IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2019 001711

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Sarah Gebert
Deceased:	Mr W [1]
Date of birth:	[redacted] 1986
Date of death:	05 April 2019
Cause of death:	*Hanging*
Place of death:	[redacted] Victoria

1. This finding has been de-identified by order of Coroner Sarah Gebert to replace the names of the deceased and his family members with pseudonyms to protect their identity and redact identifying information

INTRODUCTION

1. Mr W[1], born [redacted] 1986, was 32 years old at the time of his passing. He lived in [redacted] with his fiancé [redacted] (**Ms T**), whom he had been in a relationship with for over three years. Mr W is also survived by his mother [redacted] and sister [redacted].
2. On 5 April 2019, Mr W was discovered deceased by his fiancé at their home address having apparently taken his own life.

THE CORONIAL INVESTIGATION

3. Mr W'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.

4. 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.

5. 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.

6. Victoria Police assigned Constable Hannah Trotter to be the Coroner's Investigator for the investigation of Mr W's death. Constable Trotter conducted inquiries on my behalf and submitted a coronial brief of evidence. Following receipt of the coronial brief, I sought and received statements from Mr W's treating clinicians, and Ambulance Victoria (**AV**) in relation to the care they provided to Mr W proximate to his passing.

7. I also referred this matter to the Mental Health Investigations Team of the Coroner's Prevention Unit (**CPU**) to provide advice in relation to the appropriateness of the response by AV to his call to Triple Zero on 31 March 2019 . The CPU is staffed by healthcare professionals, including practising physicians and nurses, who are not associated with the

[1] Referred to in this finding as 'Mr W', unless more formality is required.

health professionals and institutions under consideration and are therefore able to give independent advice to coroners.

8. As part of the coronial investigation, I also received an expert opinion from psychiatrist Professor Malcolm Hopwood in relation to the mental health care provided to Mr W including the trauma-therapy treatments used in his case.

9. This finding draws on the totality of the coronial investigation into the death of Mr W including evidence contained in the coronial brief. 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.[2]

BACKGROUND

10. Mr W was born in the United States and moved to Australia from [redacted] in 2016. In June 2016, he commenced a relationship with Ms T, and they were engaged approximately 18 months later. At the time of his passing, Mr W was on a bridging visa awaiting a spousal visa.

11. Mr W dedicated most of his life to [redacted]. He was the head of engineering at [redacted] and had spent many years at sea with the organisation before moving to Melbourne. Mr W was also a talented drummer and, in Melbourne, played in two different [redacted] bands.

12. Mr W grew up in a small town in the United States where he was raised by his parents and grandparents in a tight community. He remained close with his maternal family and had returned to visit them in the United States after settling in Melbourne, as recently as Christmas 2018.

Mental health

13. Mr W reported some lifelong anxieties. He reported frequent suicidal thinking for many years and several attempts, the most serious prior to his recent exacerbation being in 2016. Mr W identified his stressors as intense daily distress associated with alleged childhood sexual abuse

[2] 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.

by his paternal grandmother and psychological abuse by his paternal grandmother and father; the health of his fiancé; and the added difficulty of settling in Australia.

14. Mr W had seen a private psychologist in 2017 which was not helpful and, after obtaining a mental health plan from his General Practitioner, Dr Ron Smith, he engaged with clinical forensic psychologist and family therapist, Dr Oriella Cattapan, in December 2018.

15. Mr W reported to Dr Cattapan that he controlled his suicidal ideation by keeping busy and relying on Ms T. Dr Cattapan saw Mr W over six sessions and the focus, after the fourth session, was on his childhood trauma.

16. In January 2019, Dr Cattapan contacted Dr Smith with concerns about Mr W's extremely low mood, disturbed sleep, and suicidal ideation. Dr Smith diagnosed Mr W with depression and prescribed the use of the anti-depressant escitalopram. The medication was recorded to be initially effective, however in March 2019 Mr W reported that the efficacy had waned, and Dr Smith increased the dose accordingly.

17. Mr W reported to Dr Cattapan that he experienced some auditory and visual disturbances. He told Ms T that he had experienced hallucinations, including seeing and hearing his grandmother standing in the doorway, and hearing his grandmother's and father's voices.

18. On 28 March 2019, Dr Cattapan wrote to psychiatrist Dr Jim Bott, seeking a referral for Mr W. Dr Cattapan had seen Mr W that day where he had reported a desire to *cut off his hand*. Dr Cattapan raised the possibility of a potential thought disorder requiring specialist treatment and enquired about Dr Bott's availability. Dr Bott responded that his next availability would be in late April 2019. An appointment had not been formally arranged at the time of Mr W's death.

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

Circumstances in which the death occurred

19. On Sunday 31 March 2019, Mr W woke *feeling really bad*. He told Ms T, *today's the day*, and that he needed to end his life. Ms T contacted their friend [redacted] who contacted Ambulance Victoria (**AV**).

20. A mental health nurse spoke with Mr W and Ms T over the phone. Mr W told the mental health nurse that he did not want an ambulance to attend or to go to hospital; that he was not suicidal at that time and felt safe. During the phone call, both Mr W and Ms T were advised about safety

planning, and to contact Triple Zero or attend the nearest emergency department if the situation escalated.

21. Later that day, Mr W sent a text message to Dr Cattapan stating:

> *Hello Oriella, sorry it is a Sunday but I have had a really tough day and following your advice I wanted to let you know that I had suicidal feelings this morning and they were pretty scary for my partner and she and my friends are worried, I just wanted to let you know and get your advice, I feel safe now although very embarrassed for causing a fuss but they are worried and encourage me to see your help in this moment.*

22. Dr Cattapan advised Mr W to do grounding and acupressure exercises and offered a phone call. Mr W replied informing her that a call was not necessary as he felt safe, was *coming around*, and planned to spend the day with Ms T.

23. On Wednesday 3 April 2019, Dr Cattapan saw Mr W. He reported continued struggles with suicidal thoughts, despite feeling well supported by his friends and fiancé.

24. On Friday 5 April 2019, Mr W worked from home and Ms T left for work in the morning. Both Mr W and Ms T were invited to attend a surprise party at 6.00pm, and the plan was for Mr W to drive and meet Ms T at the function after work.

25. Mr W arrived just as everyone had begun hiding for the surprise, and text Ms T to state that he had arrived. Ms T replied that she was hiding and couldn't come out to collect him.

26. Ms T states that Mr W then began panicking and said he was going to leave. She called him after the surprise and Mr W was in the car driving home. Mr W reportedly told Ms T, *I'm just going home, I can't be there – I'll pick you up later*. Ms T told Mr W that she would make her own way home after the party.

27. Ms T sent Mr W a text message after the phone call apologising for being short and explaining that she was disappointed he had left without seeing her. At approximately 6.40pm, Mr W wrote back, *no worries, I love you*. Ms T replied shortly after saying, *I love you.*

28. At approximately 7.30pm, Ms T sent Mr W a text message saying, *I'm ready to come home if you wanted to pick me up*. Ms T noticed that Mr W had not opened her last message and became concerned. She tried to call Mr W, but his phone went straight to voicemail.

29. Ms T booked an Uber home and arrived at approximately 8.00pm. She observed that the wire door was closed but the front door was wide open. Ms T looked through the house for Mr W but could not find him.

30. Ms T states that she then ran outside to the shed in the backyard and found the shed door ajar. Inside the shed, she observed Mr W suspended from a rafter with an orange strap used as ligature. An A-frame ladder and upturned bucket were on the floor near his feet.

31. Ms T phoned Triple Zero and was instructed to cut Mr W down and commence cardiopulmonary resuscitation (**CPR**). Ms T managed to cut Mr W down and commenced CPR until police officers and paramedics arrived to take over.

32. Tragically, CPR was unsuccessful after several attempts and Mr W was declared deceased at the scene.

33. Police conducted an investigation and a note was located inside the house reading, *take what you want burn the rest*. The police investigation concluded that there were no suspicious circumstances surrounding the death.

Identity of the deceased

34. On 5 April 2019, Mr W born [redacted] 1986, was visually identified by his fiancé Ms T.

35. Identity was not in dispute and required no further investigation.

Medical cause of death

36. Forensic Pathologist Dr Michael Burke from the Victorian Institute of Forensic Medicine conducted an examination on 7 April 2019 and provided a written report of his findings dated 9 April 2019.

37. The post-mortem examination showed changes in keeping with the history. A post-mortem CT scan was otherwise unremarkable. Toxicological analysis of post-mortem samples identified the presence of a prescribed anti-depressant and trace amounts of paracetamol within the therapeutic range. No common drugs or poisons were otherwise detected.

38. Dr Burke provided an opinion that the medical cause of death was *hanging*.

39. I accept Dr Burke's opinion as to medical cause of death.

EXPERT OPINION

40. During the coronial investigation, psychiatrist Professor Hopwood was engaged to provide an expert opinion on the appropriateness of the psychology care provided to Mr W, including the effectiveness of Mr W's safety plan and the use of Eye Movement Desensitization and Reprocessing (**EMDR**) prior to his death.

41. Professor Hopwood was also asked to consider the choice and timing of psychotherapeutic techniques employed by Dr Cattapan in the course of Mr W's treatment. He acknowledged that EMDR is a well-evidenced treatment in PTSD and a relatively well-evidenced treatment in complex PTSD cases. He commented that, where such techniques are utilised, careful monitoring of their impact is required as *they may result in transient increases in distress*. Professor Hopwood assessed that the need for monitoring was clearly considered by Dr Cattapan in her management plan.

42. Professor Hopwood opined that Dr Cattapan and Dr Smith had developed a comprehensive assessment of Mr W's difficulties and had a relatively clear management plan. He considered that the choice of pharmacotherapy was appropriate and surmised that Dr Cattapan's approach appropriately involved successful initial assessment and engagement, followed by transition into trauma-focused work utilising the technique of EMDR together with techniques around distress reduction.

43. I accept Professor Hopwood's opinion in relation to these matters and that there are no issues associated with Dr Cattapan's choice of treatments and their implementation.

CORONER'S PREVENTION UNIT

44. As already noted during the coronial investigation, I referred this case to the CPU to review whether the response provided to Mr W by AV on 31 March 2019 was appropriate in the circumstances and following their review, no prevention opportunities were identified.

FINDINGS AND CONCLUSION

45. Pursuant to section 67(1) of the Act I make the following findings:

    a. the identity of the deceased was Mr W, born [redacted] 1986;

    b. the death occurred on 05 April 2019 at [redacted] Victoria, from *Hanging*; and

c. the death occurred in the circumstances described above.

46. Having considered all of the available evidence, including the means chosen, I am satisfied that Mr W intentionally ended his own life. It is clear that Mr W experienced deep lows and recurrent episodes of debilitating depression and anxiety, including previous attempts at suicide and incidences of self-harm. Despite the professional assistance that he sought and received, together with the love and support of his fiancé, friends and family, he suffered progressive worsening mental health in the months leading up to his passing as he struggled to overcome the mental and emotional impacts of significant alleged childhood trauma.

47. I convey my sincere condolences to Ms T, Mr W's family, and friends for their loss. I acknowledge their efforts to support and care for Mr W, and the tragic circumstances in which his death occurred.

COMMENTS

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

a. Dr Cattapan did not contact Mr W's fiancée because at that time, as acknowledged, without his permission it would be a breach of confidentiality and because he had indicated that he was already talking with her himself. She further indicated that contacting family or friends can be seen as infantilising and undermining of the person and Mr W was a deeply private and gentle person.

b. It is unknown whether Mr W would have consented to Dr Cattapan contacting his fiancé if his view had been sought.

c. Mr W's fiancé described him having visual hallucinations of his grandparents and father and asking her if she can see them, current self-harm incidences and insomnia, which Dr Cattapan was not aware of at the time.

d. According to the Australian Psychological Society (**APS**), *Psychologists usually see clients individually, but, where appropriate, can also include family members to support treatment and provide advice for others affected by the individual experience of trauma*.[3]

e. The APS Ethical Guidelines on Confidentiality include:

[3] Australian Psychological Society, Post-traumatic stress disorder. https://psychology.org.au/for-the-public/psychology-topics/posttraumatic-stress-disorder.

5.3.3. When psychologists choose to disclose client information, they have to decide who will be informed. For example, with clients at risk of suicide, options at a professional level might include a GP, Crisis Assessment and Treatment team, or police. For clients' personal support, options might include their parents, partner or close friend.

f. The Psychology Board of Australia is currently developing a code of conduct for Australian Health Practitioner Regulatory Agency (**AHPRA**) registered psychologists which will be available for public consultation in 2023.

g. The Psychology Board of Australia is the only national health practitioner board that does not have a code of conduct. The APS, a membership-only society, 2007 Code of Ethics was utilised when the Psychology Board of Australia was established in 2011 and is mandatory for all AHPRA registered psychologists, regardless of APS membership. The current 2007 Code of Ethics does not reflect working with a client's family/partner and any limitations.

h. The Psychology Board of Australia states the code of conduct under development will reflect the *Universal Declaration of Ethical Principles for Psychologists* which is inclusive of individuals, families, groups and communities. There is currently limited guidance for all psychologists in Australia to the safe and appropriate involvement of partners/families.

i. Trauma treatment is significantly distressing for the patient receiving it and many of those impacts are experienced by the patient's support network. In appropriate circumstances, members of those support networks should be, whenever possible, informed about what trauma treatment is, understand the proposed safety plans in place and whether they have a role in it, and be separately supported throughout the treatment process. Inclusion and support for support persons could involve direct contact with treating clinicians, or advice to the patient to encourage the members of their support network to access The Blue Knot Foundation or similar websites which have information and resources available.

RECOMMENDATION

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

    a. That the Psychology Board of Australia in the development of a national code of conduct for AHPRA registered psychologists consider:

- the role partners and family have in a person's care, especially when a client is at greater risk and,
- that a client may wish to involve their partner and family at any stage of a therapy and,
- that psychologists actively and regularly discuss with a client the appropriate and safe involvement of partner's and family.

50. Pursuant to section 73(1A) of the Act, I order that a copy of this finding (in redacted form) be published on the internet.

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

Ms T, Senior Next of Kin

Scott Shelly, legal representative for Dr Oriella Cattapan

Psychology Board of Australia

Constable Hannah Trotter, Coroner's Investigator

Signature:

Coroner Sarah Gebert

Date : 16 March 2023

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.