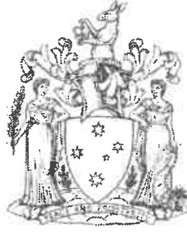

IN THE CORONERS COURT

OF VICTORIA

AT MELBOURNE

Court Reference: COR 2016 2346

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)

Section 67 of the ***Coroners Act 2008***

Findings of:	Paresa Antoniadis Spanos, Coroner
Deceased:	Julie Ann Lindsay
Date of birth:	14 November 1961
Date of death:	On or about 25 May 2016
Cause of death:	Shotgun discharge to the head
Place of death:	Mount Prospect, Victoria

INTRODUCTION

1. Julie Ann Lindsay was a 54-year old divorced woman who resided alone in a rented farmhouse in Mount Prospect and had been employed as a Human Resources/Payroll Office at Nature's Cargo since January 2016. She was the mother of James and Stephanie. Stephanie died in a car accident in 2012 and her death had a profound effect on Ms Lindsay, who never recovered from the loss.

2. Ms Lindsay had a medical history of neurological neoplasm, Meniere's Disease, benign positional vertigo, post-traumatic stress disorder and depression. Her depression began in about 2005, with episodes often triggered by workplace stress. Ms Lindsay had a history of admission to a mental health facility.

CIRCUMSTANCES IMMEDIATELY PROXIMATE TO DEATH

3. On 25 May 2016 Amanda Ford from Ballarat Mental Health Services telephoned Victoria Police and requested they perform a welfare check on Ms Lindsay. Ms Ford believed Ms Lindsay was suicidal due to her recent behaviour and comments and had not been answering her phone.

4. Leading Senior Constable Geoff Davies attended Ms Lindsay's farmhouse. Ms Lindsay's car was parked beside the house. The back door was open, and the house was neat and tidy. There was no sign of Ms Lindsay.

5. A short while later LSConstable Davies contacted the son of Ms Lindsay's landlord George Haintz, who commented that he and his family had observed a change in Ms Lindsay's demeanour lately. He said she did not look well and had seemed extremely down and depressed.

6. Mr Haintz accompanied LSC Davies down to a shed on the property near a dam Ms Lindsay was known to frequent. He found her lying deceased near the dam. A gunshot wound to the head was apparent.

CORONIAL INVESTIGATION

7. Victoria Police commenced investigation of Ms Lindsay's death pursuant to directions from the coroner. A letter to Ms Lindsay's son James Lindsay evincing her intention to end her own life and a 'to do' list was found.[1] A double-barrelled, over

[1] Ms Lindsay also mailed a suicide letter to her son.

and under 12-guage shotgun was in situ, partially under Ms Lindsay. One cartridge in the shotgun had discharged, and there was another cartridge still in the chamber. A 60-centimetre thin piece of pine was in Ms Lindsay's hand and a thin piece of cord wrapped around her ankle. The firearm was registered to Ms Lindsay.

8. One of the attending police officers was LSC Davies from Creswick Police who investigated Ms Lindsay's death and compiled the coronial brief on which this finding is largely based. The brief includes statements from Frederick Haintz, her General Practitioner (GP), LSC Davies, photographs depicting the scene and photographs taken during the examination of Ms Lindsay's body in the mortuary at the Coronial Services Centre.

9. After receiving the brief, I sought a statement and employment related documentation from Ms Lindsay's former employer, Nature's Cargo, a statement and medical records from psychologist Mark Poyser, medical records from Ballarat Mental Health and the Springs Medical Centre and a further statement from her GP. I also obtained a report from one of the court's in-house Mental Health Investigators (MHI) within the Coroners Prevention Unit (CPU).[2]

PURPOSE OF A CORONIAL INVESTIGATION

10. The purpose of a coronial investigation of a *reportable death*[3] is to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.[4] For coronial purposes, *death* includes suspected death.[5] Ms Lindsay's death clearly falls within the definition of reportable death.

11. The *cause* of death refers to the *medical* cause of death, incorporating where possible the *mode* or *mechanism* of death. For coronial purposes, the *circumstances* in which

[2] The CPU are a specialist unit in the court that is staffed with practicing physicians, nurses and other allied health clinicians who are independent of the health services being investigated.

[3] The term is exhaustively defined in section 4 of the ***Coroners Act 2008*** [the Act]. Apart from a jurisdictional nexus with the State of Victoria a reportable death includes deaths that appear to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from an accident or injury; and, deaths that occur during or following a medical procedure where the death is or may be causally related to the medical procedure and a registered medical practitioner would not, immediately before the procedure, have reasonably expected the death (section 4(2)(a) and (b) of the Act).

[4] Section 67(1).

[5] See the definition of "death" in section 3 of the Act.

death occurred refers to the context or background and surrounding circumstances but is confined to those circumstances sufficiently proximate and causally relevant to the death, and not all those circumstances which might form part of a narrative culminating in death.[6]

12. The broader purpose of any coronial investigations is to contribute to the reduction of the number of preventable deaths through the findings of the investigation and the making of recommendations by coroners, generally referred to as the *prevention* role.[7]

13. Coroners are empowered to report to the Attorney-General in relation to a death; to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and to make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice.[8] These are effectively the vehicles by which the coroner's prevention role can be advanced.[9]

14. It is important to stress that coroners are not empowered to determine the civil or criminal liability arising from the investigation of a reportable death and are specifically prohibited from including in a finding or comment any statement that a person is, or may be, guilty of an offence.[10]

IDENTIFICATION

15. Ms Lindsay's identity was not contentious and her landlord, Fred Haintz, signed a Statement of Identification dated 25 May 2016 before a member of Victoria Police at the scene. The issue of identity warranted no further coronial investigation.

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[6] This is the effect of the authorities – see for example *Harmsworth v The State Coroner* [1989] VR 989; *Clancy v West* (Unreported 17/08/1994, Supreme Court of Victoria, Harper J.)

[7] The 'prevention' role is now explicitly articulated in the Preamble and purposes of the Act, compared with the *Coroners Act 1985* where this role was generally accepted as 'implicit'.

[8] See sections 72(1), 67(3) and 72(2) regarding reports, comments and recommendations respectively.

[9] See also sections 73(1) and 72(5) which requires publication of coronial findings, comments and recommendations and responses respectively; section 72(3) and (4) which oblige the recipient of a coronial recommendation to respond within three months, specifying a statement of action which has or will be taken in relation to the recommendation.

[10] Section 69(1). However, a coroner may include a statement relating to a notification to the Director of Public Prosecutions if they believe an indictable offence may have been committed in connection with the death. See sections 69 (2) and 49(1).

MEDICAL CAUSE OF DEATH

16. Ms Lindsay's body was brought to the Coronial Services Centre. Forensic pathologist Dr Greg Young from the Victorian Institute of Forensic Medicine (VIFM), conducted an external examination of Ms Lindsay's body in the mortuary and reviewed the circumstances of death as reported by police to the coroner, medical records from the Springs Medical Centre and Mr Poyser, two notes authored by Ms Lindsay, photographs of the scene and post-mortem CT scanning of the whole body undertaken at VIFM (PMCT).

17. Dr Young advised that external examination showed extensive injuries to the head and no other unexpected signs of trauma. Further that review of the PMCT confirmed extensive disruption of the skull with multiple metal pellets seen within the head. No other significant pathology was seen.

18. Routine toxicological analysis of post-mortem samples taken from Ms Lindsay's body did not detect alcohol or any other commonly encountered drugs or poisons.

19. Based on the external examination and the PMCT, Dr Young considered that the findings appeared consistent with an intra-oral shotgun discharge to the head.

20. Dr Young advised that it would be reasonable to attribute Ms Lindsay's death to *1(a) shotgun discharge to the head*, without the need for an autopsy.

CIRCUMSTANCES IN WHICH DEATH OCCURRED

21. Shortly after her daughter's death in March 2012, Ms Lindsay moved to a farmhouse situated on the property of the Haintz family in Mount Prospect.

22. In 2013, during radiation treatment for a benign right glomus jugulare tumour[11], Ms Lindsay's landlord often cared for her. She told her landlord that she was suicidal and angry about having to pay for her treatment privately, which placed her under financial pressure. At the time Ms Lindsay was receiving treatment via Skype from a psychologist in Shepparton where she had previously resided.

[11] A glomus jugulare tumour is a usually benign tumour of a part of the temporal bone in the skull. These tumours can affect the ear, upper neck, base of the skull and the surrounding blood vessels and nerves. Symptoms include difficulty swallowing, dizziness, hearing loss, pulsations in the ear, hoarseness, pain and facial nerve palsy.

23. On 4 January 2016, Ms Lindsay commenced employment as a part-time Banking Officer at Nature's Cargo.[12] Subsequently, she was promoted to the position of Payroll/Human Resources Officer with an accompanying pay rise and full-time hours.

24. Ms Lindsay attended four sessions with a psychologist between 1 March and 6 May 2016. The first appointment was with Alexandra Shuttlesworth during which Ms Lindsay reported profound grief over the death of her daughter, and that she felt overworked and underpaid at Nature's Cargo. On the K10[13], Ms Lindsay scored 32, which placed her in the 'severe' range. Although distressed, Ms Lindsay's levels of anxiety and depression were manageable.

25. Her next three appointments were with psychologist Mark Poyser. At a session on 15 April 2016, Ms Lindsay described herself as increasingly teary and angry and 'stuck'. Ms Lindsay reiterated her close relationship with her daughter and the possibility that she was suffered from Post Traumatic Stress Disorder was explored. Mr Poyser considered she was suffering from a severe and chronic trauma reaction. As Ms Lindsay reported having panic attacks, they worked on devising a panic attack plan.

26. At some point, Ms Lindsay began to experience conflict with a co-worker at Nature's Caro. In an email to the Managing Director[14], Ms Lindsay stated her belief the co-worker was campaigning against her and that she had moved offices to avoid the snide comments and discontent reportedly directed at her.

27. On 15 April 2016, Ms Lindsay attended an appointment with her GP. She was teary and upset and could not pinpoint exactly why she felt that way. She explained that there were multiple issues that were distressing her -her ankle was bothering her, she remained angry about the treatment for her tumour and she was struggling with people at work. Ms Lindsay thought ceasing antidepressant medication may have been a mistake but was not keen to recommence. An appointment with Mr Poyser was scheduled for later that day.

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[12] A wholesale foodservice supplier.

[13] A widely used scale measuring psychological distress.

[14] This email was sent on 12 May 2016. There was no evidence that Ms Lindsay raised this as an issue before 12 May 2016.

28. At an appointment with her GP on 22 April 2016 Ms Lindsay reported she had been doing well since her last visit. She felt that Mr Poyser had helped her and she planned to return for another appointment.[15] She was pleased about being promoted at work. The GP gave her a script for the antidepressant escitalopram.

29. Ms Lindsay returned to Mr Poyser on 6 May 2016. She reported a recent promotion at work and that she felt she was finally being recognised for her skills and experience. However, she was doing her old job as well as her new one, which left her feeling exhausted and overwhelmed. Nevertheless, she was pleased with her promotion.

30. On 10 May 2016, Ms Lindsay met with the Managing Director (MD), General Manager and Chief Financial Officer of Nature's Cargo, as well as the colleague with whom she had a reportedly conflictual relationship. The meeting was convened at short notice as Nature's Cargo were reportedly only informed of an issue about an hour earlier. According to the MD, the purpose of the meeting was to discuss Ms Lindsay's concerns. However, to the MD, relations between Ms Lindsay and her colleague appeared tense and the meeting was forced to conclude without resolution.

31. Ms Lindsay emailed the MD the next morning and apologised for the incident. She expressed that she loved her job, but the loss of her daughter and breakdown left her doubting she was a good person. Ms Lindsay went on to write that she felt victimised by her colleague who she believed had been speaking negatively about her to others colleagues who had ostracised her in turn. Their conduct had caused her to suffer a panic attack and go into "flight and hide mode".

32. The MD replied to her email that afternoon and expressed regret that the personality clash had occurred at a time when Ms Lindsay was already vulnerable. He commented that a very busy and robust workplace like Nature's Cargo can bring its own challenges but thanked Ms Lindsay for her service and gave his best wishes for the future. Nature's Cargo were not aware of Ms Lindsay suffering from any medical or mental health condition.

33. Seemingly affronted, Ms Lindsay replied at 1:02am on 13 May 2016 and wrote "*Your email.... was caring and I'm sure genuine, but the comment inferring I'm unable to*

[15] Ms Lindsay attended a further appointment with Mr Poyser on 29 April 2016.

cope in a busy work environment is insulting." Ms Lindsay said she had been blindsided by the meeting and felt she could no longer work at Nature's Cargo, writing, "*I may be a sensitive person, but I will never accept insinuations that I'm not excellent at my profession.*"

34. At 1:47am, Ms Lindsay sent an email to the General Manager of Nature's Cargo thanking him for his support but that she felt she could not return to work after the 10 May 2016 meeting. Ms Lindsay stated she was considering her options and reiterated how offended she was at the supposed intimation she was not up to the job. Ms Lindsay did not return to Nature's Cargo and received termination pay.

35. In the week preceding her death, Ms Lindsay euthanized her cat, sent her dog Lilly to a kennel and gave her pony Minnie to friends to care for.

36. Ms Lindsay spoke to Mr Poyser on 23 May 2016 and explained that she had had a severe panic attack at her workplace and "ran away". She said that she had become overwhelmed with the pressure of performing two jobs and was exhausted. Ms Lindsay said she had been fired because she left the workplace after the panic attack. This had caused her a severe crisis and she had become suicidal[16]. Ms Lindsay told Mr Poyser that she would see her GP the next day at 10:00am and he arranged to call her after this at 11:30am and made an appointment for the following week. Ms Lindsay said she was terrified she would be locked up if she told her GP she had attempted to end her own life.

37. On 24 May 2016 Ms Lindsay attended an emergency appointment with her GP. The progress notes described Ms Lindsay as being in "absolute crisis". Ms Lindsay said she had fallen apart since she 'passively quitting' her job and had a good plan to end her own life over the weekend but would not disclose any details. She had given away her clothing and belongings, mailed a note and important documents to her son, and mailed a letter to Creswick Police telling them where to find her body. Ms Lindsay told her GP that the reason she had not ended her own life was because she was a "chicken" but she added that she now felt safe and had no plan to die. According to her note, the GP enquired about Ms Lindsay's plans several times but she would not disclose the details.

[16] Mr Poyser stated that Ms Lindsay had been distressed in their prior sessions but never suicidal.

38. Ms Lindsay said she planned to call Mr Poyser soon after her appointment to request a crisis consultation. Her plan for the day was to get some sleep and pick up Lilly and take her for a walk. She also said that she would make enquiries about accessing a disability support and would bring the forms to the GP if she needed help with them. Ms Lindsay's GP reiterated that she was very glad she was alive and impressed upon her that she needed to see Mr Poyser and make another appointment for later in the week. She stressed that the loss of Ms Lindsay's job was because of illness and was not performance based and recommended that Ms Lindsay begin the escitalopram that had been prescribed on 22 May 2016.

39. Mr Poyser spoke to Ms Lindsay after her GP appointment as planned, encouraged her to seek extra support from BHS-MHS and arranged to call her the following day.

40. On 25 May 2016, Ms Lindsay's GP referred her to the Ballarat Health Service Mental Health Service (BHS-MHS). Ms Lindsay's GP told the BHS-MHS that she was terrified of an involuntary admission and scared to be referred to a mental health service but was agreeable to immediate follow up from psychiatric services.

CORONERS PREVENTION UNIT

41. Given Ms Lindsay's recent contact with mental health services and her access to firearms, I sought an opinion from a clinician within the Coroners Prevention Unit (CPU) [17] about Ms Lindsay's clinical management and care proximate to her death as well as the impact of a recent workplace conflict.

Nature's Cargo

42. The CPU noted that Ms Lindsay was employed with Nature's Cargo for four months and no issues with her performance or attendance were noted. There was no evidence that Nature's Cargo were aware that Ms Lindsay was experiencing significant workplace stress prior to 10 May 2016. Once they did become aware, Nature's Cargo took steps to resolve the conflict between Ms Lindsay and her colleague but did not intervene further when Ms Lindsay did not return to work.

43. The CPU considered that it would have been reasonable to offer support such as an employee assistance program, even though Ms Lindsay resigned two days later. It

[17] The CPU is a specialist unit in the Court that is staffed by practicing physicians and allied health practitioners who are independent of the health services being investigated.

would also not have been unreasonable for Nature's Cargo to contact Ms Lindsay to explore her reasons for resigning and her access to support given the precipitous cessation of her employment.

Ms Lindsay's GP

44. Ms Lindsay's GP provided a further statement where she explained that she did not consider Ms Lindsay met the criteria for an involuntary admission to hospital as at their last consultation as she was not threatening to harm herself or others and was accepting of treatment. Ms Lindsay refused to discuss her earlier plan to take her life and accordingly, the GP could not explore whether she had the means to carry out the plan. Also , the GP was not aware that Ms Lindsay had access to a firearm.

45. With respect to Ms Lindsay's suicide risk, the GP did not consider she was obliged to initiate immediate contact with BHS-MHS. The progress note that read "*I will notify Psyche Triage of her fragile state*" was intended to ensure that BHS-MHS were updated on recent events and the names of involved practitioners if Ms Lindsay or anyone else contact them. During the final consultation Ms Lindsay's GP offered to contact BHS-MHS to obtain immediate help but Ms Lindsay declined, saying she felt more in control of herself, was afraid of an admission and felt more comfortable engaging with her current treatment team. Ms Lindsay's GP believed that the immediate crisis had passed as Ms Lindsay had demonstrated forward planning, an appointment was booked with her GP on 26 May 2016, she had spoken to Mr Poyser and booked an appointment with him on 27 May 2016.

46. The CPU considered that Ms Lindsay's appropriately conducted a suicide risk assessment, negotiated a safety plan and made a referral to BHS-MHS with Mr Lindsay's consent. However, Ms Lindsay's access to means was not explored as she declined to detail her plans and denied ongoing intent to act on her plan. Given the changeability of suicide risk, especially after a crisis and the increased rate of firearm suicides in regional Victoria[18], this failure to explore access to highly lethal means such as firearms was a missed opportunity. The CPU suggested this could have formed part of the negotiated safety plan, even though Ms Lindsay refused to disclose her suicide plan.

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[18] Between 2007 and 2016, 3% of suicides in metropolitan Melbourne were via firearm, whereas 10.8% of suicides in regional Victoria were via firearm.

47. The delay in referring Ms Lindsay to mental health services was another missed opportunity as it was possible that Ms Lindsay was already deceased when her GP contacted BHS-MHS. The CPU agreed that an immediate referral was not indicated but considered that a timely referral on the same day would have been appropriate in the absence of other supports to monitor Ms Lindsay overnight. A timely referral to mental health services would not necessarily have triggered an immediate response by BHS-MHS. However, BHS-MHS did unsuccessfully attempt to contact Ms Lindsay immediately after they received a referral, and over the following three and a half hours. It was BHS-MHS staff who requested a welfare check when Ms Lindsay could not be contacted during the four and a half hours after they received the referral.

48. The CPU concluded that while Ms Lindsay did not present as an immediate suicide risk and accordingly, did not require an immediate referral to mental health services, Ms Lindsay's GP had identified that her risks were such that a referral to BHS-MHS was indicated. Given her increased suicide risk and the changeable nature of suicide risk, the CPU considered that an immediate referral or at least a referral on the same day would have been appropriate. This would have been particularly prudent where other supports such as family and friends were not available to monitor for signs of deterioration overnight, as was the case with Ms Lindsay.

FINDINGS/CONCLUSIONS AS TO CIRCUMSTANCES

49. The standard of proof for coronial findings of fact is the civil standard of proof on the balance of probabilities, with the *Briginshaw* gloss or explications. [19]

50. Adverse findings or comments against individuals or institutions are not to be made with the benefit of hindsight but only on the basis of what was known or should reasonably have been known or done at the time, and only where the evidence supports a finding that they departed materially from the standards of their profession and in so doing caused or contributed to the death under investigation.

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[19] *Briginshaw v Briginshaw (1938) 60 C.L.R. 336 esp at 362-363. "The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding, are considerations which must affect the answer to the question whether the issues had been proved to the reasonable satisfaction of the tribunal. In such matters "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences…"*

51. Applying the standard of proof to the available evidence my conclusions are that:

   i) The deceased's identity was Julie Ann Lindsay, born 14 November 1961.

   ii) Ms Lindsay died at 290 Blampied-Mollongghip Road, Mount Prospect, on or about 25 May 2016.

   iii) Ms Lindsay's cause of death is shotgun discharge to the head.

   i) I am satisfied that the shotgun wound to Ms Lindsay's head was self-inflicted.

   ii) The lethality of means chosen, recent expressions of suicidality to treating clinicians and Ms Lindsay's letters to her son support a finding that she intentionally ended her own life.

   iii) While the available evidence does not support a finding that there was any omission on the part of Ms Lindsay's employer or any want of clinical management or care on the part of her GP that caused or contributed to her death, there were some missed opportunities that could have *potentially* changed the outcome.

COMMENTS

Pursuant to section 67(3) of the Coroners Act 2008, I make the following comments on a matter connected with the death, including matters relating to public health and safety or the administration of justice:

52. The Royal Australian College of General Practice has comprehensive education about suicide prevention that is available to GP's on their website. This resource covers access to means in suicidal patients and specifically discusses how to manage access to firearms when patients are deemed to be at risk of suicide.

53. Like Nature's Cargo, many workplaces have employee assistance and wellbeing programs that include access to psychologists or counsellors for support in relation to workplace and other life stressors. In the case of precipitous resignation and/or termination of employment in the setting of unresolved workplace conflict, it may be of benefit to take a proactive and supportive approach by extending access to employee assistance and wellbeing programs to former employees in the period immediate following the termination of employment.

RECOMMENDATION

Pursuant to section 72(2) of the Coroners Act 2008, I make the following recommendation/s on a matter connected with the death, including matters relating to public health and safety or the administration of justice:

54. Given the increased access to firearms in regional and rural areas, and their lethality as means of suicide, I recommend that the College of General Practitioners targets promotion of their comprehensive website education about suicide prevention to General Practitioners who treat patients in regional and rural areas.

PUBLICATION OF FINDING

55. Pursuant to section 73(1A) of the Act, I order that this finding and comments following an investigation into Ms Lindsay's death be published on the Internet in accordance with the rules.

DISTRIBUTION OF FINDING

56. I direct that a copy of this finding is provided to the following for their information:

The family of Ms Lindsay

Ballarat Health, Mental Health Service

Leading Senior Constable Geoffrey Davies (#29444) c/o O.I.C. Creswick Police

The Proper Officer, Royal Australian College of General Practitioners

The Proper Officer, Nature's Cargo

Signature:

Paresa Antoniadis Spanos

Coroner

Date: 19 January 2021