IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2012 2550

# FINDING INTO DEATH WITH INQUEST

*Form 37 Rule 60(1)*
*Section 67 of the Coroners Act 2008* (Vic)

**Inquest into the Death of:** PETER ANDREW McNAY

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| Delivered On: | 6 October 2014 |
| Delivered At: | Coroners Court of Victoria<br>65 Kavanagh Street<br>Southbank, VIC 3006 |
| Hearing Dates: | 6 October 2014 |
| Findings of: | JOHN OLLE, CORONER |
| Coroner's solicitor | Kate Hamilton |

I, JOHN OLLE, Coroner having investigated the death of PETER ANDREW McNAY
AND having held an inquest in relation to this death on 6 October 2014
at Melbourne
find that the identity of the deceased was PETER ANDREW McNAY
born on 11 October 1961
and the death occurred on 1 July 2012
at 3/152 Duke Street, Braybrook VIC 3019
from:

1 (a) HANGING

in the following circumstances:

1. Peter McNay was born on 11 October 1961 and was 50 years old at the time of his death. He resided alone at Braybrook and is survived by his mother Gwendoline Lee and brothers Graham and Ian McNay. He has been described by his mother as a generous, kind-hearted, sensitive and conscientious individual.

2. A coronial brief was provided by Victoria Police to this Court, comprising statements obtained from family, witnesses, treating clinicians and investigating officers. It has wholly addressed the circumstances surrounding Mr McNay's death and I have drawn on all of this material as to the factual matters in this finding.

**SUMMARY INQUEST**

3. At inquest, a summary was read into evidence by Coroner's solicitor, Kate Hamilton. I am satisfied that the summary accurately reflects the evidence.

4. Mr McNay had a history of substance abuse since the age of 13, including alcohol, marijuana and heroin. He continued to use alcohol and marijuana, but ceased using heroin in 2009.[1] In April 2011 Mr McNay's brother Laurie committed suicide. Mr McNay attended counselling to assist in grieving the loss of his brother[2] and later reported to his general practitioner, Dr Eric Salter, that since that event he returned to old habits of smoking marijuana and getting drunk.[3]

[1] Neuropsychological report by Martin Jackson, dated 26 August 2010.

[2] Statement of Gwendoline Lee, dated 1 May 2013, 2.

[3] Report of Dr Eric Salter, dated 11 October 2013, 2.

5. Mr McNay also had a mental health history including past diagnoses of situational crisis, polysubstance abuse, depressed mood, generalised anxiety secondary to alcohol and heroin abuse, depression and cluster A and B personality traits.[4] He had multiple contacts with mental health and Drug and Alcohol services, including involuntary psychiatric admissions, and had a history of self-harm and multiple suicide attempts. Prior to the day of his death, Mr McNay's last contact with a mental health service occurred on 18 and 19 June 2012 after an incident involving his mother and the police. He was taken to Western General Hospital by police and was assessed by a mental health clinician, who determined that Mr McNay did not appear depressed and his judgment was intact, but that there were longstanding personal and social issues leading to a situational crisis.[5]

6. On 1 July 2012 at approximately 2.32pm[6] Mr McNay contacted Mercy Mental Health Crisis Assessment and Treatment Team (CATT) and spoke to Registered Psychiatric Nurse Melissa VanDenOever. He stated that wanted to hang himself and that he had been thinking about it for over a year since his brother committed suicide. Ms VanDenOever asked Mr McNay for his name, date of birth and address, which he provided with minimal prompts. She then attempted to explore Mr McNay's protective factors and asked questions including whether there was anything he could think of like family, friends, pets or anything significant to him that might keep him from harming himself, to which Mr McNay responded 'not one single thing'. Ms VanDenOever then attempted to establish Mr McNay's immediate risks by asking if he had any specific plans to hang himself and if he had the means to do so. Mr McNay responded that he was standing on top of the washing machine trying to tie a noose while he was talking to her. Ms VanDenOever stated that she wanted to help him, to which he replied 'you can't help me, nobody can help me'. She advised him that she needed to contact police so that they could perform a welfare check and Mr McNay responded 'I'll be fine' and terminated the call.[7]

7. Ms VanDenOever immediately contacted triple-0 at 2:34:54pm and requested a welfare check. At 2:35:52pm police were despatched to Mr McNay's house and arrived at

[4] Report of Dr Dean Stevenson, Clinical Services Director at Mercy Public Hospitals Incorporated, dated 17 October 2013, 1-2.

[5] Ibid 4.

[6] Statement of Constable Reece Duffield, dated 23 April 2013, 3.

[7] Statement of Melissa VanDenOever, dated 24 December 2012, 1.

2:47pm.[8] Police entered the residence via an unlocked front door and announced their presence. They located Mr McNay in the bathroom hanging from a black rope attached around his neck with the other end attached to a beam inside an open manhole. One police member immediately lifted Mr McNay to take the pressure off his neck while another police member cut the rope with a knife. Mr McNay was placed on the ground and the rope was removed from around his neck. He was not breathing and police administered CPR until paramedics arrived, who then attended to Mr McNay and confirmed that he was deceased.

**Evidence given at summary inquest**

8. Senior Constable Reece Duffield gave evidence at inquest in relation to the response of Victoria Police. Police were despatched at 2:35pm from Footscray Police Station, located seven kilometres from Mr McNay's residence. At the time of despatch it was raining lightly and the roads were wet. Police utilised police lights and sirens the entire duration of the journey to Mr McNay's residence, but due to the weather conditions were limited in relation to how fast they could travel. On the way police conducted a LEAP check which revealed that Mr McNay had a prior history of violence towards police. Consequently, due to standard police safety procedures the unit was advised to wait for the Police Sergeant to attend before entering the residence. Police waited outside the residence for approximately two minutes before entering the residence with the Sergeant. The duration of the trip was 13 minutes.

9. Mr McNay's mother Gwen Lee attended at, and addressed, the Court. Mrs Lee spoke eloquently about her son, and raised concerns regarding his death. One particular concern was in relation to why Footscray Police attended at Mr McNay's residence, rather than Sunshine Police, who are located in closer proximity. S/C Duffield gave evidence that this was a boundary issue. As Mr McNay lived on the Braybrook side of Duke Street, an area covered by Footscray Police, Footscray Police attended. However, S/C Duffield stated that Sunshine Police were contacted and requested to despatch, however were unable to attend due to no police units being available.

10. Mrs Lee spoke positively of staff at the Royal District Nursing Homeless Service for their assistance in helping Mr McNay obtain counselling for his mental health issues. She stated that help of this kind could be useful for people with mental health issues. I

[8] Statement of Constable Reece Duffield, above n 6, 2.

commend the Royal District Nursing Homeless Service for their ongoing support of those with mental health issues.

**POST-MORTEM INSPECTION AND REPORT**

11. A post-mortem inspection and report was undertaken by Dr Jacqueline Lee, Forensic Pathologist at the Victorian Institute of Forensic Medicine. Dr Lee reported that external examination of Mr McNay's body showed an incomplete up-going ligature groove. There was no other evidence of injury.

12. Toxicological analysis of blood detected the presence of alcohol, methadone, Diazepam, Nordiazepam and Quetiapine. Dr Lee reported that in the absence of a full post-mortem examination, rational interpretation of any toxicological analysis may not be possible.

13. Dr Lee determined that the cause of death is hanging.

**FINDING**

14. I am satisfied, having considered all of the evidence before me, that no further investigation is required. Mr McNay appeared to be troubled with personal and mental health matters, despite the support he received from family and treating clinicians.

15. I am satisfied that Mr McNay intentionally took his own life and that there were no suspicious circumstances.

16. I find that Victoria Police and Ambulance Victoria responded in a timely and appropriate manner.

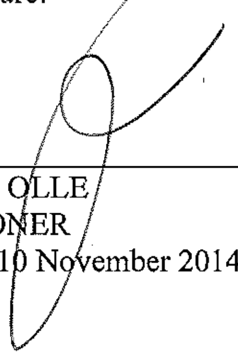
17. I find that the conduct of the Mercy Mental Health Crisis Assessment and Treatment Team, in particular Ms VanDenOever, was reasonable and appropriate in the circumstances.

18. I find that Peter Andrew McNay died on 1 July 2012 and that the cause of his death is hanging.

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

The family of Peter McNay;
Investigating member, Victoria Police; and
Interested parties

Signature:



JOHN OLLE
CORONER
Date: 10 November 2014