Court Reference:4896 / 08

FORM 37

Rule 60(1)

FINDING INTO DEATH WITH INQUEST

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

Inquest into the Death of Nicholas Raymond Lobo

Delivered On:	1st December 2009
Delivered At:	Melbourne
Hearing Dates:	1st December2009
Findings of:	Deputy State Coroner West
Representation:	No Representation
Place of death/Suspected death:	6 Mutual Court, Forrest Hill
SCAU	L/S/C K. Taylor

FORM 37

Rule 60(1)

FINDING INTO DEATH WITH INQUEST

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

In the Coroners Court of Victoria at Melbourne

I, Deputy State Coroner West having investigated the death of:

Details of deceased:

Surname:	Lobo
First name:	Nicholas
Address:	6 Mutual Court, Forrest Hill

AND having held an inquest in relation to this death on 1st December, 2009

at Melbourne

find that the identity of the deceased was Nicholas Raymond Lobo

and the death occurred on the 31st October, 2008

at 6 Mutual Court, Forrest Hill

from

1.(a) Drowning

2. Increased blood ethanol level

in the following circumstances:

1.Nicholas Lobo, aged 60 years, was an Indian national who lived alone at 6 Mutual Court, Forrest Hill. He came to Australia in the early 1990s and shortly thereafter got married, however, the marriage subsequently failed. Despite being a qualified computer programmer, Mr Lobo was unemployed at the time of his death and suffered from depression and excessive alcohol consumption. His past medical history included non insulin dependent diabetes mellitus, hypertension and hypercholesterolemia.

2.On the 31st October 2009 at approximately 6.40 pm, Nicholas Lobo was discovered by his brother, Thomas, submerged and deceased in the bathtub at his Forrest Hill home. Family attended at his premises after being notified of welfare concerns by staff at Linwood House,

an intensive rehabilitation and recovery centre, and to which he had not returned after being home on day leave.

3.The Linwood program provides a voluntary residential facility with 24 hour staffing and aims to facilitate the independent living of residents in the community, following discharge from an acute inpatient mental health service. On the 29th October 2008, Mr Lobo had been discharged to Linwood House from Upton House, where he had been admitted as an involuntary patient following a number of self harming episodes. On the 30th October he was permitted day release from Linwood and returned to the facility without incident, however, on the 31st he was denied the opportunity of returning home permanently. After agreeing to day leave he went home, with contact taking place during the day, via telephone. When he failed to return at the end of the day, family were notified to request a welfare check.

4.Subsequent autopsy examination found no natural disease processes of a type likely to have caused or contributed to the death, and as there are no specific findings in cases of drowning, the pathologist formulated the cause of death as "consistent with drowning". In view of that finding, together with the circumstantial evidence of where he was found, I am satisfied that Mr Lobo drowned. Toxicological analysis of body tissue found a blood alcohol concentration of 0.21%.

5.Investigation into the circumstances surrounding the death, revealed that Mr Lobo had a long history of depression and anxiety, which included hearing voices and believing he was under constant surveillance. His high alcohol intake, lack of motivation and sleep deprivation, all impacted on his mental health and diabetes management. After being diagnosed as suffering schizoaffective disorder he was treated over a two week period with antipsychotic medication before being discharged on a Community Treatment Order and admitted for respite at Linwood. At Linwood he was assessed as to his suitability for day leave prior to being permitted to go home, by the hospital medical officer in psychiatry and when phone contact was made with him at 2.00pm, he stated he was fine and gave no indication of there being any suicidal ideation.

6.No suicide note was left by Mr Lobo, nevertheless, I am satisfied that his death was due to an intentional act and that it was not accidental. He had a recent past history of self harming behaviour and the fact that when he was found he was in his underwear, satisfies me that the tragic outcome was not due to alcohol impairment whilst taking a bath.

COMMENTS

Pursuant to section 67(3) of the Coroners Act 2008, I make the following comment(s) connected with the death (including any notification to the Director of Public Prosecutions under Section 69(2) of that Act):

7.This tragedy highlights the dilemma facing health professionals who manage and treat individuals with mental illness and their difficulty in predicting when a patient is at risk of crossing the suicide threshold. Prior attempts and risk factors may be well documented, however, such material can rapidly go out of date and thus be less helpful as an indication

of future behaviour. There is a significant mortality rate for persons suffering schizoaffective disorder, with the patient's actions frequently being impulsive. I am satisfied that there is no evidence in this case to suggest that Nicholas Lobo's medication regime, or treatment plan, was other than appropriate. Sadly, despite the availability of community support services, Mr Lobo chose to end his life.

Signature:

Date: 1st December, 2009