



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 and family by the direction of the Coroner pursuant to s 57(1)(c) of the Coroners Act 1995)

I, Leigh Mackey, Coroner, having investigated the death of DR

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

- a) The identity of the deceased is DR (date of birth 1 April 1982). DR is a father of three children, KN, BY and OJ. He grew up in Tasmania, principally around Hawley Beach. He attended TAFFE and worked at times, in electronics. DR was an alcoholic and consequently suffered liver disease, seizures, hospitalisation and underwent inpatient detoxification. On 24 December 2015 he gave a history at the emergency department of the Mersey Community Hospital of escalating alcohol use particularly over the previous three years following the failure of his business and marriage and loss of his home. He claimed to be drinking at that time 8 to 12 beers daily but denied illicit substance use.¹ He also had a history of anxiety and depression.

- b) DR met AC at the Bridge Rehabilitation Centre where they were both receiving rehabilitation for addiction, him to alcohol and her to illicit drugs. They commenced a relationship in August 2019. The relationship had difficulties. The couple each had issues with addiction as did AC's daughter. AC resumed her use of methylamphetamine (Ice) in November 2022. DR became subject to a Police Family Violence Order (PFVO) protecting AC and was charged with her assault on 5 August 2023 and on 17 August 2023 with breaching the PFVO.

DR's living and social circumstances became chaotic. DR was unable to live at the home he shared with AC. AC and her daughter were both using

¹ Tasmanian Health Service Medical Records p75.

ice, DR faced prosecution for family violence matters and was in financial difficulty. In mid-September 2023 he and AC travelled to and stayed at various places on the East Coast of Tasmania. His behaviour over this period was bizarre. He spoke of being on a quest and of religion. He was abusive to AC physically and verbally and insisted on her joining him in prayer. On 29 September 2023 he took AC to a forestry road near St Helens at night. He was heightened. He pinched and struck AC and told her he was from the Gods. He ran into the bush on the arrival of members of Tasmania Police. He was charged with the assault of AC and damage to property.

On 4 October 2023 DR was driving and struck another vehicle claiming the other driver was a drug lord. Members of Ambulance Tasmania and Tasmania Police attended and he was taken to the emergency department of the North West Regional Hospital (NWRH) where he was examined and found to be in an altered conscious state, experiencing transient seizure activity and expressing a "*flight of ideas and delusions of grandeur*".² He was diagnosed with bipolar affective disorder manic episode with psychotic features and admitted under a treatment order issued under the *Mental Health Act 2013* (MHA) by the Tasmanian Civil and Administrative Tribunal (TASCAT) to the Spencer Clinic at the NWRH until discharge on 25 October 2023.

The discharge plan was for transfer of his care to the Burnie Adult Community Mental Health Service (BACMHS) for case management and provide a script for medication and 1 week supply of lorazepam. Following discharge a case worker, Ms Towns, from BACMHS visited him at his home where he was residing contrary to the PFVO, and where AC and her daughter were also present.

On 28 November 2023 AC left the home in the morning to attend an appointment. She told DR she would return at approximately 12.00pm. DR spoke by telephone with Ms Towns that morning and raised having suicidal thoughts with her but asserted he had no intent or plan to act on them. He was encouraged to call if suicidal thoughts persisted or he started to think about a plan to act on them, was provided with the mental health helpline number for after-hours support and encouraged to present to an emergency department if he felt he wanted to act on these thoughts. DR stated that he would phone later with an update after talking his feeling through with AC.

² Tasmanian Health Service Medical Records p11.

Upon returning to the home AC was unable to locate DR inside. She looked for DR outside and found him suspended from a tree limb with a rope around his neck tied in a noose. Postmortem toxicological analysis of his blood demonstrated the presence of prescribed medication and cannabis.³

c) DR's cause of death was asphyxia due to neck compression following ligature suspension (hanging). There is no evidence of the involvement of any other person in his death. Examination of his mobile phone reveals he messaged family members with requests for money in the days prior to his death, received an after-hours mental health helpline number and at some time that morning he searched "*hangman's noose*".⁴ I find that DR intentionally took his own life by suspending himself from a tree in the backyard of his home.

d) DR died on 28 November 2023 at Cuprona, Tasmania.

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

- The Police Report of Death for the Coroner;
- Affidavits confirming identity;
- Affidavits from attending and investigating police officers;
- Tasmanian Health Medical Records;
- Port Sorrell Medical Centre medical records;
- Opinion of the forensic pathologist regarding cause of death;
- Affidavit of Mr McLachlan-Troup, Forensic Scientist, sworn 6 February 2024;
- Affidavit of EL sworn 3 May 2024;
- Affidavit of TU sworn 22 March 2024;
- Affidavit of AC sworn 28 November 2023;
- Reports of Dr Auchincloss dated 13 July 2025 and 9 December 2025; and
- Letter of Tasmanian Health Service dated 16 October 2025.

Treatment Orders under the *Mental Health Act 2013*

DR first came under compulsory psychiatric care when an interim order was made by TASCAT on 9 October 2023 requiring his treatment at the NWRH. By application dated 11 October 2023 DR sought to review the interim order on the basis it was

³ Affidavit of Mr McLachlan-Troup, Forensic Scientist, sworn 6 February 2024.

⁴ Affidavit of First Class Constable Parsons sworn 9 March 2024.

discriminatory, medical information was being withheld from him, and he had been refused religious activity. The review was unsuccessful, and a treatment order was made on 16 October 2023 requiring compliance with treatment and inpatient care at the NWRH.

As a result of DR's discharge from the NWRH on 25 October 2023 the treatment order was varied to change the treatment setting to the community. On 16 November 2023 DR was reviewed by Dr Miach (psychiatrist at BACMHS). He gave a history that included sleeping in a swag and using cannabis every two days, his mood was "*near normal*" and denied being a risk to himself or others.⁵ Dr Miach concluded that DR had suffered a recent manic phase of bipolar affective disorder which had now resolved and could have his treatment order revoked. The order was consequently discharged effective as of 16 November 2023.

The removal of an individual's freedoms of treatment, movement and living arrangements by a treatment order must be undertaken in a way that is mindful of the mental health service delivery principles identified in Schedule 1 of the MHA (section 15) which, broadly, require respect and sensitivity, the preservation of dignity and the least restrictive interference with the rights of a person suffering mental illness. The need to "*emphasise and value ... early detection and intervention*" is also a service delivery principle in the MHA (schedule 1 para 1(e)).

The psychiatric care of DR

DR had a significant history of substance abuse, primarily alcohol, and was experiencing stress due to that abuse together with financial and relationship difficulties. In the context of these stressors DR suffered psychosis and came under a treatment order in the month prior to his death. He remained an inpatient at the NWRH for 20 days until discharged and the treatment order was removed after another 22 days. On discharge from the NWRH he was returned to the same stressors that had previously existed, to a home he shared with known users of illicit substances, in breach of a PFVO, to otherwise no other accommodation options, to circumstances that exposed him to risk of prosecution and to unresolved financial difficulties.

At review on 16 November 2023 with Dr Miach the plan was for ongoing use of medication and review in one month or "*sooner if appropriate*".⁶ He concluded that DR no longer lacked decision making capacity nor presented as a risk to himself or others.⁷

⁵ Tasmanian Health Service Medical Records p97.

⁶ Tasmanian Health Service Medical Records p97.

⁷ Tasmanian Health Service Medical Records p97.

The treatment order was on that basis removed. The records of that consultation do not disclose the basis upon which Dr Miach reached that opinion other than that he showed “*insight*”, agreed to take his medication and asserted that he was not a danger to himself or others.⁸

The records regarding DR’s care at the NWRH and BACMHS, have been reviewed by Dr Stephane Auchincloss a consultant psychiatrist in private practice and a member, in the mental health stream, of TASCAT sitting weekly on matters at TASCAT brought under the MHA. She notes that DR had severe and disabling mania with psychosis requiring three weeks inpatient admission and that factors in his history, including camping and cannabis use, were not conducive to future medication adherence.⁹ His discharge was to ongoing uncertainty regarding his accommodation and financial position. She further notes that it is common for patients who experience a manic phase of bipolar disorder to “*crash’ into severe depression or into a mixed state of concurrent manic and depressive symptoms*” after their apparent recovery. These factors and this risk called for a more cautious approach to, the closer monitoring of DR upon his discharge and greater attention given at discharge to his accommodation and other stressors he faced upon his return to the community.¹⁰

After DR’s discharge his BACMHS case worker, Ms Towns, was left to grapple with these issues. She visited him at the home and maintained regular telephone contact with him. She discussed options for financial assistance/advice and accommodation. Dr Auchincloss considers DR’s transition back to the community could have been made smoother were these issues recognised and resolved before his discharge and as part of his discharge planning.

After DR’s discharge and release from the treatment order he consulted with Dr Miach on 24 November 2023. At this time, he presented with confusion regarding his medication, he had ceased olanzapine, had escalating difficulties sleeping, was sweating and had a feeling of tightness in his chest. The symptoms were suggestive of early hypomania¹¹ and, in the opinion of Dr Auchincloss, warranted a more assertive approach than to have prescribed olanzapine and a review in three weeks. A more assertive approach would have involved an earlier follow up, an assessment of his risk and a review of the efforts to support his accommodation and living arrangements.

⁸ Tasmanian Health Service Medical Records p97.

⁹ Dr Auchincloss report dated 13 July 2025 p12.

¹⁰ Dr Auchincloss report dated 13 July 2025 p12.

¹¹ Tasmanian Health Service Medical Records p93.

DR raised suicidal ideation with Ms Towns hours before he died. At that time, he was dealing with several known psychosocial stressors and had racing and suicidal thoughts. Ms Towns was reassured by DR and by her risk assessment of him that he would not act on these thoughts. She planned to closely monitor his mental state. Dr Auchincloss' opinion was that a more assertive approach was again warranted including discussion with his treating inpatient team and referral for rapid community based medical review.

Comments and Recommendations

The Tasmanian Health Service were given the opportunity to consider and comment on the opinion of Dr Auchincloss. They note the “[*assertive*] follow up” given to DR by Ms Towns in challenging circumstances where accommodation options in the Northwest of the state are few. I accept and find that Ms Towns did provide reasonable support to DR upon his discharge and given the short time between the telephone call between her and DR on 28 November 2023 and DR's death, the engagement of the treating team by her would not have prevented him from taking his life.

I note that the decision to discharge DR from the treatment order was made in accordance with the MHA and based on DR having decision making capacity. The termination of the treatment order left open the option of readmission should DR's mental state worsen.¹²

I accept DR's was a complex case in a regional area where access to accommodation and services is difficult. A treatment order has a potential therapeutic and protective benefit beyond mandating the treatment and living arrangements of a mental health patient. It can serve to highlight the need for assertive treatment, supervision and care.¹³ Whilst there is a need to act in the least restrictive way whilst treating persons with mental health issues, (schedule 1 paragraph 1(b) MHA), this ought to be balanced by the need to be responsive and to promote early detection and intervention (schedule 1 paragraph 1(e) MHA).

When considering the psychiatric care given to DR, I have the benefit of hindsight and the capacity to interrogate the decision making surrounding his care through that prism unpressured by outside influences and challenges that may impact on clinical decision making in real time. The benefit of coronial investigation, as distinct from the pursuit of legal liability, is to examine what lessons can be learned from hindsight to inform improvements to safety into the future. I accept that health practitioners involved in the

¹² Letter of Tasmanian health service dated 16 October 2025.

¹³ Dr Auchincloss report dated 9 December 2025 p 23.

care of those suffering mental illness are reliant, in addition to mental state examinations, on the history they are given and that history can be unreliable. DR whilst truthful concerning his suicidal ideation to Ms Towns was untruthful regarding the absence of any intent or plan to act on that ideation. Risk assessments are also not necessarily a good predictor of the risk of suicide.

It is not contentious that DR suffered severe hypomania in October 2023 in the context of homelessness, financial and relationship strain and substance abuse necessitating the obtaining of a treatment order and that following his discharge he became unwell with fever, insomnia, perspiration and chest pain and was using cannabis which may indicate unstable bipolar illness, amongst other differential diagnosis.¹⁴ The record of his consultation with Dr Miach on 16 November 2023 does not include a written record of assessment of the criteria for a treatment order under the MHA (section 7 and section 40) beyond noting that he had insight. DR presented at the 24 November 2023 assessment with Dr Miach as unwell, noncompliant or at least confused regarding his medication requirements. DR exhibited signs of relapse to hypomania and was experiencing significant psychosocial stressors as he had at the time of his initial illness in October 2023. The question as to whether his mental state was impaired to the degree that he lacked decision-making capacity and required assessment for a treatment order under the MHA was appropriate to ask at this time. The records do not disclose any consideration of this aspect of DR's care. DR's family suggest that at this consultation DR requested to be returned to the NWRH. Whether or not this occurred is not disclosed in the notes and I make no finding in respect of it.

I am unable to find that a more assertive approach to DR's discharge, psychiatric or community care, nor the maintenance or reinstatement of a treatment order under the MHA contributed to his death. However the failure to fully consider the criteria for assessing decision making capacity under the MHA, the decision that DR did have decision making capacity, the failure to reinstate a treatment order or at least more closely supervise him after his 23 November 2023 review are missed opportunities to interrupt his trajectory to suicide and I make the following **recommendations** pursuant to section 28 of the *Coroners Act* 1995:

1. Discharge arrangements for psychiatric patients must carefully consider and respond to stressors that may be destabilising on a patient's discharge; and

¹⁴ Letter of Tasmanian Health Service dated 16 October 2025.

2. Assessments for the existence of decision-making capacity within the meaning of the MHA should be recorded in writing and address all the criteria in the MHA (sections 7 and 40).

I extend my appreciation to investigating officer constable Nicholas Parsons for his investigation and report.

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

Dated: 13 April 2026 at Hobart, in the State of Tasmania.

Leigh Mackey
Coroner