IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2018 3490

FINDING INTO DEATH WITHOUT INQUEST

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

Findings of:	**CORONER DARREN J BRACKEN**
Deceased:	**MITCHELL JAMES DOWLING**
Date of birth:	30 JULY 1997
Date of death:	18 JULY 2018
Cause of death:	HANGING
Place of death:	93 NEWRY STREET, CARLTON NORTH, VICTORIA 3054

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HIS HONOUR:

BACKGROUND

1. Mitchell James Dowling was only 20 years old when he died by hanging on 18 July 2018. Mr Dowling was an Arts student at the University of Melbourne and lived at 93 Newry Street, Carlton North with friends and fellow students.

2. Mr Dowling was a much-loved son and brother. His parents, Damian and Lisa Dowling, brother Padrick and sisters Sophie and Katherine, live in Geelong.

3. Mr Dowling was passionate about Drama and completed VCE Drama and Theatre Studies in 2015. In 2016, Mr Dowling commenced his degree course, majoring in Psychology and Gender Studies. Initially he lived at St Hilda's College in Parkville. In June 2017, one of Mr Dowling's college friends contacted his mother and told her of concerns that she and other of his friends held in relation to Mr Dowling's mental health.

4. Mr Dowling's parents met with the woman who had contacted Mr Dowling's mother on 23 June 2017 and she explained that on 21 June 2018 after he had been drinking Mr Dowling put a belt around his neck and made choking noises. This woman explained to Mr Dowling's parents that Mr Dowling "*got down*" when he was drinking.

5. Following the meeting, Mr Dowling's mother spoke with Mr Sergio Fabris, Vice Principal of St Hilda's College about Mr Dowling. Mr Fabris told her that Mr Dowling was drinking excessively which was causing problems with his roommate. Mr Fabris wanted to ban Mr Dowling from drinking, failing which he would be required to leave the College. Mr Dowling's parents supported the imposition of an alcohol ban which was put in place on 30 June 2017.

6. Mr Dowling's mother arranged for Mr Dowling to see a psychologist, Laura Capitanio. Mr Dowling's the first of eight consultation with Ms Capitanio occurred on 6 July 2017 and the last on 7 September 2017.

7. Mr Dowling told Ms Capitanio about his weekly binge drinking and two attempts at self-asphyxiation whilst intoxicated – on one occasion using a plastic bag and on another a belt.

Ms Capitanio considered that:

> *"At initial presentation, Mitchell appeared to mostly satisfy the diagnostic criteria for a Major Depressive Disorder with Atypical Features, Moderate; however, he did not satisfy Criteria B for the Atypical Features Specifier due to the absence of one of the following; appetite disturbance, hypersomnia and leaden paralysis."*

8. Ms Capitanio assessed Mr Dowling's risk of suicide at the time as low to moderate and noted protective factors including his family and social supports.

9. According to Ms Capitanio, Mr Dowling progressed well but chose to discontinue the psychological treatment after eight sessions. At the last session, Ms Capitanio considered that Mr Dowling no longer met the diagnostic criteria for Major Depressive Disorder with Atypical Features and was aware of his triggers. She reported that:

> "*He was aware of the triggers (alcohol, social problems) and warning signs (negative self-criticism) of his emotional distress…Throughout his psychological treatment, he chose to abide by, and commit to, his agreement of safe alcohol consumption. Mitchell spoke about his future pans from the first session. Mitchell continued to deny suicidal intent and plans and he used treatment strategies to help strengthen his tolerance of negative emotions and feelings".*

10. In January 2018 Mr Dowling moved into the Newry Street house with friends all of whom were aware of his previous mental health issues but considered that he was doing well. The four friends were a close-knit unit and regularly did things together.

11. In or about May 2018, Mr Dowling met Brady Price on the online dating app "*Tinder*" and they dated regularly during June and July 2018.

12. In June 2018, Mr Dowling told his mother that he was having issues with his housemates, citing a lack of interaction with them.

13. On 1 July 2018, Mr Dowling visited his parents in Geelong and helped plan his upcoming 21st birthday party. During this visit he told his mother that "*I feel stressed. I don't know why'.* He returned to Melbourne on 4 July 2018. He visited his family in Geelong again between 13-16 July 2018 making further arrangements for his party.

14. Mr Dowling last saw Mr Price on 16 July 2018 after he returned to Melbourne from his parents' home in Geelong.

15. One of Mr Dowling's housemates stated that he had an argument with Mr Dowling "*a couple of weeks"* prior to Mr Dowling's death, and that this caused some ongoing tension, at least between the two of them.

THE PURPOSE OF A CORONIAL INVESTIGATION

16. Mr Dowling'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, appears to have resulted, directly or indirectly, from an accident or injury, and was not from natural causes.[1]

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

    (a) the identity of the deceased.

    (b) the cause of death and

    (c) the circumstances in which death occurred.[2]

18. For coronial purposes, '*circumstances in which death occurred*'[3] refers to the context and background the death including the surrounding circumstances. Rather than being a consideration of all circumstances which might form part of a narrative culminating 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.

19. The coroner's role is to establish facts, rather than to attribute or apportion blame for the death.[4] It is not the coroner's role to determine criminal or civil liability,[5] nor to determine disciplinary matters.

20. 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.

21. Coroners are also empowered to:

    (a) report to the Attorney-General on a death;[6]

[1] Section 4 *Coroners Act 2008*.
[2] See Preamble and s 67, *Coroners Act* (2008).
[3] Section 67(1)(c).
[4] *Keown v Khan* (1999) 1 VR 69.
[5] Section 69 (1).

(b) comment on any matter connected with the death investigated, including matters of public health or safety and the administration of justice;[7] and

(c) 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.[8]

22. Coronial findings must be underpinned by proof of relevant facts on the balance of probabilities.[9] 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.[10]

23. Proof of facts underpinning a finding that would, or may, have an extremely deleterious effect on a party's character, reputation or employment prospects demand a weight of evidence commensurate with the gravity of the facts sought to be proved.[11] Facts should not be considered to have been proved on the balance of probabilities by inexact proofs, indefinite testimony, or indirect inferences,[12] rather such proof should be the result of clear, cogent or strict proof in the context of a presumption of innocence.[13]

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

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

24. On 19 July 2018, Damian Dowling identified the deceased as his son, Mitchell James Dowling born on 30 July 1997.

25. Mitchell Dowling's identity is not in dispute and requires no further investigation.

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

26. On 19 July 2018, Dr Sarah Parsons, a pathologist practising at the Victorian Institute of Forensic Medicine, conducted an external examination upon Mr Dowling's body. Dr Parsons

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[6] Section 72(1).
[7] Section 67(3).
[8] Section 72(2).
[9] *Re State Coroner; ex parte Minister for Health* (2009) 261 ALR 152.
[10] *Qantas Airways Limited v Gama* (2008) 167 FCR 537 at [139] per Branson J but I note that 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 170-171 per Mason CJ, Brennan, Deane and Gaudron JJ.
[11] *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.
[12] *Briginshaw v Briginshaw* (1938) 60 CLR 336, at pp. 362-3 per Dixon J.
[13] *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 170-171 per Mason CJ, Brennan, Deane and Gaudron JJ.

provided a written report, dated 7 August 2018, in which she opined that the cause of Mr Dowling's death was '*Hanging*'. I accept Dr Parson's opinion.

27. Toxicological analysis of postmortem samples detected the presence of ethanol (alcohol)(0.14g/mL) but no other common drugs or poisons.

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

28. On 17 July 2018, Mr Dowling and his housemates went to a "*Trivia Night*" at the Workers' Club in Fitzroy. Mr Dowling arrived after the others at approximately 8.00pm. Mr Dowling and one of his housemates discussed some differences of opinion and in his statement to police this housemate said that "…*by the end of it we said to each other the things we would work on. We gave each other a hug".* Mr Dowling was said to be upset and crying after this conversation and told his housemates that the housemate with whom he had had the discussion "…*had told him all the housemates had issues with him…".* They agreed to talk about it later.

29. At approximately 11.30-11.45pm Mr Dowling and his friends went to the Evelyn Hotel. One housemate reported that Mr Dowling was "*really chatty and seemed fine".* Another housemate reported that he and Mr Dowling "…*were getting along better than we had in the past few weeks".* The group drank beer.

30. Two housemates returned to the Newry Street house at approximately 12.30pm. Mr Dowling and the fourth housemate and others left the hotel when it closed between 1.00 – 1.30am. Mr Dowling walked off from the group and one housemate (who occupied the room adjacent to Mr Dowling's) stated that she heard him arrive home at approximately 1.30am. The fourth housemate arrived home at approximately 2.30am.

31. At approximately 12noon on 18 July 2018, two housemates became concerned that Mr Dowling had not been active on Facebook and went to check on him. They found him hanging by a belt from a rod in the wardrobe of his bedroom.

32. Emergency services were called and paramedics who arrived shortly afterward at 12.15pm declared Mr Dowling deceased at the scene.

COMMENTS PURSUANT TO SECTION 67(3) OF THE ACT

Dr and Mrs Dowling's Concerns

33. Mr Dowling's parents expressed concerns about Ms Capitanio's management of their son, concerns which were doubtless exacerbated by Ms Capitanio's refusal to meet with them or provide them with a copy of her records relating to her treatment of Mr Dowling.

34. Dr and Mrs Dowling informed the Court they were concerned about Ms Capitanio's diagnosis (believing this to have been Adjustment Disorder) and treatment of Mr Dowling. Given these concerns, I referred the matter to the Coroners Prevention Unit (**CPU**)[14]Health and Medical Investigation Team for review.

35. The CPU (Mental Health) reviewed Ms Capitanio's detailed statement and advised me that Ms Capitanio considered that Mr Dowling mostly satisfied the criteria for Major Depressive Disorder with Atypical Features, Moderate[15], but did not satisfy criteria B for the specifier of Atypical Features. Treatment focused on addressing Mr Dowling's binge drinking (and associated consequences), improving his mood and improving his sensitivity to interpersonal rejection. Mr Dowling's symptoms appeared to gradually improve and he reduced his alcohol use.

36. Throughout treatment Ms Capitanio spoke to Mr Fabris at Mr Dowling's College, sent a letter to his GP and regularly discussed with Mr Dowling his support network, including a recommendation that Mr Dowling continue to see his GP.

37. At Mr Dowling's last appointment with Ms Capitanio, Ms Capitanio reported that Mr Dowling indicated that he did not wish to continue psychological treatment as he felt that he had achieved a reduction in his symptoms. Ms Capitanio determined that Mr Dowling no longer satisfied the diagnostic criteria for Major Depressive Disorder with Atypical Features; that he was aware of the impact of alcohol and social problems on his mental state including of the signs of a deteriorating mental state. Ms Capitanio reported that Mr Dowling's suicidal

[14] The role of the CPU is to assist coroners investigating deaths, particularly deaths which occur in a healthcare setting. It is staffed by healthcare professional, including practising physicians and nurses, who are independent of the health professionals and institutions under consideration.
[15] Major depressive disorder is characterised by five or more of the following symptoms every day (or nearly every day) during the same two week period: depressed mood for most of the day, diminished interest/pleasure in all or most activities, decreased appetite or an unintentional change of 5%body weight in a month, insomnia or hypersomnia, psychomotor agitation or retardation, fatigue or loss of energy, feelings of worthlessness or excessive/inappropriate guilt, diminished ability to concentrate of make decisions, recurrent thoughts of death/suicide. Of the five symptoms required for a diagnosis, one must be depressed mood or diminished interest/pleasure. The specifier "with atypical features" is given when the following features predominate during the majority of days of the current or most recent major depressive episode or persistent depressive disorder: A. Mood reactivity (i.e mood brightens in response to actual or potential positive events. B. Two (or more of the following; significant weight gain or increase in appetite, hypersomnia, leaden paralysis (i.e heavy, leaden feelings in arms or legs) and/or a long standing pattern of interpersonal rejection sensitivity (not limited to episodes of mood disturbance that results in significant social or occupational impairment: C. Criteria are not met for "with melancholic features" or "with catatonia" during the same episode.

ideation declined throughout treatment and that at the last appointment he denied suicidal intent and plans.

38. Dr Capitanio recommended that Mr Dowling continue psychological treatment and Mr Dowling said that he may do so in the future. Ms Capitanio had no further contact with Mr Dowling who did not return to see Dr Morrison. There is no evidence on the available information that Mr Dowling saw any other health professional for mental health concerns in the ten months before his death.

39. The CPU advised me that the available evidence indicated that Mr Dowling was not suffering a current mental illness at his last appointment with Ms Capitanio. There is no evidence that Ms Capitanio diagnosed Mr Dowling as suffering from an Adjustment Disorder and the CPU advised me that, even if that were the case, the diagnosis of an adjustment disorder is a time limited diagnosis which would not necessarily be relevant ten months later.

40. The CPU advised me further, that from its review of Ms Capitanio's records it appears Mr Dowling was aware of his vulnerability if exposed to interpersonal difficulties and if he continued to use alcohol to excess.

41. On or about 18 June 2020 I directed my solicitor to write to Dr and Mrs Dowling in order to advise them, inter alia, of the advice provided to me by the CPU and of my view that I could fulfill my obligations and make findings as required by the *Coroners Act* [2008] without conducting an inquest and that I was considering doing so, with however, the inclusion of recommendations to address concerns raised by Dr and Mrs Dowling in their correspondence.

42. My proposed recommendations were as follows:

> *That the Australian Psychological Society* **(APS)** *advise its members that when treating young adults, they consider providing the patient with written information relevant to the diagnosis which can be provided to the patient's family, friends and support. In particular, the information could include information about future symptoms which may indicate a relapse and the need for future therapy.*
>
> *That the APS advise its members that when treating young adults in relation to self-harm and suicide issues that they consider seeking patient approval/consent for the psychologist to consult directly with the patient's parents or a parent or partner about the patient's condition and what may be needed to support the patient.*

That the APS consider reminding its members that, regardless of their ongoing duty of confidentiality to deceased patients, that there is a specific exemption contained in Health Privacy Principle 2.4 of the Health Records Act 2001 (Vic) which states that:

" a health service provider may disclose health information about an individual to an immediate family member of the individual if:

(ii) the disclosure is made for compassionate grounds.

43. Dr and Mrs Dowling responded by letter dated 25 June 2020. The confirmed that they had accessed Ms Capitanio's clinical records which were contained in the coronial brief made available to them and were now aware that Ms Capitanio's diagnosis was Major Depressive Disorder with Atypical Features (**MDAF)** and that:

"*Our concerns regarding Mitchell's mental health care and request for an inquest was made in the knowledge of this diagnosis of MDAF".*

MDAF is recognised as a relapsing disorder with associated increased risk of completed suicide. It remains our assessment on reading the Coronial Brief that Mitchell's mental health care focused excessively on managing him in isolation of his close social and emotional support network and had greater steps been taken to ensure involvement of that network the risk of completed suicide in the event of a relapse of MDAF would have been reduced.

Whilst the Coronial brief provides no definitive evidence that Mitchell was experiencing a current mental illness proximal to, or at the time of, his death, the brief does provide evidence of interpersonal conflict. Interpersonal conflict is a recognised trigger for relapse of MDAF and is described in the Coronial brief as the precipitant for Mitchell's depressive illness in 2017. It remains our belief that Mitchell had experience a relapse of MDAF prior to his death.

44. Dr and Mrs Dowling are critical of what appears to be a failure by Ms Capitanio to involve a psychiatrist in Mr Dowling's care. In addition, they proposed the following amendments (as emphasised) to bolster my proposed recommendations as follows:

*That the Australian Psychological Society (**APS)** advise its members that when treating young adults, unless clear reasons contraindicate such action, they provide the patient with written information relevant to the diagnosis which can be provided to the patient's*

family, friends and/or supports. In particular the information should include information about future symptoms which may indicate a relapse and the need for further therapy.

That the APS advise its members that when treating young adults in relation to self-harm and suicide issues that, unless clear reasons contraindicate such actions, management should include exploring the option for the patient approving/consenting for the psychologist to directly consult with the patient's parent or a parent or partner about the patient's condition and that which may be needed to support the patient.

That the APS advise its members that when treating young adults, unless clear reasons contraindicate such action, management should include establishing whether the patient has discussed the diagnosis with family, friends and/or supports, exploring reasons why they may not have done so and possibly recommending that they do so and where appropriate, facilitating such action.

That the APS advise its members that when treating young adults, if the involvement of psychiatric care is considered appropriate, clear advice is provided as to how to access such care and the patient's general practitioner is promptly notified regarding the recommendation in order to further facilitate access to such care.

45. I directed that Ms Capitanio be asked whether the issues sought to be raised by Mr Dowling's parents were considered by her and/or recommended by the APS.

46. Ms Capitanio responded by way of a supplementary statement dated 23 November 2020. She responded to each question put to her as follows:

"***When treating young adults such as Mr Dowling, what, if any written information relevant to the diagnosis (particularly regarding future symptoms which may indicate a relapse) do you provide to your patients which can be provided to the patient's family, friends and other supports? Is the provision of such written information recommended by the APS? "Did you provide any such (and if so, what) information to Mr Dowling?'***

47. Ms Capitanio advised me that she provides written information about her diagnosis to young adults who present with an intellectual disability or acquired brain injury or to those who request it. Otherwise, diagnostic information is provided verbally.

48. Ms Capitanio explained that she frequently provides patients with handouts (often sourced from the Centre for Clinical Interventions website) containing an overview of therapeutic

techniques and strategies learned during treatment. Alternatively, she recommends patients access the website.

49. Ms Capitanio also noted that, in accordance with the APS Code of Ethics, it is her practice to provide (during the process of obtaining informed consent) an explanation of foreseeable consequences if a patient should decline to participate in or withdraw from treatment. She confirmed that such an explanation was given to Mr Dowling during his first and last consultations with her.

50. Finally, Ms Capitanio advised me that she provides written documentation of the diagnosis and presenting symptoms to the referring general practitioner to facilitate discussion with the patient.

51. Ms Capitanio advised me that, save in circumstances in which the patient has an intellectual disability, there no specific recommendation that such written information be provided to young adult patients.

52. Ms Capitanio advised me that she did not give any written diagnostic information to Mr Dowling. She did recommend that he access resources from the Centre for Clinical Interventions website, particularly those relating to depression and distress tolerance. She told me that at his last consultation with her, she reminded him of triggers (such as alcohol consumption or social problems) and warning signs, such as negative self-criticism.

"***When treating young adults such as Mr Dowling, do you consider seeking the patient's approval or consent to you directly consulting with the patient's parents or partner about the patient's condition and what supports the patient may require?" Did you consider doing so in Mr Dowling's case? Is this a step recommended in management of young adults by the APS?***

53. Ms Capitanio referred to the need to weigh competing principles of patient confidentiality and autonomy against any immediate risk of self-harm whilst maintaining patient engagement. She advised me that she encourages young adults to use a "*partners in care"* approach involving family and friends.

54. With regard to Mr Dowling, Ms Capitanio told me that she identified protective factors including displays of psychological insight; his experiences with success and feelings of effectiveness (particularly with his education) a sense of belonging and connection (especially with female friends; community support from St Hilda's College and his GP: and family warmth, support and acceptance especially from his mother. She noted that Mr Dowling

articulated reasons for living and actively denied suicidal intent. Ms Capitanio encouraged Mr Dowling to embrace his supports as much as possible. She told me that if she had any concerns about Mr Dowling's immediate safety, she would have sought consent from him to consult with his parents to arrange appropriate medical, psychiatric and/or social care. In the absence of consent, she would have disclosed the risk in any event.

55. Ms Capitanio said that the APS does not have specific clinical guidelines relating to young adults.

"Do you canvass with young adult patients whether they have discussed the diagnosis with family, friends and/or supports? Is this a step recommended by the APS?

56. Ms Capitanio advised me that when treating young adults she often highlights the usefulness of using a "*partners in care approach* "and advises that the emotional support provided by familial and social ties enhances psychological well-being. However, she does not specifically canvass whether the patient has discussed his/her diagnosis with family/friends or support, due, she reported, to "*considerations of client autonomy and self-determination"*

57. There is no recommendation by the APS that practitioners ask young adult patients if they have discussed their diagnosis with family or friends.

"At any time when treating Mr Dowling did you consider whether involvement of a psychiatrist was appropriate?

58. Ms Capitanio advised me that she discussed the involvement of a psychiatrist in Mr Dowling's care during his first consultation with her – this was due to his age and gender, ambivalence about his sexual orientation and the presence of suicidal thoughts of asphyxiation or intoxication which precipitated the referral for psychological treatment; however, Mr Dowling was unwilling to engage with a psychiatrist due to his denial of current suicidal intent at the time of her assessment and treatment.

59. Ms Capitanio further explained that she continued to assess Mr Dowling's level of risk throughout his ongoing attendances with her. He reported improvements and at the conclusion of their sessions, there were no indicators of active risk and he denied suicidal thoughts or intent, leading Ms Capitanio to opine that involvement of a psychiatrist was not warranted.

Comments

60. Figures obtained from the Victorian Suicide Register reveal that in Victoria, in the years 2018 and 2019 there were 520 and 534 suicides , of which 63 and 64 respectively were young men in the 18-24 age group. Data available for 2020 reveals that, as at 30 September 2020 the number for the same group is 44 from a year to date total of 391. By comparison, in 2018 and 2019, 21and 19 young women in the same age group took their own lives with 12 recorded in 2020 to date.

61. The proposed recommendations, as thoughtfully amplified by Dr and Mrs Dowling, are directed to encouraging psychologists to consider encouraging young adult patients, where appropriate, to actively engage family, friends and other supports so that loved ones, aware of the diagnosis and treatment, are alert to changes in mood or behaviour (which may signal deterioration in mental state or relapse) thereby potentially preventing self-harm. The fact that a young adult has actively sought out treatment indicates a wish to recover and openness to advice thereby presenting the mental health practitioner with a valuable opportunity to seek to maximise and mobilise every support potentially available to the patient. Young people in this age group (18-24) are, of course, adults at law and entitled to reject involvement of family and friends; in addition, not every young adult may have a loving supportive network around them; however, even if only a few accepted advice from a treating mental health practitioner to actively involve their support network, there is the potential for lives to be saved and families spared the tragic loss endured by the Dowling family.

62. I can see no downside to the provision of simple, clear written information relevant to the diagnosis being provided to young adults, as suggested by Mr Dowling's parents. The provision of written information to the referring GP, may not always result in this information being discussed with the patient. In this particular for example, Mr Dowling did not return to see the referring GP so the discussion envisaged by Ms Capitanio did not eventuate. A simple patient handout would provide information which he/she can review and absorb, perhaps when experiencing a recurrence of symptoms, and may prompt an informed discussion with family, friends or other supports.

63. I accept that Ms Capitanio's clinical judgement throughout her treatment of Mr Dowling was that referral to a psychiatrist was not warranted. It is not possible to say with any certainty whether or not more active encouragement by Ms Capitanio to directly involve his loving family would have prevented Mr Dowling's tragic death ten months after his last consultation

with her, however, the fact she did not do so certainly represented a lost opportunity. Accordingly, I make the recommendations below.

Conclusion

64. I have sought to determine what led Mr Dowling to take his life on this night. The argument with his housemate at the Workers' Club in Fitzroy, although apparently resolved and Mr Dowling being told that those with whom he shared a house had 'issues' with him combined with his consumption of alcohol likely caused him at least emotional distress.

65. It is often difficult to determine what may have precipitated a person's decision to end their life. The decision is sometimes influenced by issues known only to the deceased person. I am unable to state, with any degree of certainty, the reason or reasons for Mr Dowling choosing to end his own life. I have sought to determine what led Mr Dowling to take his life on this night. The argument with his housemate at the Workers' Club in Fitzroy, although apparently resolved and Mr Dowling being told that those with whom he shared a house had 'issues' with him combined with his consumption of alcohol likely caused him at least emotional distress.

66. Sometimes a decision to end one's life is impulsive and without any warning signs.

67. There is an increased risk of suicidal behaviour as well as completed suicide in the context of emotional dysregulation and a high blood alcohol level. The CPU advised me that the Victorian Suicide Register data held by the Coroners Court of Victoria shows that alcohol is consistently detected during post-mortem examination in 25-35% of Victorian suicides each year.

68. Substance misuse predisposes suicide by disinhibiting or providing "courage" to overcome resistance in carrying through the act, clouding one's ability to see alternatives, and worsening of mood disorders. The association between alcohol consumption and self-harm/suicide is not entirely clear. Theoretically, consumption of alcohol may influence self-harm/suicide due to the depressant influence of the substance itself, or acute alcohol intoxication contributing to disinhibited or impulsive behaviours.

69. I am satisfied, having considered all the evidence before me that no further investigation is required and there are no suspicious circumstances. I am satisfied that Mr Dowling, in a state of emotional distress, intentionally took his own life.

RECOMMENDATIONS

Pursuant to section 72(2) of the *Coroners Act 2008,* I make the following recommendations connected with the death:

1. *That the Australian Psychological Society (**APS)** and other peak bodies representing psychologists, including the Australian Clinical Psychology Association **(ACPA)** and the Australian Association of Psychologists (**AAP**) advise their members that when treating young adults, unless clear reasons contraindicate such action, they provide the patient with written information relevant to the diagnosis which can be provided to the patient's family, friends and/or supports. In particular the information should include information about future symptoms which may indicate a relapse and the need for further therapy.*

2. *That the APS, ACPA and AAP advise their members that when treating young adults in relation to self-harm and suicide issues that, unless clear reasons contraindicate such actions, management should include exploring the option for the patient approving/consenting for the psychologist to directly consult with the patient's parent or a parent or partner about the patient's condition and that which may be needed to support the patient.*

3. *That the APS, ACPA and AAP advise their members that when treating young adults, unless clear reasons contraindicate such action, management should include establishing whether the patient has discussed the subject of treatment and any diagnosis with family, friends and/or supports and, if not, encourage and potentially provide strategy for such discussion with a view to such supports aiding treatment.*

4. *That the APS, ACPA and AAP advise their members that when treating young adults, if the involvement of psychiatric care is considered appropriate, clear advice is provided as to how to access such care and the patient's general practitioner is promptly notified regarding the recommendation in order to further facilitate access to such care.*

5. *That the APS, ACPA and AAP remind their members that, regardless of their ongoing duty of confidentiality to deceased patients, that there is a specific exemption contained in Health Privacy Principle 2.4 of the Health Records Act 2001 (Vic) which states that:*

> *"a health service provider may disclose health information about an individual to an immediate family member of the individual if:*
>
> *(ii) the disclosure is made for compassionate grounds.*

Pursuant to section 73(1A) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

FINDINGS AND CONCLUSION

Having investigated the death, without holding an inquest, I make the following findings pursuant to section 67(1) of the *Coroners Act 2008*:

(a) The identity of the deceased was Mitchell James Dowling, born 30 July 1997;

(b) Mr Dowling's death occurred;

i. on 18 July 2018 at 93, Newry Street, Carlton North, Victoria;

ii. from hanging; and

iii. in the circumstances described in paragraphs 29 – 33 above.

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

(c) Dr Damian Dowling and Mrs Lisa Dowling, senior next of kin;

(d) Ms Laura Capitanio, Elementa Psychology, Kew;

(e) Dr Zena Burgess, CEO, The Australian Psychological Society;

(f) Associate Professor Vida Bliokas, President, The Australian Clinical Psychology Association;

(g) Anne Marie Collins, President, Australian Association of Psychologists; and

(h) Senior Constable Karly Gilmour, Coroner's Investigator, Victoria Police.

Signature:

DARREN J BRACKEN

CORONER

Date: 20 January 2021