IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2019 003390

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Darren J. Bracken
Deceased:	Dane Warren Simpson
Date of birth:	9 May 1967
Date of death:	2 July 2019
Cause of death:	1(a) HANGING
Place of death:	Bunurong Coastal Reserve, Inverloch, Victoria, 3996

CIRCUMSTANCES

1. On 2 July 2019, Mr Dane Warren Simpson was 52 years old when he was found deceased in the vicinity of the Shack Bay car park near Inverloch. Mr Simpson had apparently taken his own life by hanging. Immediately before his death Mr Simpson lived with his wife and four children in St.Andrews.[1]

THE CORONIAL INVESTIGATION"

2. Mr Simpson's death was reported to the Coroner because 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.

3. The role of a coroner is to independently investigate reportable deaths to establish, if possible, the deceased's identity, the cause of death and the 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. Pursuant to the Act, coroners also have the important functions of seeking to reduce the number of preventable deaths, promoting public health and safety and facilitating the administration of justice through the making of comments or recommendations about any matter connected to the death under investigation.

5. Victoria Police assigned Senior Constable B Heber as the Coroner's Investigator for Mr Simpson's death. S/C Heber conducted inquiries on my behalf, including taking statements from witnesses, collating reports for example those drawn by the forensic pathologist and treating clinicians and assembled a coronial brief of evidence.

6. This finding draws on the totality of the coronial investigation into Mr Simpson's death 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.

[1] St.Andrews some 52 kilometres to the north-east of Melbourne.

7. In the coronial jurisdiction, facts must be established on the balance of probabilities.[2]

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

Circumstances in which the death occurred

8. Mr Simpson's wife provided a detailed statement for the coronial brief eloquently setting out Mr Simpson's mental health battle, his desire to keep his condition from others and his ultimate decision to no longer hide his ill mental health from his family. Her statement too describes Mr Simpson's deteriorating mental state over the years despite family and professional support.

9. The brief contains a statement from Myhealth Medical Centre where Mr Simpson was a patient from 2007 to 2019. Dr Michaelson described Mr Simpson being prescribed Prozac although at least until December 2015 his mental health was "…*not a big issue*…". Dr Michaelson drew a Mental Health Plan for Mr Simpson in February 2006 referring him to a mental health nurse and psychologist for treatment of "…*anxiety* / depression…". Mr Simpson did not take up the referral to the mental health nurse but did see the psychologist. Dr Michaelson described Mr Simpson's deteriorating mental state to the point that his obsessive-compulsive behaviour became debilitating in 2019. Dr Michaelson referred to Mr Simpson having consulted Dr Nicholapillai, a psychiatrist the Austin Hospital, and psychologist Dr Mogan.

10. Dr Mogan, practising at the Anxiety and OCD (Obsessive Compulsive Disorder) Clinic Melbourne provided reports dated 24 July and 18 October 2019 for the coronial brief. Dr Mogan, a specialist in the treatment of anxiety, OCD and hoarding disorders described Mr Simpson having attended the clinic on four occasions in May and June 2019. In his statement Dr Mogan refers to Mr Simpson telling him of a 25 year history of depression and OCD. Dr Mogan referred to documents with which he had been provided by psychiatrist Dr Nicholapillai and Mr Simpsons' referring Doctor. Dr Mogan considered that Mr Simpson was suffering from consistent themes of symptoms of OCD, depression and anxiety at severe levels. Dr Mogan described the nature of OCD creating doubt and uncertainty, increasing feelings of distress as well as driving a strong sense of responsibility guilt and impulsivity. Dr Mogan opined that underpinning Mr Simpson's distress was a severe and prolonged

[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.

obsessive-compulsive disorder exacerbated by specific sexual obsessions in the context of Mr Simpson working in a secondary school. Dr Mogan commented that Mr Simpson had stopped working because of intolerable stress before he started seeing him. Dr Mogan referred to providing Mr Simpson with psychological support to help him manage his distress as well as introducing him to exposure and response prevention strategies to manage these situations more effectively. After having seen Mr Simpson on 14 June Mr Simpson was due to again see Dr Mogan on 1 July 2019 however, Mr Simpson didn't keep that appointment. Dr Mogan refers to there having been insufficient time for Mr Simpson to engage in a therapy process because his emotional life was so destabilised by the intensity and prolonged nature of his symptoms.

11. On the basis of a request I made for a further statement Dr Mogan provided a statement dated 26 October 2020. In that statement Dr Mogan refers to diagnosing Mr Simpson with major depression and generalised anxiety and obsessive-compulsive disorder symptoms. Dr Mogan also referred to Dr Gordon's[3] assessment as at 15 May 2020 that Mr Simpson had "… *Nil risk of suicidal ideation or intent*." Dr Mogan explained that his intended treatment plan for Mr Simpson involved " exposure and response prevention.". Dr Mogan referred to having conducted preliminary sessions with Mr Simpson but not having had the opportunity to progress the exposure and response prevention therapy. He also makes reference to his practice being not to consult family members about the progress of patients' treatment until the treatment was more advanced than Mr Simpsons had been. Dr Mogan explained that he last spoke to Mr Simpson was 25 June 2019 when Mr Simpson sought an urgent appointment. Dr Mogan explained that he could not see Mr Simpson until 1 July and told him of acute care being available at the Austin Hospital, explained that Mr Simpson could contact his GP or the crisis assessment and treatment team. Dr Mogan referred to sending a text message to Mr Simpson on 27 June 2019 about the appointment for 1 July 2020 [sic] and on 2 July 2020 [sic] learning that Mr Simpson had been found dead.

12. Dr Jerome Nicholapillai psychiatrist provided a report the coronial brief dated 21 May 2019. Dr Nicholapillai noted that Mr Simpson was keen to seek help, whilst his affect was appropriate his mood was dysphoric, and he had obsessive thoughts. He considered that Mr Simpson had good insight and noted that he denied any thoughts of self-harm or of harming others. Dr Nicholapillai considered that Mr Simpson had an obsessive-compulsive disorder and his plan was to consider increasing Mr Simpson's dosage of fluoxetine, psychology

[3] Dr Gordon is another general practitioner at the Myhealth North Eltham clinic who saw Mr Simpson.

referral, low-dose antipsychotics and if symptoms persist and to closely monitor Mr Simpson's mental state. Such was the advice Dr Nicholapillai provided to Dr Mogan.

13. Dr Victoria Harpwood, the clinical director of the NEAM Austin Hospital provided a report for the coronial brief dated 10 November 2020. Dr Harpwood referred to Mr Simpson having consulted services at the hospital through the telephone triage service on 2 June and 18 June 2019. Dr Harpwood's statement refers to Mr Simpson then denying current suicide ideation plans or intent during the telephone call conversation of 2 June 2019. Dr Harpwood's statement refers to Mr Simpson declining assistance from the crisis assessment and treatment service of the hospital or of psychiatric hospitalisation. Her statement refers to Mr Simpson identifying strong protective factors, his wife and children as well as a supporting brother. Dr Harpwood's statement refers to notes made of this telephone call being sent to Mr Simpson's general practitioner and psychologist. During the second telephone consultation on 18 June, with a 'triage clinician', Dr Harpwood's notes referred to Mr Simpson describing increasing suicidal ideation but having denied plan or intent. This telephone call said to have been over some 35 minutes during which Mr Simpson and the triage clinician discussed a number of potential management options in mental health services including admissions to acute psychiatric unit as a voluntary patient, admission to the acute psychiatric unit as a voluntary patient, admission to the prevention and recovery centre as a voluntary patient, community rehabilitation and the option of linkage with the north-east crisis assessment and treatment service. Mr Simpson declined these options and expressed a preference for admission to a private psychiatric hospital. The triage clinician sent a letter to Mr Simpson dated 18 June 2019 outlining community based options for him to access.

14. Dr Harpwood's statement refers to there having been no formalised pathway to escalate patients requiring review to a psychiatrist during the period that Mr Simpson contacted the triage service. Dr Harpwood's statement refers to a such a process having been put in place as of 9 September 2020 providing the triage service access to a consultant psychiatrist available for escalation and general governance oversight. Dr Harpwood provided a copy of the Austin Hospital critical incident mortality audit that occurred as a result of Mr Simpson consulting the Austin Hospital and his death shortly thereafter. As a result of that review the Austin Hospital implemented a number of recommendations mainly focussed on ensuring process discipline for triage assessments including auditing.

15. After considering the materials in the brief of evidence, I directed that the independent health practitioners in the Health and Medical Investigation Team ("**HMIT"**) of the Coroners Prevention Unit review Mr Simpson's medical treatment. As a result of this review, I sought further statements from Dr Nicholapillai and the Myhealth Clinic. Both Dr Nicholapillai and a Dr Gordon provided statements.

16. Dr Nicholapillai confirmed his diagnosis of Obsessive-Compulsive Disorder, expressed the view that there was no evidence that Mr Simpson could not appropriately be treated by his general practitioner and attached a copy of the letter he sent to Dr Michaelson describing the content of his consultation with Mr Simpson on 21 May 2019. In his statement Dr Nicholapillai also referred to Mr Simpson denying thoughts of self-harm or suicide on 21 May 2019.

17. Dr Gordon provided a detailed account of his consultations with Mr Simpson the last of which was including details of what Mr Simpson told him of his, Mr Simpson's telephone consultations with the triage assessment clinicians at the Austin Hospital. Dr Gordon sets out Mr Simpsons discussion with him on 13 May 2019 of suicidal thoughts and describes how those Mr Simpson told him on 15 May 2019 of those thoughts no longer being present. Dr Gordon describes drawing a mental health plan for Mr Simpson and of an appointment having been made for Mr Simpson to see Dr Nicholapillai. Dr Gordon refers to seeing Mr Simpson on 3 June 2019 and of reading Dr Nicholapillai's report and of Mr Simpson then telling him that he was sleeping better, and he was considering returning to work and that the thoughts which had caused him to call the 'crisis hotline' recently were no longer present. The last time Dr Gordon saw Mr Simpson was 27 June 2019 when, he said Mr Simpson told him that his medication was helping although his sleep and appetite were poor. They discussed changing psychologists. Dr Gordon described Mr Simpson as guarded and reserved but to having expressed feelings of being trapped or helpless and gave no direct or indirect verbal cues of suicidal thoughts. A double appointment for further review was made for the following week. Dr Gordon didn't consider it appropriate to contact Mr Simpson's wife because Mr Simpson had only been a patient for a short time and Dr Gordon saw no expressed danger to himself or others justifying such contact.

18. After reviewing considering the HMIT review of Mr Simpson's medical treatment and the subsequent statement provided by Dr Nicholapillai I will make a number of recommendations for the treatment of those suffering such illness as Mr Simpson was. Whether a doctor contacts a patient's family members about their condition is a difficult issue for a treating

doctor; doctor patient confidentiality is and must remain primary. Each doctor must weigh the 'pros and con's' and decide in context – a very delicate and difficult issue. The recommendations I make below will, I hope, serve as a prompt to raise this issue in clinical settings. To be clear I make no criticism of Dr Gordon or Dr Nicholapillai or any other clinician who treated Mr Simpson in this regard.

The Identity of the Deceased

19. On 2 July 2019 Ms Tracy Simpson identified the deceased as her husband Dane Warren Simpson, born 9 May 1967

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

Cause of Death

21. On 3 July 2019 Dr Malcolm Dodd a specialist forensic pathologist practising at the Victorian Institute of Forensic Medicine (**VIFM**), performed an external examination of the Mr Simpson's body and in a resultant report dated 9 July 2019 opined that the cause of Mr Simpson's death was 'Hanging'.

22. Toxicological analysis of post-mortem samples identified the presence of a small amount of ethanol, Diazepam and Fluoxetine.

23. I accept Dr Dodd's opinion.

FINDINGS AND CONCLUSION

24. Pursuant to section 67(1) of the *Coroners Act 2008* I find :

    a) The identity of the deceased was Dane Warren Simpson, born 9 May 1967.

    b) Mr Simpson died on 2 July 2019 at Bunurong Coastal Reserve, Inverloch, Victoria from HANGING; and

    c) his death occurred in the circumstances set-out above.

25. Having considered all of the circumstances, I am satisfied that Mr Simpson acted intentionally but under the stresses and strain of his medical condition to take his own life.

RECOMMENDATIONS

1. Pursuant to section 72(2) of the Act I recommend that:

    (1) The Royal Australian College of General Practitioners consider reviewing advice to their members in relation to treating those with Obsessive Compulsive Disorder and to reiterating the utility of gathering collateral information from families and involving family members in treatment, in particular where obsessive thinking and compulsive behaviour may carry the risk of self-harm.
    (2) The Australian Psychology Society consider reviewing advice to their members in relation to treating those with Obsessive Compulsive Disorder and to reiterating the utility of gathering collateral information from families and involving family members in treatment, in particular where obsessive thinking and compulsive behaviour may carry the risk of self-harm.
    (3) That the Royal Australian and New Zealand College of Psychiatrists consider reviewing advice to their members in relation to treating those with Obsessive Compulsive Disorder and to reiterating the utility of gathering collateral information from families and involving family members in treatment, in particular where obsessive thinking and compulsive behaviour may carry the risk of self-harm.

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

Ms T Simpson, Senior Next of Kin

Senior Constable Heber, Coroner's Investigator

Mr Paul Wappett, CEO, Royal Australian College of General Practitioners

Mr Andrew Peters, CEO, Royal Australian and New Zealand College of Psychiatrists

Dr Zena Burgess, CEO, Australian Psychology Society

Signature:

Date : 13 July 2022

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.