FINDINGS and COMMENTS of Coroner Olivia McTaggart following the holding of an inquest under the *Coroners Act* 1995 into the death of:

Jana Culic

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Record of Investigation into Death (With Inquest)

Coroners Act 1995
Coroners Rules 2006
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I, Olivia McTaggart, Coroner, having investigated the death of Jana Culic with an inquest held at Hobart in Tasmania make the following findings.

Hearing Dates

9 December 2022

Representation

Assisting the Coroner: Sergeant Darren Orr

Introduction

1. Jana Culic, aged 35 years, died as a result of jumping from the Tasman Bridge on 4 June 2020. At the time of her death, she suffered serious mental illness and was subject to a treatment order under the *Mental Health Act* 2013. I was required under the *Coroners Act* 1995 to hold a public inquest into her death.

Evidence in the investigation

2. In making my findings, I have had regard to the evidence gained in the comprehensive investigation into Ms Jana Culic's death. The documentary evidence tendered at inquest comprised the following exhibits:
    - Police report of death to the coroner;
    - Affidavits confirming life extinct and identification;
    - Opinion of the forensic pathologist regarding cause of death;
    - Toxicology report from Forensic Science Service Tasmania;
    - Medical Records from the Tasmanian Health Service, Mental Health Services and Glenorchy Medical Centre;
    - Mental Health Treatment Order;
    - Affidavit of Vaia Papadimitriou, mother of Ms Culic;
    - Affidavit of Thomas O'Brien, Nurse Unit Manager at Tolosa Street Centre;
    - Affidavit of Lisa Shadwick, Clinical Nurse Consultant at Tolosa Street Centre;

- Affidavits of Katrina Ostrenski and Duncan Lee, witnesses to the circumstances of Ms Culic's death;
- Guardianship and Administration Board of Tasmania records;
- Affidavits of investigating police officers, including a Forensic Services officer, and photographs;
- Medical report by Dr Anthony Bell, coronial medical consultant, who reviewed Ms Culic's care;
- Diary belonging to Ms Culic; and
- Tasmania Police records and information regarding Ms Culic.

3. I did not hear oral testimony from any witnesses at inquest as I did not need to do so in order to make the required findings.

Background

4. Ms Culic was born on 27 January 1985 and was 35 years of age at the time of her death. Ms Culic had never married and had no children. She was the only child to her parents, John Culic and Vaia Papadimitriou. Ms Culic's parents divorced in 1988 and, following their separation, Ms Culic lived with each parent at different times and in different states. Ms Culic graduated from Hobart Matriculation College. In the several years following, Ms Culic worked as a masseuse and a receptionist.

5. From about 2002, Ms Culic started using methamphetamine and amphetamines. The evidence indicates that, unfortunately, her drug use triggered serious and ongoing mental health issues. Ms Culic was (eventually) diagnosed with schizophrenia, borderline personality disorder and bipolar disorder. She continued to use illicit substances until her death. At the time of her death, she was not in employment, was in receipt of a disability support pension and received support from NDIS.

6. Between 2015 and her death in 2020, Ms Culic had 19 admissions to Statewide Mental Health Services facilities and the Emergency Department of the Royal Hobart Hospital (RHH). These admissions related to her existing mental health diagnoses as well as drug-induced psychosis, polysubstance abuse, suicide attempts, social issues and criminal offending. Ms Culic had poor insight into her condition and was regularly non-compliant with treatment. Her care and treatment by community mental health teams was also made difficult by Ms Culic's transience and homelessness. During this period, she was subject to seven assessment orders and three treatment orders under the

Mental Health Act 2013. She also participated in a diversion program following being charged with a number of offences.

7. On 17 November 2018, Ms Culic, whilst under the influence of command auditory hallucinations, jumped from the Tasman Bridge in an attempt to end her life. However, she survived and admitted herself to the RHH where she was treated for multiple spinal fractures. After being treated for her injuries, she was then transferred to the psychiatric ward at the RHH. On 24 January 2019, Ms Culic became the subject of a Guardianship Order, whereby the Public Guardian was empowered to make decisions on her behalf regarding her health care and where she was to live. This order remained in force at the time of her death.

8. On 6 March 2019, Ms Culic was transferred from the psychiatric ward at the RHH to Mistral Place, a mental health inpatient facility operated by Mental Health Services. On 24 May 2019, Ms Culic was transferred from Mistral Place to the Tolosa Street Centre (also operated by Mental Health Services) for ongoing care, treatment and rehabilitation. Ms Culic remained a resident of Tolosa Street at the time of her death. She was difficult to manage and treat due to her conditions and substance use. Ms Culic found the lockdown regulations particularly difficult and, on 15 May 2020, she left the facility in breach of the restrictions. This prompted an admission to the RHH for further assessment, before she returned to Tolosa Street.

Treatment Order

9. At the time of her death, Ms Culic was a person *"held in care"* under the *Coroners Act* 1995 because she was subject to a treatment order pursuant to the *Mental Health Act* 2013 which, amongst other stipulations, rendered her "*liable to be detained*" in an approved hospital, if necessary, for the purposes of receiving treatment. She was not, in fact, involuntarily detained at Tolosa Street at any relevant time.

10. Being a person held in care, I was required by section 24(1)(b) of the Act to hold a public inquest into Ms Culic's death and, in addition to my usual functions, to report on her care, supervision and treatment whilst she was a person held in care as required by section 28(5) of the Act.

11. The treatment order applicable to Ms Culic, and upon which I am required to comment, was made by the Mental Health Tribunal on 7 April 2020 for a period of six

months. By the order, Ms Culic was required to take anti-psychotic, mood stabilising and anti-cholinergic medications.

Circumstances surrounding death

12. On 1 June 2020, Ms Culic told her mother on the phone that she believed the restrictive practices relating to COVID 19 which prevented her free movement were not legal. Ms Culic's mother was concerned for her daughter's mental state and contacted Ms Culic's guardian. She also arranged for a one hour accompanied outing for Ms Culic on 3 June 2020. On 2 June 2020, a NDIS support worker took Ms Culic for a walk to the Glenorchy shops. On 3 June 2020, Ms Culic underwent a medical review and told the multidisciplinary team that she felt like a burden because of the amount of one-on-one time she required from staff at Tolosa Street. She nevertheless expressed the desire to eventually be able to live on her own.

13. At 4.00am on 4 June 2020 a Tolosa staff member checked on Ms Culic and could not find her. Her room had been purposely flooded by plugging the shower drain with clothes and leaving the shower running. Staff members checked the facility and surrounding suburbs by vehicle at 4.15am, 5.15am and 6.15am without finding Ms Culic. The police were alerted to the situation at 7.30am. It appeared that Ms Culic scaled the fence surrounding the Tolosa Street facility to escape.

14. At 7.03pm, two witnesses contacted police and said they saw someone climbing over the rail on the Tasman Bridge. The evidence does not allow me to conclude how Ms Culic made the journey from Tolosa Street to the Tasman Bridge, although I am satisfied that at 7.05pm, she jumped from the bridge and landed in the water. Police and emergency services were dispatched to search for Ms Culic.

15. At 7.30pm, Ms Culic was located in the water by a helicopter search crew on the southern side of Montagu Bay near Rosny Point, approximately one kilometre from the Tasman Bridge. She was lifted from the water, deceased, by a police vessel.

16. The forensic pathologist who performed the autopsy formed the opinion that Ms Culic died as a result of both neck and chest injuries and drowning. She was found to have only therapeutic quantities of her prescription medication in her system and no illicit substances.

17. I am satisfied that Ms Culic voluntarily jumped from the Tasman Bridge in order to end her life. I cannot determine her state of mind immediately before her death but I do not rule out that she may have been influenced in her decision by delusions or hallucinations associated with her mental illness.

Care, supervision and treatment of Ms Culic

18. It was entirely appropriate in the context of Ms Culic's lack of decision making capacity and serious mental illness, for her to be subject to a treatment order under the *Mental Health Act*. I am also satisfied that she was accommodated in Tolosa Street with significant support from health professionals. She was subject to regular specialist review and her medication was properly prescribed and administered as required. The aim of assisting Ms Culic's rehabilitation by a supported living environment was also appropriate.

19. The Tasmanian Health Service completed a Root Cause Analysis report on 16 December 2020. The members of the specialist panel who prepared the report (who were not involved with Ms Culic's care) found that there were no deficits in her care or treatment that contributed to her death. The panel, in reviewing her comprehensive medical records, noted that Ms Culic had showed improvement in her mental health in the two months prior to her death and that her actions on 4 June 2020 were not able to be foreseen at that particular time. I also accept that this is correct, although it is clear that her suicide risk was consistently high. The panel noted that whilst Ms Culic was frustrated and distressed by the COVID-19 restrictions, her carers and support persons did all that was possible to alleviate her distress.

20. I am satisfied pursuant to section 28(5) of the Act that Ms Culic's care, supervision and treatment whilst she was subject to the order under the *Mental Health Act* was of a good standard.

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

Findings required by s28(1) of the *Coroners Act 1995*

a) The identity of the deceased is Jana Culic;

b) Ms Culic died in the circumstances set out in this finding;

c) Ms Culic's cause of death was neck and chest injuries and drowning due to an intentional fall/jump from the Tasman Bridge; and

d) Ms Culic died on 4 June 2020 at Hobart, Tasmania.

Acknowledgements

22. I extend my appreciation to Sergeant Darren Orr for his preparation of the inquest and also to investigating officer Constable Jonathon Walter for his investigation and report.

23. I convey my sincere condolences to the family and loved ones of Ms Culic.

Dated: 7 March 2023 at Hobart in the State of Tasmania

Olivia McTaggart
Coroner