IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2018 006154

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Sarah Gebert
Deceased:	Mr W
Date of birth:	[redacted] July 1997
Date of death:	9 December 2018
Cause of death:	*Hanging*
Place of death:	[redacted] Warragul, Victoria

INTRODUCTION

1. Mr W,[1] born on [redacted] July 1997, was 21 years of age at the time of his death. He is survived by his parents [redacted] and [redacted], his brother [redacted], and three half-sisters.

2. Mr W was described as a *very deep thinker* and a *free spirit* with *a twinkle in his eye...when he made people laugh.* His best friend [redacted]) described him as the *life of the party* who *was just loved by everyone*. He was *very individual*, and *mature beyond his years*. [redacted] remembered her son *as a contradiction,* in that, publicly *he was really confident, laughing, jumping in front of cameras but internally he was insecure and hated photos of himself or talking about himself.*

3. On 9 December 2018, Mr W was located by his brother, apparently deceased, in the garage of their home.

THE CORONIAL INVESTIGATION

4. Mr W'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.

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

6. 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.

7. Victoria Police assigned Senior Constable Brian Cook (**SC Cook**) to be the Coroner's Investigator for the investigation of Mr W's death. SC Cook conducted inquiries on my behalf, including taking statements from witnesses and compiling a coronial brief of evidence. The brief comprises statements from Mr W's family and friends, his treating general practitioner

[1] Referred to in this finding as 'Mr W', unless more formality is required.

(**GP**), police members who had dealings with Mr W the night before his death, the forensic pathologist who examined him, investigating police as well as other relevant material.

8. Mr W's father also raised some concerns by correspondence to the Court on 18 December 2019 and 19 November 2020. A submission was consequently obtained from the Chief Commissioner of Police (**CCP**) in response.

9. As part of the coronial investigation, the Coroners Prevention Unit (**CPU**)[2] was asked to review the appropriateness of mental health care provided to Mr W by his childhood GP Dr Michael Crameri prior to his death. The CPU is staffed by healthcare professionals, including practising physicians and nurses, who are not associated with the health professionals and institutions under consideration and are therefore able to give independent advice to coroners. In the course of the CPU review, a further statement was also obtained from Dr Crameri.

10. This finding draws on the totality of the coronial investigation into Mr W's death 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.[3]

Background

11. Mr W worked as an [redacted] with [redacted] in Warragul. He *didn't like his job* but *planned to finish his apprenticeship* and look for another company to work. His apprenticeship would have been completed a few weeks after his death.

12. Mr W *partied hard* and was a *recreational drug taker on weekends.* In around April 2018, Mr W and [redacted] moved from their mother's home to live with [redacted]'s partner [redacted].

13. When Mr W was between the ages of 15 and 18, his father spoke to him about his own mental health struggles in his youth. He asked Mr W if *he considered suicide*, to which Mr W *always*

[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] 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.

said no. The evidence suggests that Mr W internalised his emotions and mental health struggles and *would keep a lot of things bottled up*.

14. Mr W confided in his best friend [redacted] about his mental health, but *only in private.* [redacted] recalled that Mr W *could be very up and down*, and publicly *he would always put on a brave face and not let anyone in but* [they] *would have discussions regarding* [his mental health] *when no-one else was around.* Family and friends, other than those closest to him, were unaware that Mr W was seeing a mental health professional or that he was on medication for any related concerns as *he just didn't share that sort of emotion.*

15. On 7 November 2018, Mr W consulted with Dr Crameri requesting a mental health check. He reported *past depression 2 years ago* and during that consultation, *presented with symptoms consistent with depression.* Dr Crameri conducted a Kessler Psychological Distress Scale (K10) assessment[4] with Mr W who returned a score of 34 out of 50, where *a score above 30 show[s] depression quite likely.* Dr Crameri and Mr W discussed the options of counselling and medication, and Mr W was subsequently prescribed Zoloft (sertraline) 50mg, to be increased to 100mg after two weeks and for him to return for a review in three weeks.

16. At the review on 28 November 2018, Mr W reported improved mood (from 5/10 to 6/10), reduced anxiety (from 5/10 intensity to 2/10 intensity) and improved feelings of anger. His appetite and sleep were noted to be reasonable at both reviews.

17. After Mr W commenced sertraline, [redacted] also noticed that Mr W *looked a million times better* and was *much more motivated to get things done.*

18. [redacted] last saw her son on a Wednesday in December 2018 when Mr W and [redacted] were at her home. She recalled that Mr W *was in a good mood, mucking around, singing.* Mr W was *excited* and looking forward to his travel around Australia in 2019 with his best friend [redacted] after he completed his apprenticeship. He was also *extremely excited* about the birth of his brother's child.

19. [redacted] last saw his son on Friday 7 December 2018, when Mr W attended his home to help fix his ute. [redacted] also saw Mr W at approximately 5.00pm that day and noted that Mr W*seemed normal.*

[4] The Kessler Psychological Distress Scale provides a standardised system for identifying anxiety or depressive issues in a patient's presentation. A score less than 20 indicates depression unlikely, and a score above 30 indicates depression quite likely.

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

Circumstances in which the death occurred

20. At approximately 10.00am on Saturday 8 December 2018, Mr W started consuming alcohol while at a friend's 21st birthday celebration. The party progressed from a bowling alley to a golf club, and then the home of *a mate's*.

21. At some point during the day, Mr W returned home and went to sleep.

22. At 6.45pm, after not being able to contact him by phone, [redacted] attended Mr W's home to wake him up and remind him about a work function he had to attend at 7.00pm. [redacted] observed that Mr W was *still in bed, still pretty* intoxicated, but *pretty much bounced out of bed, was having a laugh with the guys I had gone there with, he seemed right as rain*.

23. Mr W drove his Toyota Hilux vehicle to attend his work function at the Court House café. There, he consumed *probably 5-6 shots of a mixture of spirits and Galliano and 7-8 Vodka drinks*. He had planned to meet up with his friends after the work function and go to the Bank nightclub.

24. At approximately 10.40pm, Mr W left the Court House café and returned to his vehicle. A short time later, he made a left turn at speed and lost control of his vehicle, colliding into a parked vehicle. Mr W's vehicle came to rest on its side. He did not sustain any injuries and managed to make his own way out of the vehicle.

25. Mr W contacted [redacted] and told him that he had an accident, and [redacted] attended the scene and spoke to Mr W who *said he was fine*.

26. Leading Senior Constable John Hardiman (**LSC Hardiman**) and Leading Senior Constable Jeff Robertson (**LSC Robertson**) also attended the scene and Mr W produced a probationary driver licence. He admitted to driving *too hard around the corner*, and that he was "*pissed*".

27. Mr W underwent a preliminary breath test and, a short time later, an evidentiary breath test at Warragul Police Station (**the police station**), revealing a breath alcohol concentration of 0.155g/210L of breath. Mr W was served with a Notice of Immediate Suspension of Licence

or Permit[5] and informed that his driver licence was *immediately suspended for a period of 12 months*.

28. On his arrival at the police station, Acting Sergeant Frank Duffy conducted a supervisor welfare check on Mr W and noted on the Attendance Register that there were *no visible signs of injury to Mr W or indications of mental impairment*. At 12.20am, before Mr W left the police station, Acting Sergeant Duffy conducted a *disposal interview*, and Mr W shook hands with both LSC Hardiman and LSC Robertson. Mr W then declined the LSCs' offer to drive him home, stating that he would walk as he only lived around the corner (approximately 500 metres from the police station).

29. At approximately 12.30am on 9 December 2018, Mr W and [redacted] exchanged text messages and when [redacted] asked if MrW would like him to *come around*, Mr W *said he was all good*.

30. At around noon of 9 December 2018, [redacted] was at home when he received and made a number of phone calls regarding his brother's whereabouts. At 12.22pm, [redacted] sent a text message to [redacted] saying that Mr W's phone was turned off and to *check the shed* as *Mr W tinkered in there a bit*. It was then that [redacted] entered the shed and found his brother suspended from a wooden beam by a belt.

31. [redacted] called out for his partner's assistance and together, they lay Mr W on the ground and [redacted] commenced cardiopulmonary resuscitation (**CPR**) until he *realised that* [Mr W] *was gone*.

32. Emergency services were called and ambulance paramedics attended at shortly after. Sadly, Mr W was unable to be assisted and was pronounced deceased at 12.30pm.

33. Police commenced an investigation and collected photographic evidence to form part of the coronial brief.

34. In Mr W's bedroom, police located three letters addressed to "[redacted]", "[redacted]" and "[redacted]", in which Mr W expressed his gratitude and adoration for the intended recipients, as well as his belief that he was *not built for the world*.

35. Police also located a small amount of cannabis, a *bong*, two small clip seal bags containing white residue, and empty and partially used medications including sertraline and Panamax.

[5] Under section 51 of the *Road Safety Act 1986*

36. Following their investigation, police did not find evidence of any suspicious circumstances.

Identity of the deceased

37. On 9 December 2018, Mr W, born [redacted] July 1997, was visually identified by his brother, [redacted].

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

Medical cause of death

39. Forensic Pathologist Dr Gregory Young from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an examination on 11 December 2018 and provided a written report of his findings dated 12 December 2018.

40. The post-mortem examination did not reveal any unexpected signs of trauma.

41. Toxicological analysis of post-mortem samples identified a blood alcohol concentration (**BAC**) of 0.14g/100mL and the presence of sertraline[6] (~0.08mg/L) in a quantity consistent with therapeutic use.

42. Dr Young provided an opinion that the medical cause of death was *Hanging*.

43. I accept Dr Young's opinion.

FURTHER INVESTIGATIONS

Family Concerns

44. Mr W's father raised concerns regarding the appropriateness of the mental health treatment provided including the medication prescribed by Dr Crameri, as well as the post interview process of Victoria Police.

45. [redacted] also raised the following suggestions, amongst others, with a prevention focus:

    (a) the recategorising SSRIs as specialist-only prescription medications for persons under 24 years old in the initial stages of treatment; and

[6] Sertraline is an anti-depressant drug for use in cases of major depression.

(b) *education and awareness* regarding the side effects of SSRIs, especially in high risk categories.

Review of Care of Dr Crameri

46. The CPU reviewed the treatment provided to Mr W by Dr Crameri on 7 and 28 November 2018. In their review, the CPU referred to the *Clinical Guidance on the Use of Antidepressant Medication in Children and Adolescents March 2005*[7] and the *Use of SSRI*[8] *Antidepressants in Children and Adolescents, October 2004*[9].

47. The CPU considered that Dr Crameri's decision to commence Mr W on sertraline was reasonable and based on an appropriate clinical assessment. Dr Crameri's request that Mr W returned in three weeks was compliant with the *Clinical Practice Guidelines for Mood Disorders*[10]. At the review, Mr W reported an improvement in symptoms (though not full remission, which the CPU advised was the expected response given the treatment duration). The CPU considered that it was appropriate for Dr Cameri conduct a further review in 2 to 3 months when it could be determined whether the current medication and dose would achieve full or only partial remission for Mr W.

48. Dr Crameri was aware of SSRIs being associated with some accompanying risk of increased suicidal ideation (being most prominent in adolescents) and considered Mr W's age (21) at the time. Dr Crameri consequently reviewed Mr W for the presence of suicidal ideation on both occasions and no significant risk of suicide was identified. The CPU considered that Dr Crameri followed up with Mr W within an appropriate time frame, and his treatment of Mr W was appropriate.

Prescription of SSRIs

49. In relation to the suggestion to recategorise SSRIs to be prescribed by specialists only for under 24s who are in the initial stages of treatment, the CPU provided the following advice:

---

[7] The *Clinical Guidance on the Use of Antidepressant Medication in Children and Adolescents March 2005* was issued jointly by the Royal Australian and New Zealand College of Psychiatrists (**RANZCP**), the Royal Australian College of General Practitioners (**RACGP**) and the Royal Australasian College of Physicians (**RACP**).

[8] Selective Serotonin Reuptake Inhibitor

[9] The *Use of SSRI Antidepressants in Children and Adolescents, October 2004* was prepared by the Adverse Drug Reactions Advisory Committee of the Therapeutic Goods Administration.

[10] Issued by the RANZCP.

(a) This would significantly limit access to treatment for young people with depression and as a result, potentially increase the suicide rate in this age group.

(b) The evidence suggests that while there is a greater risk of suicidal behaviour and thinking during the first 1-2 months of treatment for those aged 18-24, this risk remains small. The average risk of such events was 4%, compared with 2% of patients treated with a placebo. No suicides occurred in the trials undertaken.

(c) While there is a small (but statistically significant) increased risk of suicidal thinking/behaviours for this age group, the evidence suggests that access to antidepressants has reduced the overall suicide rate.

(d) The Royal Australian and New Zealand College of Psychiatrists (**RANZCP**), the Royal Australian College of General Practitioners (**RACGP**) and the Royal Australasian College of Physicians (**RACP**) support children and adolescents having access to antidepressants.

(e) Sertraline is in the top 10 most frequently prescribed Pharmaceutical Benefits Scheme (**PBS**) medications.[11] As such, requiring young people to see a psychiatrist for a prescription of SSRIs will likely place a demand on private psychiatrists that will be unable to be met.

(f) Considering the availability of private psychiatrists currently (and the predicted increase if only psychiatrists can prescribe antidepressants to young people) and the cost to see a psychiatrist, this will likely lead to many young people who require antidepressants not getting them or significant delays in commencing treatment.

(g) If a patient has a complex presentation or a GP is unsure about prescribing an antidepressant, there is always an option to refer for a specialist opinion, however this was not the case with Mr W and there was no indication that a specialist opinion was required.

50. I accept the advice provided by the CPU regarding these matters and whilst I am unable to identify any prevention opportunities, I have made comments arising from the family concerns.

[11] This data is not GP-specific and is not specific to young people.

Post Interview Process

51. Given that Mr W had recent involvement with police prior to his death, Victoria Police Professional Standards Command (**PSC**) conducted an oversight investigation in accordance with the Victoria Police Manual Oversight Principles. Following their investigation, PSC considered that all relevant members acted in accordance with policy and guidelines, and that Mr W's welfare was appropriately managed and addressed whilst in company with police both at the collision scene and at Warragul Police Station.

52. As part of the coronial investigation, I sought a response from the CCP to the concerns raised by [redacted]. The CCP noted the following:

    (a) The Victoria Police Manual (**VPM**) provides guidance to members when dealing with persons in police care or custody. When a person is taken into police care or custody, police assume a responsibility for their safety, security, health and welfare, and must also have regard to the *Charter of Human Rights and Responsibilities Act 2006*.

    (b) Mr W was never in police custody and had voluntarily accompanied police to the police station for the purposes of a breath test pursuant to obligations imposed on him under the *Road Safety Act 1986*.

    (c) The ability of police to detain a person under section 351 of the *Mental Health Act 2014* is dependent on whether a person appears to have a mental illness.

    (d) During the 85-minute period between police first observing Mr W (10.55pm) until he left the police station (12.20am), police noted that Mr W's eyes were red and glazed, he smelt of alcohol, was softly spoken and apologetic and remorseful. He was cooperative with police, engaged in conversation and was able to answer the questions asked of him. Police noted that his state of sobriety was such that he understood his caution when he was interviewed for the offence of careless driving, and he informed police that he was taking antidepressants but that he was compliant with his medication regime.

    (e) Based on their interactions with and observations of Mr W that night, Acting Sergeant Duffy, LSC Hardiman and LSC Robertson did not have concerns for Mr W's welfare at the station or his mental health or ability to care for himself when he left the police station.

(f) Leading Senior Constable Kevin Scouller (**LSC Scouller**) also observed Mr W at the police station and recalled that he was *sitting quietly and did not appear distressed or upset in anyway*.

(g) Mr W provided no indication to police of his intention to self-harm during his interactions with them, and there is no evidence to suggest that Mr W had a propensity to self-harm. The only information known to police about any possible mental health issues was Mr W's disclosure that he was taking antidepressants, but that information alone would not and could not have alerted police to Mr W possibly having a mental health history or suicidal tendencies, and that singular fact was not enough information to warrant his arrest and detention under section 351 of the *Mental Health Act*.

53. Following the investigation into the conduct of the police members who interacted with Mr W on 8 and 9 December 2018, the CCP considered that *those members acted appropriately and in strict compliance with law and policy*.

FINDINGS AND CONCLUSION

54. Pursuant to section 67(1) of the Act, I make the following findings:

(a) the identity of the Deceased was Mr W, born [redacted] July 1997;

(b) the death occurred on 9 December 2018 at [redacted], Warragul, Victoria, from *Hanging*; and

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

55. I further find that there is no basis upon which I can make adverse findings or comments against any party.

COMMENTS

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

56. There is evidence of an increased risk of suicidality, including suicidal ideation, attempts and self-harm events associated with each of the SSRIs. The size of the increase compared to placebo is small though statistically significant, and there is evidence of the efficacy of SSRIs in reducing the overall suicide rate. Nevertheless, with SSRIs as a first line medication for depression and anxiety (including in young people) due to better tolerability and lower risk of

overdose, GPs should be cognisant of the potential for treatment emergent suicidality in people aged under 25 years, especially in the first 1-2 months. Early follow up is important both to monitor efficacy of the SSRI and assess for treatment emergent suicidality. Dr Crameri stated that he is aware of this risk and that sertraline is a first line medication for anxiety and depression. In addition he provided early follow-up (three weeks following commencement of sertraline) and reviewed for the presence of treatment emergent suicidality, of which there was none identified.

57. While Mr W denied suicidal ideation during his appointment with Dr Crameri, it often cannot be predicted when stressful events may occur and how a person may react to such events. There is no evidence that Mr W experienced suicidality in the days or weeks prior to his death, and the evidence suggests that his mental state had improved after commencing sertraline. It is likely that Mr W being arrested for drink driving in combination with his level of intoxication impacted his decision to take his life. One of Mr W's former girlfriends told police that Mr W's car and his ability to drive meant *the world to him*, and that when Mr W *drinks a lot it can tip his emotions over the edge.*

58. There is also an increased rate of suicidal behaviour as well as completed suicide among individuals with an alcohol use disorder. Post-mortem studies find alcohol or other drugs at measurable levels in 30-50% of suicides. Substance misuse predisposes suicide by disinhibiting or providing "courage" to overcome resistance in carrying through the act, clouding one's ability to see alternatives, and worsening of mood disorders. The association between alcohol consumption and self-harm/suicide is not entirely clear. Theoretically, consumption of alcohol may influence self-harm/suicide due to the depressant influence of the substance itself, or acute alcohol intoxication contributing to disinhibited or impulsive behaviours.

59. I convey my sincere condolences to Mr W's family for their loss, and acknowledge the tragic circumstances in which his death occurred.

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

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

[redacted] and [redacted] Senior Next of Kin

Dr Michael Crameri, represented by Avant Law Pty Ltd

Senior Constable Brian Cook, Victoria Police, Coroner's Investigator

Signature:

Coroner Sarah Gebert

Date : 18 November 2021

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.