IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2016 3746

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)
Section 67 of the Coroners Act 2008

Findings of:	**GREGORY MCNAMARA, CORONER**
Deceased:	**INGRID MARY MARR**
Date of birth:	28 January 1986
Date of death:	11 August 2016 or 12 August 2016
Cause of death:	Hanging
Place of death:	421A Camberwell Road, Camberwell, Victoria

BACKGROUND

1. Ingrid Mary Marr was a 30-year-old woman who lived at Camberwell at the time of her death.

2. Ms Marr had a history including substance abuse, a reported diagnosis of borderline personality disorder, and exposure to the suicides of her father, a close friend and her current partner's mother. On several occasions prior to her death Ms Marr was hospitalised following overdose and self-harm incidents.

3. On 12 August 2016 Ms Marr's partner discovered her deceased, having hanged herself.

THE PURPOSE OF A CORONIAL INVESTIGATION

4. Ms Marr's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008.*

5. 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.

6. The Coroner's Investigator prepared a coronial brief in this matter. The brief includes statements from witnesses, including family members, the forensic pathologist who examined Ms Marr, treating clinicians and investigating officers.

7. I have based this finding on the evidence contained in the coronial brief. In the coronial jurisdiction facts must be established to the standard of proof of the balance of probabilities.[1]

PERSONAL HISTORY

8. Ms Marr had a difficult childhood, and it is believed that Ms Marr's father had undiagnosed depression which exacerbated family issues. It was suggested during Ms Marr's teenage years that she might suffer from borderline personality disorder, and Ms Marr informed later clinicians that she was diagnosed with this disorder at the Austin Hospital.

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[1] 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.

9. Ms Marr had a history of substance abuse including methamphetamine. She was admitted to hospital on several occasions for drug-induced psychosis.

10. On 19 February 2006 Ms Marr's father took his own life using a firearm. Ms Marr was out of the house at the time but returned home to find her mother crying near her father's body.

11. Between December 2008 and May 2013 Ms Marr was admitted to hospital following overdoses on four occasions and following self-harm injuries on two occasions.

12. On 12 November 2013 a close friend and former partner of Ms Marr's took his own life by hanging. Ms Marr and her sister Erica Marr discovered his body. Ms Marr was deeply affected by this incident and in December 2013 was again admitted to hospital following an overdose.

13. Around February 2014 Ms Marr began a relationship with Daniel Coghlan which would continue for the remainder of her life. Ms Marr reported ceasing to use illicit substances following her friend's death in 2014 but Mr Coghlan states that she continued to abuse codeine.

14. Ms Marr was admitted to hospital following overdoses in March 2014 and October 2014.

15. On 29 June 2016 Mr Coghlan's mother took her own life by hanging. This greatly affected Ms Marr. Ms Marr had recently become pregnant and due to the trauma of this event, Ms Marr and Mr Coghlan made the mutual decision to terminate the pregnancy. The termination procedure occurred on 28 July 2016 and led to an infection which required hospitalisation.

MATTERS IN RELATION TO WHICH THE CORONER MUST, IF POSSIBLE, MAKE A FINDING

Circumstances in which the death occurred

16. On 11 August 2016 Ms Marr felt that she wanted to die and so drank a glass of wine and cut herself. At 2.18pm she called Mr Coghlan saying she had done something stupid. Mr Coghlan contacted emergency services.

17. At approximately 3.00pm police arrived at Ms Marr's address and entered through a partially open rear door. They discovered Ms Marr lying in bed unconscious and requested ambulance assistance. Ambulance attended and provided first aid to Ms Marr.

18. Ms Marr was brought to the Emergency Department at St Vincent's Hospital by police and ambulance under section 351 of the *Mental Health Act* 2014. She reported to Dr Amelia Scharkie that after her earlier actions she had no active plans or intent to commit suicide.

19. Ms Marr stated to Registered Psychiatric Nurse Grant Phillips that she had chronic suicidal ideation but found that her partner Mr Coghlan, her dog and her mother were significant safety factors. She reiterated that she had no intention to harm herself again.

20. RPN Phillips formulated the opinion that "*Ms Marr was a woman with an established diagnosis of Borderline Personality Disorder who had self-harmed that day in the context of significant stressors. The self-harm was impulsive and she denied on-going suicidal ideation.*"

21. RPN Phillips noted that at this point Ms Marr and Mr Coghlan had a plan in place for him to take Ms Marr to stay with her mother on her mother's farm the following day.

22. In this context, Ms Marr was discharged from the Emergency Department and given two pills of 30mg oxazepam. Ms Marr returned home with Mr Coghlan at approximately 10.00pm on 11 August 2016. Ms Marr and Mr Coghlan watched a movie together and her mood seemed to improve. Mr Coghlan recalls falling asleep at around 11.00pm or 11.30pm.

23. Between approximately 3.00am and 4.30am on 12 August 2016 Mr Coghlan woke and found a note from Ms Marr headed '*suicide*'. Upon reading the note, Mr Coghlan searched for Ms Marr and found her hanging from a timber beam of their patio by a dog lead. Mr Coghlan reports that this is the same method of suicide used by his mother.

24. Mr Coghlan cut Ms Marr down and contacted emergency services before commencing CPR. Paramedics arrived and took over CPR but resuscitation was unsuccessful.

25. At 4.58am on 12 August 2016 Ms Marr was pronounced dead.

Medical cause of death

26. On 15 August 2016, Dr Matthew Lynch, a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, conducted an examination upon Ms Marr's body and provided a written report, dated 15 August 2016. In that report, Dr Lynch concluded that a reasonable cause of death was '*hanging*'.

27. This report was later amended to reflect Ms Marr's correct age but the cause of death was unaltered.

28. Toxicological analysis of the post mortem samples taken from Ms Marr identified the presence of ethanol (alcohol) at a concentration of approximately 0.7 g/100mL, codeine, diazepam, nordiazepam, temazepam, oxazepam, clonazepam, 7-aminoclonazepam (a metabolite of clonazepam), venlafaxine and desmethylvenlafaxine.

Identity of the deceased

29. On 12 August 2016, Daniel James Coghlan visually identified Ms Marr's body as being that of his partner Ingrid Mary Marr, born 28 January 1986.

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

COMMENTS PURSUANT TO SECTION 67(3) OF THE ACT

31. I am satisfied that Ms Marr acted with the intention of taking her own life.

32. Exposure to the suicide of family members is well-known to be connected to suicide risk. A systematic review of studies relating to suicide bereavement found that the suicide of a partner or ex-partner results in high risk of suicide and that "*children of a parent who died by suicide may inherit an elevated risk for psychiatric disorders and suicidality*".[2]

33. At my direction, the Coroners Prevention Unit (CPU)[3] searched the Victorian Suicide Register[4] for the period 2009-2014 to establish the prevalence of previous suicide exposure among Victorian suicides. The CPU identified 417 suicides (11.9% of all suicides for the period) where the deceased had been exposed to a previous suicide. In 83 (19.9%) of these deaths, there was evidence that the deceased had been exposed to multiple suicides in the past.

34. Overall, around three-quarters of cases involved previous exposure to the suicide of a relative; and approximately one-quarter involved exposure to the suicide of a friend, acquaintance or stranger. The time elapsed between exposure and subsequent suicide varied greatly, with 11.8% of exposures occurring within a year of subsequent suicide, and 23.3% of exposures taking place 10 years or more beforehand. However the time elapsed was not known in 35.3% of the deaths.

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[2] Alexandra Pitman et al, "Effects of suicide bereavement on mental health and suicide risk" (2014) *Lancet Psychiatry* 1(1) 86-94.
[3] 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, as well as assisting in monitoring and evaluating the effectiveness of the recommendations. The CPU comprises a team with training in medicine, nursing, law, public health and the social sciences.
[4] The Victorian Suicide Register is a database operated by the Coroners Court of Victoria which stores a range of information on suicides investigated by Victorian Coroners including socio-demographic details of the deceased, physical and mental health issues, service contacts, legal and police contacts, stressors, motives, evidence of intent to die, and evidence regarding the method of death.

35. The CPU data reported here would need to be combined with other information (for example, information on the overall proportion of Victorians who have been exposed to suicidal behaviour of others in their lifetime) before any conclusions could be drawn about suicide exposure as a risk of subsequent suicide in Victoria.

36. Additionally, consideration would need to be given to the emerging literature on genetic factors in suicide risk, at least in cases where the previous suicide exposure involves a genetically related person. But at the very least, the CPU data highlights that around one in eight Victorians who suicide have had previous exposure to another person's suicide.

FINDINGS AND CONCLUSION

37. Having investigated the death, without holding an inquest, I make the following findings pursuant to section 67(1) of the *Coroners Act 2008*:

    (a) the identity of the deceased was Ingrid Mary Marr, born 28 January 1986;

    (b) the death occurred on 11 August 2016 or 12 August 2016 at Camberwell, Victoria, from hanging; and

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

38. I convey my sincerest sympathy to Ms Marr's family.

39. Pursuant to section 73(1A) of the *Coroners Act 2008*, I order that this Finding be published on the internet.

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

    (a) Mr Daniel Coghlan, senior next of kin.

    (b) Office of the Chief Psychiatrist.

    (c) St Vincent's Health.

    (d) Detective Leading Senior Constable Marc Callegaro, Victoria Police, Coroner's Investigator.

Signature:

GREGORY MCNAMARA

CORONER

Date: 16/8/17