IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2016 6067

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)

Section 67 of the Coroners Act 2008

Amended pursuant to *Section 76 of the Coroners Act 2008* on 22 March 2019[1]

Findings of:	Caitlin English, Coroner
Deceased:	Nathan John Shanahan
Date of birth:	17 April 1976
Date of death:	22 December 2016
Cause of death:	I(a) Toxic effects of a gas
Place of death:	The Calder Highway, Hattah, Victoria

[1] This document is an amended version of the finding into Nathan John Shanahan's death dated 12 March 2019. A correction to paragraph 3 has been made pursuant to Section 76 of the *Coroners Act 2008* (Vic), following a telephone conversation with Kosha Shanahan on 21 March 2019.

INTRODUCTION

1. Nathan John Shanahan was a 40-year-old man who lived in Wendouree at the time of his death.

2. Mr Shanahan had a history of Major Depressive Disorder, anxiety and Post Traumatic Stress Disorder (PTSD) following service in the Australian Defence Force (ADF).

3. On the afternoon of 22 December 2016, Mr Shanahan was found deceased in his vehicle at the Calder Highway.

THE PURPOSE OF A CORONIAL INVESTIGATION

4. Mr Shanahan's death was reported to the Coroner as it appeared to be unnatural and so 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, the forensic pathologist who inspected Mr Shanahan, treating clinicians and investigating officers.

7. As part of the coronial investigation, I sought advice from the Coroners Prevention Unit (CPU)[2] in relation to data concerning Victorian suicides of current and former serving ADF members.

8. I have based this finding on the evidence contained in the coronial brief. In the coronial jurisdiction facts must be established on the balance of probabilities.[3]

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[2] 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. 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.

[3] 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.

IDENTITY

9. On 22 December 2016, Peter Renton visually identified his work colleague Nathan John Shanahan, born 17 April 1976.

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

BACKGROUND

11. In 2005, Mr Shanahan joined the ADF. He was deployed to the Solomon Islands for approximately six months in 2016. Upon his return, Mr Shanahan's wife Kosha Shanahan noticed some differences in Mr Shanahan's '*frame of mind*' and told him that he needed to spend some time with his family. Upon his return they became engaged and were married approximately one year later.

12. In 2010, Mr Shanahan left the ADF following a period of leave without pay. Mr Shanahan subsequently gained employment at the Northern Territory Fire and Rescue Service and he and his wife moved to the Northern Territory. Whilst living in the Northern Territory Mr Shanahan and his wife had two children.

13. Around 2012, Mr Shanahan applied for a role with the Country Fire Authority (CFA) and was successful. Mr Shanahan and his family moved to Mildura where he was posted.

14. On Anzac Day in 2014, Mr Shanahan told Mrs Shanahan that '*he did not feel like himself and had not felt right mentally for some time*'.[4] Mr Shanahan attended his local general practitioner Dr Nalinda Amarasinghe and was referred to Clinical Psychologist Lienne Wenzel for treatment of depression and anxiety. Mr Shanahan saw Ms Wenzel intermittently from June 2014 to June 2016.

15. Mr Shanahan presented to Ms Wenzel with symptoms of anxiety and depression, he displayed perfectionist traits and set high standards for himself. He disclosed intermittent substance abuse and periods of binge drinking but noted that this never effected his work attendance or performance. Ms Wenzel noted that Mr Shanahan '*took his work very seriously and was committed to furthering his knowledge and skills within the fire department*'.[5]

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[4] Coronial brief, Statement of Kosha Shanahan dated 1 February 2017, 7.
[5] Coronial brief, Statement of Lienne Wenzel dated 29 March 2017, 19.

16. In 2015, Mr Shanahan walked from Mildura to Adelaide carrying a pack to raise money for 'Soldier On', a charity that raises money for soldiers suffering with PTSD and other mental illnesses.

17. According to Ms Wenzel, Mr Shanahan's mental state varied over the two-year period in which he sought treatment from her and '*seemed to reflect how things were going in his personal life*'.[6] In Ms Wenzel's professional opinion Mr Shanahan '*displayed symptoms consistent with a Major Depressive Disorder*'[7] and '*despite his history in the Army, he did not disclose, nor did he exhibit symptoms of Post-Traumatic Stress Disorder...*'.[8]

18. Around April 2016, one of Mr Shanahan's colleagues at the CFA took his own life. According to Mrs Shanahan this really affected her husband.

19. Also, in April 2016, Mr Shanahan celebrated his 40th birthday. Following his birthday celebrations Mrs Shanahan became concerned as Mr Shanahan appeared to be '*very emotional*'[9] and was '*drinking heavily*'.[10]

20. On the evening of 16 June 2016, Mrs Shanahan called her husband at work and they had an emotional discussion regarding the future of their relationship. Mr Shanahan began texting Mrs Shanahan regarding suicidal thoughts and attempted to leave their home the following morning with a backpack containing a rope.

21. Mrs Shanahan told Mr Shanahan that he needed to go to hospital or to his family for help. They separated at that point and Mr Shanahan was collected by his father and sister on 18 June 2016 and lived with his parents in Wendouree until his death. He continued to work at the CFA in Ballarat.

22. On 26 June 2016, Mr Shanahan attended general practitioner Dr Neville Ravindranyagam at the Wendouree Medical Centre. Dr Ravindranyagam was of the view that Mr Shanahan was suffering from symptoms of severe depression and was experiencing difficulty sleeping. Mr Shanahan also had symptoms of PTSD which he disclosed he had experienced since serving with the ADF in the Solomon Islands.

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[6] Coronial brief, Statement of Lienne Wenzel dated 29 March 2017, 19.
[7] Coronial brief, Statement of Lienne Wenzel dated 29 March 2017, 20.
[8] Coronial brief, Statement of Lienne Wenzel dated 29 March 2017, 20.
[9] Coronial brief, Statement of Kosha Shanahan dated 1 February 2017, 8.
[10] Coronial brief, Statement of Kosha Shanahan dated 1 February 2017, 8.

23. In his statement Mr Shanahan's father John Shanahan states '*I honestly feel his trip to the Solomon Islands was the start of Nathan's issues as he witnessed a lot of violent and confronting incidents but was never given the debriefing and assistance he needed*'.[11]

24. Dr Ravindranyagam referred Mr Shanahan to Consultant Psychiatrist Dr Manisha Mishra for management of his depression, PTSD, and relationship issues.

25. On 2 August 2016, Mr Shanahan attended Dr Mishra and reported a long history of depression and anxiety following some negative experiences whilst serving in the ADF, with further complications of relationship difficulties. Dr Mishra advised Mr Shanahan to consider increasing his dosage of Escitalopram from 20 mg to 30mg for a few weeks to see the effect. Dr Mishra also advised Mr Shanahan to take Imovane 15mg to assist him with sleep.

26. Mr Shanahan disclosed to Dr Mishra that whilst serving in the ADF, he witnessed an alleged sexual assault in 2006 whilst serving in the Solomon Islands. He reported this to the authorities, however was told not to intervene. Mr Shanahan reported feeling unheard and invalidated by the authorities and noted that in 2008 the traumatic experience had re-emerged in his mind. This resulted in him leaving the Special Air Service Regiment training in 2009 as he was anxious with the uncertainties around the role.

27. On 11 August 2016, Mr Shanahan attended Dr Mishra and reported '*feeling down and tired since disclosing the trauma (during the first session)*'[12] and further reported that '*the memories had resurfaced*'[13] but '*acknowledged being more aware of his feelings/emotions*'.[14]

28. Following several sessions with Dr Mishra throughout August and September 2016, Mr Shanahan presented with a stable state of mind and did not express any suicidal thought, plan or intent and reported to be enjoying work and his social life. Dr Mishra advised Mr Shanahan to continue taking his medication and discussed further strategies to assist Mr Shanahan to manage his impulsivity.

29. On 7 October 2016, Mr Shanahan cancelled an appointment with Dr Mishra due to work commitments. A follow up appointment was booked for 2 November 2016, as Dr Mishra was on leave for three weeks.

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[11] Coronial brief, Statement of John Shanahan dated 1 February 2017, 11.
[12] Coronial brief, Statement of Dr Manisha Mishra dated 19 April 2017, 26.
[13] Coronial brief, Statement of Dr Manisha Mishra dated 19 April 2017, 26.
[14] Coronial brief, Statement of Dr Manisha Mishra dated 19 April 2017, 26.

30. On 1 November 2016, Mr Shanahan again cancelled his appointment with Dr Mishra.

31. On 9 December 2016, Mr Shanahan attended Dr Ravindranyagam for a medical appointment. Dr Ravindranyagam noted that Mr Shanahan appeared to be '*relaxed and cooperative*'.[15] Mr Shanahan told Dr Ravindranyagam that he was on holidays and planned to visit his children in Mildura. Mr Shanahan also reported that he had stopped attending Dr Mishra as he '*felt better in himself*'[16] but was happy to make an appointment to see her should the need arise.

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED

32. On 20 December 2016, Mr Shanahan contacted Mrs Shanahan and asked her where she was as he wanted to come and collect the children. Mrs Shanahan noted that her husband sounded agitated, so she thought it would be safer if she took the children to him.

33. On the evening of 21 December 2016, Mr Shanahan attended a community party with Mrs Shanahan. She noted that he was drinking more '*than normal*'[17] and appeared to become '*very paranoid*'[18] and subsequently left the party.

34. Mrs Shanahan left the party soon after and returned home to find Mr Shanahan in the backyard drinking. Mrs Shanahan began to organise their children for bed. When she returned she noticed that Mr Shanahan was not there. Mr Shanahan returned a short time later, having gone out to buy more beer.

35. Upon his return Mr Shanahan appeared '*agitated*'.[19] Mrs Shanahan's brother, Lewis Loder who had been staying with her, said to Mr Shanahan, '*from a safety point of view*'[20] he '*could not stay and he had to go*'.[21] Mr Shanahan became distressed and damaged several items in the home prior to leaving.

36. At approximately 6.30am on 22 December, Mr Shanahan arrived at Mrs Shanahan's residence as it had been previously arranged that he would take the children. Mr Shanahan

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[15] Coronial brief, Statement of Dr Neville Ravindranyagam dated 28 April 2017, 22.
[16] Coronial brief, Statement of Dr Neville Ravindranyagam dated 28 April 2017, 22.
[17] Coronial brief, Statement of Kosha Shanahan dated 1 February 2017, 9.
[18] Coronial brief, Statement of Kosha Shanahan dated 1 February 2017, 9.
[19] Coronial brief, Statement of Kosha Shanahan dated 1 February 2017, 9.
[20] Coronial brief, Statement of Kosha Shanahan dated 1 February 2017, 9.
[21] Coronial brief, Statement of Kosha Shanahan dated 1 February 2017, 9.

appeared to be '*visibly affected by something*'[22] and he was '*incoherent and struggling to stay awake*'.[23]

37. Mr Shanahan went to lie on the lounge and told Mrs Shanahan that he would soon leave. Mrs Shanahan left the residence at approximately 8.00am with her children and took them to a friend's house.

38. At approximately 12.30pm, Mr Shanahan called Mrs Shanahan and told her that he was leaving. Mrs Shanahan told Mr Shanahan to drive safely and to let her know when he arrived.

39. At approximately 1.30pm, Mrs Shanahan was standing out the front of her work and saw Mr Shanahan crossing the road towards her. Mrs Shanahan gave Mr Shanahan '*a very long hug and...told him that he needed to go to Hospital*'.[24] Mr Shanahan replied, '*not a chance*'.[25] Mr Shanahan then told Mrs Shanahan that he needed to go before it got too late.

40. Around one hour later Mr Shanahan sent Mrs Shanahan a text message which was a picture of a bucket with two containers of chemicals. Mrs Shanahan texted her husband '*I think these are a toxic combination of chemicals*'[26] to which her husband replied '*correct*'.[27] Mrs Shanahan was concerned for her husband's welfare and immediately called him asking Mr Shanahan for his location. Mr Shanahan would not reveal his location to Mrs Shanahan. She told Mr Shanahan that she would contact the police and he asked her not to do so. Mrs Shanahan ended the call and forwarded the text message to Mr Shanahan's father and sister so that they would contact the police.

41. At approximately 4.20pm, Clinton McArthur was driving home along the Calder Highway when he observed a blue Holden Commodore parked on the side of the road near the intersection of the Calder Highway and the Old Calder Highway. Mr McArthur noted that the vehicle's left indicator was on and the vehicle's doors were closed.

42. At approximately 5.15pm, Mr McArthur was again driving along the Calder Highway and noted that the vehicle was still there.

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[22] Coronial brief, Statement of Kosha Shanahan dated 1 February 2017, 9.
[23] Coronial brief, Statement of Kosha Shanahan dated 1 February 2017, 9.
[24] Coronial brief, Statement of Kosha Shanahan dated 1 February 2017, 9.
[25] Coronial brief, Statement of Kosha Shanahan dated 1 February 2017, 9.
[26] Coronial brief Exhibit, text message between Kosha Shanahan and Nathan Shanahan.
[27] Coronial brief, Exhibit, text message between Kosha Shanahan and Nathan Shanahan.

43. Mr McArthur pulled up approximately seven metres behind the vehicle and noticed that the Holden Commodore's engine was still running. Mr McArthur approached the vehicle and observed Mr Shanahan slumped forward in the vehicle. Mr McArthur attempted to rouse Mr Shanahan by knocking on the vehicle window, however Mr Shanahan did not respond.

44. Mr McArthur opened the vehicle door and smelt a chemical odour coming from the vehicle. Mr Shanahan remained unresponsive, and Mr McArthur immediately contacted emergency services.

45. Emergency services attended the scene, and Mr Shanahan was subsequently declared deceased.

46. Victoria Police searched Mr Shanahan's vehicle and located a bucket containing two bottles. Officers also noted a chemical odour emanating from the vehicle.

CAUSE OF DEATH

47. On 23 December 2016, Associate Professor David Ranson, a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, conducted an inspection and provided a written report, dated 21 February 2017. In that report, Associate Professor Ranson concluded that a reasonable cause of death was '*I(a) Toxic effects of a gas*'.

48. Toxicological analysis identified the presence of zopiclone and citalopram.

49. Associate Professor Ranson commented that '*...The attached toxicology report indicates that although some therapeutic drugs at appropriate levels were found Carboxyhaemoglobin was not present indicating that this death was not due to Carbon monoxide poisoning. No other drug or poison was detected within the limits of the analysis making determination of an unequivocal cause of death problematic*'.

50. Associate Professor Ranson stated, '*it is possible that mixing certain domestically obtained chemicals can release noxious gases that can lead to severe lung injury and/or death*'. He further commented '*there are a number of toxic gaseous substances that can be formed by chemical reactions using household or garden chemicals in this type of setting. The most likely chemical that would have a strong odour would be Hydrogen Sulphide unfortunately this is not able to be tested for*'.

51. I accept Associate Professor Ranson's opinion as to cause of death.

Intent

52. I take into account Mr Shanahan's ongoing struggle with severe mental health issues since leaving the ADF. Despite the medical care Mr Shanahan received, together with the love and support that was provided by his family and friends, I find that he intentionally ended his own life.

COMMENTS PURSUANT TO SECTION 67(3) OF THE ACT

53. In the period since I commenced my Coronial investigation into the death of Nathan Shanahan, important and positive developments have improved our understanding of, and response to, suicidality among current and former serving members of the ADF ('veterans').

54. First, the Australian Senate's Foreign Affairs, Defence and Trade References Committee completed its inquiry into suicide among Australian veterans and published its August 2017 final report titled *The Constant Battle: Suicide by Veterans*. The report included 24 recommendations ranging across areas including suicide prevention programs, access to mental health services, improvement in services to veterans, and trials of new programs to assist veterans.

55. Second, the Australian Government through the Hon Dan Tehan MP responded to the final report by accepting and endorsing most recommendations and indicated a range of activities to be undertaken, or already underway, to address mental health and suicide risk to veterans.

56. Third, on 21 September 2018 the Australian Institute of Health and Welfare (AIHW) published its first annual public update on suicide among serving and ex-serving ADF personnel. This was a result of the Senate Committee process; the AIHW prepared the original report for the Committee, which then recommended the Australian Government establish a National Veteran Suicide Register to be maintained by the AIHW so regular updates on the suicides could be produced to inform public policy. Among the notable findings reported therein, the AIHW established that the suicide rate among male veterans was higher than the suicide rate among all Australian males; this suicide rate was particularly elevated among male veterans aged under 30 years.

57. Given these developments, I believe it is fair to conclude that the supports available to ADF veterans - and particularly those experiencing suicidality and post-traumatic stress disorder - are either improved or in the process of improving from the time of Nathan Shanahan's

untimely and tragic death. Therefore, I do not propose to make any recommendation regarding Australian Government and Australian community support for veterans.

58. During my investigation I requested that the Coroners Prevention Unit prepare a data summary on Victorian suicides of current and former serving ADF members, to contextualise Nathan Shanahan's death. The CPU compiled its summary using the Victorian Suicide Register, and I was assisted particularly by the information regarding service history and incidence of diagnosed post-traumatic stress disorder. However, I noted that the CPU experienced substantial challenges in identifying relevant deaths because evidence regarding ADF service of deceased people was often vague. Furthermore, when the evidence supported that a deceased person was a current or (more often) former serving ADF member, there was a general lack of detail about the service history. For example, the CPU could not confirm the deceased's duration of ADF service in 33 of 69 suicides (47.8%), and could not establish whether the deceased had served overseas in 41 of 69 deaths (59.4%); and among the 62 suicide deceased who were former ADF members, in 29 cases (46.8%) the CPU could not establish the period of time elapsed between discharge from service and death.

59. As the CPU has limited ability to identify and describe relevant suicide deaths, I commend the establishment of ongoing funding for the national suicide monitoring program for suicide among serving and ex-serving and reserve ADF personnel, which is under AIHW auspices. This program is crucial because we need to understand the frequency and nature of these suicides to design appropriate suicide prevention and early intervention initiatives.

60. The first AIHW update report (dated 21 September 2018) was valuable for its account of suicide frequencies and rates, but could offer more insight into the nature of the suicides. For example, at a most basic level the data was not disaggregated by state, which was disappointing given that most suicide prevention initiatives are delivered at a state level. Furthermore, the data was not disaggregated by service branch; by period of service; by length of time between discharge and death; by history of service overseas; or any other features that may be meaningful for identifying vulnerable cohorts. I assume all this information would be available to the AIHW via the Defence Personnel Management Key Solution (PMKeyS) database, which underpins the monitoring program.

61. I would therefore encourage the AIHW to consider how the data could be presented in the future, to enhance its utility for prevention.

62. Additionally, I believe it would be of great benefit if both the Coroners Court of Victoria and the AIHW were to share their information regarding relevant Victorian suicides of current and former serving ADF members. The AIHW's data holdings would enable the Court to identify relevant suicides with greater confidence; and the data in the Victorian Suicide Register - which includes information about psycho-social stressors, mental health disorders and so on - would presumably be useful to the AIHW in developing a more detailed understanding of prevention opportunities.

RECOMMENDATION

63. Pursuant to section 72(2) of the *Coroners Act 2008*, I make the following recommendation:

That the Australian Institute of Health and Welfare engage with the Coroners Court of Victoria to explore whether there are opportunities to share data on Victorian suicides among current and former serving Australian Defence Force members, to inform the design and implementation of suicide prevention initiatives.

FINDINGS AND CONCLUSION

64. Having investigated the death, without holding an inquest, I find pursuant to section 67(1) of the *Coroners Act 2008* that Nathan John Shanahan, born 17 April 1976, died on 22 December 2016 at the Calder Highway, Hattah, Victoria, from toxic effects of a gas in the circumstances described above.

65. I convey my sincere condolences to Mr Shanahan's family for their loss.

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

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

Mrs Kosha Shanahan, senior next of kin.

Mr Barry Sandison, Chief Executive Officer, Australian Institute of Health and Welfare.

Defence Legal, The Department of Defence.

Ms Flynn Parker-Greer, Department of Veteran Affairs.

Sergeant Anthony Keely, Victoria Police, Coroner's Investigator.

Signature:

CAITLIN ENGLISH
CORONER
Date: 22 March 2019