Munro he had some health issues and *"he knew it was downhill from where he was at. He didn't want to be around to watch things get worse. Based on the long history I knew of Rod, I knew that he didn't plan on sticking around. I knew if he was planning to do it, he would do it."* On 5 November 2018 he received a call from Levi indicating Mr Daw was not well. Mr Munro was away but he started to head towards Mr Daw's place and while driving he called Calvary St Lukes with his concerns. He does not recall what hospital staff said to him. When he arrived at Mr Daw's address he found him smoking in his garden. Mr Daw advised Mr Munro he just wanted downtime in his garden. Mr Munro respected what he wanted and therefore left and when he did so he says Mr Daw seemed peaceful and calm.

Mr Munro was of the view from his observations when he visited Mr Daw, while he was an inpatient that he seemed okay and there was nothing wrong when he was there. Mr Daw advised him he was involved in daily activities.

Mr Levi Daw says he visited his father at his home at approximately 13:00 hours on 5 November 2018. When he arrived his father was in bed and *"seemed very out of it."* He believed his father had taken some pills and wanted to end his life. He got his father out of bed and had coffee with him and spoke to him for about an hour and a half during which time his father told him he was tired of it all. After that he asked Levi to leave so he did what he was asked to do. Levi then says his father *"always would say that when he goes it'll be his way."* The hospital telephoned him between 13:30 hours and 14:00 hours and he advised that he was with his father and he was okay. They asked Levi to keep them informed. They called again after he had returned home to look after his daughters at approximately 17:30 hours. They advised Levi they had not heard from Mr Daw, he hadn't checked himself in and they said they would have to call police. He told them he would go back and check on him. He returned at approximately 18:00 hours and found his father lying in the bath. He noticed a silver scalpel which he believes his father used to inflict his wounds. Mr Daw was trying to get out of the bath and as he did so he fell on the floor. Levi said *"Dad the hospital is going to call the police"* and his father told him to call the ambulance. He did and he did what the paramedics told him to do which was wrapping cloth around his father's wrists where the wounds were. His father wasn't saying anything or looking at Levi. Not long after paramedics arrived and were about to start to provide treatment *"but as my Dad was so close to death and I knew he had a do not resuscitate I told them to stop, they asked me if I was sure I told them yes."*

(vi) Did Mr Levi Daw Request the Ambulance Officers not to Resuscitate Mr Daw and did they Comply with that Request?

At the time of Mr Baker's attendance at Mr Daw's home he had about one year's experience as a paramedic. On arrival Levi Daw identified himself and led he and Mr Watson to the bathroom where they observed Mr Daw lying on the floor. They were told by Levi that his father had a medical condition and a history of suicidal ideation and attempts of suicide. Their first priority was to make the scene safe for them particularly in respect of infectious disease. Mr Watson left to get towels and call for backup because it was anticipated it would be difficult to extricate Mr Daw from the scene. This was because, as Mr Watson says, the house was very small with *"tight hallways and rooms."*

While Mr Watson was absent Mr Baker assessed airway, breathing and circulation. It was determined Mr Daw was still alive which was confirmed after he placed a monitor on Mr

Daw. Mr Daw was very unwell as he had severe cuts to both inside elbows and wrists. Mr Baker applied defibrillator pads for resuscitation in case of cardiac arrest. At that time Levi said *"please don't do that because he has a do not resuscitate order."*[3] Mr Baker asked Levi Daw to produce the order and advised him it was not applicable where there has been a suicide attempt. Levi could not produce the order but continually requested no intervention.

Mr Daw continued to deteriorate and a short time later arrested at which time it was determined he had already exsanguinated. It was determined blood had been washed down the bath plug as blood clots were found in the bath tub. Resuscitation was withheld in accordance with clinical practice guidelines. The injuries were not compatible with life. Backup arrived and checked the scene and agreed that life was extinct. The scene was handed over to police. Since this incident AT has introduced specific cardiac arrest guidelines for trauma-related instances.

In his affidavit Mr Watson essentially corroborates what Mr Baker has said. They determined CPR was pointless due to blood loss and the significance of the injuries which Mr Daw had sustained. Since this incident Mr Watson confirms AT has introduced protocols for traumatic arrest which have included intraosseous access and fluid resuscitation by means of a bone injection gun. As far as ACDs are concerned Mr Watson says nothing has changed; they follow their clinical procedure guidelines.

Mr McDermott has advised that when providing care in accordance with ACDs AT is primarily guided by Clinical Practice Guideline *CPG A0203 Withholding and/or Ceasing Prehospital Resuscitation.* This guideline provides as follows:

- An ACD may be cited by the attending ambulance crew, or they may accept in good faith the advice of those present at the scene. If there is any doubt about the application of an order the default position of resuscitation should be adopted.
- An ACD only applies in relation to a current condition. When ceasing or withholding resuscitating efforts the attending clinician needs to be satisfied that the patient's cardiac arrest is most lightly due to this current condition cited in the ACD.
- Ambulance crews must clearly record full details of the information given to them and the basis for their decision regarding resuscitation. This is particularly important in circumstances where a copy of the ACD has not been cited as this documentation may serve as evidence of their good faith

[3] I assume what Mr Levi Daw was referring to was an ACD.

Mr McDermott says frequently a paramedic's decision to intervene is time critical; that is the decision to actively treat must be made rapidly to prevent further, and in some cases irretrievable, progression of the patient's presenting clinical condition. ACD's or Do Not Resuscitate (DNR) orders are often not available to paramedics within this very short decision-making timeframe. In those circumstances information provided by bystanders, carers, or family members is the only information a paramedic may have to make the decision to intervene or withhold treatment. In addition there can be many difficulties associated with the information provided by these people. For example family and/or bystanders may misunderstand and subsequently misrepresent the wishes of the patient, at this highly emotional time there is potential for family members to provide information that is contrary to the patient's wishes or suggest a course of action not in the best interests of the patient and in rare instances information provided by bystanders and family members may be based on a malicious motive.

In this case Mr McDermott makes the following points:

- the decision to intervene or withhold treatment in this case was time critical. The officers' initial clinical observations were Mr Daw *"was clearly in extremis[4] and peri- arrest.[5]";*
- no ACD or DNR paperwork was available and the information provided to the paramedics was limited to the information provided to them via the emergency call and that provided to them by Mr Levi Daw;
- ambulance crews do not have infield access to hospital notes to further inform decision-making and in this case they would not have had time to consider such material;
- the decision to withhold resuscitation was ultimately a *"clinical judgement call"* on their part.

Mr McDermott makes the very valid point that the cause of death and Mr Daw's presenting clinical condition meant there was a strong likelihood that resuscitation measures would have been unsuccessful. He says standard ambulance resuscitating techniques would have been insufficient as it was likely Mr Daw required a massive blood transfusion which cannot be provided on the scene. Rapid transport to hospital was not achievable in the available time frame prior to his progression to cardiac arrest; the records indicate Mr Daw was declared deceased within 3 minutes[6] of the primary ambulance crew's arrival. In addition

[4] When a person is very ill and likely to die.
[5] In this case the period just before a full cardiac arrest.
[6] AT's records indicate the ambulance crew were with Mr Daw at 18:22 hours and his time of death is recorded at 18:25 hours.

scene extrication during resuscitation is often not undertaken due to the interruptions to resuscitating measures required to enable moving and loading. Finally transporting patients in moving ambulances whilst under active resuscitation involves significant risk to paramedics as they are unrestrained in a moving vehicle. This practice is often not undertaken due to this risk.

I find Mr Levi Daw did request the paramedics not resuscitate his father however the decision not to resuscitate him was not influenced by that request but by the application of clinical practice guidelines; put simply the injuries which Mr Daw had sustained which led to massive blood loss were not compatible with life. In all the circumstances Mr Baker and Mr Watson acted appropriately.

Mr McDermott goes on to say there is scope to further develop *CPG A0203* to provide guidance to paramedics in circumstances where decisions about withholding and/or ceasing resuscitation are required. He says the need for ACDs to be linked to the condition causing the cardiac arrest requires investigation and reconsideration. He says it appears there is no specific requirement to specify individual medical conditions in the ACD documentation provided by the State Government[7]. He says the need for the cardiac arrest to be specifically linked to a nominated condition may now be obsolete. In addition he says a bill which deals with ACDs passed through Parliament late last year and it provides greater legal certainty to the status of ACDs. He says the new legislation will need to be evaluated and AT's guidelines and education to its staff updated.

The *Guardianship and Administration Amendment (Advanced Care Directives) Bill* 2021 received Royal Assent on 3 November 2021. Section 2 provides the amendments set out in this legislation commence on a day to be proclaimed. At the time of writing the Act has not been proclaimed and it is therefore not in effect. In summary these provisions provide for the making and implementation of ACDs. There are witnessing requirements prescribed and the provisions permit an ACD to contain both binding and non-binding directives. Refusals or instructions to withdraw health care that are clear and unambiguous are binding. All other directives are non-binding but they must be complied with to the extent that it is reasonably practicable to do so. The legislation makes provision for circumstances in which a health practitioner is not obliged to comply with the terms of the ACD. ACD's may be registered with the Guardianship and Administration Board[8] however registration is not mandatory. There is provision made for revoking an ACD. In addition there is a provision that provides a health practitioner, authorised decision-maker or other person acting under the authority

[7] A copy of this documentation was provided by Mr McDermott with his letter.
[8] This Board's functions have been assumed by the Tasmanian Civil and Administrative Tribunal from 5 November 2021.

of the *Guardianship and Administration Act* 1995 to give effect to an ACD is protected from liability for any action taken or not taken as long as that act or omission is done in good faith and without negligence. The Act also enables recognition of ACDs made in other Australian jurisdictions.

Comments and Recommendations

I am satisfied that there are no suspicious circumstances surrounding Mr Daw's death. I am further satisfied that Mr Daw acted with the express intention of ending his life. While I am not able to determine the precise reasons why Mr Daw took his life I note that his health and ongoing medical issues and depression were likely to have been significant contributing factors. I reiterate that in all the circumstances the attending paramedics acted appropriately and in accordance with their clinical practice guidelines.

In the circumstances there is no need for me to make any further comment or recommendations.

In concluding, I convey my sincere condolences to the family and friends of Mr Daw.

Dated: 18 August 2022 at Hobart in the State of Tasmania.

Robert Webster

CORONER