IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2016 3591

FINDING INTO DEATH WITHOUT INQUEST

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

Findings of:	**CORONER DARREN BRACKEN**
Deceased:	**JACK DAVID WATSON**
Date of birth:	8 August 1989
Date of death:	2 August 2016
Cause of death:	Plastic bag asphyxia in the setting of a vitiated atmosphere with inert gases
Place of death:	Cobb and Co Road, Carlsruhe, Victoria

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HIS HONOUR:

BACKGROUND

1. Jack David Watson was 26 years old when on 2 August 2016 he was found dead in his car parked on Cobb & Co Road, Carlsruhe. Mr Watson and his then ex-partner Ellen Barnard were the parents of two children the older of whom was born in 2011 and the younger in October 2014.[1]

2. In the time leading up to his death Mr Watson was involved with multiple public health services due to suicidal behaviours.

Mental health history

3. Mr Watson had a long history of mental health issues and, at around the age of 16 or 17, was diagnosed with Attention Deficit Hyperactivity Disorder (**ADHD**). These difficulties negatively affected his relationship with Ms Barnard, which began in 2008, and limited his ability to maintain employment.[2]

4. Around the end of 2014 Mr Watson was taking a sustained high dose of prescribed dexamphetamine and had periodic breakdowns and crises. In February 2015 he lost his job and, according to Ms Barnard, had "*a major low*". He was initially unable to remain in the home with his children and lived away from home for around a month.[3]

5. In mid-2015 Mr Watson's condition improved and he began to re-engage with mental health practitioners.[4]

6. In late July 2015 Mr Watson and Ms Barnard moved from Glenroy to Trentham where she worked full-time and he was responsible for caring for their children. Around December 2015 he stopped engaging with his mental health support and did not connect with services based in his new area.[5]

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[1] Statement of Ellen Barnard dated 21 November 2016, Coronial Brief, page 6.
[2] Statement of Ellen Barnard dated 21 November 2016, Coronial Brief, page 6.
[3] Letter from Dr Sam Jolayemi to Dr Nicola Doyle dated 24 March 2015, Ballarat Health Services Medical Records, page 98; Statement of Ellen Barnard dated 21 November 2016, Coronial Brief, page 6.
[4] Statement of Ellen Barnard dated 21 November 2016, Coronial Brief, page 7.
[5] Statement of Ellen Barnard dated 21 November 2016, Coronial Brief, page 7.

7. In March 2016 Mr Watson began working casually and, in May 2016, he and Ms Barnard purchased a block of land with the intention of building a house.[6]

Relationship breakdown and deterioration in mental state

8. In June 2016 Mr Watson "*just started not being present*", according to Ms Barnard, and "*would not dress the kids nor do any housework while he was home*". He ceased to communicate with Ms Barnard and stopped going to work.[7]

9. Ms Barnard told Mr Watson that his behaviour at home was not acceptable and that he was not working on improving his mental health.[8]

10. Ms Barnard states that at this time "*Jack told me that if I left him, he would kill himself*". He asked for six months to fix himself. She reports that he tried to improve his behaviour for around a week, after which he stopped trying.[9]

11. Around 1 July 2016 Ms Barnard told Mr Watson that she wished to separate.[10]

12. From this time forward Mr Watson began to share hopeless thoughts, including that he would not be present for Xavier's upcoming birthday in August. He acted in unstable and out-of-character ways and hacked into Ms Barnard's social media and email accounts. Ms Barnard initially stayed away from home with the children.[11]

13. Mr Watson indicated to a friend that he was expecting a package in the mail that "*would take care of it*". Mr Watson began packing up his possessions and told Ms Barnard that he planned to suicide by inert gas asphyxiation. He became superficially polite and cooperative.[12]

14. On the afternoon of Wednesday, 6 July 2016, Mr Watson's mother, Lorraine, contacted Mental Health Services at Ballarat Health Services and shared her concerns with about Mr Watson's suicide risk with a triage clinician, Tristan Brumby-Rendell.

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[6] Statement of Ellen Barnard dated 21 November 2016, Coronial Brief, page 7.
[7] Statement of Ellen Barnard dated 21 November 2016, Coronial Brief, page 7.
[8] Statement of Ellen Barnard dated 21 November 2016, Coronial Brief, page 8.
[9] Statement of Ellen Barnard dated 21 November 2016, Coronial Brief, page 7.
[10] Statement of Ellen Barnard dated 21 November 2016, Coronial Brief, page 8; Adult/Aged Triage Referral dated 6 July 2016, Ballarat Health Services Medical Records, page 26.
[11] Statement of Ellen Barnard dated 21 November 2016, Coronial Brief, page 7; Adult/Aged Triage Referral dated 6 July 2016, Ballarat Health Services Medical Records, page 26.
[12] Adult/Aged Triage Referral dated 6 July 2016, Ballarat Health Services Medical Records, page 26.

Mr Brumby-Rendell contacted Ms Barnard, who shared similar concerns. Ms Barnard attempted to convince Mr Watson to speak to the triage clinician, but he refused.[13]

15. Mr Brumby-Rendell assessed Mr Watson's risk of self-harm as high and, as Mr Watson refused to engage, determined that Police should be contacted to attend. He informed Ms Barnard of this and called Trentham Police Station.[14]

16. At 4.15pm Senior Constable Brett Eden was assigned the task. SC Eden spoke to Ms Barnard on the phone then went to Mr Watson's home. Before SC Eden arrived, Mr Watson suspected that Police were attending and left home in his car. At this point Ms Barnard informed SC Eden that Mr Watson intended to suicide by inert gas asphyxiation.[15]

17. Police searched for Mr Watson without success. At around 8.40am on the following morning SC Eden attended Mr Watson's home and saw that his car was parked outside. SC Eden knocked on the front door and spoke to Mr Watson when he answered the door.[16]

18. Mr Watson informed SC Eden of his suicidal thoughts and plans. SC Eden requested that Ambulance attend for the purposes of apprehending him pursuant to section 351 of the *Mental Health Act 2014* (Vic) and taking him to a public hospital for assessment. Ambulance arrived shortly and took Mr Watson to the Emergency Department at Ballarat Base Hospital.[17]

19. SC Eden found a large nitrogen cylinder in the car with a hose and face mask attached. SC Eden returned the cylinder to BOC Gas & Gear in Ballarat. [18]

Inpatient admission to Ballarat Health Services

20. Mr Watson was reviewed on intake by a senior clinician of the North East adult mental health team. The clinician determined that Mr Watson needed immediate treatment due to his risk of serious self-harm, and placed him under an Assessment Order pursuant to section 30 of the *Mental Health Act 2014* (Vic) as there was no less restrictive means reasonable available to enable him to be assessed. He was admitted to the Adult Acute Unit.[19]

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[13] Adult/Aged Triage Referral dated 6 July 2016, Ballarat Health Services Medical Records, page 26.
[14] Adult/Aged Triage Referral dated 6 July 2016, Ballarat Health Services Medical Records, page 26.
[15] Statement of Senior Constable Brett Eden dated 12 October 2016, Coronial Brief, pages 18-19.
[16] Statement of Senior Constable Brett Eden dated 12 October 2016, Coronial Brief, pages 18-19.
[17] Statement of Senior Constable Brett Eden dated 12 October 2016, Coronial Brief, page 20.
[18] Statement of Senior Constable Brett Eden dated 12 October 2016, Coronial Brief, page 21.
[19] Statement of Dr Ravindra Mutha dated 27 September 2016, Coronial Brief, pages 14-15; Assessment Order dated 7 July 2016, Ballarat Health Services Medical Records, page 14.

21. On the next day, 8 July 2016, Mr Watson was assessed by Consultant Psychiatrist Dr Ravindra Mutha. Mr Watson described his mental health state and history to Dr Mutha, including his recent suicidal thoughts, plans and preparations. He reported that he had been prescribed dexamphetamine at five 5mg tabs daily for his ADHD, was taking the antidepressant desvenlafaxine at 100mg once daily and the antipsychotic quetiapine at 25mg once daily.[20]

22. Dr Mutha diagnosed Mr Watson with an Adjustment Disorder, ADHD and recurrent depression with anxious distress, with the possibility of underlying personality traits. Dr Mutha placed Mr Watson under an Inpatient Temporary Treatment Order pursuant to section 46 of the *Mental Health Act 2014* (Vic) enabling him to be compulsorily detained and treated at Ballarat Health Services.[21]

23. Mr Watson remained at the Adult Acute Unit until 14 July 2016. During this time he was treated with his regular desvenlafaxine and quetiapine as well as the anxiolytic diazepam and the anti-insomnia medication zopiclone. According to Dr Mutha,

> "*Whilst inpatient, Mr Watson was pleasant, cooperative and engaging well with other patients in the unit. His sleep, appetite, concentration and energy levels were noted to be satisfactory.*"[22]

24. While Mr Watson was in hospital, he spoke to his father David Watson and "*was completely calm and told [his father] that he would say what he needed to and manipulate the doctors to let him out*". Mr Watson's father told hospital doctors what Mr Watson had told him and was told that "*...they couldn't do anything about it.*"[23] A nursing note dated 8 July 2016 records "*Father stated Mr Watson still has plans to commit suicide.*"[24]

25. In his engagement with his treating team, Mr Watson was focussed on being discharged. His stated plan was to live with a childhood friend in Melbourne. He told his treating team that hospital treatment would be counterproductive and threatened to disengage with mental health services unless discharged.[25]

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[20] Statement of Dr Ravindra Mutha dated 27 September 2016, Coronial Brief, page 15.
[21] Statement of Dr Ravindra Mutha dated 27 September 2016, Coronial Brief, page 15; *Mental Health Act 2014* (Vic) ss 45-46.
[22] Statement of Dr Ravindra Mutha dated 27 September 2016, Coronial Brief, page 15.
[23] Statement of David Watson dated 2 November 2016, Coronial Brief, page 12.
[24] Progress note dated 8 July 2016 (mis-recorded as 08/08/16), Ballarat Health Services Medical Records.
[25] Statement of Dr Ravindra Mutha dated 27 September 2016, Coronial Brief, page 15.

26. Nursing notes record on at least two occasions that Mr Watson's calm affect was incongruous with his known thoughts and plans of suicide. Despite his affect and despite denials of current or recent suicidal thoughts or plans, his risk of deliberate self-harm was recorded as moderate on these occasions.[26]

27. A treatment plan was developed which included psychosocial interventions, a risk management plan, post-discharge psychologist input through a mental health care plan and referral to appropriate mental health services in Melbourne. Mr Watson agreed to involve friends and family members in formulating his risk management plan.[27]

28. On 14 July 2016 Mr Watson was reviewed by Dr Mutha in the presence of senior clinician Christine Kean, his parents and two childhood friends with whom he planned to stay post-discharge. According to Dr Mutha, Mr Watson "*described his mood as good with nil thoughts of self-harm or suicide since admission and reiterated that he would be safe if discharged from hospital.*"[28]

29. Mr Watson informed Dr Mutha that he planned to initially stay with a friend in Thornbury for several days then move to stay with another friend in South Yarra. He planned to see his private psychiatrist in Coburg for a renewal of his dexamphetamine prescription and continue seeing his GP based in Niddrie.[29]

30. Dr Mutha assessed Mr Watson as having a low suicide risk at that stage, but moderate risk on a long-term basis. This was discussed with Mr Watson, his parents and his friends.[30] It is unclear if Dr Mutha was aware of the comments Mr Watson had made to his father regarding how "*he would say what he needed to and manipulate the doctors to let him out*".

31. During this assessment, Mr Watson's parents and Ms Barnard reported having concerns about Mr Watson's safety and noted that they were of the opinion that Mr Watson had had chronic suicidal thoughts. Mr Watson reiterated that he thought remaining as an inpatient would be counterproductive and stated that he would not engage with services unless discharged.[31]

32. Dr Mutha determined that Mr Watson should be discharged on a voluntary basis with a plan to see his private psychiatrist later that day and a plan for referral to Alfred Psychiatry at

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[26] See progress notes dated 12 July 2016 (9.40pm) and 13 July 2016 (12.50pm), Ballarat Health Services Medical Records.
[27] Statement of Dr Ravindra Mutha dated 27 September 2016, Coronial Brief, page 16.
[28] Statement of Dr Ravindra Mutha dated 27 September 2016, Coronial Brief, page 16.
[29] Statement of Dr Ravindra Mutha dated 27 September 2016, Coronial Brief, page 16.
[30] Statement of Dr Ravindra Mutha dated 27 September 2016, Coronial Brief, page 16.
[31] Consultant Psychiatrist note dated 14 July 2016 (10.00am), Ballarat Health Services Medical Records.

Alfred Health. They also requested that Mr Watson's GP arrange a mental health care plan for mindfulness-based Cognitive Behavioural Therapy.[32]

33. Mr Watson was discharged on that date, and an interim discharge summary was faxed to his GP and his private psychiatrist in Coburg.[33]

Alfred Health

34. On 15 July 2016, Ballarat Health Services senior clinician Christine Kean (who had been present at Mr Watson's review with Dr Mutha the previous day) referred Mr Watson by telephone to Alfred Community Psychiatry Intake. According to Associate Professor Simon Stafrace of Alfred Health:

> *"The referring clinician, CK, introduced the patient as a 26-year-old married school technician who lives in Trentham with his wife and two children aged ten and five years. CK stated that he had a psychiatric history of chronic depression, recurrent suicidal ideation and Attention Deficit Disorder (ADD); had been an inpatient at Ballarat Hospital from the 7 to 14 July 2016; and had been admitted there for treatment of anxiety, lowered mood, social withdrawal, poor sleep, suicidal ideation and increased difficulties coping at work. CK stated that just prior to his admission the patient had purchased materials in order to gas himself. CK stated that the patient had contacted his parents to disclose the plan to commit suicide and that they had been able to obtain urgent psychiatric care for JW, with the assistance of police. CK stated that the patient and his wife had separated and that the patient planned to move into the Alfred Health catchment area in South Yarra to stay with a friend whose name was Jess. CK stated that the patient's wife, Ellen, remained very supportive of JW and that the patient himself was motivated to seek specialist mental health care."*[34]

35. Ms Kean made a second telephone call to Alfred Psychiatry Triage, who stated that they would contact Mr Watson by phone that day.[35]

36. Ms Kean called Mr Watson to tell him that he would be contacted, and he reported to her that he was continuing to feel stable.[36]

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[32] Statement of Dr Ravindra Mutha dated 27 September 2016, Coronial Brief, page 16.
[33] Statement of Dr Ravindra Mutha dated 27 September 2016, Coronial Brief, page 16.
[34] Statement of Associate Professor Simon Stafrace dated 24 November 2017.
[35] Statement of Dr Ravindra Mutha dated 27 September 2016, Coronial Brief, page 16.

37. The Alfred Psychiatry Triage clinician contacted the Community Psychiatry Intake Clinician who agreed that follow-up would be provided by the Crisis Assessment and Treatment Team (**CATT**) over the weekend.[37]

38. A CATT worker, Registered Psychiatric Nurse Jan Macintire, contacted Ms Barnard that evening to confirm Mr Watson's correct phone number, then called Mr Watson.[38]

39. Mr Watson told Ms Macintire that he was staying with a friend in Thornbury (which is not in the Alfred Health catchment area) and that he was moving to South Yarra on the weekend. He said he had seen his private psychiatrist, that his mood was improved, that he was not preoccupied by suicidal ideation and that he felt supported. Ms Macintire explained the services available through CATT and provided Mr Watson with a direct telephone number. [39]

40. Based on her conversations with Mr Watson and Ms Barnard, Ms Macintire categorised Mr Watson's referral as "*Category E*" under the Victorian Mental Health Triage Scale, meaning that he required a "*non-urgent mental health response*". Ms Macintire did not recommend further visits over the weekend.[40]

41. Ms Macintire referred Mr Watson's case back to the Alfred Health Community Continuing Care Team (**CCT**) on 18 July 2016. The case was discussed at the Alfred Psychiatry Community Intake Meeting on that day and risk was assessed as low and not imminent.[41] The case was allocated to clinician Fiona Kumar, who was to contact Mr Watson and arrange a face-to-face assessment. It is not clear whether the CCT knew of what Mr Watson had said to his father about manipulating doctors and telling them what he needed to so that he would be let out, a significant indicator of Mr Watson's state of mind. [42]

42. Ms Kumar attempted to call Mr Watson on 21 July 2016 and left a message when he did not answer. Another clinician, Karen Lowe, made another attempt on 25 July 2016, and Ms

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[36] Statement of Dr Ravindra Mutha dated 27 September 2016, Coronial Brief, page 16.
[37] Statement of Associate Professor Simon Stafrace dated 24 November 2017.
[38] Statement of Associate Professor Simon Stafrace dated 24 November 2017.
[39] Statement of Associate Professor Simon Stafrace dated 24 November 2017.
[40] Statement of Associate Professor Simon Stafrace dated 24 November 2017.
[41] This was not documented until 20 July 2016: see Statement of Associate Professor Simon Stafrace dated 15 November 2019.
[42] Statement of Associate Professor Simon Stafrace dated 24 November 2017; Psychiatry Progress Note dated 20 July 2016, Alfred Health Medical Records.

Kumar made a further attempt on 29 July 2016. On both occasions Mr Watson did not answer and the clinician left a message. [43]

43. Alfred Health made no other attempts to engage with Mr Watson until they were contacted on 1 August 2016 during the events immediately preceding his death.

THE CORONIAL INVESTIGATION

Coroners Act 2008

44. Mr Watson's death constituted a "*reportable death*" pursuant to section 4 of the *Coroners Act 2008* (Vic) (**the Act**) as his death occurred in Victoria, was unexpected and was not from natural causes.[44]

45. The Act requires a coroner to investigate reportable deaths such as Mr Smith's and, if possible, to find:

    (1) The identity of the deceased;

    (2) The cause of death; and

    (3) The circumstances in which death occurred.[45]

46. For coronial purposes, "*circumstances in which death occurred*",[46] refers to the context and background to the death including the surrounding circumstances, rather than being a consideration of all circumstances which might form part of a narrative which culminated in the death. Required findings in relation to circumstances are limited to those circumstances which are sufficiently proximate to be considered relevant to the death.

47. The Coroner's role is to establish facts, rather than to attribute or apportion blame for the death.[47] It is not the Coroner's role to determine criminal or civil liability,[48] nor to determine disciplinary matters.

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[43] Statement of Associate Professor Simon Stafrace dated 24 November 2017; Statement of Associate Professor Simon Stafrace dated 15 November 2019.
[44] *Coroners Act 2008* (Vic) s 4.
[45] *Coroners Act 2008* (Vic) preamble and s 67.
[46] *Coroners Act 2008* (Vic) s 67(1)(c).
[47] *Keown v Khan* [1999] 1 VR 69.
[48] *Coroners Act 2008* (Vic) s 69 (1).

48. One of the broader purposes of coronial investigations is to contribute to a reduction in the number of preventable deaths, both through the observations made in the investigation findings and by making recommendations.

49. Coroners are also empowered to:

(1) Report to the Attorney-General on a death;[49]

(2) Comment on any matter connected with the death investigated, including matters of public health or safety and the administration of justice;[50] and

(3) Make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice.[51]

Standard of Proof

50. Coronial findings must be underpinned by proof of relevant facts on the balance of probabilities, giving effect to the principles explained by the Chief Justice in *Briginshaw* v *Briginshaw*.[52] The strength of evidence necessary to so prove facts varies according to the nature of the facts and the circumstances in which they are sought to be proved.[53] The principles enunciated by the Chief Justice in *Briginshaw* do not create a new standard of proof; there is no such thing as a "Briginshaw Standard" or "Briginshaw Test" and use of such terms may mislead.[54]

51. Proof of facts underpinning a finding that would, or may, have an extremely deleterious effect on a party's character, reputation or employment prospects demands a weight of evidence commensurate with the gravity of the facts sought to be proved and the finding to be based on those facts.[55] Facts should not be considered to have been proved on the balance of

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[49] *Coroners Act 2008* (Vic) s 72(1).
[50] *Coroners Act 2008* (Vic) s 67(3).
[51] *Coroners Act 2008* (Vic) s 72(2).
[52] (1938) 60 CLR 336, 362-363. See *Domaszewicz v State Coroner* (2004) 11 VR 237, *Re State Coroner; ex parte Minister for Health* (2009) 261 ALR 152 [21]; *Anderson v Blashki* [1993] 2 VR 89, 95.
[53] *Qantas Airways Limited v Gama* (2008) 167 FCR 537 at [139] per Branson J but bear in mind His Honour was referring to the correct approach to the standard of proof in a civil proceeding in a federal court with reference to section 140 of the *Evidence Act 1995* (Cth); *Neat Holdings Pty Ltd v Karajan Holdings Pty Ltd* (1992) 67 ALJR 170 at pp170-171 per Mason CJ, Brennan, Deane and Gaudron JJ.
[54] *Qantas Airways Ltd v Gama* (2008) 167 FCR 537, [123]-[132].
[55] *Anderson v Blashki* [1993] 2 VR 89, following *Briginshaw v Briginshaw* (1938) 60 CLR 336, referring to *Barten v Williams* (1978) 20 ACTR 10; *Cuming Smith & Co Ltd v Western Farmers' Co-operative Ltd* [1979] VR 129; *Mahon v Air New Zealand Ltd* [1984] AC 808 and *Annetts v McCann* (1990) 170 CLR 596.

probabilities by inexact proofs, indefinite testimony, or indirect inferences,[56] rather such proof should be the result of clear, cogent or strict proof in the context of a presumption of innocence.[57]

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Identity of the Deceased - Section 67(1)(a) of the Act

52. On 22 July 2017, Ms Lorraine Watson identified the deceased as her son, Jack David Watson born on 8 August 1989.

53. Mr Watson's identity is not disputed and requires no further investigation.

Cause of death - Section 67(1)(b) of the Act

54. On 3 August 2016 Dr Gregory Ross Young, a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, performed an external examination on Mr Watson's body, reviewed a police report of the circumstances surrounding Mr Watson's death, scene photos and a post-mortem CT Scan. Dr Young provided a written report, dated 26 August 2016, in which he opined that a reasonable cause of death was:

"Plastic bag asphyxia in the setting of a vitiated atmosphere with inert gases".

I accept Dr Young's opinion.

55. Toxicological analysis of post-mortem blood samples detected dexamphetamine (at approximately 0.03 mg/L)[58] and desvenlafaxine (at approximately 1.4 mg/L).[59] Urine samples contained dexamphetamine (at approximately 0.6 mg/L) and detectable quantities of desvenlafaxine, quetiapine[60] and the pain reliever paracetamol.[61]

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[56] *Briginshaw v Briginshaw* (1938) 60 CLR 336, at pp. 362-3 per Dixon J.
[57] *Briginshaw v Briginshaw* (1938) 60 CLR 336, at pp. 362-3 per Dixon J.; *Cuming Smith & CO Ltd v Western Farmers Co-operative Ltd* [1979] VR 129, at p. 147; *Neat Holdings Pty Ltd v Karajan Holdings Pty Ltd* (1992) 67 ALJR 170 at pp170-171 per Mason CJ, Brennan, Deane and Gaudron JJ.
[58] Dexamphetamine is reported as "amphetamine", a collective word to describe central nervous system stimulants structurally related to dexamphetamine. As Mr Watson was prescribed dexamphetamine and there is no indication of consumption of other amphetamines, I am satisfied on the balance of probabilities that the substance detected was dexamphetamine.
[59] Desvenlafaxine (reported as desmethylvenlafaxine) is an antidepressant sold under trade names including Pristiq. Desmethylvenlafaxine can also occur as a metabolite of the antidepressant venlafaxine, which is sold under trade names including Efexor.
[60] Quetiapine is sold under trade names including Seroquel.
[61] Paracetamol is sold under trade names including Panadol.

56. Apart from paracetamol, which is available over the counter, all of these substances had been prescribed to Mr Watson during his treatment.

Circumstances in which the death occurred - Section 67(1)(c) of the Act

57. On 31 July 2016 Ms Barnard asked Mr Watson to help with the children after she had a family health emergency. Mr Watson returned to Trentham with the family and stayed the night.[62]

58. On the morning of 1 August 2016 Mr Watson took his older son to kindergarten and Ms Barnard took the younger son to day care and went to work.[63]

59. Ms Barnard had begun a relationship with one of her colleagues by this point, and at midday on 1 August this colleague called her to tell her that his house had burnt down. Ms Barnard was afraid that Mr Watson may have started the fire.[64]

60. Ms Barnard attempted to call Mr Watson but he did not answer. She contacted Police,[65] then called Alfred Psychiatry Triage to convey concerns about Mr Watson's safety and suicide risk. Reflecting on Mr Watson's recent behaviour, Ms Barnard thought that there may have been a "*finalising*" quality to Mr Watson's conversations with her and their children which raised the possibility of suicidal plans.[66]

61. Alfred Psychiatry Triage referred this to Alfred Health's Police, Ambulance and Crisis Emergency Response Service (**A-PACER**). The A-PACER police liaison undertook a welfare check at Mr Watson's last known address in South Yarra, but he was not present.[67] Alfred Health took no further action.

62. Ms Barnard stayed at her boss' home overnight on 1-2 August 2019. She received a text message from Mr Watson at around 4.45pm saying goodbye and asking her to look after the boys. She brought this to the attention of Police.[68]

63. Mr Watson later sent a map of Cobb and Co Road in Carlsruhe to Ms Barnard's phone.[69]

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[62] Statement of Ellen Barnard dated 21 November 2016, Coronial Brief, page 9.
[63] Statement of Ellen Barnard dated 21 November 2016, Coronial Brief, page 10.
[64] Statement of Ellen Barnard dated 21 November 2016, Coronial Brief, page 6.
[65] Statement of Ellen Barnard dated 21 November 2016, Coronial Brief, page 6.
[66] Statement of Associate Professor Simon Stafrace dated 24 November 2017.
[67] Statement of Associate Professor Simon Stafrace dated 24 November 2017.
[68] Statement of Ellen Barnard dated 21 November 2016, Coronial Brief, page 6; Form 83 Police Report of Death for the Coroner dated 2 August 2016.
[69] Form 83 Police Report of Death for the Coroner dated 2 August 2016.

64. On 2 August 2019, Senior Constable Ashley Green and Senior Constable John Wilson searched the Trentham Township for Mr Watson, using a description of his car. At around 4.00pm they saw the car parked on Cobb and Co Road in Carlsruhe and approached it.[70]

65. They found Mr Watson deceased in his vehicle with a mask on his face attached by a plastic tube to a nitrogen cylinder. Another cylinder was in the rear of the car.[71] Both cylinders were labelled as supplied by BOC Gas.[72]

66. I find that Mr Watson died on 2 August 2019 and that he had intentionally taken his own life.

67. I am satisfied, having considered all of the available evidence, that no further investigation into Mr Watson's death is required.

COMMENTS PURSUANT TO SECTION 67(3) OF THE ACT

68. Due to the involvement of Ballarat Health Services and Alfred Health in Mr Watson's care in the time shortly before his death, his case was referred to mental health practitioners in the Coroners Prevention Unit (**CPU**)[73] to evaluate his management.

69. The time after discharge from a mental health service and the time around transitions between mental health services are known to be periods of extreme high risk when many suicides occur. Active outreach at these times and ensuring continuity of care are recognised as an effective way of reducing suicidal behaviour.[74]

Ballarat Mental Health Services transfer

70. The CPU reviewed Mr Watson's treatment with regard to the Ballarat Health Services Patient Transfer – Mental Health Services clinical practice protocol (**Patient Transfer Protocol**), which outlines the requirements for transferring a patient to another area community health service. This protocol identified that the current treating psychiatrist is responsible for, inter alia, referring the patient to a receiving treating psychiatrist, documenting the outcome of this discussion and documenting planned actions in relation to the transfer.

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[70] Statement of Senior Constable Ashley Green dated 27 October 2016, Coronial Brief p 22.
[71] Statement of Senior Constable Ashley Green dated 27 October 2016, Coronial Brief p 22.
[72] Photographs 7 and 13, Coronial Brief, pages 27 and 30.
[73] The CPU was established in 2009 to assist coroners to perform their prevention role – that is to fulfil their legislative obligation to contribute to a reduction in the number of preventable deaths.
[74] SANE Australia, *Suicide Prevention and Recovery Guide: A resource for mental health professionals* (2014, 2nd ed), page 18.

71. In Mr Watson's case, the referral was not made between psychiatrists as required by the protocol. It is unclear whether the nature and content of the referral would be have been different had it been conducted in accordance with the protocol. Ms Kean had been present at Dr Mutha's review with Mr Watson and his family on 14 July 2016 and should, and would have been equally aware of all information relevant to Mr Watson's continuing care, including discrepancies between others' reports of his suicidality and his denials. There is however no evidence in the brief that she was so aware.

72. The protocol required that Ballarat Health Services staff use the 'ISBAR'[75] handover methodology, a framework for standardised and effective communication used in health services. Whilst the referral process largely complied with the framework requirements it is notable that the recommendation or request made to Alfred Health was non-specific and that Alfred Health were asked to follow up but were not given a time frame. Further recommendations in relation to the need for an urgent face-to-face review as opposed to a telephone conversation were not made.

73. Associate Professor Stafrace of Alfred Health has noted that:

> *"One of the challenges is making firm decisions with regards to the level of follow-up that is necessary for a patient who is previously not directly known to The Alfred is the absence of direct clinical knowledge about the patient, in particular the subtler signs that indicate instability in their mental state or an escalation in risk profile."*[76]

74. With CPU advice, I consider that it would be desirable for a referring mental health service with direct clinical knowledge of a patient to recommend a time by which the receiving service ought to see the patient it is also desirable that such a time be informed by direct clinical knowledge of the patient, a comprehensive history and input from the patient's family.

75. For this reason, I recommend that Ballarat Health Services amend the section "Transfer between another Area Mental Health Services – Community Services" of the Patient Transfer Protocol to explicitly require that the referral include a timeframe by which the receiving service ought to see the patient, including a recommendation in relevant circumstances that the initial consultation occur face-to-face rather telephone or some other method when an assessment of the direct clinical knowledge, the patient's history and input from the patient's

[75] Introduction, Situation, Background, Assessment and Recommendation/Request.
[76] Statement of Associate Professor Simon Stafrace dated 24 November 2017.

family contact suggests it would be prudent. The assessment, the material on which it was based and the outcome should documented in the information provided to the receiving health service.

Management by Alfred Health

76. The CPU noted two significant failures in Alfred Health's management of Mr Watson following referral. First, they noted that appropriate action was not taken following failed attempts to contact him.

77. According to Associate Professor Stafrace of Alfred Health:

> *"Practice concerning patients who are referred by an out of area health service following hospitalisation and who are identified as having static risks requiring the patient to receive ongoing clinical support, should adhere to ... principles in the event that contact is not made or clients fail to attend scheduled appointments, in particular:*
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> - *Discussion no later than the next day at clinical handover, with the multidisciplinary team including team leaders and medical staff.*
> - *Escalation if risks are identified as high and imminent, and if low, no later than seven days after initial referral.*
> - *Contact with known friends and family members to establish patient's welfare and advise of non-attendance and non-engagement.*
> - *Contact with the referring out-of-area service to advise that the referred client has not been engaged."*[77]

78. There does not appear to have been consultation with or escalation to a treating psychiatrist or senior clinician regarding the unsuccessful attempts to contact Mr Watson for at least 14 days after referral to the Alfred Health Continuing Care Team. That Mr Watson was not seen by anyone from a mental health service since 14 July 2016, the day that he was discharged is disturbing particularly given Mr Watson's conduct and condition over the months before his admission to the Ballarat Base Hospital. That there was no attempt made to contact Mr

[77] Statement of Associate Professor Simon Stafrace dated 24 November 2017.

Watson's friends or family prior to Ms Barnard contacting Alfred Health on 1 August 2016 is also disturbing.

79. The CPU also noted that Alfred Health's management of Mr Watson did not meet their own guidelines for management of patients who have recently been discharged from an inpatient unit. These guidelines dictate that management should be the same for patients discharged from inpatient units other than Alfred Health's inpatient units as it is for patients discharged from an Alfred Health inpatient unit.

80. According to Alfred Health guidelines, an appointment should be set for a patient with a case manager within seven days of discharge from an inpatient unit. If the patient does not attend the scheduled appointment, active follow-up, perhaps with some sense of urgency rather than a mere a telephone call or calls should occur within 24 hours.

81. Mr Watson was not offered a post-discharge appointment when he was contacted on 15 July 2016 and, when later attempts to contact him were unsuccessful, there was no timely follow-up and certainly none within 24 hours.

82. I consider that Alfred Health's communication with and management of Mr Watson in the time following his transfer to their service did not meet their own guidelines. This failure is seriously regrettable.

83. Associate Professor Stafrace informed the Court that Alfred Health was revising its guideline on "Management and Follow Up of Clients Who Do Not Attend Appointments, Including Depot Administration" to include and better define the management and follow up of clients who are referred to the service from 'out-of-area' and who do not attend engage or contact the Alfred as expected.

84. I have been provided with further submissions from Dr Stafrace, dated 15 November 2019 together with an amended Guideline titled "*Management and Follow Up of Clients Who Do Not Attend Appointments, Including Depot Administration*" which came into effect on 11 November 2019.

85. In this submission, Dr Stafrace says, *inter alia,* that Alfred Health made a number of attempts to contact Mr Watson on receipt of his initial referral. The initial referral did not indicate a sense of urgency or imminent concern to warrant immediate escalation or immediate contact with Ballarat Mental Health Service or with Mr Watson's next of kin; furthermore, such action by Alfred Health may have breached its obligation of confidentiality to Mr Watson,

given that he was a voluntary patient; and potentially undermine the relationship of trust that Alfred Health seeks to build with its patients. Dr Stafrace advised me that:

"In my experience, this relationship of trust is crucial if Mental Health services are to provide useful and meaningful care, that assist clients on their journey tor recovery".

86. With respect to all of the outlined consideration and on the basis of the information available to it at the time, Alfred Health did not consider Mr Watson to be at an immediate risk to himself or others and would not have reasonably been able to anticipate or prevent the tragic outcome which occurred.

87. Alfred Health considers that it made reasonable and appropriate attempts to contact Mr Watson following receipt of the initial referral. Dr Stafrace, on behalf of Alfred Health, concedes that attempts to contact Mr Watson's treating psychiatrist after the appointment on 15 July 2016, and Mr Watson's relatives after the second contact attempt on 25 July 2016, should have been considered, but would not have likely identified Mr Watson as requiring immediate treatment and care.

88. Whether any such contact would have prevented Mr Watson's death cannot now be known. Whether accurate assessments of the mental state of people such as Mr Watson can be adequately made over the telephone seems to me be, to be at best unclear. I am conscious of workloads and stretched resources but am equally conscious of how difficult it may be to assess mental state and how dynamic the mental state of people with Mr Watson's history often is. That Mr Watson was not seen by a psychiatrist or even an appropriately qualified nurse between when his discharge from Ballarat Hospital on 15 July 2016 and his death on 2 August 2016 is unlikely to have helped his mental state.

89. Alfred Health's amended Guideline now includes further guidance on referrals with issues similar to those in Mr Watson's case (i.e where there are difficulties making contact with a referred patient). Referrals are now allocated to a team, rather than to an individual case Manager. Each team now has an allocated senior team clinician known as the Team Leader. This provides for an earlier opportunity for case escalation to occur.

90. Finally, Dr Stafrace assured me that Alfred Health will continually strive to improve its practice to reduce the occurrence of similar tragedies.

91. I am satisfied that Alfred Health has appropriately amended its Guideline.

RECOMMENDATIONS

I recommend that Ballarat Health Services amend the section "Transfer between another Area Mental Health Services – Community Services" of the Patient Transfer Protocol to explicitly require that the referral discussion address a recommended timeframe for the receiving service to see the patient, including the relative urgency of a face-to-face interview as opposed to telephone contact. These matters should also be documented in the information sent to the receiving health service.

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

FINDINGS AND CONCLUSION

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

    (a) The identity of the deceased was Jack Watson, born 8 August 1989;

    (b) Mr Watson's death occurred:

        (i) on 2 August 2016 on Cobb and Co Road in Carlsruhe, Victoria;

        (ii) from plastic bag asphyxia in the setting of a vitiated atmosphere with inert gases;

    (c) He intentionally took his own life;

    (d) In the circumstances set out in paragraphs 57-67 above. I direct that a copy of this finding be provided to the following:

(a) Ms Lorraine Watson, Senior Next of Kin;

(b) Dr Linda Danvers, Ballarat Health Services;

(c) Dr Neil Coventry, Office of the Chief Psychiatrist;

(d) Ms Natalie Papps, Alfred Psychiatry, Alfred Health; and

(e) Senior Constable Ashley Green, Victoria Police.

Signature:

DARREN J. BRACKEN

CORONER

Date: 31 December 2020