IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2018 003733

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Paresa Antoniadis Spanos
Deceased:	Deborah Marie Holtkamp
Date of birth:	22 August 1965
Date of death:	29 July 2018
Cause of death:	1(a) Mixed drug toxicity
Place of death:	7 Binghams Road, Harcourt, Victoria, 3453

INTRODUCTION

1. On 29 July 2018, Deborah Marie Holtkamp was 52 years old when she was found deceased at home in circumstances indicative of suicide. At the time, Ms Holtkamp lived at 7 Binghams Road, Harcourt, with her husband, Brett Holtkamp.

2. Ms Holtkamp suffered from a long history of depression and was described by her General Practitioner (**GP**) as a "vulnerable person" due to her history of childhood abuse. About 13 years before her death, Ms Holtkamp began experiencing suicidal ideation, including a prior suicide attempt, however she did not seek support for her mental health prior to her death.

3. In addition to her mental health issues, Ms Holtkamp suffered from chronic back pain and sciatica resulting from a car accident. She also struggled with prolapsed discs, spinal arthritis, fibromyalgia, Grave's disease, and insomnia. According to Mr Holtkamp, who stated he was her full-time carer, Ms Holtkamp's health had been deteriorating in the past five years.

4. The Holtkamp's moved to Harcourt in May 2017 for Mr Holtkamp's work. Ms Koltkamp felt isolated there as she was unable to drive. The couple argued about the move and were in the process of separating when Ms Holtkamp died.

THE CORONIAL INVESTIGATION

5. Ms Holtkamp's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (the Act). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.

6. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

7. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

8. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Ms Holtkamp's death. The Coroner's Investigator conducted inquiries on my behalf, including

taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

9. This finding draws on the totality of the coronial investigation into the death of Deborah Marie Holtkamp including evidence contained in the coronial brief. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[1]

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

Identity of the deceased

10. On 29 July 2018, Deborah Marie Holtkamp, born 22 August 1965, was visually identified by her husband, Brett Holtkamp who signed a formal Statement of Identification to this effect before a member of Victoria Police.

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

Medical cause of death

12. Senior Forensic Pathologist Dr Matthew Lynch from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination on 31 July 2018 and provided a written report of his findings dated 2 October 2018.

13. Dr Lynch advised that the post-mortem examination revealed findings consistent with the stated circumstances.

14. Routine toxicological analysis of post-mortem samples detected morphine (~ 0.1 mg/L); diazepam (~ 0.3 mg/L) and its metabolite nordiazepam (~ 0.3 mg/L); zopiclone (~ 0.1 mg/L) used to treat insomnia; and the over-the-counter antihistamine promethazine (~ 0.1 mg/L).

15. The toxicologist's report advised that presence of multiple Central Nervous System (CNS) depressant drugs (such as morphine, diazepam/nordiazpema, zopiclone) may result in respiratory depression and (over) sedation.

[1] Subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

16. Dr Lynch provided an opinion that it would be reasonable to attribute the medical cause of Ms Holtkamp's death to *mixed drug toxicity*.

17. I accept Dr Lynch's opinion.

Circumstances in which the death occurred

18. On 30 December 2017, Ms Holtkamp attended the Castlemaine Health Urgent Care Centre (**CHUCC**) complaining of anxiety and an inability to cope in the context of the breakdown in her relationship. Ms Holtkamp said she had anxiety arising from being "put down" for a period of 16 months, and that she did not want to be at home because Mr Holtkamp was there. She reported wanting to separate but was finding this difficult due to fears of being on her own with no financial backup, as her husband was her only means of support. Ms Holtkamp reported feeling isolated, having no friends, and experiencing suicidal ideation but without a plan. She said she did not know what to do and felt like she "couldn't go on like this" but declined to see a member of the mental health team. Ms Holtkamp's suicide risk was assessed as "relatively low", and she was discharged with a prescription for diazepam and a plan to see her GP in a week.

19. Throughout the first half of 2018, Ms Holtkamp attended numerous appointments with her GP during which she discussed her ongoing insomnia, stress, and relationship issues. She was noted to have a flat affect and told her GP that she was experiencing ongoing suicidal ideation without a plan or intent. However, Ms Holtkamp declined a referral to a community mental health service and, instead, was provided with the number for the local mental health triage service.

20. On 25 June 2018, Ms Holtkamp attended an appointment with her GP during which she said she was having further suicidal ideation due to her relationship issues but worried that she "would not complete the job and be left further disabled." She also stated that she had researched alternative accommodation but felt "trapped" by her situation.

21. On 26 July 2018, Ms Holtkamp told her GP that she had ceased her antidepressant medication as she wanted to "live more independently." He cautioned her about this but noted that Ms Holtkamp appeared more stable and that she was expressing greater self-respect than previously.

22. On 28 July 2018, the Holtkamps argued about Ms Holtkamp's feeling of isolation and her desire to move back to Castlemaine. Mr Holtkamp left the residence and stayed overnight at

alternative accommodation. When he returned at 11.45am the following morning, he found Ms Holtkamp deceased after an apparent overdose. A suicide note was located at the scene.

FURTHER INVESTIGATIONS

23. To assist my investigation into the death of Ms Holtkamp, I referred the matter to the Victorian Systematic Review of Family Violence Deaths, part of the Coroners Prevention Unit,[2] who undertook a review of Ms Holtkamp's contact with services prior to her death in order to assess, among other things, whether there were any prevention opportunities disclosed by the circumstances in which she died.

24. Sources of evidence that were considered included the coronial brief, medical records from Lyttleton Street Medical Centre and CHUCC, Ms Holtkamp's Medicare records, and the Castlemaine District Community Health (**CDCH**) housing support records for the period July 2017 to July 2018 inclusive.

Castlemaine Health

25. During the course of Ms Holtkamp's assessment at the CHUCC on 30 December 2017, she made several concerning comments, including her feelings of anxiety, inability to cope and that she was being "put down". These are recorded in her progress notes and, according to CPU, it would have been reasonable for Ms Holtkamp to be asked about family violence during this presentation.

26. Ms Holtkamp exhibited several indicators of possible family violence including recent separation, reluctance to follow advice, depression, a sleeping disorder, and a previous suicide attempt.[3] In addition, she openly acknowledged that her presentation to the CHUCC was due to stress from relationship issues including being "put down".

27. In these circumstances, prompting questions should have been used to establish whether family violence is occurring, in accordance with the Common Risk Assessment Framework (**CRAF**), so that further steps could have been taken, including safety planning and a referral

[2] The Coroners Prevention Unit (CPU) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the Coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. The CPU also reviews medical care and treatment in cases referred by the coroner. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.

[3] According to the Common Risk Assessment Framework, part of the Family Violence Risk Assessment and Risk Management Framework, which includes a practice guide for mainstream services to use to identify family violence, including 20 possible adult indicators.

to specialist family violence services.[4] This may have been particularly helpful for Ms Holtkamp given her desire to obtain her own accommodation away from her husband. Specialist family violence services may have assisted her by providing funding via a flexible support package, applying for priority access long term public housing, access to family violence crisis accommodation, and exploring other support options, such as the disability and family violence crisis response initiative. Such assistance may have significantly improved Ms Holtkamp's wellbeing and given her options.

28. CPU noted that since Ms Holtkamp's death, reforms have been implemented to improve service sector responses to family violence. This includes a review of the CRAF and implementation of a new Victorian Family Violence Risk Assessment and Risk Management Framework, the Multi-Agency Risk Assessment and Management Framework (**MARAM**). The MARAM practice guide for the identification of family violence risk is more comprehensive than the CRAF and includes a list of 40 indicators of family violence.

29. Had Ms Holtkamp been assessed in line with the MARAM practice guide, further indicators of family violence would have been evident during her presentation at the CHUCC, including chronic back pain, no support networks, unemployment, no friends or family support, and isolation.

30. Publicly funded health services such as Castlemaine Health were listed as prescribed agencies under the MARAM Framework in April 2021 and are now required to work towards aligning their services with the MARAM Framework. The Castlemaine Health Annual Report 2019-2020 provides limited information around family violence but indicates that the organisation has taken some steps towards MARAM Framework alignment, including attendance at MARAM Framework alignment training by senior staff.

Lyttleton Street Medical Centre

31. Between January and July 2018, Ms Holtkamp attended nine separate appointments at the Lyttleton Street Medical Centre, including eight with her regular GP. Whilst records do not indicate whether Ms Holtkamp was asked directly whether she was experiencing family violence during her consultations, it is reasonable to expect that such enquiries should have been made, given the available information and relevant policies and procedures at the time.

[4] Department of Health and Human Services (DHHS), Family Violence Risk Assessment and Risk Management Framework and Practice Guides 1-3 (2012), 2nd Edition, 55-60.

32. During her various consultations, Ms Holtkamp presented with five of the 20 possible indicators of family violence in an adult listed in the CRAF, including recent separation, reluctance to follow advice, depression, sleeping disorder, and a previous suicide attempt. Additionally, her GP should have been aware of her recent presentation to the CHUCC, including her disclosure about being "put down", which may have referred to behaviours that met the definition of abuse outlined in the CRAF. It is reasonable to expect that Ms Holtkamp's GP should have asked further prompting questions to identify whether family violence was occurring and, if it was, taken further action, such as offering a referral to a specialist service.

33. As noted above, reforms have been implemented to improve service sector response to family violence since Ms Holtkamp's death, including the implementation of the MARAM framework. As with CHUCC, had Ms Holtkamp been assessed in line with the MARAM framework, further indicators of family violence would likely have been evident during her frequent GP appointments in 2018.

Castlemaine District Community Health – Homelessness Program

34. Ms Holtkamp engaged briefly with the Castlemaine District Community Health Homeless programme (**CDCHHP**) between 28 December 2017 and 11 January 2018, seeking support with housing due to her relationship breakdown. The support worker asked about family violence and her safety, and in responding Ms Holtkamp implied she did not feel unsafe at home. She also disclosed that she was suffering from depression, and the support worker documented that further exploration of her safety and mental health was required, with an appointment made for 4 January 2018.

35. On 4 January 2018, Ms Holtkamp met with the support worker from CDCHHP and was provided with a list of private rental properties, however there was no discussion regarding her safety at this meeting. She later contacted the service to advise that Mr Holtkamp had agreed to go to couples' counselling and that she had decided to stop looking for alternative accommodation at that time. Ms Holtkamp had no further contact with the CDCHHP.

36. I note that under the *Family Violence Protection Act 2008* (Vic), prescribed organisations (including the CHCHHP) must ensure that their policies, procedures, practice guidelines, and tools align with the MARAM. Had the MARAM been in place at the time of Ms Holtkamp's contact with the CDCHHP, it is likely that the support worker would have been prompted to make further enquiries about Ms Holtkamp's safety and exposure to family violence.

FINDINGS AND CONCLUSION

37. The standard of proof for coronial findings of fact is the civil standard of proof on the balance of probabilities, with the Briginshaw gloss or explications.[5] Adverse findings or comments against individuals in their professional capacity, or against institutions, are not to be made with the benefit of hindsight but only on the basis of what was known or should reasonably have been known or done at the time, and only where the evidence supports a finding that they departed materially from the standards of their profession and, in so doing, caused or contributed to the death under investigation.

38. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:

    a) The identity of the deceased was Deborah Marie Holtkamp, born 22 August 1965.

    b) The death occurred on 29 July 2018 at 7 Binghams Road, Harcourt, Victoria, 3453.

    c) The cause of Ms Holtkamp's death was from *mixed drug toxicity*.

    d) The death occurred in the circumstances described above.

    e) The weight of available evidence supports a finding that Ms Holtkamp intentionally took her own life in the context of the breakdown of her relationship and limited resources which made it difficult for her to move out and live independently of her partner.

COMMENTS

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

39. In 2009, in the matter of the death of Darcey Iris,[6] Judge Gray recommended that the Royal Australian College of General Practitioners (RACGP) consider the introduction of compulsory family violence for GPs, to which the RACGP responded by highlighting the Federal Government's funding package to enable the College to develop and deliver nationwide specialised training regarding family violence. Additionally, the College proposed

[5] *Briginshaw v Briginshaw* (1938) 60 CLR 336 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…'.

[6] COR 2009 000447

the introduction of Medicare rebates to support a national approach to healthcare delivery for women and children suffering from family violence.

40. Similarly, in 2016 the Royal Commission into Family Violence in Victoria noted concerns in relation to the ability of GPs to identify family violence, and recommended the Victorian Government encourage the Ministerial Council to approve standards that facilitate a mandatory requirement that GPs complete family violence training as part of their continuing professional development. While the Victorian Minister for Health raised this recommendation with the Australian Health Workforce Ministerial Council, the Medical Board of Australia, the RACGP, the Australian College of Rural and Remote Medicine, and the Australian Health Practitioner Regulation Agency, family violence professional development training is still not mandatory for GPs.

41. I note the response from the RACGP to recommendations made by Coroner Jamieson in the death of Mr A[7] in 2019[8] that GPs attend a mandatory four hours of training and education regarding family violence each year, including, but not limited to, identification, risk assessment or understanding of the relevant frameworks.

42. In their response, the RACGP stated that, whilst they do not support a "one-size" approach to family violence training or specific "once-off" mandatory training, they acknowledge that training in family violence is an important component of general practice, and that general practice education and training should focus on an outcomes-focused, competency-based model, rather than one of compliance. Furthermore, GPs are expected to achieve general practice family violence management competencies, which are embedded within the core skills of the RACGP Curriculum for Australian General Practice. The RACGP further noted their preference for a wide variety of approaches and resources, considering the different levels of professional competence, to ensure that family violence remains an ongoing general practice priority.

43. I note that the RACGP is collaborating with the Safer Families Centre, University of Melbourne, as part of The Readiness Program - a national training program for primary care providers to effectively recognise, respond, refer, and record domestic and family violence using a trauma and violence informed approach. RACGP Victoria is currently in negotiation with the Victorian Department of Health to develop and deliver additional educational

[7] Name redacted.
[8] COR 2019 001858.

opportunities and support services for GPs related to domestic and family violence and information sharing schemes.

44. Furthermore, GPs should also be guided by the Royal Australian College of General Practitioners (**RACGP**) manual *Abuse and Violence: Working With our Patients in General Practice* (also known as the White Book) which contains a table of potential presentations of intimate partner abuse, as well as guidance about what GPs should do if they suspect family violence is occurring. It is important to note that whilst the White Book is less comprehensive than the MARAM framework, it has recently been updated with further information regarding current services and risk assessment tools available to practitioners.

45. GPs are not prescribed under the MARAM framework (unlike publicly funded health services) and are not legally obliged to align their services with it. However best practice dictates that GPs follow its guidance, which will hopefully increase the positive impact of MARAM framework on the identification of and response to family violence by GPs. Furthermore, the inclusion of prescribed organizations, such as homelessness programs like the CHCHHP, into the MARAM will hopefully lead to an increase in the identification and response to family violence.

46. Despite this, whilst the RACGP has developed a six hour online professional development program on family violence for GPs, it is not compulsory to undertake this or any other continuing professional development family violence training. This coupled with the fact that GPs are not prescribed under the MARAM Framework, means that gaps within GPs' knowledge and skills in identifying and responding to family violence may persist.

47. This case highlights once again how important GPs are in identifying possible family violence and referring their patients to appropriate support services. While there are significant demands on the primary care system, GPs can play a pivotal role in identifying patients potentially at risk, recognising that the presentation of family violence may be nuanced and not immediately apparent, and eliciting the relevant history from patients so that timely and focused referrals can be made.

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

Brett Holtkamp, Senior Next of Kin

Castlemaine Health Urgent Care Centre

Lyttleton Street Medical Centre

Castlemaine District Community Health – Homelessness Program

Royal Australasian College of General Practitioners

Senior Constable M. Lewis, Victoria Police, Reporting Member

Signature:

Paresa Antoniadis Spanos

Coroner

Date: 10 January 2022

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.