FORM 37

Rule 60(1)

FINDING INTO DEATH WITH INQUEST

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

Court Reference: 197/07

Inquest into the Death of Mark Andrew Downie

Delivered On:	2 June 2009
Delivered At:	Morwell
Hearing Dates:	2nd June 2009
Findings of:	E.C Batt
Place of death/Suspected death:	15 Sally Court Traralgon
SCAU	Jason Gibbons

I, E C. Batt, Coroner, having investigated the death of Mark Andrew Downie holding an Inquest at Morwell on 2nd June 2009 find that the identity of the deceased was Mark Andrew Downie and that death occurred on 16th January 2007
at 15 Sally Court, Traralgon from an overdose of a combination of Chlorpromazine, Mirtazepine and Dianzapine in the following circumstances –

The deceased, aged 32, had a history of issues with his mental health. He enjoyed the very strong support of his mother Denise Monks throughout. He had faced mental health issues and depression in a setting of Poly substance abuse.

On 11th September 2006 the deceased was imprisoned. Whilst in custody at Fullham Prison he attempted suicide on two occasions, on 17th October 2006 and
8th November 2006. On 1st December 2006 an order was made under S.16(3)(b) of the Mental Health Act 1986 to transfer the deceased from the Melbourne Assessment Prison to the Thomas Embling Hospital. He was extremely distressed and injuring himself. The deceased's sentence lapsed on 2nd December 2006 and he was transferred to the Flynn Ward of the Latrobe Regional Hospital on 5th December 2006 and then released.

On 9th December 2006 he purchased items with the apparent intention of suicide by carbon monoxide poisoning in a car. Upon the intervention of his mother police arrested Mr. Downie under S.10 of the Mental Health Act and ultimately on
13th December 2006 he was admitted to the Flynn Ward again.

His condition improved sufficient for three overnight releases to be undertaken and on 2nd January 2007 Denise Monks took her son out of the

hospital to reside with her. This was done after Mark had satisfied hospital staff, and his mother, that he could conduct himself appropriately within a normal ward for 3 days. Mrs. Monk was advised to keep her sons medication (Zyprexa, Avanza and Chlorpromazine) out of the way and only leave him with appropriate doses. The deceased was still feeling paranoid but hospital staff assured Mrs. Monk that this would settle. This did not eventuate however. Alexander Bonyhai was assigned as Mark Downie's case manager following his discharge. It became apparent to Denise Monks that her son was minimalizing the state of his paranoia in a home visit by the case manager.
On 15th January she telephoned Mr. Bonyhai to discuss this. A psychiatric outpatient appointment was organized for 18th January 2007.

On 16th January 2007 the deceased entered his mother's home to discover his night medication appropriately laid out for him. Intent upon taking his own life and in the absence of his mother, he searched the home and discovered the rest of his medication that had been properly stored away by her. He took a lethal overdose of a combination of these drugs and was discovered deceased by his mother shortly thereafter. Toxicological examination revealed toxic levels of Chlorpromazine.

Recommendations

That consideration be given to a Gippsland Prevention & Recovery Care Service (PARCS) being constructed at Warragul. The deceased in this case clearly needed admission to a "stepdown" unit which is less clinical than an inpatient facility but could provide a psychiatric nurse 24 hours a day and monitoring of medication. Whilst it is accepted that progress in getting well from phychiatric illness is sometimes better achieved at home than in a hospital, the move from hospital to home in this case, like in many others, needed a more supported bridge than relying on loving and well meaning family members.

Date at Morwell, 25th May 2010

E.C. Batt
CORONER