IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2008 2867

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)
*Section 67 of the **Coroners Act 2008***

Inquest into the Death of Lloyd FELMAN

Delivered On:	11 September 2014
Delivered At:	Coroners Court of Victoria 65 Kavanagh Street SOUTHBANK VIC 3006
Hearing Dates:	10-11 April 2012 27-28 June 2012
Findings of:	CORONER JACQUI HAWKINS
Representation:	Ms D Foy appeared on behalf of Southern Health Mr S Cash appeared on behalf of Alfred Hospital Mr J Bleechmore appeared on behalf of Phillip Felman
Police Coronial Support Unit	Senior Constable K Taylor appeared to assist the Coroner.

I, Jacqui Hawkins, Coroner, having reviewed the investigation into the death of
LLOYD FELMAN

AND the inquest[1] held by Coroner Hendtlass in relation to this death

on 10-11 April 2012 and 27-28 June 2012

at Coroners Court of Victoria, 222 Exhibition Street, Melbourne, Victoria, 3000

find that the identity of the deceased was LLOYD FELMAN

born on 8 May 1950

and the death occurred between 3 and 4 July 2008

at Lions Park, Manners Road, Seymour, Victoria

from:

1 (a) AMITRIPTYLINE TOXICITY

in the following circumstances:

1. Mr Lloyd Felman was a 58 year old retired solicitor, living on a disability pension when he was found deceased on 4 July 2008. He resided with his elderly sister at 2/22 Octavius Avenue, Caulfield. Mr Felman had been married twice and had two children from each marriage.

2. Mr Felman had a long and complex medical history including back pain, inflammatory arthritis, depression, major injuries to his neck and lower back which required numerous hospital admissions and an over-reliance of prescription medication and alcohol.

3. On 3 July 2008 Mr Felman drove a hired motor vehicle from Melbourne to Lions Park, Manners Road, Seymour. He then connected a grey plastic industrial vacuum hose to the exhaust pipe of the vehicle, secured it, then fed the other end of the grey hose into the driver's side door and the window. Mr Felman then sat in the front passenger seat of the vehicle. At some time either prior to or after this Mr Felman consumed a large quantity of prescription medication and alcohol. Mr Felman then started his car's engine while parked with the intention of filling the vehicle with engine exhaust fumes.

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[1] This finding does not purport to refer to all aspects of the evidence obtained in the course of the investigation. The material relied upon included statements and documents tendered in evidence together with the transcript of proceedings and submissions of legal counsel. The absence of reference to any particular aspect of the evidence, either obtained through a witness or tendered in evidence does not infer that it has not been considered.

4. At 12.45 am on 4 July 2008, Security Patrolman, Mr Gavin Keep went to Lions Park for a rest break and noticed a silver coloured Toyota Yaris 3 door hatchback sedan parked with a hose connected between the exhaust pipe and the driver's side window. He called 000 and was advised to go over to the car, open the door, turn the engine off and check the body. Mr Felman was located in the front passenger seat. Police and ambulance attended and found Mr Felman deceased on arrival.

5. Sergeant Dean Williams located documentation that identified Mr Felman and conducted a LEAP check which found that Mr Felman had made a previous suicide attempt on 28 June 2008 and had been taken to the Alfred Hospital for assessment.

6. Sergeant Williams also located a quantity of prescription medications consisting of Amitriptyline[2] and Diazepam[3] and a bottle of Grants Whisky located within the vehicle. It was estimated that there were 22 Endep tablets and 50 Valium tablets missing from their respective packaging,

7. Also located within the car was a petrol receipt for the Mobil Petrol Station located on the Hume Highway, Seymour dated 3 July 2008 at 14.48 hours.

JURISDICTION

8. At the time of Mr Felman's death the *Coroners Act 1985* (Vic) applied. From 1 November 2009, the *Coroners Act 2008* (Coroners Act) has applied to the finalisation of investigations into deaths that occurred prior to its introduction.

9. The Coroners Court of Victoria is an inquisitorial jurisdiction.[4] The role of a coroner in this State includes the independent investigation of deaths to contribute to a reduction in the number of preventable deaths, the promotion of public health and safety, and the administration of justice.

10. A coroner may comment on any matter connected with the death, may report to the Attorney-General and may make recommendations to any Minister, public statutory authority or entity, on any matter connected with the death, including recommendations relating to public health and safety or the administration of justice.[5]

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2 Amitriptyline, marketed in Australia as Endep, is a tricyclic anti-depressant medication.

3 Diazepam, marketed in Australia as Valium is benzodiazepine used in the treatment of anxiety.

4 Section 89(4) of the Coroners Act.

5 Sections 72(1) and (2) of the Coroners Act.

CORONIAL INVESTIGATION AND INQUEST

11. Coroner Hendtlass commenced an investigation and held an inquest into the death of Mr Felman on 10-11 April 2012 and 27-28 June 2012.

ASSIGNMENT OF INQUEST FINDINGS

12. Coroner Hendtlass retired on 31 December 2013 without making any findings in this investigation. The State Coroner of Victoria, His Honour Judge Gray, assigned the completion of this Finding into Death with Inquest (Finding) to me pursuant to section 96 of the Coroners Act.

13. In writing this Finding, I have conducted a thorough forensic examination of the evidence including reading all the witness statements contained within the inquest brief, exhibits, supplementary statements, medical records and submissions. I have also thoroughly read the transcript of the directions hearing and the inquest.

Witnesses called to give evidence at the Inquest

14. The following witnesses gave *viva voce* evidence at the Inquest:
    - Dr Colin McIver, Psychiatry Registrar, Monash Medical Centre;
    - Dr Tristan Leech, Trauma Registrar, Alfred Hospital;
    - Dr Christine Kotsios (nee Sierakowski), Psychiatric Registrar, Alfred Hospital;
    - Leading Senior Constable Robert Dabonde, Victoria Police;
    - Dr Patricia Lo Cascio, Psychologist and Family Therapist, Private Practice;
    - Phillip Felman, Brother of Lloyd Felman;
    - Dr Salo Grokop, General Practitioner, Private Practice; and
    - Dr Craig Hilton, General Practitioner, Bay Street Family Medical Centre.[6]

Issues investigated

15. Section 67 of the Coroners Act requires me to find if possible the identity of the deceased, the cause of death, and the circumstances in which the death occurred.

IDENTITY OF THE DECEASED

16. I find that the identity of Lloyd Felman was without dispute and required no additional investigation.

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6 Dr Hilton was granted a certificate pursuant to section 57(1)(b) of the Coroners Act, which enabled him to give evidence without that evidence being used in any proceeding against him.

CAUSE OF DEATH

17. Dr Malcolm Dodd, Forensic Pathologist at the Victorian Institute of Forensic Medicine conducted an external examination on 8 July 2008 and initially attributed Mr Felman's death to 1(a) Circumstances in keeping with Carbon Monoxide Poisoning.[7]

18. This cause of death was reconsidered following the finalisation of the toxicology report on 1 August 2008 because no carboxyhaemoglobin was detected in the blood. The finding was at odds with the circumstances of Mr Felman's death. Dr Dodd explained that this may be because a certain amount of exhaust fumes were inhaled with reduced levels of carbon monoxide emission in a vehicle supplied with a catalytic converter and/or carbon dioxide levels which were inhaled but could not be tested for at autopsy.[8]

19. Dr Dodd commented that of note however were levels of amitriptyline and its active metabolite nortriptyline in blood in aggregate concentration of approximately 1.7mg/L.[9] The toxicological report indicates the therapeutic use of amitriptyline ranges up to approximately 0.5mg/L, with concentrations associated with fatalities ranging from 1mg/L. In short, "this level of antidepressant mediation would appear to be sufficient to explain the cause of death in this case".[10]

20. The toxicology report also identified 0.03% per 100ml of blood alcohol concentration. Diazepam and warfarin were also detected.

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED

21. In order to properly understand the cause of Mr Felman's death, it is necessary to examine the circumstances in which it occurred. I do not propose to recount or summarise all of the evidence but rather refer to the parts that are necessary touching upon the relevant circumstances investigated as part of the inquest.

22. Insofar as this Finding considers the circumstances immediately surrounding Mr Felman's death, I have conducted an appraisal of the response by key individuals and services involved with his mental health care and management including:

- Monash Medical Centre;
- The Alfred Hospital; and
- Medical consultations with General Practitioners.

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7 Autopsy Report, p3

8 Supplementary Report provided by Dr Malcolm Dodd, Inquest brief. p25

9 Supplementary Report provided by Dr Malcolm Dodd, Inquest brief. p25

10 Supplementary Report provided by Dr Malcolm Dodd, Inquest brief. p26

23. When making my findings in relation to the circumstances of Mr Felman's death, particularly in relation to the conduct of individuals and organisations, the appropriate standard of proof to apply is articulated in *Briginshaw v Briginshaw*[11] which requires me to be satisfied on the balance of probabilities. The effect of this authority is that Coroners should not make adverse findings against or comments about individuals, unless the evidence provides a comfortable level of satisfaction that they caused or contributed to the death.

24. In the three weeks prior to his death, Mr Felman displayed unusual behaviour which involved high risk activities that resulted in him being admitted to the Monash and Alfred Hospital on three separate occasions. The circumstances in which he attended hospital were often in stark contrast to his presentation at assessment. On each occasion he displayed no indication of self-harm or suicidal ideation and gave verbal accounts which in retrospect did not actually reflect the truth of the situation. Consequently he was psychiatrically assessed and found to have no mental illness, therefore was deemed not to have met the criteria for involuntary treatment under the *Mental Health Act* 1986 (Mental Health Act) and was discharged from hospital.

25. In addition to these emergency department presentations Mr Felman was also seeking prescription medication from a number of general practitioners including his own regular GP.

26. I now consider each of these mental health contacts in turn.

Attendance at Monash Medical Centre on 18 June 2008

Background to attendance

27. On Wednesday 18 June 2008, Leading Senior Constable (LSC) Robert Dabonde received information via the Police Communication Centre of a suicide attempt outside Gate 9 at the Caulfield Racecourse. Details included that a male was sitting inside a late model Audi vehicle. Police attended this location and found no sign of the vehicle.

28. LSC Dabonde then telephoned the person who notified police to obtain further information. He was informed that the male had hoses attached to the exhaust pipe of the car which led into the vehicle. When the person confronted the male, he got out of the car, put the hoses in the boot and drove off.[12] Police checked the registration number provided for the car and attended Mr Felman's address in Caulfield North to speak with him. Mr Felman was asked to

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11 (1938) 60 CLR 336

12 Exhibit 5 – Statement of LSC Robert Dabonde, p1

open the boot of the car and police observed two hoses.[13] Police also reported that they had found empty medication packets in Mr Felman's possession. In response to enquiries about the hoses he said he was conducting an experiment to see if he could heat up the car.[14]

29. LSC Dabonde believed Mr Felman was drug or alcohol affected and may have been suffering a mental illness and took him to the Monash Medical Centre so that he could be assessed in relation to the Mental Health Act.

Assessment and examination of Mr Felman's mental health

30. Mr Felman presented to the Monash Medical Centre at 6.09pm and was seen by Dr David Brewster, Intensive Care Registrar. Mr Felman denied any previous depression, or being suicidal. He denied being a drinker or taking any tablets that day.[15] On examination, Dr Brewster found Mr Felman had normal vital signs, was not distressed, there was no evidence of respiratory problems, no clinical signs of carbon monoxide poisoning, nor overdosing on any sedative medications.[16] In short, Mr Felman presented with no evidence of any physical medical problems. However, Dr Brewster was concerned about the circumstances of his attendance at the hospital as reported by the police and requested a psychiatric assessment of his mental state and suicide risk. [17]

31. Mr Tim Hoppen, Registered Nurse working in the Psychiatry Department at Monash Medical Centre attended to Mr Felman at approximately 6.30pm and LSC Dabonde left the hospital. Mr Hoppen reviewed the Client Management Interface and saw that Mr Felman had a previous admission as an inpatient to a psychiatric unit in 2005.

32. Mr Hoppen conducted a mental health risk assessment. Mr Felman reported that his mood was unhappy but otherwise fine. Mr Hoppen said that Mr Felman was adamant from the onset of the assessment process that he had not been attempting to harm himself but rather had been "experimenting to see if he could melt the upholstery (in the car) with the heat from the exhaust".[18] He reported he had done this because he was unhappy the car was going to be repossessed. Mr Hoppen reported that Mr Felman adamantly denied recent or current suicidal thoughts and also denied any past self harm/suicidal behaviours.[19]

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13 Exhibit 5 – Statement of LSC Robert Dabonde, p2
14 Exhibit 5 – Statement of LSC Robert Dabonde, p3
15 Inquest brief, p44
16 Inquest brief, p44
17 Inquest brief, p45
18 Inquest brief, p47
19 Inquest brief, p47

33. Mr Felman's brother, Phillip Felman attended the hospital advising he was a lawyer and was "angry" about Mr Felman's treatment. Phillip Felman was "annoyed" that his brother had been transported to the hospital by police and threatened litigation if he was treated involuntarily under the Mental Health Act.[20] Phillip Felman was concerned he would be detained as an involuntary patient and was of the opinion that in the past that had been a disaster.[21] Phillip Felman reported that his brother's attempt to burn the car was part of a long history of doing "silly things".

34. Mr Hoppen then liaised with the Psychiatric Registrar, Dr Colin McIver and requested that he attend the Emergency Department.

35. Dr McIver reviewed Mr Felman and agreed with Mr Hoppen that Mr Felman was not exhibiting any overt evidence of psychotic phenomenon or affective disturbances and that he did not meet the criteria for involuntary admission. They considered that whilst Mr Felman's explanation was unusual, it was plausible given the reported long term pattern of high risk experiments.[22]

36. Dr McIver stated that there was considerable resistance from both the patient and his brother to any follow up including psychiatric admission or community visits.[23] Due to the unusual nature of the situation Dr McIver contacted the Consultant Psychiatrist for advice.

37. Dr McIver testified that he found Mr Felman to be functional, rational and capable, albeit angry at the time.[24] Further, he found Mr Felman had insight and understood how his actions could be perceived by others. Dr McIver described risk as an inexact science requiring a judgement call and in this case he adjudged Mr Felman to be low risk for further self-harm or suicide, which was strongly supported by his brother.[25]

38. Dr McIver confirmed that it would have been a stretch to detain him in this case because "he didn't strictly meet the criteria and we're very conscious of taking away someone's freedom and rights without clear risks and clear cause and he just didn't have them".[26] However,

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20 Inquest brief, p47
21 Transcript of evidence, p176
22 Inquest brief, p48
23 Inquest brief, p51
24 Transcript of evidence, p30
25 Transcript of evidence, p25
26 Transcript of evidence, p33

because the circumstances were bizarre and did not add up, Dr McIver thought it was important to have someone monitor Mr Felman.[27]

39. Following his discussion with the Consultant Psychiatrist, Dr McIver believed that if Mr Felman could be supervised by his brother, then he could be discharged. Dr McIver testified that if there was no agreement for an adequate supervisory arrangement which included support from a Crisis Assessment and Treatment Team (CATT) of Mr Felman then he could have recommended involuntary treatment under the Mental Health Act.[28] Consequently, Mr Felman was discharged from hospital by the psychiatry department.

40. Submissions for Monash Medical Centre say that the decision to discharge Mr Felman with his brother's supervision and CATT team follow up the next day was reasonable in the circumstances.[29]

41. Further, it was submitted that Dr McIver and Mr Hoppen undertook:

- A thorough assessment of Mr Felman's presentation at the time.
- Consulted with the on-call psychiatric consultant.
- Properly reached a sound clinical decision with respect to his need for supervision.
- Properly assessed Mr Felman in accordance with the criteria for involuntary treatment under the Act.

Attendance at the Alfred Hospital 23 and 24 June 2008

Background to attendance

42. On 23 June 2008 at approximately 11.00pm LSC Dabonde attended a motor vehicle collision in Kooyong Road, Elsternwick. LSC Dabonde recognised the driver as Mr Felman and observed an empty bottle of gin and empty prescription medications packets. LSC Dabonde took Mr Felman to the Alfred Hospital for assessment.[30]

Assessment and examination of Mr Felman's mental health

43. At approximately 11.45pm, Mr Felman was assessed by Dr Tristan Leech in the Emergency Department. He was provided with information regarding the circumstances in which he was found. There was a suspicion that Mr Felman had taken an overdose of these medications. Mr Felman had no immediate life-threatening injuries.[31]

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27 Transcript of evidence, p43

28 Transcript of evidence, p34

29 Submission on behalf of Alfred Health, p6

30 Exhibit 5 – Statement of LSC Robert Dabonde, p4

31 Exhibit 3 – Statement of Dr Tristan Leech, p1

44. At 11.30am Mr Felman was planning to self-discharge against medical advice and Dr Leech was called to speak to him. Dr Leech felt there were three reasons Mr Felman should remain in hospital including intoxication, possible head and/or spine injury and risk of self-harm.[32]

45. Dr Leech had requested diagnostic tests to exclude possible head and spinal injuries and was awaiting the MRI cervical spine investigation to exclude significant soft tissue injury to his neck and the CT spine. Despite the fact that he was awaiting these results Dr Leech was able to satisfy himself from examining Mr Felman that he posed a low risk of having a significant spinal injury and he felt Mr Felman understood the consequences of leaving without appropriate assessment and management.

46. Dr Leech identified certain risk factors for self-harm including chronic pain, unemployment, previous depression and previous alcohol abuse and certain protective factors (not wanting to cause problems for his children and presence of his immediate family to supervise him). Dr Leech had made a referral to the Psychiatric Registrar, however had not been able to contact her at the point at which he was discharged.

47. Dr Leech telephoned Mr Felman's general practitioner Dr Hilton who was familiar with Mr Felman's history. Dr Hilton advised he considered Mr Felman low risk for suicide, despite a previous attempt in 2005. Dr Leech felt reassured by the conversation with Dr Hilton and decided on balance that Mr Felman was at low risk of self harm.[33]

48. Following a detailed discussion with Mr Felman, Dr Leech found him to be clear and cohesive and understanding of the risk of self-discharging against medical advice. As such, Dr Leech deemed him competent and therefore free to refuse medical treatment and did not see any reason to keep him as an involuntary patient. Dr Leech did however, strongly advise him to stay in hospital but he insisted on self discharge.[34]

28 June 2008

Background to attendance

49. On 28 June 2008, LSC Dabonde received information that a male was sitting in a vehicle with the engine running and a hose connected from the exhaust pipe leading into the vehicle. The male looked asleep in the vehicle. LSC Dabonde recognised the address which belonged to Mr Felman and observed a Toyota Yaris in the driveway with the engine running and a large

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32 Exhibit 3 – Statement of Dr Tristan Leech, p2

33 Exhibit 3 – Statement of Dr Tristan Leech, p2

34 Inquest brief, p43

hose on the ground near the exhaust pipe. It appeared the hose had fallen off. The other end of the hose was in the driver's window. The window was almost all the way up holding the hose in place.[35]

50. Sergeant Lamb opened the door of the car and turned the ignition off. Mr Felman was sitting in the driver's seat holding the end of the hose in his hand. He was then removed from the vehicle and appeared to be groggy on his feet. A quarter of a bottle of gin and an empty bottle of tonic water were located in the car.[36] Mr Felman was taken to the Alfred Hospital for assessment.

51. Once back at the police station LSC Dabonde sent an email to all members at the station informing them to pay particular attention to Mr Felman's address due to the frequency of attendances.[37]

Assessment and examination of Mr Felman's mental health

52. At approximately 2.40am on 28 June 2008 Mr Felman arrived at the Emergency Department of the Alfred Hospital and was examined by Dr Christine Kotsios (nee Sierakowski), Psychiatry Registrar. Mr Felman said he had been conducting an experiment in his car (ie that he was attempting to measure the pressure in the exhaust pipe). He said that he had taken 8 or 10 Amitriptyline tablets as he had a long history of insomnia; it was his understanding this was not a dangerous dose. Dr Kotsios confirmed that this was within the recommended therapeutic range. Mr Felman also reported he had consumed alcohol, although was unsure how much.[38] He told Dr Kotsios that he took the medication and the alcohol and then went to check on his experiment and fell asleep in the car. He denied experiencing any suicidal thoughts or having any suicide intent and was adamant he was conducting an experiment.[39]

53. Dr Kotsios reviewed the medical file and saw that he had been assessed by a psychiatric registrar at the Monash Medical Centre emergency department on 18 June 2008 after being found in a car with a hose attached to the exhaust pipe. She noted that Mr Felman had been discharged home with his brother Philip Felman after he corroborated Mr Felman was performing an experiment and that such risky behaviour had occurred for many years.[40] A

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35 Exhibit 5 – Statement of LSC Dabonde, p5

36 Exhibit 5 – Statement of LSC Dabonde, p6

37 Exhibit 5 – Statement of LSC Dabonde, p6

38 Exhibit 4 – Statement of Dr Christine Sierakowski, p1

39 Exhibit 4 – Statement of Dr Christine Sierakowski, p2

40 Exhibit 4 – Statement of Dr Christine Sierakowski, p3

previous involuntary patient admission to Monash Medical Centre in 2005 was also noted due to concerns about his safety.[41]

54. During her examination of Mr Felman she noted he did not appear depressed and he denied symptoms of depression. No depressive themes such as helplessness, worthlessness or guilt were apparent on examination. He also denied suicidal thoughts, plans or intent.[42]

55. Dr Kotsios suggested a voluntary admission to the adult psychiatric unit at the Alfred Hospital to provide a period of observation and containment given the noted risk-taking behaviour. However, Mr Felman did not wish for this to occur. Philip Felman also expressed that he was willing to take Mr Felman home and provide supervision. Dr Kotsios said "she had some doubts regarding Mr Felman's story and his denial of suicidal intent". [43]

56. Dr Kotsios discussed Mr Felman's presentation and examination with Consultant Psychiatrist Dr Julian Friedin, on the phone. They reviewed her findings against the criteria for involuntary treatment as set out in section 8 of the Mental Health Act and found:

- Mr Felman did not present with features of a mental illness;
- Mr Felman did present with a history of risk-taking behaviours and his past medical history did include numerous injuries consistent with the history;
- Mr Felman was assessed as not requiring immediate treatment due to the lack of acute risk factors, no psychiatric disorder, past history, denial of current suicidal intent and availability of family support;
- The least restrictive option available was felt to be in the community rather than an acute psychiatric inpatient setting; and
- Benefits of hospitalisation may be counter-productive. [44]

57. In evidence Dr Kotsios explained that each of the criteria in section 8 needed to be satisfied.[45] Accordingly there was no basis upon which Dr Kotsios could mandate Mr Felman to remain in hospital as an involuntary inpatient.

58. Whilst Mr Felman did not meet the criteria of involuntary admission,[46] the assessment did suggest a chronic risk of further self harm and the following options were offered:

- Voluntary admission for further assessment;
- Follow up with community CATT team;

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41 Exhibit 4 – Statement of Dr Christine Sierakowski, p4
42 Exhibit 4 – Statement of Dr Christine Sierakowski, p4
43 Exhibit 4 – Statement of Dr Christine Sierakowski, p6
44 Exhibit 4 – Statement of Dr Christine Sierakowski, p7
45 Transcript of evidence, p91
46 Exhibit 4 – Statement of Dr Christine Sierakowski, p8

- Contact with Mr Felman's General Practitioner, however he did not want this to occur; and
- Mr Felman was provided with the psychiatry triage telephone number.

59. Mr Felman was also provided education regarding the potential side effects of Amitriptyline, particularly if he exceeded the recommended dose. In fact he was advised not to take Amitriptyline.[47]

60. Unfortunately, Mr Felman did not accept any of the options offered and was discharged. Dr Kotsios said a follow up call was made the next day by the triage clinician and Philip Felman said that Mr Felman was well and they did not require any further assistance.

Appropriateness of the Alfred Hospital Admissions

61. In relation to the admission on 23 and 24 June 2008, it was submitted that Dr Leech had conducted a proper assessment considered all the issues including that advised against self-discharge and strongly advised him to stay but ultimately he deemed him competent and could not admit him to hospital involuntarily.

62. In relation to the admission on 28 June 2008, it was submitted that Dr Kotsios acted appropriately in the circumstances. Dr Kotsios made excellent and comprehensive notes in relation to her assessment and examination of Mr Felman which made assessing her actions a much easier task. She was appropriately sceptical about Mr Felman's presentation and did seek information from him in relation to his admission 10 days before to Monash Medical Centre. Despite the strange circumstances of his attendance, Dr Kotsios did not assess Mr Felman as an acute suicide risk and the difficulty in his presentation to her was that he did not have an identifiable mental disorder. It was submitted that Dr Kotsios appropriately escalated his care to a Consultant Psychiatrist and he was deemed not to fit the criteria of an involuntary admission.

63. Associate Professor George Mendelson provided a statement to the Court and considered the decisions made at Alfred Hospital on 24 June and 28 June 2008 for Mr Lloyd Felman to be discharged, accompanied by his brother, were reasonable on the basis of his mental status at those times and the information concerning Mr Felman's behaviour available to the treating

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47 Exhibit 4 – Statement of Dr Christine Sierakowski, p7

medical practitioners at those times.[48] He further agreed that on both occasions Mr Felman did not satisfy the criteria according to the Mental Health Act.[49]

Medical Consultations with General Practitioners proximate to his death

64. According to his general practitioner, Dr Craig Hilton who had managed Mr Felman intensively from 2002 to 2008, he had a long and comprehensive medical history including chronic pain. Dr Hilton described Mr Felman's chronic pain as one of the most difficult he had ever managed,[50] stating that he had to constantly balance one clinical need against another.[51]

65. Mr Felman's last appointment with Dr Hilton was on 16 June 2008 where he received a 30mg morphine injection for his lower back pain.

66. In the two weeks prior to his death, Mr Felman attended three different general practitioners, seeking prescription medications for Diazepam and Amitriptyline.

67. On 22 June 2008, Mr Felman attended Dr Salo Grokop for a complaint of lower back pain causing insomnia. Of note, Dr Grokop found that he had a "somewhat jaunty demeanour not necessarily in keeping with his presenting complaint".[52] Dr Grokop explained that Mr Felman asked for Diazepam as he was not able to see his usual GP and that he had not had Diazepam for a while. Dr Grokop prescribed Diazepam and told him to discuss the consultation with Dr Hilton. Dr Grokop commented that the consultation did not alert him to any sudden lowering of mood or dramatic instability in his life.

68. On 26 June 2008 Mr Felman went to see Dr Martin Williams, General Practitioner for a flare up of his chronic pain for which he usually took Diazepam and Amitriptyline. Dr Williams said there was evidence of previous back surgery in the form of scarring and he prescribed Mr Felman 50 x 25mg of Amitriptyline tablets. Dr Williams stated he did not detect any apparent depression.

69. On 29 June 2008, Mr Felman attended Dr Ben Srikumar, General Practitioner complaining of severe pain and muscular spasm in the lumbar spine. Consequently, Dr Srikumar prescribed

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48 Exhibit 1 – Statement of Associate Professor George Mendelson, p4

49 Exhibit 1 – Statement of Associate Professor George Mendelson, p5

50 Transcript of evidence, p262

51 Transcript of evidence, p257

52 Exhibit 8 – Statement of Dr Salo Grokop, p2

Diazepam and Amitriptyline. Dr Srikumar noted that he did not display any symptoms of depression.

70. I am unable to determine the reason Mr Felman stockpiled his Amitriptyline and Diazepam. I consider it possible that he intended to consume it in an excessive quantity for the purpose of self-harm or suicide. However, it is also possible that his 'wholesale chemist shop',[53] as described by Phillip Felman was indicative of his dependency on prescription medication.

Intention to Suicide

71. An issue at Inquest was whether Mr Felman's death was a result of suicide defined as:

> (V)oluntarily doing an act for the purposes of destroying one's life while one is conscious of what one is doing. In order to arrive at a verdict of suicide there must be evidence that the deceased intended the consequence of his act.[54]

72. Therefore, in making a determination that Mr Felman's death was a result of suicide, I must be satisfied to the requisite degree of the following two things:

- First, that he intended to consume the amytripyline; and
- Second that he did so with the intention of ending his life.

73. The evidence with respect to the first limb is consistent and cogent; Mr Felman intentionally consumed the medication. It is the latter aspect that presents, in this case as with many others, the difficulty. The second limb presents the particular difficulty of determining that which is not outwardly observable. I further note that I must be satisfied that Mr Felman intended his action to result in his *death*, as opposed to Mr Felman engaging in parasuicide (otherwise known as a suicide gesture)[55].

74. It is the contention of Mr Phillip Felman that on the occasions Mr Felman was admitted to the hospitals for his risk taking behaviour, he was not trying to commit suicide. He further contended that Mr Felman would not take his own life because he had too much to live for. However, during his evidence Phillip Felman did concede that there was an abundance of indicators that pointed towards him trying to kill himself.[56]

75. LSC Dabonde who had the misfortune to attend to Mr Felman on the three occasions he was taken to hospital believed from his experience as a police officer that Mr Felman would

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53 Transcript of evidence, p168

54 *R v Cardiff City Coroner, Ex parte Thomas* [1970] 1 WLR 1475.

55 A suicide gesture is an apparent attempt by a patient to cause self-injury without lethal consequences and generally without actual intent to commit suicide. Mosby's Medical, Nursing and Allied Health Dictionary, Elsevier Science, 9th edn, 2013.

56 Transcript of evidence, p190

eventually succeed in his attempts to suicide.[57] LSC Dabonde formed the opinion that Mr Felman "was determined to end his life, mainly because of the pain that he was suffering. It had got to the point where he couldn't take the pain any more and medication was on (sic) no use".[58]

76. Dr Hilton considered suicide could not be discounted due to factors such as his past suicide attempt in 2005, his ongoing depression, alcohol use, chronic pain, opiate analgesic use, chronic disability, loss of career, loss of business, loss of family, loss of dignity, series of significant medical problems, in his mind "all set alarm bells ringing".[59] Further, he said:

> Mr Felman presented a medical case that was exceptionally complicated in every respect and there was always a very high risk either of suicide or of deterioration by self harm or neglect in one form or another. I hoped there would be a way of optimising his problems, but I was under no illusions of the low chance of success. I cannot think of any unattended means that could have made any difference to the final outcome.[60]

77. Ms Patricia Lo Cascio agreed with this and added that Mr Felman was a:

> [...] very bright professional man finds himself unable to lead the life that he was used to leading, to maintain relationships that he's used to maintaining, despair kicks in which is part of depression and sometime people like Mr Felman, after they've dug a great big hole for themselves by refusing help, find they have no way out.[61]

78. Further she stated:

> I suspect that the only thing he saw that was left for him was to take control of his own life by taking his own life which is extremely sad, because unlike a lot of people, he had all the help he could have wanted. People couldn't have done more.[62]

79. It is important to note at this juncture that although I have considered the information and opinions provided as relevant background information, I am required to determine the intention of Mr Felman at the time he consumed the medication on 3 July 2008 which resulted in his death. This is made all the more difficult because there is no evidence before me of any contemporary and explicit indications by Mr Felman of suicidal intent.

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57 Transcript of evidence, p121

58 Exhibit 5 – Statement of LSC Dabonde, p6

59 Exhibit 9 – Statement of Dr Craig Hilton, p2

60 Exhibit 9 – Statement of Dr Craig Hilton, p2

61 Transcript of evidence, p147

62 Transcript of evidence, p147

FINDINGS

80. I find that Lloyd Felman's death occurred between 3 and 4 July 2008. Having considered all the evidence in relation to cause of death, particularly in light of the toxicological report and the supplementary report provided by Dr Malcolm Dodd, I find that the medical cause of death is

    1(a) AMITRIPTYLINE TOXICITY.

81. A finding of suicide, in my opinion should only be made upon clear, cogent, persuasive proof, not upon indirect inferences or inexact proof. To make such a finding a comfortable degree of satisfaction must be realised, the test expounded in *Briginshaw* should be applied.

82. I find that Mr Felman took an overdose of Amitriptyline and set himself up in a secluded area (Lions Park, Seymour) with a hose attached to the exhaust pipe of the car with the other end attached to the inside of the car with the intention of taking his own life, I therefore find that the circumstances of his death were consistent with suicide.

83. I further find that, despite the circumstances in which Mr Felman was found, there was no positive evidence that motor vehicle exhaust gases caused or contributed to his death.

84. I find that Monash Medical Centre and its employees, Mr Hoppen and Dr McIver conducted a thorough examination and assessment of Mr Felman's mental health and that their clinical management and decision making was reasonable and appropriate in the circumstances.

85. I find that the Alfred Hospital and its employees, Dr Leech on 23 and 24 June 2008 and Dr Kotsios on 28 June 2008, both conducted thorough and appropriate assessments and examinations of Mr Felman's mental health and their care and management was reasonable in all the circumstances.

86. I find that Mr Felman was a difficult patient in that, despite his risk taking behaviour and the circumstances surrounding his attendance at the hospitals on all occasions, he did not present as mentally ill and therefore was not able to be treated as an involuntary patient under the Mental Health Act. In the context of a general understanding that the least restrictive option is most appropriate, Mr Felman's capacity to make sound decisions with respect to his own mental health and his strong opposition to treatment, the hospitals appropriately allowed him the right to self-determination and accepted his refusal.

87. I find that LSC Dabonde was pro-active in his management of his three separate encounters with Mr Felman. Further, I find that LSC Dabonde had an excellent awareness of individual's

presenting with mental health problems, however it is unfortunate that his thorough and effective insight into Mr Felman's actions was ultimately to no avail.

88. Finally, I acknowledge the impact Mr Felman's death has had on those who loved him and I express my sympathy to his family and friends.

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

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

- Felman family
- Mr Phillip Felman
- Monash Medical Centre
- Alfred Hospital
- LSC Robert Dabonde, Victoria Police
- Senior Constable David Duff, Investigating Member

Signature:

CORONER JACQUI HAWKINS
Date: 11 September 2014