IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2014 004216

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)
Section 67 of the Coroners Act 2008

Findings of:	Paresa Antoniadis Spanos, Coroner
Deceased:	PAR*
Date of birth:	18 January 1995
Date of death:	18 August 2014
Cause of death:	Plastic bag asphyxia
Place of death:	Taylors Lakes

*In this finding, the deceased's name and anything likely to identify him or his family has been redacted at the request of the Senior Next of Kin so that the Finding and Comment can be published on the Court's website, in accordance with general practice in this jurisdiction where there has been no inquest.

I, PARESA ANTONIADIS SPANOS, Coroner,

having investigated the death of PAR without holding an inquest:

find that the identity of the deceased was PAR

born on 18 January 1995

and that the death occurred on or about 18 August 2014

at a residential address in Taylors Lake

from:

I (a) PLASTIC BAG ASPHYXIA

Pursuant to section 67(1) of the **Coroners Act 2008**, I make findings with respect to **the following circumstances**:

1. PAR was a 19-year old university student who lived with his mother and sisters in Taylors Lakes.

2. According to PAR's mother, MA, when PAR returned from a holiday in Thailand in January 2014 he complained about excessive sweating in his groin area that caused him considerable distress. He saw several doctors and underwent investigations that did not reveal a cause of the sweating. It is not clear if PAR actually experienced a physical issue with sweating or if this was a symptom of mental health issues such as extreme self-consciousness. Regardless, his belief that he was sweating excessively had a detrimental impact on his mental health leading to social withdrawal and a depressed/anxious mood.

3. MA saw changes in her son's mood: he became more angry and upset, would yell at his family and on one occasion said he did not want to live. MA took PAR to the Calder Medical Clinic where he saw General Practitioner [GP] Dr Jeffrey Salter on 23 June 2014 and again on 28 July 2014. Although reluctant at first, at the July consultation PAR agreed to commence antidepressant medication and was commenced on a Serotonin-Noradrenaline Reuptake Inhibitor [SNRI], desvenlafaxine ("Pristiq"), at a starting dose of 50mg daily and was to return in four weeks' time for review and titration of the dose.

4. On Sunday 17 August 2014, PAR engaged in social activities with his family and appeared to be his normal happy self. When they returned home in the late afternoon, PAR went to his room and appeared occupied on his computer. Later he sent his oldest sister a text message saying he would not be going to university the next day.

5. On Monday 18 August 2014, MA went to work as usual. Mid-morning PAR sent her a text message asking her to pick up some of his favourite foods for dinner. MA arrived home at about 4.00pm. She spoke to her sister on the phone for about 15 minutes and was in the

process of leaving again to do the grocery shopping when she noticed PAR's bedroom door was closed and thought he might be having a nap. When she knocked and entered she saw her son lying on the bed with a plastic bag on his head. She ran to the bed and removed the plastic bag but realised he was dead.

6. MA was distraught but managed to call 000 and follow the operator's instructions to perform cardiopulmonary resuscitation with the assistance of a neighbour who responded to her cries for help.

7. Ambulance paramedics and police officers arrived a short time later, the former confirming that PAR was deceased and the latter to commence an investigation of his death. One of the attending police officers was First Constable Adam Sekoa from Keilor Downs Police who prepared the brief on which the coronial investigation is largely based. The brief included evidence that PAR purchased the plastic bag, helium gas and the headband used to secure the plastic bag around his head on the day of his death.

8. There was no autopsy as the family indicated a preference for no autopsy given the circumstances. However, at my direction, Forensic Pathologist Dr Joanna Glengarry from the Victorian Institute of Forensic Medicine [VIFM] reviewed the circumstances as reported by the police and post-mortem CT scanning of the whole body [PMCT] and conducted an external examination of the body in the mortuary. Dr Glengarry found no evidence of injury on external examination or PMCT and no evidence of natural disease other than diffuse lung opacification on PMCT and advised that it would be reasonable to attribute death to *plastic bag asphyxia.*

9. As regards the role played by helium, Dr Glengarry advised that while helium gas is not toxic in itself, it displaces oxygen from within the plastic bag leading to asphyxia or lack of oxygen.

10. After consideration of the brief compiled by F/Const Sekoa, I focused further investigative efforts on the clinical management and care provided to PAR by Dr Salter in the two months immediately preceding his death. I asked a Mental Health Investigator [MHI][1] from the Coroners Prevention Unit to assess the clinical management and care provided by Dr Salter.

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[1] Mental Health Investigators [MHI] are part of the Coroners Prevention Unit [CPU] established in 2008 to strengthen the prevention role of the Coroner. CPU assists the Coroner to formulate prevention recommendations and comments, and monitors and evaluates their effectiveness once published. MHI is staffed by appropriately qualified clinicians who are independent of the health professionals or institutions involved. They assist the Coroner's investigation of deaths occurring in the mental healthcare setting by evaluating the clinical management and care provided and identifying areas of improvement so that similar deaths may be avoided in the future.

11. At the suggestion of the MHI, I asked Dr Salter to provide a more fulsome statement than the brief one provided to F/Const Sekoa and he provided an eight page letter and two annexures. The MHI considered this statement and Dr Salter's clinical records and advised that:

   a. Dr Salter's summary of treatment provides evidence that he completed reasonable and comprehensive assessments of PAR on 23 June and 28 July 2014, including assessment of his mental state, thoughts of self-harm and psychosocial issues. The later assessment resulted in a diagnosis of depression and prescription of desvenlafaxine. Although Dr Salter did not utilise any formal test of depression (such as the K10 Kessler Psychological Distress Scale) there is no requirement to do so, and the value of such tests is subjective.

   b. During both appointments, Dr Salter reportedly encouraged PAR to see a psychologist or other counsellor but he refused. Non-pharmacological approaches are the first line treatment for depression across all ages and this is included in the National Health and Medical Review Council's Clinical Practice Guidelines on Depression in Adolescents and Young People 2011 [NHMRC Guideline]. Counselling can only occur, and be effective, if the patient is willing to engage in it.

   c. Dr Salter stated that he prescribed desvenlafaxine to PAR because he knew it to be efficacious for the mixed anxiety and depression with which he presented and that it was less likely to cause male sexual dysfunction than many other antidepressants.

   d. The preferred antidepressant identified in the NHMRC Guideline is fluoxetine, a Selective Serotonin Reuptake Inhibitor [SSRI], because research shows that it is likely to be effective in the treatment of depression in adolescents, though further research is required.

   e. Product information in relation to both desvenlafaxine and fluoxetine includes warnings about clinical worsening, including the possibility of increased suicidality in young adults. It also indicates that the safety of use by children and adolescents has not been established for either antidepressant.

   f. Dr Salter's selection of desvenlafaxine does not comply with the NHMRC Guideline, but there is no evidence it was more likely to cause adverse events or that it was less likely to be effective in treating PAR's mixed anxiety and depression than the recommended drug.

   g. Dr Salter's summary of treatment suggests that the 28 July 2014 consultation was not rushed and included education about the causes of depression and anxiety and

treatment options, including psychological counselling and the benefits and risks of antidepressants. There is nothing to suggest there was a need to refer PAR to a youth mental health service; indeed, it is evident that Dr Salter had no reluctance in referring his patient for specialist review when it was indicated.

h. The GP's management plan was for PAR to commence desvenlafaxine, consult the pain management clinic for which a referral was provided (back pain was perceived to contribute to his mental state) and return for review in four weeks. Dr Salter's rationale for scheduling a review in four weeks was that he had commenced PAR on a low dose and was planning to increase the dosage slowly. Further, PAR did not present as at risk and Dr Salter knew him and his family to be reliable and compliant with advice.

i. The NHMRC Guideline recommends that young adults commenced on antidepressants be reviewed within seven days and weekly for four weeks thereafter. This level of monitoring and appointments with a GP requires the agreement of the patient, who may find non-bulk-billed consultations expensive.

j. The NHMRC Guideline does not stipulate the type of monitoring required (that is whether face-to-face with the clinician, by telephone, by family/friends) but it is reasonable to expect that in the treatment of young people some contact is made by either patient or prescriber that is aimed at assessing the efficacy of new medication and the emergence or exacerbation of any psychiatric symptomology. However, given the lack of reported negative change in PAR's presentation by his mother and friend, it is unlikely that even if Dr Salter had reviewed PAR within seven or 14 days of commencing desvenlafaxine it would have prevented his death.

12. The MHI concluded that it was not unreasonable for Dr Salter to diagnose and treat PAR for mixed anxiety/depression. Moreover, it was difficult to establish a direct link between PAR's suicide and either Dr Salter's choice of desvenlafaxine or a four-week period for review.

13. I find that PAR, late of Taylors Lakes, died there on or about 18 August 2014 and that the cause of his death was plastic bag asphyxia. Although his family were aware of his distress, and assisted him to access medical help, it is tolerably clear that there was nothing overt in PAR's behaviour proximate to his death to indicate heightened distress or that he would take the course he ultimately did. Given the lethality of the means he chose, I am satisfied that PAR intended to take his own life.

14. Although Dr Salter's management of PAR following his diagnosis of anxiety/depression did not adhere to all aspects of the NHMRC Guideline, the GP's management was not unreasonable in the circumstances. I am unable to conclude on the basis of the available evidence that there is a causal link between Dr Salter's management – either his choice of desvenlafaxine or a four-week period for review – and PAR's apparently impulsive suicide.

COMMENT/S

Pursuant to section 67(3) of the ***Coroners Act* 2008**, I make the following comment on a matter connected with the death:

1. General Practitioners routinely diagnose and treat young adult, aged 18-24 years, who have anxiety and depression. They also provide ongoing monitoring and management of these conditions.
2. The National Health and Medical Research Council has developed the Clinical Practice Guideline on Depression in Adolescents and Young People (2011) which provides evidence-based information to guide the treatment of young adults in the primary health care setting.

RECOMMENDATION

Pursuant to section 72(3) of the ***Coroners Act 2008***, I make the following recommendation on a matter connected with the death:

1. That the Royal Australian College of General Practitioners draws its members' attention to the National Health and Medical Research Council Clinical Practice Guideline on Depression in Adolescents and Young People (2011).
2. That the National Health and Medical Review Council considers how it might improve the way in which it promulgates clinical guidelines and draws the attention of clinicians to them.

I direct that a copy of this finding be provided to the following:

PAR's mother and father

Dr Salter C/- Avant Law

First Constable Adam Sekoa c/o Officer in Charge, Keilor Downs Police

Royal Australian College of General Practitioners

National Health and Medical Review Council

Signature:

PARESA ANTONIADIS SPANOS
CORONER
Date: 21 February 2017