IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2018 4398

FINDING INTO DEATH WITHOUT INQUEST

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

Findings of:	Simon McGregor, Coroner
Deceased:	JJ
Date of birth:	1948
Date of death:	2 September 2018 or 3 September 2018
Cause of death:	**1(a) Hanging**
Place of death:	Hampton, Victoria, 3188

HIS HONOUR:

THE CORONIAL INVESTIGATION

1. JJ was a 60-year-old man who lived with his wife in Hampton at the time of his death. On the morning of 3 September 2018, JJ was found deceased from hanging in his home.

2. JJ's death constituted a '*reportable death*' under the *Coroners Act 2008* (Vic) (**the Act**), as the death occurred in Victoria, and appeared to be unnatural and unexpected.[1]

3. 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.

4. 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.

5. The Coroner's Investigator, Senior Constable James Russell prepared a coronial brief in this matter. The brief includes statements from witnesses, including family, the forensic pathologist, treating clinicians and investigating officers. As JJ received medical and mental health treatment shortly prior to his death, I also requested a review of the care and management provided to him.

6. After considering all the material obtained during the coronial investigation, I determined that I had sufficient information to complete my task as coroner and that further investigation was not required.

7. I have based this finding on these materials. In the coronial jurisdiction facts must be established on the balance of probabilities.[2] 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.

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[1] *Coroners Act 2008* s 4.

[2] This is 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.

8. In considering the issues associated with this finding, I have been mindful of JJ's basic human rights to dignity and wellbeing, as espoused in the *Charter of Human Rights and Responsibilities Act 2006*, in particular sections 8, 9 and 10.

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

Circumstances in which the death occurred

9. JJ was born in Poland. He moved to Australia with LL in 1981 and they subsequently married. JJ worked as a carpet layer most of his life, and later worked developing townhouses. He was generally fit and well, with no significant health complaints prior to about 2015.[3]

10. In June 2017, JJ had a surgical resection of a cystic pituitary macroadenoma and was prescribed hormone supplementation including thyroxine, testosterone and hydrocortisol.[4] JJ had reported recurrent headaches and fatigue in the lead up to the identification of the cyst and the surgical procedure.[5] Following the procedure, JJ continued to complain of tiredness and generally attributed this to his hormone levels.[6]

11. In December 2017, JJ was assessed by the Alfred Health Psychiatric Liaison Service and was thought to be experiencing an adjustment disorder with depression and anxiety. He had no other psychiatric history.[7]

12. JJ continued to see doctors about his ongoing fatigue, but was told his hormone levels were reasonable. His appetite decreased and he lost weight. JJ was frustrated that he felt unwell, but the doctors he saw did not identify a physical source of his symptoms.[8] He strongly denied depression was part of his problems to his general practitioner (**GP**).[9]

13. On 14 August 2018, JJ was transported by ambulance to Alfred Hospital following an intentional overdose. He had consumed stockpiled prescription medication and left a suicide note. JJ told medical staff he believed his symptoms, such as deterioration in mood, sleep and appetite were due to hypopituitarism. He was reviewed by the endocrinology team and was

[3] Statement of LL dated 9 May 2019, Coronial Brief.
[4] Statement of Dr Cees Ferwerda dated 19 May 2019, Coronial Brie
[5] Statement of LL dated 9 May 2019, Coronial Brief.
[6] Statement of LL dated 9 May 2019, Coronial Brief; Statement of Dr Cees Ferwerda dated 19 May 2019, Coronial Brief.
[7] Alfred Health medical records pages 45 and 67.
[8] Statement of LL dated 9 May 2019, Coronial Brief.
[9] Statement of Dr Cees Ferwerda dated 19 May 2019, Coronial Brief.

weaned off hydrocortisol supplementation. He was assessed to be depressed and commenced on antidepressant, venlafaxine.[10]

14. JJ was preoccupied with his medical symptoms and did not believe he was experiencing a depressive illness, believing the cause of his symptoms was a lack of cortisol,[11] despite recording normal levels.[12] His wife noted that she thought his physical health needed to improve before his mental state would improve.[13]

15. On 20 August 2018, JJ was admitted to the psychiatry inpatient unit as a voluntary patient with ongoing suicidal ideation, anxiety, depressed mood, and rumination about his physical illness and symptoms, and disappointment in healthcare staff about the timeliness of diagnosis and treatment.[14] JJ expressed that he did not believe he needed an antidepressant or an admission.[15]

16. Throughout his admission, JJ's mood improved, and his insight fluctuated. However, he remained preoccupied with his physical health and retained his belief that low cortisol levels was the cause of his symptoms. JJ reported some periods of ongoing suicidal thinking.[16] His treatment while an inpatient included antidepressant venlafaxine, melatonin for insomnia, the antipsychotic quetiapine, medical reviews, physiotherapy, and graduated leave with his wife. JJ made plans to increase socialising with friends, and discharge planning included family meetings, social work review, supports for his wife, referral for community follow up with Monash Health Crisis Assessment and Treatment Team (**CATT**), and a follow up endocrinology appointment.[17]

17. JJ was discharged on 29 August 2018. His diagnosis at discharge was major depression[18] with somatic preoccupation[19] rising to the level of overvalued ideas[20] at times. His discharge

[10] Statement of Dr Amanda Vo dated 30 April 2019, Coronial Brief.
[11] Cortisol is a hormone made by the two adrenal glands and it is essential for life. Cortisol helps to maintain blood pressure, immune function and the body's anti-inflammatory processes. The pituitary gland regulates the amount of cortisol released by the adrenal glands.
[12] Statement of Dr Amanda Vo dated 30 April 2019, Coronial Brief.
[13] Alfred Health medical records page 166.
[14] Alfred Health medical records page 215.
[15] Alfred Health medical records page 214.
[16] Alfred Health medical records pages 226 and 233 - 236.
[17] Alfred Health medical records pages 60-65.
[18] A major depressive disorder is the most commonly diagnosed depressive disorder. A person with major depressive disorder becomes very low-spirited and loses their enjoyment of life. They lack concentration and energy and have changes in their appetite and sleep patterns. Feelings of guilt are also common. Their feelings of hopelessness and despair can lead to thoughts of suicide.
[19] Somatic disorders can include when mental factors are expressed as physical symptoms and the person's main concern is with physical symptoms such as pain, weakness, fatigue, nausea, or other bodily sensations. The person may or may not have a medical disorder that causes or contributes to the symptoms. However, when a medical disorder is present, a person with somatic symptoms or a related disorder responds to it excessively

summary was sent to his general practitioner, and he was provided with one month's supply of his medications.

18. Monash CATT sent JJ a text message on 29 August 2018, and he contacted them the following day and they conducted a home visit.[21] JJ reported 6/10 mood, decreased sleep and continued to express concern about his cortisol level.[22] He denied any suicidal thinking and was noted to be compliant, however from the available evidence it is unclear if this was referring to his medication or his agreement to ongoing contact.[23] The agreed plan was for daily contact.[24]

19. On 31 August 2018, CATT telephoned JJ to reschedule the planned home visit due to workload and he agreed to a phone contact which occurred at 3pm. JJ was tired after having visited the South Melbourne Market and it was noted his mood was better and he was feeling more positive.[25]

20. On 1 September 2018, CATT conducted a further home visit. JJ denied any suicidal thinking or plans and stated that his mood was better. However, he continued to feel lethargic with poor sleep. CATT clinicians did not assess any new or acute clinical risks.[26]

21. On 2 September 2018, JJ had phone contact with CATT and an appointment was made for the following day for psychiatry medical review for medication titration at his home the following day.[27] JJ went to bed in his room at about 6pm that evening.[28]

22. At about 8.10am on 3 September 2018, LL went upstairs and found a note on the door to JJ's room. The note was in Polish, but instructed her not to enter the room. She knew something was wrong and entered and saw JJ hanging. She immediately contacted emergency services.[29]

23. Victoria Police members attended and observed JJ hanging from a ceiling rafter that was exposed by a removed manhole cover.[30] There was a step ladder and a further note on the floor. Ambulance Victoria paramedics attended and confirmed that JJ was deceased.[31]

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[20] An overvalued idea can include a solitary, abnormal belief that is neither delusional nor obsessional in nature, but which is preoccupying to the extent of dominating the sufferer's life.
[21] Monash Health medical records, Triage Information, page 2.
[22] Statement of Natasha Byl dated 13 May 2019, Coronial Brief.
[23] Monash Health medical records, clinical risk screen, page 11.
[24] Statement of Natasha Byl dated 13 May 2019, Coronial Brief.
[25] Monash Health medical records, progress notes, page 14.
[26] Monash Health medical records, progress notes, page 14.
[27] Monash Health medical records, progress notes, page 15.
[28] Statement of LL dated 9 May 2019, Coronial Brief.
[29] Statement of LL dated 9 May 2019, Coronial Brief.

24. LL explained to police that the note left by JJ indicated that he was sick, but the sickness was not depression, and that he could not go on like that anymore.[32]

Identity of the deceased

25. On 3 September 2018, LL visually identified JJ, born 1948.

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

Medical cause of death

27. Forensic Pathologist Dr Gregory Young from the Victorian Institute of Forensic Medicine **(VIFM)**, conducted an examination of JJ and provided a written report of his findings. Post mortem examination showed a ligature abrasion around the neck

28. Dr Young concluded that a reasonable cause of death was:

    1(a) Hanging

29. Toxicological analysis did not detect alcohol or any commons drugs or poisons.

30. I accept Dr Young's conclusions as to cause of death.

REVIEW OF CARE

31. As JJ had received psychiatric care and treatment in the days prior to his death, I asked the Coroner's Prevention Unit (**CPU**)[33] to review the available materials and provide advice about the care provided to him and the discharge decisions made by Alfred Health and Monash Health.

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[30] Statement of Detective Senior Constable Jacqueline Reeves dated 31 March 2019, Coronial Brief.
[31] Statement of Senior Constable James Russell dated 10 June 2019, Coronial Brief.
[32] Police Summary prepared by Senior Constable James Russell, Coronial Brief; Victoria Police Report of Death For the Coroner – Form 83, prepared by Senior Constable James Russell, dated 3 September 2018.
[33] 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.

Alfred Health

32. The CPU concluded that the care and treatment of JJ by Alfred Health was reasonable. The treatment was clearly documented, comprehensive and contemporary. The initial assessment, collateral verification, medical assessments, and subsequent specialist reviews, multidisciplinary reviews and treatment were all consistent with expected practice. Medications were prescribed according to contemporary guidelines and there was evidence of education to JJ about taking his medications and the importance of adherence.

33. The decision to discharge JJ was made with his wife who believed that her husband would be better at home and that his periods of leave to the home during the admission had been successful. The CPU considered that in the context of JJ's low risk assessments and improvement in mood and decreased frequency and intensity of reported suicidal thinking, the decision to discharge him was appropriate.

Monash Health

34. The CPU considered that Monash Health CATT follow up and engagement was timely with a combination of telephone and face to face visits. JJ did not present to CATT with any new or acute onset risks and appeared willing to have ongoing assessments and contact. The medical records did not document any collateral information (for example provided by LL) that contradicted this assessment.

35. Post mortem toxicology showed that JJ had ceased all his psychiatric medications for a long enough period before his death to result in their clearance from his system. There was nothing in the Alfred Health admission to suggest that JJ was non-adherent to medications whilst an inpatient, but he had been clear that he did not think he needed any psychiatric medications and that he did not have a psychiatric illness. JJ had been admitted to the Alfred following a high-lethality polypharmacy overdose he had planned by stockpiling his prescribed medicines. This information was available to Monash Health. CPU suggested it was reasonable to expect CATT clinicians to have been aware of this history and of the need for JJ to continue taking antidepressants for the adequate treatment of his diagnosed major depression, and to have specifically explored his adherence.

36. Correspondence from Monash Health indicated that Alfred Health did not request supervision of medication.[34] However, CPU considered a request for medication supervision was a

[34] Email to Court Registrar dated 12 May 2020, from Monash Health Medicolegal.

different clinical process to that of ensuring that the prescribed medications were in fact being taken by asking JJ and/or his wife. Monash Health medical records noted that JJ was at medium risk of suicide, the need for his medication to be titrated upwards, and of an appointment with a consultant psychiatrist planned for one week for a medication review. There was no specific documentation by CATT clinicians that confirmed their exploration of medication compliance with JJ or his wife.

37. The CPU noted that major depression is a serious psychiatric illness and the Therapeutic Guidelines note:

> *A delay in onset of response of at least 1 to 2 weeks usually occurs with all antidepressants, and full benefit may not occur for up to 4 to 6 weeks or even longer in some cases. In those who do respond, full recovery may take 6 weeks or longer. If there is a favourable response, antidepressants should be continued for at least 6 months, and preferably up to 12 months, after a single episode of major depression as there is a high risk of relapse during this period.*[35]

38. JJ had commenced the antidepressant after 14 August 2018, and therefore at the time of his death, he had only been taking it for about two weeks at a dose which required titration upwards, so its full benefit would not have been reached. The CPU considered it was unclear what the impact of his not having taken the prescribed psychiatric medications; venlafaxine, quetiapine, and melatonin, had on his mental state and risks. The Alfred Health medical records indicated a positive improvement and reduction in intensity and frequency of suicidal thinking during his admission to the inpatient unit during which he was taking the medications.

39. The CPU considered that in circumstances where the treatment plan for major depression is essentially pharmacological, it is reasonable to expect as a matter of course that the assessing CATT clinicians at each contact and visit, discuss the patient's access and adherence to, and perceived effectiveness of the prescribed medication regime. CPU considered this was especially important where the patient has a documented history of non-adherence, a belief they do not have a psychiatric illness and/or a need for psychiatric medications, and a recent serious overdose on stockpiled prescribed medications, as was JJ's case. I have made a recommendation that reflects this CPU advice.

[35] Therapeutic Guidelines 2020, Psychotropic – Major depression.

Monash Health Response

40. In light of the conclusions reached by the CPU, I provided a draft dopy of these findings to Monash Health for their comment. Monash Health provided a response which highlighted three important positions held by Monash Health.

41. First, that it is not certain that the CATT team could have known about JJ's non-compliance by asking, or that compliance with medication can objectively be assessed. Monash Health explained that if patients are feeling very depressed and hopeless, they will not always reveal their true state, including compliance or suicidal intent, and there is a reliance of self-disclosure.

42. Second, that medication review is a normal part of CATT clinical review, even when not explicitly requested, along with conducting mental state examinations, risk assessment and assessing any change in circumstances. Medication review would usually include assessing compliance, side effects and effectiveness.

43. Third, that even if compliance had been checked and JJ had been taking his medication, it is not certain his depression would have lifted or that he would not have ended his own life.

44. These are reasonable clarifications and I thank Monash Health for their response. Nonetheless, I am of the view and Monash Health agrees, that there remains an opportunity to reinforce the importance of medication compliance. I have made a recommendation to this effect.

FINDINGS AND CONCLUSION

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

    (a) the identity of the deceased was JJ, born 1948;

    (b) the death occurred on 2 September 2018 or 3 September 2018 at Hampton, Victoria from hanging; and

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

46. I find that he intended the tragic consequences of his actions.

47. I convey my sincere condolences to JJ's family for their loss.

RECOMMENDATION

Pursuant to section 72(2) of the *Coroners Act 2008*, I make the following recommendation connected with the death:

1. To ensure there is appropriate monitoring of patients with a treatment plan for major depression which is essentially pharmacological, I recommend that Monash Health CATT affirm that medication compliance is a regular part of their clinical reviews, along with assessments of mental state, current situation and clinical risk.

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

Senior Next of Kin

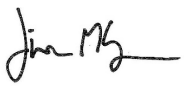
Senior Constable James Russell, Coroner's Investigator

Monash Health

Alfred Health

Office of the Chief Psychiatrist

Signature:



SIMON McGREGOR

CORONER

Date: 14 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