IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2020 005777

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Ingrid Giles
Deceased:	Mr KE[1]
Date of birth:	[redacted] 1984
Date of death:	22 October 2020
Cause of death:	1(a) Neck compression 1(b) Hanging
Place of death:	[redacted], Wyndham Vale, Victoria, 3024
Keywords:	Mental health; COVID-19; psychiatrist shortage

[1] This Finding has been de-identified by order of Coroner Ingrid Giles which includes an order to replace the name of the deceased and his wife with pseudonyms for the purposes of publication.

INTRODUCTION

1. On 22 October 2020, Mr KE (**KE**) was 36 years old when he was located in circumstances suggestive of suicide in his home in Wyndham Vale, Victoria.

2. During his adolescence, KE's father, recalls that he *'suffered from self-worth and confidence issues'* causing him to be *'significantly unhappy from time to time'.*

3. In 2010, KE commenced a relationship with Ms BE (**BE**). The couple would eventually marry and purchase a property in Wyndham Vale.

4. BE recalls she *'was never aware of KE having any mental health problems'* at the time they met. Though notes he was *'a big drinker'*, and would *'have a beer early in the morning and drink all day'.* She further states that KE would smoke marijuana though *'gave [it] up'.*

5. In 2015, the couple welcomed a daughter, followed by a son in 2017. KE was *'a good dad'* but *'would struggle to look after them on his own'.*

6. KE worked as a chef and had regular work at various locations, though this involved evening work and *'difficult shifts'.* BE attributes this to worsening his excessive drinking.

7. By October 2019, KE and BE's relationship had deteriorated and the pair separated though continued cohabitating. At this time, she recalls being *'concerned about his drinking. He would get drunk every day'.*

8. In August 2020, during the COVID-19 pandemic, KE was laid off from his job and received financial support through the Victorian Government scheme, 'JobKeeper', and from his family. KE attended a counsellor at this time, though did not continue due to poor rapport.

9. During this time, BE moved out of their residence *'due to his drinking'*. She nonetheless continued to see KE most days to drop off their children, or take them to school.

<u>Medical History</u>

10. KE sporadically attended General Practitioner (**GP**), Dr E.C. Wong (**Dr Wong**). He first attended Dr Wong in 2003 due to *'a period of depression'* for which he was prescribed the anti-depressant agent sertraline. KE did not attend his follow up appointment on this occasion.

11. He attended Dr Wong again in 2009 citing *'anxiety and having panic attacks'* stating he *'had paranoid thoughts when driving'*. KE was prescribed the anti-psychotic agent risperidone, though again did not attend his follow up appointment.

12. On 10 September 2020, three weeks after his separation from BE, KE attended Dr Wong reporting that he *'felt anxious, "freezing up" and was not coping'.* Dr Wong prescribed KE with diazepam and temazepam, and referred him to GP and psychotherapist, Dr Marijke van Beuge (**Dr van Beuge**), who he attended on 16 September 2020.

13. KE presented as *'tearful'* and *'angry'* and reported *'low mood'* and *'suicidal ideation but stated no plans…no motivation to do anything'.* He divulged to Dr van Beuge that he was *'self medicating with alcohol to sleep'* and drinking 12 cans of beer a day. She undertook a comprehensive mental health review and detailed risk assessment, and noted he was *'certainly at risk'* of self-harm and demonstrated multiple risk factors for suicide.

14. Dr van Beuge considered he was experiencing a mood disorder, with severe levels of depression and anxiety, but that he also required *'full psychiatric assessment'* with respect to alcohol dependence, Attention Deficit Hyperactivity Disorder (**ADHD**), complex trauma disorder and Autism Spectrum Disorder (**ASD**) with the potential requirement for hospitalisation. KE re-attended Dr van Beuge the following week on 24 September 2020 and reported feeling *'very angry'* after consuming his first dose of the anti-depressant, desvenlafaxine, and so did not continue to take it. He furthered that his mood had not changed and *'saw no future for himself but denied feeling suicidal'.*

15. Dr van Beuge informed KE he required further expert psychiatric assessment and reported that she had made referrals to multiple psychiatrists, though they all declined her request for assessment or did not respond.

16. On 1 October 2020, KE sent a text message to BE, which caused her to be concerned that he was suicidal. BE subsequently contacted Victoria Police who apprehended KE under section 351 of the *Mental Health Act 2014* (Vic) (**the Mental Health Act**), as then applied, which empowers police officers to apprehend persons to prevent *'serious and imminent harm to the person or to another person'.*[2]

17. KE was relayed by police to the Emergency Department of the Werribee Mercy Hospital.

[2] *Mental Health Act 2014* (Vic) s 351(1) (as then applied).

18. Emergency Medicine Specialist, Dr Samuel Robertson (**Dr Robertson**), assessed KE that evening and recorded he previously suffered with depression and Generalised Anxiety Disorder, for which he was not medicated. KE *'reported no suicidal plan nor ongoing thoughts of suicide at the time of the assessment'*. Dr Robertson's *'bedside mental state examination'* demonstrated that KE was cooperative and reported a *'congruent depression mood for the day's situation'*.

19. KE stated to Dr Robertson that he *'would prefer to go home and seek further input with his own psychologist at an outpatient'.* Dr Robertson concluded:

> *'My assessment was that [KE] was someone who did have a moderate risk for self-harm including suicide. However, his clinical condition did not satisfy the criteria to implement an Assessment Order'.*

20. Dr Robertson was to refer KE to Community Mental Health Services, though KE self-discharged and was collected before this could be established.

21. KE called Dr van Beuge on 13 October 2020 to cancel their next appointment, stating he had secured recent employment at the Melbourne Zoo. Dr van Beuge reiterated that KE ought to present to a nearby Emergency Department to gain a psychiatrist assessment however he was *'adamantly against this course of action'*. She relayed this information to Dr Wong, who agreed it was *'the most expedient course of action'* and continued to make referrals to private psychiatrists.

22. This was KE's last known contact with a mental health professional before his death.

THE CORONIAL INVESTIGATION

23. KE'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.

24. 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.

25. 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.

26. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of KE's death. The Coroner's Investigator conducted inquiries on the Court's behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

27. Coroner Catherine Fitzgerald had carriage of the investigation before I assumed carriage in July 2023, for the purposes of obtaining further statements, finalising the matter and handing down findings.

28. This finding draws on the totality of the coronial investigation into the death KE 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.[3]

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED

29. In the morning of 22 October 2020, BE arrived at the Wyndam Vale property where KE was residing and *'beeped [her] horn'* to alert him of her arrival. BE noticed that KE was not looking out the window, as he normally would be, and the dog was barking.

30. She approached the front door and upon entering the property, located KE suspended, by a belt, from the staircase. She contacted emergency services and attempted to release KE from the suspension but was unable to do so.

31. At approximately 8:35am, Victoria Police officers attended the scene and verified KE was deceased.

32. Further located was KE's phone, which depicted a recent search history including *'how to kill yourself'* and *'longest time it takes to hang from rope'.*

[3] 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.

IDENTITY OF THE DECEASED

33. On 22 October 2020, KE, born [redacted] 1984, and whose name is known to the Court, was visually identified by his wife, BE, who completed a Statement of Identification.

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

MEDICAL CAUSE OF DEATH

35. Professor of Forensic Medicine, Professor Noel Woodford (**Professor Woodford**) from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an examination on 24 October 2020 and provided a written report of his findings dated 26 October 2020.

36. The post-mortem examination revealed a ligature mark circumferentially around the neck and no other injuries that may have caused or contributed to the death.

37. Toxicological analysis of post-mortem samples identified the presence of nordiazepam, a metabolite of diazepam, at a concentration of ~ 0.04 mg/L.

38. Professor Woodford provided an opinion that the medical cause of death was 1(a) *neck compression and 1(b) hanging.*

39. I accept Professor Woodford's opinion.

FAMILY CONCERNS

40. During the course of the investigation into KE's death, BE relayed concerns regarding the assessment undertaken by Werribee Mercy Health on 1 October 2020.

41. She queried the hospital's decision to discharge KE, despite him being apprehended under section 351 of the Mental Health Act and being admitted for a few hours.

42. The Mental Health Act required that, having been apprehended under section 351, KE was to be reviewed by a medical practitioner or mental health practitioner in order to determine whether an Assessment Order was required, which would render KE an involuntary patient for the purpose of being further assessed.[4]

[4] *Mental Health Act 2014* (Vic), ss 29, 30, 351.

43. Medical records of Werribee Mercy Health from the time of assessment demonstrate that KE was *'co-operative and forth coming with interview'* and demonstrated *'good insight into barriers to seeking help'.*

44. Of note to Dr Robertson was that KE demonstrated *'no ongoing suicidal thought content nor report of self demise'* and his behaviour was future-focused with *'goals to reunite with family and be part of [his] childrens' [lives]'*. Further, KE relayed his intentions to continue seeking support from his psychologist.

45. On this basis, Dr Robertson determined that KE did not meet the legislative criteria for an Assessment Order to be made. I accept Dr Robertson's opinion.

46. Further, having considered the circumstances and the passage of time between his admission to Werribee Mercy Hospital on 1 October 2020 and his death on 22 October 2020, I cannot find that his death would have been prevented had an Assessment Order been made and had KE been further assessed.

47. Nonetheless, I acknowledge BE's concerns. I note they have been thoroughly investigated and I appreciate them being raised with the Court.

REVIEW BY THE CORONERS' PREVENTION UNIT

48. As part of the coronial investigation into KE's death and in response to family concerns received, the Coroners' Prevention Unit (**CPU**) undertook a review into the appropriateness and adequacy of care provided to KE in order to identify any potential prevention opportunities.

49. The 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.

50. The CPU obtained information from general practitioner and psychotherapist, Dr van Beuge, regarding her treatment of KE and the implementation of escalation procedures.

51. In medical records made at the time of consultations with KE, Dr van Beuge recorded that his complex issues were beyond her scope, but she nonetheless continued to see him to contain his distress until she could secure a referral to a psychiatrist. At the first consultation with KE,

Dr van Beuge conducted a comprehensive mental health assessment that did not suggest he would likely meet criteria for an Assessment Order under the Mental Health Act. Dr van Beuge stated on multiple occasions she encouraged KE to voluntarily seek a psychiatric assessment through a public hospital, but he was resistant to engage. The evidence indicates Dr van Beuge was proactive in trying to obtain an assessment with a private psychiatrist.

52. With respect to her second consultation with KE, Dr van Beuge stated that KE reported being unable to reduce his alcohol consumption and spoke of an angry outburst upon taking the anti-depressant, desvenlafaxine. Dr van Beuge noted she was not comfortable to prescribe KE an alternative anti-depressant owing to the potential combination of anger and excessive alcohol consumption, especially when KE was looking after his children. She determined to await a second opinion before prescribing further medication.

53. On this decision, the CPU stated that though irritability is a known side effect of desvenlafaxine, it is unclear whether this could have occurred after one dose. Further, clinical guidelines recommend prescribing an alternative anti-depressant less likely to cause the adverse reaction, which was an option open to Dr van Beuge. Despite that KE was diagnosed with depression and demonstrated multiple risk factors for suicide which warranted the prescription of an anti-depressant, the CPU could not definitively state that an alternative prescription would have prevented his death. I note that Dr van Beuge declined to make a further prescription in the context of KE's previous refusal to engage with a medication regime, and in the belief she was minimising the risk of harm to others, namely to his children.

54. Dr van Beuge nonetheless took other steps to minimise the risk of suicide including to confirm that KE did not have access to weapons and continued to encourage him to reduce his alcohol consumption.

55. Records indicate that KE was scheduled to attend Dr van Beuge on 1 October 2020, the date of his admission to Werribee Mercy Hospital, though he called to cancel the appointment. There was no indication that Dr van Beuge was made aware of KE's admission to the hospital. While a notification of the same may have presented an opportunity to re-assess KE, it cannot be said whether, had this occurred, the death could have been prevented.

56. The CPU stated that the current model of general practice in Australia does not encourage or facilitate assertive follow up by the GP if a patient ceases to attend appointments, even in circumstances where the patient suffers from mental ill health and is determined to be at risk.

57. The CPU provided a conclusion that Dr van Beuge provided reasonable care to KE in conducting a comprehensive assessment and monitoring his mental state. She appropriately identified that he was at risk and appropriately sought psychiatric input. She approached KE's care holistically and thoughtfully.

58. I accept and adopt the CPU's opinion.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was KE, born [redacted] 1984;

    b) the death occurred on 22 October 2020 at [redacted] Wyndham Vale, Victoria, 3024, from neck compression secondary to a hanging; and

    c) the death occurred in the circumstances described above.

60. Having considered all of the circumstances, including the lethality of the means chosen, I find that KE intentionally took his own life. Upon my review of the material and of the actions of the practitioners involved, I find that they acted appropriately and reasonably in the circumstances.

61. In light of KE's extended history of mental ill health, I find that a number of factors, including recent stressors of unemployment during the COVID-19 pandemic, preceded the course of action he ultimately chose.

COMMENTS

62. Pursuant to section 67(3) of the Act, I make the following comments connected with KE's death:

    a) Over the course of my investigation, there is unequivocal evidence indicating that the COVID-19 pandemic exacerbated KE's pre-existing mental ill health, given he had been laid off from his employment.

    b) The impact of COVID-19 on Victorians' lives, especially those with pre-existing mental health conditions has been extensive. A recent study[5] conducted by the Court

[5] Justin Dwyer et al, 'COVID-19 as a context in suicide: early insights from Victoria, Australia' (2021) Australian and New Zealand Journal of Public Health (Online; doi: 10.1111/1753-6405.13132).

in conjunction with researchers from other institutions found evidence of an explicit link between the impact of COVID-19 and the decision to suicide in approximately 9.5 per cent of all suspected suicides during the first year of the pandemic.

c) Our experiences in coping and dealing with the pandemic over the last few years will be analysed over the coming months and years to determine what went well and what could have been done better. This information will be crucial in informing future government policy and allocation of resources to support our recovery and build our resilience should another pandemic cast its shadow. This Court will continue to assist this task by regularly publishing updated suicide statistics and relevant findings where appropriate.

d) The evidence also indicated that KE's mental ill health, having been exacerbated by the conditions created by the COVID-19 pandemic, was further compounded by the unavailability of private psychiatrists. I note there is a well-documented national shortage of psychiatrists which worsened during the peak of COVID-19 restrictions.[6] Additional data has demonstrated that access to psychiatrists has not improved since the COVID-19 pandemic and rather, appears to continue to decline.[7]

e) KE's death serves as a tragic reminder of the importance of Government funding to the health services, particularly to mental health services in the aftermath of a pandemic. I commend the Australian Government's announcement that the 2024-25 budget will channel $361 million into mental health services[8] and emphasise that providing Australians with sufficient mental health support involves a concerted effort between multiple bodies.

f) I accordingly direct that a deidentified version of this finding be distributed to the Royal Australian and New Zealand College of Psychiatrists.

I convey my sincere condolences to KE's family for their loss and I acknowledge that the Court's investigation has been lengthy.

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[6] Productivity Commission (2020) *Mental Health (volume 2), Report no. 95*, Canberra. Accessible at < pc.gov.au/inquiries/completed/mental-health/report/mental-health-volume2.pdf>.

[7] RANZCP (2024) *Burnout and moral injury: Australian psychiatry at its limits*. Accessible at < RANZCP Workforce Report February 2024>.

[8] Australian Government, Department of Health and Aged Care, *Budget Overview.* Accessible at < Budget 2024-25: Budget overview (health.gov.au)>.

Pursuant to section 73(1B) of the Act, I order that a de-identified version of this finding be published on the Coroners Court of Victoria website in accordance with the *Coroners Court Rules 2019*.

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

Ms BE, Senior Next of Kin

Dr Marijke van Beuge, c/- Medical Indemnity Plan Society

Werribee Mercy Hospital

Royal Australian and New Zealand College of Psychiatrists

Senior Constable Neil Purkiss, Coroner's Investigator

Signature:

Ingrid Giles

Coroner

Date: 26 July 2024

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.