IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2018 790

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 63(1)
Section 67 of the ***Coroners Act 2008***
Amended pursuant to section 76 of the ***Coroners Act 2008*** *on 27 December 2023*[1]

Deceased:	Marcus William CALDWELL
Delivered on:	30 June 2023
Delivered at:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank
Hearing dates:	Directions Hearing on 14 April 2022 Inquest Hearing on 26 and 27 September 2022
Findings of:	Coroner Sarah Gebert
Counsel assisting the Coroner:	Sergeant T. Weir, Police Coronial Support Unit
Counsel for :	N. Harrington for Hanrob Pty Ltd instructed by Mills Oakley A. Imrie for WorkSafe
Key Words	*Work related death, suicide*

At the direction of Coroner Sarah Gebert, the names of the deceased's friends and work colleagues have been replaced with pseudonyms to protect their identities

1 This document is an amended version of the Finding into Death With Inquest regarding Marcus William Caldwell dated 28 July 2023. A correction to paragraph 151 on page 32 and to the distribution list at page 34 has been made pursuant to section 76 of the *Coroners Act 2008* (Vic), replacing the Department of Health with the Department of Premier and Cabinet.

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INTRODUCTION

1. Marcus William Caldwell[1] was born on 14 June 1990. He was aged 27 at the time of his passing and lived with his mother Justine Steel in Grovedale.

2. Marcus was employed by Hanrob Pet Hotels (**Hanrob**) in Tullamarine.

3. Marcus was described as *a kind and friendly person,* who loved and was passionate about animals, especially his dog Able. His friend Miss A said, *Marcus was great with dogs, he seemed to understand their minds.*

4. On the morning of 17 February 2018, Marcus was found deceased at Teddy's Look Out, Lorne in circumstances that suggested he had taken his own life.

THE CORONIAL INVESTIGATION

5. Marcus' death was reported to the Coroners Court as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**) because his death appeared to have been unexpected, unnatural or violent or to have resulted from accident or injury.[2]

The coronial role

6. Coroners independently investigate reportable deaths to find, if possible, identity, cause of death and the surrounding circumstances of the death. Cause of death in this context is accepted to mean the medical cause or mechanism of death. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death.

7. Under the Act, coroners have an additional role to reduce the number of preventable deaths and promote public health and safety by their findings and making comments and or recommendations about any matter connected to the death they are investigating.

8. When a coroner examines the circumstances in which a person died, it is to determine causal factors and identify any systemic failures with a view to preventing, if possible, deaths from occurring in similar circumstances in the future.

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[1] Referred to in my finding as 'Marcus' unless more formality is required.
[2] Deputy State Coroner Caitlin English (as she then was) initially had carriage of the investigation.

9. The standard of proof applicable to findings in the coronial jurisdiction is the balance of probabilities and I take into account the principles in *Briginshaw*.[3]

OTHER INVESTIGATIONS

10. Section 7 of the Act requires a coroner to liaise with other investigative authorities and to not unnecessarily duplicate inquiries and investigations.

WorkSafe Investigation

11. WorkSafe is Victoria's workplace health and safety regulator as well as the workplace injury insurer.

12. Following Marcus' death, WorkSafe investigated Team Hanrob Pty Ltd who operated the Hanrob Pet Hotel in Tullamarine. During this time, the coronial investigation was suspended pending the outcome of that process.

13. Following their investigation, WorkSafe advised the Court that they had decided against commencing a prosecution due to insufficient evidence. By communication with the Court on 17 October 2019, it was noted,

    a. WorkSafe was unable to determine based on the evidence, in particular the analysis undertaken by WorkSafe ergonomist Alexander Finlay (**Mr Finlay**), that the hours worked by Marcus prior to his death would have resulted in a level of fatigue that posed a risk to health. Mr Finlay undertook an analysis of the hours worked by Marcus using the *FAID Quantum software program* developed and validated by Dr Adam Fletcher and Professor Drew Dawson (**Professor Dawson**) from the Centre of Sleep Research.[4] This program assessed Marcus' level of fatigue as low compared to the general population. WorkSafe obtained an analysis from Mr Finlay, because it considered that the expert

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[3] *Briginshaw v Briginshaw* (1938) 60 CLR 336, especially at 362-363. *"The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding, are considerations which must affect the answer to the question whether the issues had been proved to the reasonable satisfaction of the tribunal. In such matters "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences …".*

[4] The program uses formulae and factors developed and validated by Dr Adam Fletcher and Professor Drew Dawson at the Centre for Sleep Research, University of South Australia. It provides a representative score of the hours of work related fatigue exposure of a worker. It models human biology and is best used as a statistically significant indicator of general human response. The score is based on 1) time of day of work and breaks, 2) duration of work and breaks, 3) work history in preceding seven days and 4) biological limits on recovery sleep.

report provided by Professor Dawson for the WorkSafe investigation did not appear to have involved an analysis of the actual hours worked by Marcus, amongst other things.

b. Marcus had taken a week of leave preceding his death which diminished the likelihood that at the time of his death he was fatigued because of his employment, to the point where this would have presented a risk to health.

c. Marcus was diagnosed with schizophrenia that he managed with medication. While his general practitioner (**GP**), psychiatrist and some co-workers alleged that they didn't see any signs of instability, evidence by other co-workers contradicted this. It is not clear how conscientious Marcus was about taking his medication.

14. Ms Steel requested additional investigations be undertaken by WorkSafe, and WorkSafe advised the Court by correspondence dated 23 March 2020, that after reviewing the additional material they remained of the view that there was insufficient evidence of a breach of the relevant work place legislation.[5]

15. Further advice was provided to the Court on 26 August 2020 that the case had been referred to the Director of Public Prosecutions pursuant to section 131(3) of the *Occupational Health and Safety Act 2004* (**OHS Act**) following a request made by Ms Steel regarding WorkSafe's decision not to prosecute Team Hanrob Pty Ltd for breaches of the OHS Act. The Court was advised that based on the evidence provided, the Director concluded that there was insufficient evidence to satisfy the test of a reasonable prospect of conviction in relation to a prosecution of Team Hanrob Pty Ltd. Accordingly, pursuant to section 131(4) of the OHS Act, the Director advised that she did not consider a prosecution should be brought in this case.

16. Following this advice, the coronial investigation resumed.

Sources of evidence and Inquest

17. As part of the coronial investigation, the Coroner’s Investigator prepared a coronial brief in this matter. The brief comprised statements from witnesses, including family members and friends, Hanrob employees including managers, Marcus’ GP as well as his treating

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[5] The additional material included statements from Ms A, Ms J, Mr S, Mr B, Ms B, Ms D and Mr M.

psychiatrist, the forensic pathologist who examined him and investigating officers as well as other documentary evidence.

18. WorkSafe also provided the Court with a copy of the WorkSafe brief of evidence which formed part of the material before the Court.

19. Marcus' medical records were also obtained from his Consultant Psychiatrist Dr Stephen McConnell (**Dr McConnell**), Monash Health and the Surf Coast Medical Centre (where his GP practiced).

20. To further assist the coronial investigation, the Coroners Prevention Unit reviewed the medical evidence and provided advice regarding Marcus' mental health care proximate to his death.[6]

21. The Court also sought an expert opinion from a psychiatrist with expertise in schizophrenia and workplace stress which was subsequently provided by Professor Richard Newton (**Professor Newton**).

22. Statements were provided by the Chief Executive Officer (**CEO**) of Hanrob Pet Hotels, Andrew Biggs (**Mr Biggs**) around workplace wellbeing issues along with relevant policies and procedures at the time of Marcus' death and later.

23. Ms Steel made an application for an inquest to be conducted as part of the investigation.[7] She raised a number of concerns including '*the bullying and pressures Marcus was put under directly by the Managers*' whilst employed at Hanrob as well as other issues such as whether appropriate pet care ratios were adhered to at the time of her son's death.

24. After considering all the available evidence, I convened a directions hearing on 14 April 2022, and foreshadowed potential findings I intended to make, subject to further submissions, regarding the contribution of Marcus' workplace to his death. I said at that hearing:

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[6] 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.
[7] Dated 25 June 2019.

Subject to further evidence and submissions, in my view the evidence currently available suggests that Marcus was suffering considerable workplace stress as a result of the combination of conditions at his workplace in the period proximate to his death. That had a marked adverse effect on his wellbeing and played a significant role in the decision he made to end his life. It is not apparent on the evidence available that there were sufficient measures in place to protect his welfare and the harm that may have been caused in these circumstances. I am not able to say that his work was the sole reason for his decision (in my view, no-one is privy to the inner most thoughts of an individual), nor am able to quantify the extent of any contribution.

25. At that hearing, I outlined the basis for my view with reference to the evidence available and indicated that a full inquest could be convened and any party could file their own expert evidence, if these findings were not accepted. I invited a response from Hanrob and on their behalf, the following was communicated to the Court on 23 May 2022 by their legal representative,

Whilst it is our view that some of the expert evidence in this matter is questionable, in the interests of dispensing with this matter with a minimum of distress to Mr Caldwell's family, and in the interests of the efficient administration of justice, my client, Hanrob, is content to accept the Coroner's preliminary findings in this matter and proceed on the basis that the Coroner will conduct a shorter inquest concerned with prevention issues, particularly with respect to the need for healthy workplaces.

26. Having received this indication, an inquest was convened over two days to focus on prevention issues, with evidence to be heard from Professor Dawson, Professor Newton and Mr Biggs. The scope was identified as follows,

What was the system in place for employee welfare and fatigue management at Hanrob Pty Ltd proximate to Marcus' death?

What changes were identified following Marcus' death and in particular how have those changes addressed,

a. the practice of rostering excessive hours over holiday periods,

b. staff being adequately educated on identifying and minimising workplace stress and burnout, and

c. supervisors and managers being adequately trained in identifying, preventing and managing workplace stress and burnout, including providing adequate support to staff when they approach a supervisor or manager with concerns about their wellbeing.

Any prevention opportunities arising from the death of Marcus Caldwell, including but not limited to the identification and understanding of:

a. work place stress and its impacts on mental health;

b. fatigue impairment associated with his employment;

c. moral distress and moral injury; and

d. best practice to promote mentally healthy workplaces.

27. This finding is based on evidence heard at inquest, as well as the material in the coronial and WorkSafe brief, material tendered during the inquest and the submissions received from the parties (which included Hanrob Pty Ltd and WorkSafe[8]) following the conclusion of the evidence. I will refer only to so much of it as is relevant to comply with my statutory obligations and necessary for narrative clarity.

RELEVANT BACKGROUND

28. Marcus began using drugs at age 15, had two previous suicide attempts and was involved with public mental health services. He was diagnosed with schizophrenia in around 2007. The early years of his illness were characterised by substance abuse, non-compliance, and poor insight. As a result, he had multiple relapses, often involving significant aggressive behaviours. He had frequent police contacts for aggressive and suicidal behaviours and missing persons reports from a mental health ward in the context of substance abuse and psychosis. His family had also taken out intervention orders against him. In 2010 Marcus was sentenced to 34 months in juvenile detention for assault.

29. There was no further police contact after this time and Ms Steel stated that Marcus' mental state had improved after his release.

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[8] Both submissions were dated 25 October 2022

30. At age 19, Marcus was commenced on clozapine while under the treatment of Consultant Psychiatrist, Dr McConnell at Barwon Mental Health Services. From this time onwards, his mental state remained stable with Ms Steel describing this as *like a miracle*[9]. From 2012 Marcus was treated by Dr McConnell in his role as a private psychiatrist and his GP Dr Marc Cain (**Dr Cain**), with no relapses or deteriorations in his mental state.

31. On 24 October 2017 Marcus saw Dr McConnell for the final time. Dr McConnell found Marcus' schizophrenia to be well controlled on clozapine and in remission. Given his stable mental state, Marcus was advised to return for review in 12 months.[10]

32. Marcus was able to maintain relationships with other family members and friends and shortly before his death he had commenced an intimate relationship with a colleague, Ms T.

Employment at Hanrob Pet Hotels in Tullamarine

33. Marcus was involved in the Geelong Obedience Dog Club where he met Ms D who worked at Hanrob in Tullamarine. Marcus expressed an interest in becoming a dog trainer and completed a Certificate IV in Companion Animal Services through Hanrob.

34. Marcus began working at Hanrob in Tullamarine in December 2016 as a Pet Welfare Officer. His daily duties included cleaning kennels, preparing food, feeding animals, transferring animals to the yard for exercising, grooming, maintenance and pet taxi driving.

35. Between September and December 2017 seven staff resigned from Hanrob, including Marcus' supervisor, resulting in Ms D becoming Marcus' new supervisor as the acting Pet Welfare Supervisor. According to Ms D the staff left for several reasons, with the overriding theme being that they were unhappy with upper management and the workplace conditions.[11]

36. Two additional staff were employed during this time, however both resigned before the end of 2017. According to Ms Steel, Marcus hoped to take time off in November 2017 but other staff had already requested leave. He then attempted to take time off in December 2017 but

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[9] Statement of Justine Steel, page 16 of Coronial brief.
[10] Statement of Dr Stephen McConnell, pages 37-38 of Coronial brief.
[11] Statement of Ms D, page 30 of Coronial brief.

this was declined due to the multiple staff resignations. Marcus had not taken any leave since commencing with Hanrob 12 months earlier.

37. Over the Christmas period of 2017-2018 Hanrob staff experienced increased workload in addition to short staffing. This period was one of the peak periods for the business as it coincided with annual holidays and animals requiring temporary care and housing. Ms D said that the staff resignations left her in the position to manage *about 290 dogs and 100 cats with 5 regular staff.* [12]

38. Ms D who was in charge of staff rostering, stated that between 16 December and 31 December 2017, Marcus worked 14 shifts in a row and that during this period she tried to keep his shifts to a 12 hour maximum. As Marcus lived in Grovedale (a 1.5 hour drive between Geelong and Tullamarine) Ms D said that there was a mattress at work where he could stay overnight if he was too tried to drive. According to his mother and other witnesses[13], Marcus stayed overnight at Hanrob on a number of occasions during December 2017 and January 2018.

39. Ms D said that she would monitor the staff for fatigue but *in hindsight* stated *we were all suffering from some level of fatigue over the Christmas of 2017-18.* She said that she would *encourage staff to take a break or power nap if and when required.* [14]

40. There was evidence that Marcus was working long hours, sometimes up to 14 hours, with only single days off per week throughout December 2017 and only 5 days off in all of January 2018. According to the *Employee Rosters/Time Sheet,* Marcus worked 17 consecutive days from 22 December 2017 to 7 January 2018 (inclusive).[15]

41. According to Marcus' mother in the two months prior to her son's death she noticed that Marcus was suffering from '*burnout due to work stress*'.[16] Marcus began complaining to her daily about the high demand, equipment breaking, and feeling unappreciated. Marcus reportedly felt that some of the expectations of Ms D were unreasonable, and her behaviour in constantly asking who his girlfriend was and telling him that he was not allowed to date anyone from work in the presence of other staff members caused him

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[12] Statement of Ms D page 30 of Coronial brief.
[13] Statement of Ms T, page 26.
[14] Statement of Ms D, page 30 of Coronial brief.
[15] Page 309 of WorkSafe brief.
[16] Statement of Justine Steel, page 14 of Coronial brief.

embarrassment.[17] Ms Steel said that she observed that Marcus' mental health began to decline in January 2018 and that he was having trouble sleeping.[18] She distinguished this decline from his usual symptoms of schizophrenia.

42. In addition, Ms Steel said that she heard Marcus on the phone to Ms D after midnight despite having to get up four hours later to leave for work, and this was reflected in phone records showing multiple contacts between Ms D and Marcus between 11.00pm and 4.30am including on days when Marcus was scheduled to work at 6.00am.[19]

43. Marcus' friend Ms A said that she had noticed a decline in his welfare and stated, *Marcus told me that they had a big commercial vacuum cleaner that was used to clean the dog kennels. This kept breaking which meant he would manually have to clean the kennels which would take much longer. They had around 3 to 4 hundred dogs so when the vacuum cleaner broke there was insurmountable work to be done.*[20]

44. In January 2018 Ms D said that she noticed Marcus come to work looking tired and asked him to go and take a nap for an hour.[21] In mid-January 2018 she said that she noticed a change in Marcus' demeanour and that he was not happy within himself.[22] On enquiring, Marcus reported that he was tired.

45. Several of Marcus' colleagues noticed that he was somewhat more irritable around this time, including a complaint by a co-worker about an incident on 11 February 2018. Up until this point, Marcus' colleagues described him as reliable, hardworking, friendly, and getting along well with his colleagues.

46. Police later examined Marcus' phone and located a Facebook message around this time to a colleague Ms H which read, *Look (-) I'm not well at the moment, it's not just work but everything. When I'm like this I don't like to let people see it, so if I've been acting weird or ignoring you it's not you or something you've done. … I shouldn't be at work right now,*

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[17] Statement of Justine Steel, page 14 of Coronial brief.
[18] Statement of Justine Steel, page 15 of Coronial brief.
[19] Pages 731-733 of WorkSafe brief.
[20] Statement of Ms A, pages 153-154 of Coronial brief.
[21] Statement of Ms D, page 30 of Coronial brief.
[22] Statement of Ms D page 31 of Coronial brief.

my life sucks. ... All I want to do is go to lorne coz I can't see how much longer I can keep doing this.[23]

47. On 2 February 2018 Marcus saw Dr Cain for the final time for a routine appointment for clozapine prescribing. Marcus reported that he was working six days per week but enjoyed his work. He reported that he had taken up running. Marcus did not report mental state concerns, nor did Dr Cain notice any clinical indications of mental state deterioration and Marcus was not *demonstrating any evidence of schizophrenia.*[24]

48. From 4 to 10 February 2018 Marcus took time off work. He spent part of this time holidaying in Lorne with Ms T. Ms T stated that Marcus discussed work stress during this week, but nothing out of the ordinary.[25]

49. Marcus returned to work on 11 February 2018 and was rostered for at least six consecutive days. On his return, Ms D stated that she felt Marcus was not as rested as she thought he would be after a week off. On his first day back, he had an argument with a colleague resulting in a complaint being made against Marcus.

50. On 15 February 2018 Marcus stayed at Ms T's house. According to Ms T, he discussed his stress associated with work, that he felt that he was being used and was sick of feeling this way, and he felt that Ms D was lazy and unreliable.[26]

CIRCUMSTANCES OF DEATH

51. On 16 February 2018 Marcus and Ms T went to work separately. Marcus messaged Ms T between 8.00am and 9.00am, with nothing out of the ordinary mentioned.

52. At around 8.00am Marcus commenced work at Hanrob in Tullamarine.

53. Sometime prior to 10.00am, Marcus asked Ms D if he could purchase some items to fix some equipment and Ms D advised that he had to wait until her Bunnings Trade Card arrived.

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[23] Page 95 of Coronial brief.
[24] Statement of Dr Marc Cain, page 36 of Coronial brief.
[25] Statement of Ms T, page 21 of Coronial brief.
[26] Statement of Ms T, page 21 of Coronial brief.

54. At 10.05am Marcus sent a message to a friend, Mr R saying *work wouldn't be so bad if people got off their ass and did something like get my gear to keep working*[27]. Mr R, who had known Marcus for 15 years was not concerned about the text.[28] Marcus left work without informing Ms D[29], purchasing screwdriver bits at Bunnings at 11.36am and making a second purchase of 10 metre rope at 11.48am.

55. Marcus returned to work at 12.00pm and became involved in an argument with Ms D about having to pay for the items to repair the equipment himself and about Ms D staying out of his private life.[30] Multiple people described this as being out of character for Marcus, even in the context of his recently increased irritability pertaining to his work. [31]

56. At 1.00pm Marcus messaged Ms T saying that he would not go to her house that night as he did not want Ms T to see him angry. Ms T asked what was wrong and Marcus replied, *Sick of fucking work, not going to keep doing this anymore,* and *Got the tools myself and told (-) to pay me my fucking money when she gets off her fat ass and does something and to fuck off when it comes to my private life.*[32]

57. At 2.35pm Ms D saw Marcus leave work. Ms T messaged Marcus later in the day to see if he was alright and at 5.44pm Marcus responded *yes, have a good night*. Ms T responded upset as she felt that Marcus was pushing her away, and Marcus responded that he was not pushing her away but did not want to be angry around her and needed one night by himself.

58. At 9.30am the following morning being Saturday 17 February 2018, Marcus was found deceased by a member of the public at a lookout in Lorne having taken his life with the rope he had purchased at Bunnings. A box of clozapine and two or three empty blister packets of clozapine were found on the ground nearby. It was apparent that he had driven to that location in his vehicle.

59. Ms D said that she was aware that Marcus had schizophrenia, but in *all the time* she *knew Marcus he never displayed any mental health issues to* her.[33] Other work colleagues

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[27] Statement of Mr R page 35 of Coronial brief.
[28] He said of Marcus' death, that he *never saw it coming.*
[29] Ms D had left the site, as she was completing pet taxi duties to Fitzroy.
[30] Statement of Ms D, page 32 of Coronial brief.
[31] Statement of Ms E, page 26 of Coronial brief.
[32] Page 726 of WorkSafe brief.
[33] Statement of Ms D, pages 33-33 of Coronial brief.

said that they did not know he had schizophrenia, and the revelation following his death came as a surprise.

IDENTITY OF THE DECEASED

60. On 19 February 2018, Marcus William Caldwell born on 14 June 1990 was identified by his bother Matthew Stewart.

61. Identity is not in issue and required no further investigation.

CAUSE OF DEATH

62. On 19 February 2018, Dr Matthew Lynch, specialist forensic pathologist at the Victorian Institute of Forensic Medicine (**VIFM**), conducted an external examination and prepared a written report of the same date.

63. Dr Lynch formulated the cause of death as *1(a) Hanging.*

64. Toxicological analysis detected clozapine in blood in an amount of ~0.4mg/L.

65. I accept Dr Lynch's opinion as to the medical cause of death.

FURTHER INVESTIGATIONS

Mental Health Treatment

66. During the coronial investigation I referred this case to the CPU to consider the adequacy of Marcus' mental health care and medical management proximate to his passing. A summary of the CPU review is set out below.

67. Marcus had been treated with antipsychotic medication clozapine for many years and this was very effective in maintaining his recovery.

68. Clozapine is an antipsychotic medication used in treatment-resistant schizophrenia. There is ample evidence of the benefits to many patients who take the drug, however the side effects are also many and range from mild to life threatening. Prescribing only follows evidence of the failure of a patient to respond to other antipsychotic therapy and/or in whom such therapy produces intolerable adverse effects.

69. Clozapine is a part of the Commonwealth Highly Specialised Drugs Program and only registered centres can prescribe it and only by medical practitioners registered at each of the

centres. Very rigorous monitoring occurs in the first 18 weeks of treatment and once established on clozapine, ongoing prescribing requires that patients must have a blood test every four weeks[34] and cannot be provided with more than four weeks of medication at a time. Dispensing of medication is overseen by a central body[35] who monitor compliance with blood tests prior to approving dispensation of the medication. In addition, clinical guidelines recommend annual echocardiograms and six-monthly serum clozapine levels (or more frequently under certain circumstances)[36], however these are the responsibility of the prescriber and not monitored by the central body who monitor the monthly blood tests.

70. Marcus last saw Dr McConnell on 24 October 2017. During this consultation, there was no evidence that Marcus' mental state had deteriorated nor that he was non-compliant with clozapine. This appeared to be a routine review with no concerns identified. The CPU considered that in such circumstances, it was appropriate that Dr McConnell continued with the same treatment that had kept Marcus well for several years and there was no information that needed to be conveyed to other health practitioners.

71. Marcus last saw Dr Cain on 2 February 2018. This consultation was also a routine review for the purpose of Marcus' continued clozapine prescribing. No concerns were reported by Marcus or elicited by Dr Cain. Marcus reported to be working six days per week but was not concerned about this and reported to enjoy his work. Given that his mental state appeared to remain stable, the CPU again considered that it was appropriate to continue with the treatment that had kept Marcus well for many years. There was no need to escalate or alter his care. Dr Cain had been adhering with guidelines for prescribing clozapine, although was unaware that clinical guidelines had increased the recommended serum clozapine monitoring from 12-monthly to six-monthly and was still completing 12-monthly serum clozapine levels. Dr Cain stated that he is now aware of the updated guidelines and has altered his practice accordingly. The CPU noted that it was unlikely that this had any impact on Marcus' mental state or his death, given the primary purpose of serum clozapine levels is to identify dangerously high serum clozapine levels that may increase the risk of potentially fatal side effects.

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[34] To monitor white blood cell count and neutrophil count to monitor for signs of infections and/or neutropenia.

[35] ClopineCentral for patients on the Clopine brand of clozapine and Clozaril Patient Monitoring System for patients on the Clozaril brand of clozapine.

[36] Schizophrenia [published 2021 Mar]. In: Therapeutic Guidelines [digital]. Melbourne: Therapeutic Guidelines Limited; 2021 Mar. <https://www.tg.org.au>; Australian Medicines Handbook, Clozapine.

72. The CPU further noted that Dr McConnell and Dr Cain had been treating Marcus for several years and knew him very well. Dr Cain saw Marcus at least monthly for many years, as was required for ongoing clozapine prescribing.

73. Following their review, the CPU considered that the treatment provided by his health professionals appeared reasonable and no prevention opportunities were identified.

Hanrob Pet Hotel in Tullamarine

74. There was evidence which suggested that Marcus' emotional state appeared to deteriorate from around December 2017, when he began complaining about workplace issues more frequently. It was not apparent that Marcus had any other stressors outside of his work, such as relationship issues, family issues, financial issues or legal issues.

75. Marcus appeared to have a reasonable awareness of the tiredness that he experienced and attempted to manage this. According to phone records, Marcus was asked to work a 15 hour shift and responded "*yer I can do it, only cause I got the next day off. Not sure how I would go after a double*" and was advised that he would have the following three days off. He also stayed overnight at the workplace on a number of occasions in December 2017 and January 2018.

76. According to Ms Steel who worked four casual shifts with Hanrob in January 2018,

During those 4 days, there were only 4 of us rostered on to clean and exercise 385 dogs each day. This took all day with only a quick 2-minute drink, smoke, toilet break for the staff. I had a step pedometer on each day and I averaged 20 to 25kms of walking per day. I was physically exhausted each day and I am a fit person., who walks regularly. The environment is intense with so many dogs barking and requires constant attention to dog behaviour to ensure your own safety and that of all the dogs. It was not only physically but also mentally very stressful and exhausting. All staff appeared stressed exhausted and un-happy. The conditions the dogs were living in was distressing to see, for an animal lover. All dogs were covered in their own urine and poo, due to poor drainage and having short staff it took longer to clean cages. ....The sadness alone was stressful for all staff and it showed in the moral[37].

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[37] Statement of Justine Steel, pages 15-16 of Coronial brief.

77. Ms Steel said she encouraged Marcus to resign, but he responded by saying, *who's going to look after all those dogs if I do quit?*[38]

78. Ms Steel stated that on Marcus' phone were numerous messages on his Facebook Messenger account, some of which were contained in a group named the 'Hanrob Squad' which appeared to include messengers between Hanrob staff members.[39] She took screen shots of a number of messages ranging in age from 4 October 2017 to 16 February 2018 which were included in the evidence available to the Court.

79. An example of those Hanrob staff messengers included the following,

(-): *Im not prepared for summer this year. We're already overbooked to max*

Bearly any staff

(-) *Yeh i know*

….

(-) *Im gonna tell (-) or (-) when they come down that the facility is gonna crumble over Christmas*

…

(-): *Another cruel Christmas*[40]

80. The statements of several staff members available to the Court described working conditions and indicated concerns for the animals and guilt that they were unable to complete tasks or may have forgotten tasks due to stress and overwork.

81. According to Ms W, who worked at Hanrob from 12 August 2015 until she left in September 2017 *due to the stress of it all*, the facility was always understaffed and she was *always stressed and anxious as result.* She stated *half the time I'd leave work crying. This was because I was worried that I might have missed doing something or I was worried about the dogs that I was looking after. For example, some dogs needed medication and without it they might die. Because I was always so busy I could not remember if I had done*

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[38] Statement of Justine Steel, page 15 of Coronial brief.
[39] Statement of Justine Steel, page 17 of WorkSafe brief.
[40] Pages 706- 708 of WorkSafe brief.

it or not. Things like that would always be at the back of your mind.[41] She said that the managers knew about the hours and workloads but did nothing about it, despite raising it herself.

82. Ms W said of Marcus that he *worked extremely hard* and worked flat out at a nonstop pace.

83. Ms N, who worked at Hanrob for four years and left in November 2017, stated,

> *To be blunt, the work conditions were pretty shit. There were a multiple of things, poor management, various difficult people,.....Equipment broke down, we were understaffed, overbooked and we had to try and work with what we had, which made our job very difficult. .... The reason we stuck around was that we wanted to look after the animals. With new people we knew they wouldn't give a crap about the animals. ... It's taken quite a while to get rid of this feeling, to even try to explain it to my partner now, unless you worked there nobody understood how bad it was*.[42]

84. Ms N said that the equipment malfunctions were a *very stressful thing* for lots of employees other than Marcus.

85. She described Marcus as an *extremely hard worker* who was *very fast and very efficient.*

86. Marcus' girlfriend Ms T, who worked casually at Hanrob over December 2017 and January 2018 stated,

> *It was overbooked. It was that busy that there were anything up to 5 dogs in each kennel when there was only meant to be 2. There was not enough staff for the amount of animals there. It was absolutely stressful. It was overwhelming. During this busy time Marcus told me that he felt like he was being used, underappreciated and overworked by Hanrob. He was also very concerned about the welfare of the animals because they weren't being looked after properly due to the lack of staff numbers. It was nothing out of the ordinary. It was similar to what everyone else was saying there.*[43]

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[41] Statement of Ms W, pages 33-34 of WorkSafe Brief.
[42] Statement of Ms N, pages 186-187 of Coronial brief.
[43] Statement of Ms T, pages 25-26 of WorkSafe Brief.

87. Ms O who worked at Hanrob from around April 2015 to April 2018 stated that the last Christmas period (2017 – 2018), *was even worse than the previous Christmas. It was a really bad time for everyone. There was no staff and there were so many animals. It was overcrowded with animals. There was never enough time to do the job properly. ... Sometimes you didn't even have enough time to feed the animals because you were so busy cleaning. ... This kind of ruined my mental health. I would always break down. I constantly had anxiety attacks, I'd cry at the end of the shift because all the work was not done and there was always so much more to do. I'd also get upset by looking at the condition of the kennels and the condition the animals were in. The kennels were all breaking. The floors would always be sweaty and the frames would all be rusty. The animals were always sweaty. They'd be laying in sweat and urine*.[44]

88. Ms V who worked at Hanrob between August 2016 and March 2018 stated that meal breaks would be *skipped because there was too much to do. It was a priority to get to all of the animals. If you took breaks during your shifts you would probably not be able to finish all your work. It was stressful. I could not help the amount of dogs that I wanted to.*[45]

89. Ms I was the Pet Welfare Team Leader/Supervisor up until late December 2017 (after which she was replaced by Ms D). Her job included rostering under the direction of the Facility Manager. She stated that rosters could be viewed on line by Head Office and they would have a say if needed,

They would normally comment on things like if the budgeted hours had been exceeded, tasks that needed to be done, or if they believed that we had too many staff on. [46]

90. She further stated,

Hanrob did have a system in place to manage the hours and workloads of staff. This was done on a spreadsheet. The spreadsheet would generate how many hours were able to be used for staff that week. That was based on the amount of dogs, cats, and animal activities. In my opinion there was never enough hours allocated for staff numbers. The system did not include or manage shifts or hours worked by individual staff. It was left up to me to do. I

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[44] Statement of Ms O, pages 46-47 of WorkSafe brief.
[45] Statement of Ms V, page 50 of WorkSafe brief.
[46] Statement of Ms I, page 64 of WorkSafe brief.

would work closely with the staff before finalising a roster. I'd check for things like days off that they may require.

….

Apart from the spreadsheet, I am not aware of any policies or procedures to manage hours, workloads, or monitoring stress or welfare. This was just left up to me and my manager (Mr Q). I did not receive any training to manage workloads, stress or monitor the welfare of employees. I did the best that I could.[47]

91. Mr Q, who was the Facility Manager at Hanrob until 9 February 2018 stated,

Last Christmas [referring to 2017-2018] *was particularly bad because around seven staff resigned between September and December 2017. We did get some new staff but the ones that had resigned were really experienced people.*

There was never enough staff for the amount of animals during this period. In Victoria there is meant to be a staff/dog ratio. The facility was always under that ratio during that period. This was also impacted upon by the vacuum system at the facility. The vacuum system was never working properly. It was always breaking down. Apart from the stress of not having enough staff, that failure of the vacuum system made the work very labour intensive. This would put the staff under extra stress. They would get behind in their work. On occasions they would not finish work on time. The staff complained to me about the vacuum system daily.[48]

92. Mr Q stated that he reported to Ms B who was the National Operations Manager at the time of Marcus' death, on everything, that the rosters that he prepared were reviewed weekly by Ms B (and her predecessors), that he was often told that he went over budget, was told that he had used too many hours for staff and that on occasions he was told to reduce the hours.[49]

93. The Acting Pet Welfare Team Leader, Ms D stated,

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[47] Statement of Ms I, pages 64-65 of WorkSafe Brief.
[48] Statement of Mr Q page 60 of WorkSafe brief.
[49] Statement of Mr Q, page 61 of WorkSafe brief.

I was never shown any polices for rostering, hours worked, fatigue management or the monitoring of the welfare of employees.[50]

94. She said that she was *put into this position at the busiest time of the year with no official training or handover.* [51] Ms D further stated that over the Christmas of 2017 and 2018, she worked 33 days in a row and between 12 to 15 hours a day,

This was for animal welfare and to allow other staff to take days off. If I had not done this, the staff would have had to have worked more hours.[52]

95. The National Operations Manager Ms B stated,

I don't know what experience and training the Supervisors had in managing fatigue and welfare of employees. You would have to ask the Facility Manager.[53]

96. Ms B further stated,

Although the hours and shifts are viewable online, Hanrob were possibly not aware of the hours and shifts that Marcus Caldwell and others at the Tullamarine facility were working. This is because of the hierarchy. The in-depth review of hours worked at that time remained the responsibility of the Facility Manager. My role was more budget related. For example, did it fall within the budget or was it over budget. [54]

97. The CEO of Hanrob clarified at the Inquest that there was a financial component to the role of National Operations Manager *but predominantly it's about the pet welfare and care*[55] and, to ensure that the facility manager and the pet welfare manager or supervisor were trained. In addition, that the role when looking at those rosters every week, was to have an eye on *peoples' health and welfare*.[56]

98. Mr Biggs confirmed at Inquest that the Tullamarine site always posed some operating challenges as most kennel sites have 'holed floors' with a gentle slope/rise which enables drainage for an operator to hose out the kennel/boarding areas and easily clear away animal

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[50] Statement of Ms D, page 73 of the WorkSafe brief.
[51] Statement of Ms D, page 30 of Coronial brief.
[52] Statement of Ms D, page 74 of the WorkSafe brief.
[53] Statement of Ms B, page 81 of WorkSafe brief.
[54] Statement of Ms B, pages 82 -83 of WorkSafe brief. [5]
[5] T123 L28-30
[56] T164 L26-29

waste, however this site had a flat floor (no slope), rather like a concrete slab. It required a vacuum to clean the floors of animal waste and regular spot cleaning, making the operation more labour intensive.

Site visit to Hanrob in Tullamarine

99. Mr Y who was employed at the Hanrob Brisbane facility between October 2016 and June 2018 was asked to prepare a report for Hanrob about the Tullamarine site (to help transition from previous management given the resignations of long term experienced staff). He attended that location for a period of three days in mid-February 2018.

100. Mr Y spoke to Marcus on 16 February 2018 after Marcus' altercation with Ms D. Mr Y said of his interaction,

We started off talking about his dog. We then had a bit of a general chit chat. It was a very friendly conversation. There were no issues. He was not aggressive at all towards me. I then spoke to him about the incident with (Ms D). I asked what the story was between him and (Ms D). That's when he got a little bit fired up. He wasn't aggressive but he used colourful language. He told me that he was angry and frustrated as he wasn't able to do his job as he was waiting on parts from Bunnings and blamed Ms D for not being able to get those.....We then had a bit of further chit chat. This was a friendly conversation. There were no issues. I could tell he was frustrated about work but he seemed okay.[57]

101. Mr Y reviewed the site, which was one of Hanrob's busiest and stated,

At Christmas it would have been at maximum capacity. With Mr Q, Ms I and other key staff leaving prior to Christmas it would have left a massive hole in the business as far as staff, knowledge and understanding of the business. That was evident when I attended the facility. The staff were lacking in guidance, it was short staff, and the facility was a mess.[58]

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[57] Statement of Mr Y, pages 76 - 77 of the WorkSafe brief.
[58] Statement of Mr Y, page 77 of the WorkSafe brief.

Applicable Pet Ratio Code – Hanrob Pet Hotel

102. Some confusion arose during the investigation as to the applicable pet ratio for the Hanrob facility at the time of Marcus' death and this followed concern being raised by Ms Steel that the Pet Industry Association did not contain the relevant standard for Hanrob.

103. WorkSafe advised the Court that they did,

consider the Pet Industry Association Standard employment ratios as part of its investigation and acknowledges that it would appear the ratios in the standard may not have been achieved on several occasions during this time. However, WorkSafe considered that the ratios provided in this standard were of limited utility for OHS purposes, given the standard's focus on pet welfare rather than the welfare of those caring for the pet.[59]

104. I made specific inquiries to clarify what standard set out the applicable pet ratio. The Court was advised that the Code of Practice for the Operation of Boarding Establishment (**the Code**) applied to Hanrob as a boarding establishment which fell within the definition of a 'domestic animal business' under the *Domestic Animals Act 1984 (Vic)* and, that compliance with the Code's requirements is mandatory in Victoria.[60]

105. The Court was further advised that standards created by the Pet Industry Association of Australia do not form part of Victoria's regulatory framework for these businesses.

FAID Quantum software

106. Professor Dawson provided an expert opinion report for the WorkSafe investigation which was included in the WorkSafe brief of evidence. Professor Dawson was critical of the working conditions at Hanrob. He also gave evidence at the Inquest. I directed that all additional information obtained as part of the coronial investigation which may not have been considered by Professor Dawson for his original report to WorkSafe be provided to him to clarify whether his opinion would be changed, and further, that he run *FAID Quantum* software to calculate the likelihood that Marcus experienced fatigue impairment associated with his employment. As already noted, the FAID Quantum software program

[59] Email to the Court dated 17 October 2019. Example ratio: Staff count recommended by PIAA - 1:40. Page 769 of the WorkSafe Brief.
[60] Letter to the Court dated 30 July 2020, page 158 of Coronial brief. Example ratio: Dog & enclosure ratio per staff member – 1-17 dogs, minimum 1 staff member. Page 848 of WorkSafe Brief.

was developed and validated by Professor Dawson (and Dr Adam Fletcher from the Centre of Sleep Research).

107. Professor Dawson subsequently advised the Court that the additional materials *do not alter my original opinion, in fact they further reinforce my initial views* but he noted in his original report (and at inquest) that his opinion relied on the accuracy of the statements that had been made. In relation to the conduct of a FAID Quantum analysis, he said that it would be unreliable given multiple reports from Hanrob staff that the recorded hours worked were not an accurate reflection of the actual hours, resulting in many caveats to any analysis that would be conducted rendering it *useless*.[61]

Utility of a one week break from work and Marcus' compliance with his medication

108. Ms D stated that Marcus had a week off in February 2018 and when he returned, he did not appear as rested as she thought he would. WorkSafe made observations about the impact of a week off in the context of their decision not to prosecute. In addition, WorkSafe queried whether Marcus was compliant with this medication.

109. Accordingly, I directed that an expert opinion be obtained from a psychiatrist with expertise in schizophrenia and workplace stress to comment on Marcus' compliance with his medication, whether Marcus showed evidence of a relapse of schizophrenia leading to his passing, the impact (if any) of workplace stress on Marcus' mental state and the impact (if any) of Marcus' schizophrenia on his death, amongst other matters.

110. A report was provided by Professor Newton on 3 February 2022.[62] He also gave evidence at the Inquest.

Report of Professor Richard Newton

111. In his report, Professor Newton highlighted the limited utility of a brief break from work when returning to an environment of chronic fatigue and stress. On his return from his week off, Marcus was rostered to work for at least six consecutive days. It was apparent that Marcus' stress was worse after returning to work from his break, as he had at least two verbal altercations in the six days between his return to work and his death, on a background of no other known verbal altercations with colleagues.

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[61] Pages 613-614 of Coronial brief.
[62] Pages 615-623 of Coronial brief.

112. Professor Newton considered that there was no evidence that Marcus was non-compliant with clozapine. Marcus was compliant with monthly blood tests and GP appointments that were required for clozapine prescribing, even when working six days per week and multiple consecutive days.

113. Serum clozapine levels were completed 12-monthly and although slightly below the therapeutic range, were generally stable. According to Professor Newton, Marcus' clozapine levels were consistent with the low dose of clozapine that he had been prescribed for several years and timing of his dosages do not indicate poor compliance or inadequate dosing. Post-mortem toxicology analysis detected clozapine, further supporting Marcus' compliance.

114. Non-compliance with clozapine can also result in a discontinuation syndrome[63] and/or rebound psychosis[64], neither of which Marcus displayed evidence of. Professor Newton also noted that the rate of compliance in patients taking clozapine is higher compared to patients taking other antipsychotic medications. There was no evidence to indicate non-compliance for many years and Marcus' demonstrated conscientious adherence to the rigorous requirements of clozapine prescribing, despite the difficulties that this posed with his many work hours.

Was there evidence of a relapse of schizophrenia?

115. Marcus' treating clinicians had extensive knowledge of Marcus and his illness profile which meant that they would both likely identify if Marcus was experiencing any deterioration at the time of his final contact with each of them. Professor Newton did not identify any evidence in the available information that Marcus was experiencing a relapse of schizophrenia. There was no evidence of hallucinations, delusions or disorganised speech[65], at least one of which must be present for a diagnosis of schizophrenia. Other diagnostic criteria for schizophrenia are disorganised or catatonic behaviour and negative symptoms[66],

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[63] Discontinuation syndrome refers to a cluster of symptoms that can occur when abruptly ceasing a medication with significant anticholinergic properties such as clozapine. Symptoms include malaise, myalgia, rhinorrhoea, nausea, vomiting, agitation, profuse sweating, headaches and diarrhoea

[64] Rebound psychosis refers to a return of psychotic symptoms above pre-treatment levels, in the context of ceasing treatment.

[65] Frequent derailment of speech or incoherence.

[66] Negative symptoms are characterised by the lack of usual emotional or thought processes. This may include diminished emotional expression (such as a reduction in facial expressions, eye contact, intonation of speech, and hand, head and face movements that give an emotional emphasis to speech), avolition (decreased motivation to self-initiate purposeful activities), anhedonia (reduced ability to experience pleasure), alogia (diminished speech output) and asociality (lack of interest in social interactions).

neither of which Marcus appeared to exhibit. Furthermore, Professor Newton identified that Marcus' presentation leading up to his death was not consistent with his known relapse profile. Previous relapses were in the context of substance abuse and/or non-compliance with treatment. They were characterised by marked agitation, marked aggression, disorganised behaviour, disordered and pressured speech, persecutory beliefs that he was being monitored from outer space and on The Truman Show and hallucinations that were very marked and obvious to others including members of the public and police.

116. In the month prior to his death colleagues described Marcus as being uncharacteristically irritable in the workplace context, he had two verbal arguments with colleagues in the week prior to his death, he presented as tired with reduced self-care and not attending to usual hobbies (such as running and cleaning his fish tank). Professor Newton stated that this is consistent with an emotional reaction to workplace stress and does not necessarily constitute any evidence of psychiatric illness or it could also be consistent with early signs of depression, however it is not consistent with Marcus's relapse profile of schizophrenia.

117. Professor Newton further stated, *it is my opinion that the wide variety of workplace stressors identified in the documents I have reviewed were a major mediator of Mr Caldwell's mental state in the time leading up to his death*. He noted that there was no evidence within the brief apart from the rope purchase, which appeared to occur before his argument with Ms D, which suggest Marcus had suicidal intentions and that his suicide came as a surprise *to all who knew him.*

118. Professor Newton stated,

[Marcus] *reported earlier in his employment that he loved his work and the opportunity to care for the well being of animals. His workplace appears to have become more stressful over the time of his employment as a result of increasing numbers of boarding animals, reduced numbers of staff, problems with the infrastructure of the site, a change to his own work position to that of maintenance person with increased expectations being placed on him and multiple shifts with much un-rostered overtime and work intruding into his personal time. The review of the workplace conducted by Mr Y dated 14th February 2018*[67] *identifies very significant deficits in the facilities, staffing resources and organization*

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[67] Mr Y refers to attending the Tullamarine facility for a period of three days in mid-February 2018.

leading to significant impacts on the safety and well-being of staff and animals. One of the conclusions is that staff had to become pet cleaners and not welfare focused.

Moral distress and Moral injury

119. Professor Newton commented that he was struck *with how much this resonated with our understanding of the concepts* of Moral Distress and Moral injury in the workplace.

120. With Moral Injury being described by him as[68],

the harm experienced by someone when they are required to perform work that is at odds with their personal moral sense of what is right… Moral injury is the social, psychological, and spiritual injury to an individual's conscience and moral compass resulting from an act of perceived moral transgression, which produces profound emotional guilt, shame, and in some cases a profound sense of betrayal and anger. A person who violates what they believe is right may experience persistent self-criticism-feeling unworthy, unforgivable or permanently damaged, and reflecting on the perceived transgression can fill a person with sorrow and bitterness.

121. He said that in his reading of the case it seemed that Marcus was committed to the work of looking after animals and ensuring their welfare, and that increasingly his workplace was requiring him to perform in a way that was at odds with these personal values. He noted that much of the changes described in the time leading up to his death can be understood as part of the emotional response to these moral issues. He further observed that in military veterans it is increasingly understood that Moral Injury is an important mediating risk factor resulting in high self-harm and suicide rates in the veteran community.

122. In response to reducing moral injury and moral distress in the workplace, he said,

Well, first of all, not asking people – not putting people into a situation where they're being asked to do things that transgress their moral principles, would be I think an important thing, but the truth is that many organisations, particularly in health care but also … in

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[68] Another definition referred to in Australian Psychiatry, *Moral injury and psychiatrists in public community mental health services.* 30(3). *Moral injury comprises two core components: (1) exposure to a potentially morally injurious event (PMIE) such as observing, causing or failing to prevent adverse outcomes which transgress core moral and ethical values and beliefs and (2) development of psychological distress and/or negative effects on emotional, social or behavioural functioning. A related term is 'moral distress', which denotes a sense of psychological unease which arises when an individual is unable to carry out what they view as the correct ethical action, due to constraints within their work environment.*

military services, people are often asked to do things that transgress their personal sense of what's right and wrong because you're faced with impossible dilemmas and you have to choose an option. And I think in those situations, then communication, openness, ..., alignments of the leadership values with the values of the individuals within – the workers within the organisation, a recognition that when you make a decision that impacts on resourcing, work, and the availability of care, that that's going to not just impact on how – what people do, but it's actually going to impact on how people feel. And having opportunities to discuss that, all are important things that you can do within an organisation to mitigate the risk of injury. [69]

123. Professor Newton further stated with respect to workplace culture, that if there is not a culture of openness which recognises the values basis of the work people are doing and its importance, and behaving in a way that emphasises its importance, this can worsen the issue. For example, it is often the case where people in care services have to make decisions that are the *least bad, rather than the best decision*. He said that recognising that this is the case and giving worth and value to that dilemma as well as recognising the impact that it has on people, are all aspects of work place culture.

124. Professor Newton did however clarify at Inquest that moral injury is not a mental illness but it was his opinion that Marcus' experiences were *very congruent with the emerging concept of moral injury.*[70] Professor Newton agreed that there is still significant contest over the nature of the syndrome itself and the operating definition of moral injury; and that there is still significant contest between the correlation between moral distress and what might ultimately constitute moral injury itself as a syndrome.[71]

125. He further clarified that he could not give an opinion that Marcus was suffering from moral distress and moral injury, and agreed that his expert opinion on this matter was informative but necessarily speculative.[72]

Policies and procedures in place at Hanrob

126. Mr Biggs, CEO of Hanrob CEO made a number of statements for the investigation at the request of the Court (he also gave evidence at the Inquest).[73]

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[69] T78 L19-31 – T79 L1-6
[70] T86 L20-22
[71] T99 L6-12
[72] T106 L11-18

127. As outlined in submissions on behalf of Hanrob, in early 2018, Hanrob had a *basic workplace* safety system but there was no specific focus on the issues under consideration other than employing and training competent facilities managers *who it was hoped* would monitor the necessary matters.

128. A summary of the changes made after February 2018 and how those changes have affected operations included,

- In late 2017, phase 1 of *Deputy* software was introduced to record and track employee shifts and phase 2 was implemented in the first half of 2018. This system prompts and sends an alarm to management if an employee worked or rostered beyond award based allowable hours;

- In late 2021, *Employment Hero* was utilised which issues alerts where an employee is exceeding reasonable hours and continuous shift requirements contained in the relevant industrial award and is a complete Human Resource Information System;

- In September 2021, an Employee Assistance Program (**EAP**) was introduced with access to free consultation/counselling for all employees;

- In early 2022, an integrated mobile solution for reporting, documentation and management of workplace health and safety risks and incidents called SafeX was introduced, and in consultation with SafeX it will audit and update Hanrob's current workplace health and safety processes;

- At the Tullamarine site mobile cleaning stations to reduce impacts on the vacuum system were introduced; and

- The role of a permanent part-time maintenance officer to reduce mechanical breakdown, general maintenance and minor improvements was established.

129. At inquest, Mr Biggs said with respect to planning in advance for staff shortages and resignations that in January 2022, Hanrob appointed a Chief Operating Officer, who runs weekly meetings with responsibility for occupational health and safety/training as well as rostering. The weekly meetings' first agenda item is - *people, fatigue, rostering and also*

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[73] Statement of Andrew Biggs dated 3 December 2021, page 191 of Coronial brief and Statement of Andrew Biggs dated 8 July 2022, page 624 of Coronial brief

future proofing gaps with sick leave.[74] He noted that during 2017 to 2018, around 50 per cent of the staff were casual but now the objective is to achieve 20 per cent casual and 80 per cent, full-time and permanent part-time.[75]

130. An additional role noted at the Inquest was a standalone National People and Culture Manager who is responsible for the HR function.

131. After February 2018, Hanrob also engaged HR professionals to equip leaders and team members to recognise the signs of fatigue. A Fatigue Management checklist was developed and disseminated; training was facilitated as well as frequent check ins with team leaders. Additional measures were put in place to address management instability as well as education regarding identifying and minimizing workplace stress and burnout.

SUBMISSIONS

Hanrob

132. When asked about the degree of difficulty to run the Tullamarine facility with all the issues it faced at the time of Marcus' death, Mr Biggs described it as a *perfect storm* acknowledging in addition that the staff were *all pet lovers*.[76]

133. In summary Hanrob submitted that:

- *in 2017/2018 the Hanrob pet boarding and allied business (**the Business**) experienced a perfect storm of adverse events such that it proved near impossible to manage the Tullamarine site from the NSW head office at that time;*

- *there have been a host of important and profound changes in the Business since February 2018, much of which has focused upon closer management of staff, work times and systems to monitor staffing and hours. The Business at Tullamarine is now smaller and accepts fewer animals; and*

- *there are better systems in place in the Business to enable Prevention Opportunities.*

[74] T131 L22-31 T132 L1
[75] T174 L 24-28
[76] T211 L12 -31 T212 L1-3

134. Hanrob did accept the foreshadowed findings and I agree in those circumstances (without specific evidence being tested at inquest) that individual accounts contained in witness statements do not form part of the findings as to circumstances.

135. Hanrob submitted in closing:

The death of a work colleague and a valued employee was a sad event in the Business. After 40 years in the pet boarding/kennel industry, Hanrob was devastated when it read through the Coronial Brief. It accepts the perfect storm of circumstances at the challenging Tulla Site in 2017/2018 contributed to a situation in which Marcus Caldwell felt stressed, alone and, for various reasons, ended his life, off site, in Lorne in February 2018.

The comments made by the CEO Mr Biggs at the conclusion of his oral evidence, on the public record, were heartfelt and authentic: "I'm sorry… I'm really sorry to Justine."

Marcus Caldwell's death was a wakeup call to the Hanrob business. The event caused management to critically scrutinise its management systems and its relationship with its workforce. It brought into sharp focus the importance of employee wellbeing. Since February 2018, profound changes have been made to the management of the national business, and the Tulla Site. Marcus Caldwell's legacy is a better managed, and safer workplace, for both boarded pets and staff.

WorkSafe

136. In its submission to the Court, WorkSafe provided the following advice from its Psychological Health and Safety Unit regarding a best practice approach to creating mentally health workplaces.

137. The best practice approach to creating a mentally healthy workplace addresses three strategic objectives in an integrated way:

• Prevent work-related harm to employees' mental health

• Respond to support people who experience mental ill health

• Promote positive mental health.

Prevent:

138. The implementation of a risk management framework is a preventative approach for reducing the risk of mental injury and promoting mentally healthy workplaces. A systematic risk management framework involves identification of risk, assessment of risk, implementation of risk controls to eliminate or reduce these risks so far as is reasonably practicable, and the review and revision of risk controls. Each step must involve consultation with elected Health and Safety Representatives and/or employees.

139. Based on the information in the coronial investigation, identification of the hazards might include high job demands, poor environmental conditions, poor support, and fatigue. Assessment of the risks associated with the identified hazards includes evaluating the seriousness of the harm and the likelihood of it happening, taking into consideration the severity, frequency, and duration of the exposure. Following that, it is important to implement controls to eliminate or reduce the risks of the identified hazards, including controls that assist with recovery if the risks cannot be eliminated.

140. When considering the hazards identified in the coronial investigation, prevention might include job redesign and/or adjustments to workload, working hours and environmental conditions, and providing support to workers to help them to identify and manage the impacts of the risks that cannot be eliminated. After implementing changes, the workplace should continue to review these decisions in consultation with workers to determine whether those controls are sufficient or need adjustment.

Respond:

141. In addition to the actions to prevent mental injury, there should be consideration for supporting employees when they are experiencing mental health concerns or symptoms through leaders engaging in open and honest conversations about mental health with workers. Leaders should be active in implementing risk controls, including adjusting job demands to reduce risk to psychological health or supporting employees to access appropriately qualified mental health professionals, e.g., EAP. Leaders need to design work practices; organisation’s systems and the work environment considering the needs and experiences of their employees and ensure that work responsibilities can be carried out in a mentally healthy way. Leaders may require additional training and time to support workers effectively.

Promote:

142. Proactive promotion of the positive mental health and wellbeing may provide a buffer against the negative effects of work stress. Positive mental health promotion strategies aim to raise awareness of mental health, combat stigma, create a positive and supportive work environment, and create a respectful and inclusive workplace. Relevant to this inquiry, this may include genuine communication with workers, and having leaders who promote and support actions for workers to be heard, included, and respected.

FINDINGS AND CONCLUSIONS

143. Pursuant to section 67(1) of the Act I find as follows:

   (a) the identity of the deceased was Marcus William Caldwell, born 14 June 1990;

   (b) Marcus William Caldwell died on or about 16 February 2018 at Teddy's Lookout, Lorne, Victoria, from *hanging*; and

   (c) the death occurred in the circumstances described above.

144. Marcus was diagnosed with schizophrenia, however since commencing clozapine he had remained well for several years and was considered in remission. Professor Newton noted that Marcus was functioning at a high level until December 2017 and had done "*remarkably well*" in his recovery, especially considering he was able to achieve elements of recovery not often attained in patients with schizophrenia, such as friendships, stable and supportive accommodation, supportive family, a job that gave him meaning, confiding intimate relationships, roles of responsibility and experiences of success and adding worth to the community.

145. The available evidence showed that Marcus was psychiatrically well and compliant with medication, despite rigorous requirements for ongoing prescribing which he was able to manage alongside his work schedule at Hanrob. Marcus was passionate about animals and enjoyed his work.

146. The available evidence indicated a decline in Marcus' emotional wellbeing from December 2017 onwards which coincided with an increase in Marcus expressing frustration with his work conditions, short staffing following staff resignations and a change in the management structure including Marcus' direct supervisor. There was a notable absence of other stressors in Marcus' life aside from those directly associated with his employment at Hanrob.

147. Having considered all the available evidence, I find that Marcus was suffering considerable workplace stress as a result of the combination of conditions at his workplace in the period proximate to his death. This workplace stress had a marked adverse effect on his wellbeing and played a significant role in the decision he made to end his life. It is not apparent on the evidence available that there were sufficient measures in place to protect his welfare and the harm that may have been caused in these circumstances. I am not able to say that his work was the sole reason for his decision (in my view, no-one is privy to the inner most thoughts of an individual), nor am able to quantify the extent of any contribution.

COMMENTS

Pursuant to section 67(3) of the Act, I make the following comments connected with the death:

148. Professor Newton noted that there is extensive literature on the impact of work place stress on mental health and well-being in the general population. A large range of workplace stressors such as high work demand, low reward positions, physical conditions at work, physically demanding work, night shift, long working hours, low work control and high job insecurity are all associated with poor mental health outcomes such as suicidal behaviour and depression. These factors can interact with each other in an additive way worsening each as a risk factor. He noted that risks of adverse mental health outcomes are worse *in so* called elementary occupations such as cleaners and laborers.

149. Professor Newton referred to the emerging issue of moral injury and moral distress that is a particular focus in healthcare but which can also be applied to other values-based work such as animal welfare.

150. He noted that suicide prevention strategies in the community are increasingly focussing on the workplace as an important opportunity to impact on high suicide rates and that this supports the importance of the workplace as a significant source of stress contributing to mental illness and suicide.

151. Relevantly, recommendation 16 of the Royal Commission into Victoria's Mental Health System (**RCVMHS**) was directed towards establishing mentally healthy workplaces which can significantly reduce the risk of suicide and other adverse mental health outcomes in their employees. I understand that the Department of Premier and Cabinet is responsible for the implementation of this recommendation. Accordingly, a copy this finding will be distributed to that body along with a recommendation endorsing the specific recommendation.

152. In the context of this recommendation Professor Newton also said that it is important that people with severe mental illness have access to work and that *if we are going to be truly a community that supports mental health*, then having access to meaningful work that gives that person a sense of value, belonging and contribution, is vitally important.

RECOMMENDATION

Accordingly, pursuant to section 72(2) of the Act, I make the following recommendations connected with the death:

I endorse the recommendation 16 of the Royal Commission into Victoria's Mental Health System with the aim of preventing like deaths:

16. Establishing mentally healthy workplaces

The Royal Commission recommends that the Victorian Government:

1. *as an initiative of the Mental Health and Wellbeing Cabinet Subcommittee (refer to recommendation 46(2)(a)):*
    - a. *foster the commitment of employers to create mentally healthy workplaces;*
    - b. *advise on, develop and provide resources to assist employers and employees across Victorian businesses to:*
        - i. *promote good mental health in workplaces;*
        - ii. *address workplace barriers to good mental health;*
        - iii. *promote inclusive workplaces that are free from stigma and discrimination; and*
        - iv. *support people experiencing mental illness at work.*
2. *sponsor industry-based trials to demonstrate how to adapt and implement comprehensive mentally healthy workplace approaches in an industry context.*

Pursuant to section 73(1) of the Act, I order that this Finding (in redacted form) be published on the internet.

I convey my sincere condolences to Marcus' family for their loss and acknowledge the sudden and tragic circumstances of his death.

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

Justine Steel, Senior Next of Kin

Mills Oakley on behalf of Hanrob Pty Ltd

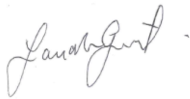
WorkSafe Victoria

Department of Premier and Cabinet

Office of the Chief Psychiatrist

Coroner's Investigator, Victoria Police

Signature:



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Coroner Sarah Gebert

Date: 28 July 2023

Re-signed: 27 December 2023

1. NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.