IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2018 6168

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)
*Section 67 of the **Coroners Act 2008***

Findings of:	Sarah Gebert, Coroner
Deceased:	Kent William THOMAS
Date of birth:	13 December 1949
Date of death:	10 December 2018
Cause of death:	*Hanging*
Place of death:	Waterloo Crescent Playground, St Kilda, Victoria
Relevant matters:	*Tinnitus*

INTRODUCTION

1. Kent William Thomas,[1] born on 13 December 1949, was 68 years old at the time of his death. He lived alone in an apartment in St Kilda.

2. Kent was survived by his two daughters, Sharon and Angela. He had a close relationship with his brother Geoffrey (**Geoff**) Thomas, but had a falling out with his mother in 1990 resulting in no further contact.

3. Kent was friendly with his neighbour of 20 years, Garry McElroy. Garry said,

   Kent was a really lovely guy and he would do anything for you, that was the type of guy he was. He also did a lot for the community and would do the gardening up the road and always cleaned the laundry at our apartment.[2]

4. On the morning of Monday, 10 December 2018, Kent was found deceased by a passer-by who was walking in the Waterloo Crescent Playground.

THE CORONIAL INVESTIGATION

5. Kent's death was reported to the coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.

6. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

7. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

8. Victoria Police assigned First Constable Martin Wilson-Ward (**FC Wilson-Ward**) to be the Coroner's Investigator. FC Wilson-Ward conducted inquiries on my behalf[3], including

[1] Referred to in my finding as 'Kent' unless more formality is required.
[2] Statement of Garry McElroy dated 26 March 2019.

taking statements from witnesses and submitting a coronial brief of evidence. The coronial brief comprises of statements including from Kent's brother, his treating general practitioners (**GPs**), Psychiatric Nurse Nigel Harrison, the forensic pathologist who examined him and investigating police, as well as other relevant documentation.

9. As part of the investigation, this case was also referred to the Coroners Prevention Unit (**CPU**).[4] The CPU were asked to review the treatment provided to Kent in the weeks prior to his death.

10. In the course of the coronial investigation copies of Kent's GP medical records from the Acland Street Medical Centre and Alfred Heath were also obtained.

11. This finding draws on the totality of the coronial investigation into Kent's death, including evidence contained in the coronial brief and information provided by the CPU. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[5]

Background

12. Kent was divorced for 30 years and had two children. Following his divorce he had a mental health admission (Pine Lodge) and there was a suggestion that he had engaged in superficial cutting behaviours. He reported that his marriage ended due to his alcohol use and gambling. Kent recovered from this episode, stopped gambling and reduced his alcohol intake.

13. In 2013 Kent experienced the onset of tinnitus.[6] Over the following months he found the ringing in his ears unbearable, was unable to sleep, and tried various medications to relieve symptoms and assist sleep, with limited success. He gave up working as a taxi driver (which he did for enjoyment rather than financial need) as he found it difficult to drive as a result of the condition. Geoff described him as often looking tired during this time. He also had his first contact with mental health services as he experienced suicidal ideation secondary to

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[3] The carriage of the investigation was transferred from Deputy State Coroner English.

[4] The Coroners Prevention Unit (CPU) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the Coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. The CPU also reviews medical care and treatment in cases referred by the coroner. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.

[5] Subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

[6] The medical records suggest the onset commenced in late November 2013.

tinnitus. He was admitted to the Alfred Hospital Aged Mental Health ward in December 2013 for two weeks and received ongoing treatment from his GP.

14. In 2018 Kent spoke to Geoff about his difficulties living with tinnitus and while he did not express suicidal ideation, he told Geoff that *things were tough, and he was struggling to go on with life and couldn't see a way out*. Kent told Geoff that he had spoken to a funeral director about his funeral arrangements, but investigations following Kent's death did not find a record of contact with this funeral director.

15. In October 2018 Kent saw GP Dr Anna Finnegan while his usual GP at the same clinic was on leave. He reported that his mood had deteriorated but he declined Dr Finnegan's offer to refer him to a psychologist. At around the same time, his friend Garry noted a deterioration in Kent's mental state and when he spoke to him, Kent said that he was not well and didn't want to discuss it with anyone. Kent stopped answering the door to Garry at around this time and Garry noticed that Kent was not going out every day as he used to. Garry also noticed that Kent started going to bed a few hours earlier than usual. He thought Kent may be unwell with a medical condition, prompting the change in his behaviour. Garry reported that others in the apartment building had also noticed and were concerned about Kent's welfare.

16. On 13 November 2018, Geoff contacted Kent's usual GP Dr Khurram Akhter voicing concerns about Kent's mental health. Kent saw Dr Akhter on 28 November 2018 and reported worsening mood and fleeting suicidal ideation with no intent. Dr Akhter made an urgent referral to Alfred Health Mental Health services. Their community mental health team (St Kilda Road Clinic) made several unsuccessful attempts to contact him. After liaising with Dr Akhter, Psychiatric Nurse Nigel Harrison conducted a home visit to Kent on 7 December 2018.

17. Kent was reviewed outside his home as he reported that tradespeople were working inside at the time. Geoff was also present. Kent denied suicidal ideation, plan or intent but stated that if he didn't wake up tomorrow it wouldn't bother him. Kent said that he felt depressed and his major concern was tinnitus, which he was told would be lifelong. He confirmed that he was engaged with a GP who was treating his depression and tinnitus. Clinician Harrison suggested that Kent seek a second opinion regarding his tinnitus and informed Kent of a successful outcome with another patient in similar circumstances. Kent was offered an

admission however declined, as he didn't feel that he needed 'protection' from himself like he did in 2013 when he accepted an admission, stating '*I don't feel like that now*'.[7]

18. Kent was also offered a review by a psychiatric registrar or psychiatrist, which he accepted but sought reassurance that Clinician Harrison would attend. Another review was scheduled in 3-4 days to explore options for tinnitus management and in the meantime, Clinician Harrison planned to schedule an appointment for Kent with a psychiatry registrar or psychiatrist. Following the review, Geoff noted it as a *breakthrough* as Kent did not *take to people usually*.

19. Also on 7 December 2018, Kent gave Garry a house key and his brother's phone number without entering into any conversation. Garry had recently left a note in Kent's mailbox saying to contact him anytime if he needed anything. It was unclear whether this occurred before or after the review by St Kilda Road Clinic.

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Circumstances in which the death occurred

20. At 6.00am on Monday, 10 December 2018 Kent was found by a passer-by hanging from a tree in a playground near his home. Emergency services were called and police arrived at approximately 6.09am. Ambulance Victoria paramedics also attended and Kent was formally pronounced deceased at 6.20am.[8]

21. The scene was processed by police including detectives, and photographic evidence formed part of the coronial brief. A note was located in Kent's shirt pocket with Geoff's name and phone number, which police called and subsequently obtained Kent's details.

22. Police attended Kent's address and found a note on the door saying *door unlocked*. Inside the house, police found a suicide note addressed to Geoff. The note expressed his sorry and thanked his brother for everything he had done for him. Kent's license, credit card and seniors card were lined up along a shelf in the loungeroom.

23. Ultimately, no suspicious circumstances were found as a result of the police investigation.

[7] Statement of Nigel Harrison dated 2 May 2019.
[8] Verification of Death Form.

Identity of the deceased

24. On 18 December 2018, Geoffrey Thomas visually identified his brother, Kent William Thomas, born 13 December 1949.

25. Identity is not in dispute and requires no further investigation.

Medical cause of death

26. Specialist Forensic Pathologist Dr Joanna Glengarry from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an external examination on 11 December 2018 and provided a written report of her findings dated 14 December 2018.

27. Toxicological analysis of post mortem samples was subsequently undertaken and detected ethanol (~0.02 g/100mL), 7-Aminoclonazepam (~0.4 mg/L)[9] but not clonazepam, venlafaxine (~0.02 mg/L)[10] and its metabolite desvenlafaxine, codeine (~0.04 mg/L)[11] and mirtazapine (0.07 mg/L).[12]

28. Dr Glengarry provided an opinion that the medical cause of death was *Hanging.*

29. I accept Dr Glengarry's opinion.

CPU REVIEW

Review by Alfred Health Mental Health Services

30. The CPU concluded that the review by Clinician Harrison on 7 December 2018 appeared reasonable. Kent was recognised to be vulnerable due to worsening depression and ambivalence about living, though not at immediate risk given he denied active suicidal thoughts and agreed to engage in treatment. Kent declined an admission as he did not feel as bad as he did when previously admitted. He did not satisfy the criteria for compulsory treatment under that *Mental Health Act 2014* (Vic) at that time as he was willing to engage in treatment in the community and no immediate risks were identified. Kent was accepted for case management with a plan for a psychiatrist or psychiatric registrar review and exploring options for tinnitus management. A further appointment was made for 3-4 days'

[9] Clonazepam is a long acting benzodiazepine used as a preventative to individuals diagnosed with epilepsy and in palliative care. In addition, it is used for its sedating effects in patient with anxiety that has not responded to other treatments.
[10] Venlafaxine is an SNRI antidepressant used in the treatment of major depression, generalized anxiety disorder, panic disorder and social phobia.
[11] Codeine is an opioid analgesic that metabolises to morphine.
[12] Mirtazapine is indicated for the treatment of depression.

time and Geoff had plans to visit Kent during this period. This was an appropriate treatment plan which addressed the primary cause of Kent's deteriorating mental state.

31. St Kilda Road Clinic sought information via phone from Kent's GP prior to the review and involved Geoff in the review. The collateral information provided by Geoff after the review was positive and did not indicate that Geoff had immediate concerns for Kent.

Tinnitus Management

32. The available information indicated a clear relationship between Kent's experience of tinnitus and his deterioration in mental health and daily functioning.

33. A link between tinnitus and comorbid psychological disorders has been demonstrated and a high prevalence of anxiety and depression is seen in tinnitus sufferers.[13]

34. In such circumstances, appropriate treatment of tinnitus would be an important aspect of any treatment plan to address his mental health.

35. It was unclear when Kent was initially assessed for tinnitus, however there was evidence in the Alfred Health medical record of a tinnitus assessment by an Ear Nose Throat (ENT) specialist during Kent's 2013 mental health admission and he was referred to an ENT surgeon on discharge to discuss tinnitus management strategies however he did not attend the appointment. During this admission, Kent also either had an MRI or was advised to seek one on discharge.

36. There was also evidence that Kent was aware of masking strategies, as he told an Alfred Health community mental health clinician in 2014 that he played radio static through headphones, which helped.

37. At the time of his death, St Kilda Road Clinic discussed the possibility of further assessment of Kent's tinnitus. Other attempts to engage Kent included lifestyle strategies and

[13] Esmaili, A. and Renton, J. A review of tinnitus. Australian Journal of General Practice, 2018; 47(4). Psychiatric disorders are more common in individuals with tinnitus, especially chronic tinnitus. It has been suggested that tinnitus sufferers have a 78% lifetime prevalence of a major depressive disorder and a 60% prevalence of a current major depressive disorder, which was significantly higher than control subjects without tinnitus (21% and 7% respectively). Sullivan, M. D., Katon, W., Dobie, R., Sakai, C., Russo, J., & Harrop-Griffiths, J. (1988). Disabling tinnitus: Association with affective disorder. *General hospital psychiatry, 10*(4), 285-291. Other research suggested similar results and in addition, showed an increased rate of anxiety in tinnitus sufferers compared to the general population (26.1% vs 9.2%). Bhatt, J. M., Bhattacharyya, N., & Lin, H. W. (2017). Relationships between tinnitus and the prevalence of anxiety and depression. *The Laryngoscope, 127*(2), 466-469. A systematic review of 18 studies between 1982 and 2011 supported a positive correlation between tinnitus and depression. Geocze, L., Mucci, S., Abranches, D. C., Marco, M. A. d., & Penido, N. d. O. (2013). Systematic review on the evidences of an association between tinnitus and depression. *Brazilian journal of otorhinolaryngology, 79*(1), 106-111.

psychotherapy, which he was not keen on. Kent was regularly prescribed benzodiazepines by his GP to assist his sleep, which was disturbed due to tinnitus. Kent reported benefits from this medication.

38. His medical records from the Acland Street Medical Centre document that a hearing aid was discussed with Kent on 2 August 2018. There was a referral to a psychologist on 8 October 2018, which he declined and an attempt to refer him to the St Kilda clinic on 29 October 2018, which Kent said he would think about.

39. Kent would sometimes report thoughts of suicide, but with no intent. During his consultation on 29 October 2018, he expressed that the tinnitus had *destroyed* him.

40. CPU Mental Health has reviewed similar cases in which a deterioration in mental state and subsequent suicide appeared directly related to the onset and/or worsening of tinnitus.

41. Jenna Turner, Audiologist and Manager, Hearing Australia Melbourne, provided an expert opinion to the Court regarding *best practice* in the treatment of tinnitus and especially the management of distress associated with enduring tinnitus (See Comments and Attachment A).

CPU Conclusion

42. Kent experienced one episode of mental ill health following his divorce but remained well for 20 years until the onset of tinnitus. He experienced a deterioration in mental health in the two months prior to his death, prompting his GP to refer him to Alfred Health for assessment and management.

43. Alfred Health had one contact with Kent prior to his death and this review appeared reasonable. There was evidence of a thorough assessment (including a risk assessment), a treatment plan was developed in consultation with Kent and Geoff, Kent appeared to be happy with the outcome of the review and Geoff's opinion of the review and outcome was also positive. The treatment plan included a level of support that was appropriate in circumstances where Kent declined a voluntary admission and also addressed Kent's primary stressor.

44. I accept the CPU's advice on this matter.

Tinnitus suicide data

45. As part of this investigation the Victorian Suicide Register (**VSR**) was interrogated to identify suicides in the context of tinnitus and whether a history of mental ill health was noted. There were 19 cases of suicide in the context of tinnitus identified between 1 January 2009 and 31 December 2015 and a further nine cases between 1 January 2016 and 30 April 2020[14]. In total there are 28 known cases of suicide in the context of tinnitus.

46. On reviewing the available evidence (including findings where cases were closed), in eight cases tinnitus did not appear to contribute to the suicide and three were unclear whether tinnitus contributed to the suicide. Tinnitus contributed to the suicide in the remaining 17 cases, as indicated by suicide notes, internet search history and/or recent discussions.

47. In some cases, other confounding factors were identified such as unrelated health conditions, other stressors (such as relationship breakdowns, childhood trauma, incarceration and legal issues) and substance abuse, mental illness and personality disorders that predated the onset of tinnitus. While tinnitus was implicated in these suicides, it is impossible to ascertain the degree to which the other identified risk factors contributed. In five cases, it appeared that tinnitus was the only current stressor and there was no or minimal mental health history prior to the onset of tinnitus.

48. Of note, once cases in which the suicide was not clearly associated with tinnitus were eliminated, all of the remaining 17 cases were male,[15] 15 were aged 45 or over (88.2%) and 12 were aged 55 or over (70.6%).[16] These results may be, at least in part, due to males and older adults being more likely to experience tinnitus.

COMMENTS

49. Pursuant to section 67(3) of the Act, I make the following comments connected with the death.

Hearing Australia

50. Ms Turner, Hearing Australia noted,

[14] Limitations were noted with the data and two were added via other forms of interrogation.
[15] Between 1 January 2009 and 31 December 2018, 74.6% of all suicides recorded in the VSR were male.
[16] Between 1 January 2009 and 31 December 2018, 49.2% of all suicides recorded in the VSR were aged 45 or older and 28.9% were aged 55 or older.

People suffering with tinnitus can often feel isolated and devastated by uncontrollable noises in their head. Social Media and 'Common wisdom' are awash with ways to deal with tinnitus, from benign to extremely dangerous. Hearing Australia has trained audiologists who can assess and treat tinnitus.

51. Hearing Australia indicated that tinnitus related distress can be improved by education, reassurance, coping strategies and counselling. The aim of such strategies is to return the tinnitus to its proper, insignificant place within the brain and not have it dominating the patient's every waking thought and feeling. Hearing Australia stated that when treating tinnitus annoyance/disturbance, there is an overlap between allied health professionals, particularly between psychologists and specialist audiologists given the amount of counselling and active listening required. Collaborative treatment with doctors, mental health professionals and the patient should aim to find a solution to manage the tinnitus annoyance/disturbance with the aim of the patient achieving a good quality of life and full participation in activities.

52. It was suggested that practitioners treating patients who report tinnitus annoyance/disturbance, refer to an Audiologist to diagnose whether there is an untreated hearing loss possibly underlying the tinnitus, and if the patient does not have a hearing loss but does suffer from tinnitus annoyance then the Audiologist can provide a plan of action for managing the presentation by recommending tailored therapies.

53. The Court was advised that Hearing Australia is able to provide hearing and tinnitus assessments to all Australians and will collaborate with other health professionals to find solutions to manage presentations in order to achieve a good quality of life and full participation in activities. Ms Turner's advice is attached as Attachment A to this finding.

Learnings from similar investigations

54. Suicides in the context of tinnitus related distress is a theme that has been identified by the Coroners Court of Victoria. Seventeen cases have been identified since 2009 in which tinnitus related distress was directly linked to the deceased's decision to suicide and several other cases were identified in which tinnitus was diagnosed but insufficient information was available to clearly link the decision to suicide to tinnitus related distress. All 17 cases in which the deceased's decision to suicide was influenced by their experience of tinnitus distress were male and 15 were aged 45 years or over. In multiple cases, the deceased had no or minimal mental health history prior to the onset of tinnitus.

55. Cases investigated have demonstrated the high importance of early intervention for tinnitus related distress and a need to raise awareness of the significant impact and distress that tinnitus can cause.

RECOMMENDATIONS

56. Pursuant to section 72(2) of the Act, I make the following recommendations:

a. The Royal Australian College of General Practitioners work with Hearing Australia to develop a guideline for general practitioners to screen for and treat tinnitus related distress in 1) newly diagnosed cases of tinnitus in which investigations are still ongoing and 2) cases of tinnitus where investigations do not identify a cause and treatment does not adequately alleviate symptoms. Such a guideline should include a suicide risk assessment and appropriate treatment options for those identified as experiencing tinnitus related distress.

b. The Royal Australian College of General Practitioners promote awareness to general practitioners of the significant psychosocial impacts of tinnitus and tinnitus related distress, including associated risks and the risk of suicide.

FINDINGS AND CONCLUSION

57. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:

(a) the identity of the deceased was Kent William Thomas, born 13 December 1949;

(b) the death occurred on 10 December 2018 at Waterloo Crescent Playground, St Kilda, Victoria, from *Hanging*; and

(c) the death occurred in the circumstances described above.

58. Having considered the available evidence, I am satisfied that by his actions Kent intended to end his own life. The evidence suggests that he was overwhelmed by the tinnitus he suffered and had struggled for many years with this condition. The note written by Kent gives some insight into his distress and the despair he felt,

I can't take it any more…..I can't live my life like this.

59. I convey my sincere condolences to Kent's family and friends for their loss and the tragic circumstances in which his death occurred.

60. Pursuant to section 73(1B) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

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

Ms Sharon Ray, Senior Next of Kin

Alfred Psychiatry, Alfred Health

Chief Psychiatrist

Hearing Australia

Royal Australian College of General Practitioners

The Tinnitus Association of Victoria

Royal Australian and New Zealand College of Psychiatrists.

First Constable Martin Wilson-Ward, Victoria Police, Coroner's Investigator

Signature:

SARAH GEBERT

CORONER

Date: 30 April 2021

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.

Attachment A

Hearing Australia

23rd January 2020

Coroners Prevention Unit

Coroners Court of Victoria

This is a response to the Coroner's request on 27 August 2019 for Hearing Australia to provide a submission about best practice in the treatment of tinnitus and especially the management of distress associated with enduring tinnitus.

People suffering with tinnitus can often feel isolated and devastated by the uncontrollable noises in their head. Social Media and "Common wisdom" are awash with ways to deal with tinnitus, from benign to extremely dangerous. Hearing Australia has trained audiologists who can assess and treat tinnitus.

The steps in the assessment and treatment of tinnitus includes:

1. Assessment
2. Counselling
3. Sound therapy devices, such as hearing aids or masking devices
4. Sleep
5. Stress management

Each sufferer experiences tinnitus differently, but their reactions can follow a similar theme once their Limbic system is involved.

- An imbalance of negative emotions directed toward the tinnitus, over time, can easily upset a patient's mental wellbeing with dreadful consequences.
- Improving their knowledge of current theories concerning tinnitus can be reassuring that they are not going mad or worse.
- Whilst the battleground is within their brain, giving people coping strategies, tactics, and therapeutic treatment is much more beneficial.
- Depending on whether there is a hearing loss involved, hearing aids can be beneficial in managing tinnitus symptoms.
- There are also standalone-masking devices that appear like a hearing aid or other acoustic based treatments, as well as sound and light therapies.

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Hearing Australia

- There is an overlap between allied health professionals in this area particularly between psychologists and specialist audiologists given the amount of counselling and active listening required.
- There are also organizations such as the Tinnitus Association of Victoria, https://tinnitus.org.au/ and Tinnitus Australia https://tinnitusaustralia.org.au/ , that can act as a support network for members.
- The aim is not to eradicate the tinnitus completely, but to return it to its proper, insignificant place within the brain and not have it dominating the patient's every waking thought and feeling.
- Usually therapy can last from one month to six months with yearly follow-ups.

For practitioners treating patients who report tinnitus annoyance/ disturbance it is suggested that:

- The patient is referred to an Audiologist to diagnose whether there is an untreated hearing loss possibly underlying the tinnitus
- If the patient does not have a hearing loss but does suffer from tinnitus annoyance then the Audiologist can provide a plan of action for managing the annoyance/ disturbance of the tinnitus by recommending tailored therapies (such as the ones outlined above).
- Hearing Australia is able to provide hearing and tinnitus assessments to all Australians. We work collaboratively with Doctors, mental health professionals and the patient to find a solution to manage the tinnitus annoyance/ disturbance with the aim of the patient achieving a good quality of life and full participation in activities.
- Practitioners who would like advice are welcome to contact Hearing Australia on (03) 8610 4300 to speak with an Audiologist
- Some information for practitioners to use with patients can be found here https://www.hearing.com.au/Hearing-loss/Symptoms/Tinnitus—What-is-it-and-how-to-treat-it

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