IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2019 0188

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Ingrid Giles
Deceased:	HMI (a pseudonym)[1]
Date of birth:	30 December 1986
Date of death:	10 January 2019
Cause of death:	1(a) Self inflicted incised injuries to wrists
Place of death:	Whittington, Victoria, 3219
Keywords:	Suicide; Depression; Mental health; Cannabis use; Paranoia; Medical treatment; Recommendation

[1] This Finding has been de-identified by order of Coroner Ingrid Giles to replace the name of the deceased with a pseudonym of a randomly generated three letter sequence for the purposes of publication.

INTRODUCTION

1. On 10 January 2019, HMI was 32 years of age when he died from self-inflicted injuries.

2. At the time of his death, HMI lived with his partner, Ms L, and their three children. He was working as a boner for a chicken company.

3. HMI had been diagnosed by a general practitioner (**GP**) with mixed anxiety and depression and a panic disorder in early 2017. The GP placed him on a Mental Health Treatment Plan and referred him to a psychologist. The GP described his depression as severe.

4. HMI was also referred by his GP to Barwon Health Mental Health Drug and Alcohol Service for assistance in managing severe withdrawal symptoms from cannabis. He was reviewed by the GP two weeks later and reported he was improving, though he had not yet seen the Drug and Alcohol Service. It is unclear whether HMI subsequently took up referrals to the Drug and Alcohol Service or psychologist.

THE CORONIAL INVESTIGATION

5. HMI'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. Coroner Paul Lawrie (**Coroner Lawrie**) originally had carriage of this investigation. I took carriage of this matter in July 2023 for the purposes of seeking further discrete advice from

the Coroners Prevention Unit (**CPU**) to build upon advice already sought by Coroner Lawrie,[2] finalising the investigation and making findings.

9. Victoria Police assigned Senior Constable Noah Beasley (**SC Beasley**) to be the Coroner's Investigator for the investigation of HMI's death. SC Beasley conducted inquiries on the Court's behalf, including taking statements and submitting a coronial brief of evidence.

10. This finding draws on the totality of the coronial investigation into HMI'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]

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

Circumstances in which the death occurred

11. In the week prior to his death, HMI began to experience episodes of paranoia, expressing the belief that people were out to do harm to him and his family. He had reportedly been smoking cannabis after work for some time.

12. Concerned for him, his partner Ms L arranged for him to see a GP in the afternoon on Thursday, 10 January 2019 at Newcomb Medical Centre, where he had been a patient since about 2016.

13. HMI woke early on 10 January 2019. He had been having trouble sleeping. He told Ms L that he wanted to see his father that day. He appeared panicked to Ms L and not his usual self.

14. They subsequently spent most of the day at HMI's parents' home. At about 2:30pm, he attended his GP consultation with Dr Majid Sharifian (**Dr Sharifian**). HMI was accompanied to the medical centre by Ms L and his parents. Ms L accompanied HMI at the consultation itself.

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[2] The CPU was established in 2008 to strengthen the prevention role of the coroner. The CPU assists the coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. CPU staff include health professionals with training in a range of areas including medicine, nursing, and mental health; as well as staff who support coroners through research, data and policy analysis.

[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.

15. At this appointment, HMI reported daily cannabis use in the previous 12 months, low mood, insomnia and social isolation. He denied anxiety and suicidal ideation and plans. Dr Sharifian undertook a mental state examination (**MSE**) of HMI and formed the opinion that HMI's low mood was in keeping with depression. Dr Sharifian did not form a view that HMI required crisis intervention.

16. According to Ms L, Dr Sharifian asked HMI if he was '*paranoid, jittery and shaky'* which he denied, and when Ms L interjected and said '*yes'*, HMI asked her to be quiet. There is no reference to this conversation in the medical record nor mention of disordered thinking, such as existence of delusions or perceptual disturbance.

17. HMI was prescribed desvenlafaxine 50mg daily and PRN (as needed) diazepam 5mg. He was advised to reach out to alcohol and other drug services regarding his cannabis use.

18. Later that day, he appeared to settle after taking his medication and laid down on the bed in his mother's room. Ms L spoke with him during this time and asked if he felt suicidal, which he denied.

19. HMI and his family ate dinner together that evening, though HMI did not eat very much which was thought to be unusual.

20. At approximately 9:30pm, HMI told his family that he was going to have a shower. After a while, his brother checked on him, to which HMI replied to the effect of "*Yeah, I'm coming*".

21. At approximately 11:00pm, as he walked past the bathroom, HMI's father discovered a trail of blood in the house. He yelled out to the family and followed the trail to the back yard where they discovered HMI on the ground with injuries to his wrists. They called emergency services and attempted to stem the bleeding.

22. Victoria Police arrived on scene first. HMI then began to lose consciousness just as Ambulance Victoria paramedics arrived. Cardio-pulmonary resuscitation (**CPR**) was attempted but, despite efforts, HMI could not be revived. He was declared deceased at 11:28pm.

23. Police discovered a single razor blade in the bathroom. On the bathroom wall, the words "I Love You" had been scribed in blood. Police formed the view that there were no suspicious circumstances surrounding the death.

Identity of the deceased

24. On 11 January 2019, HMI, born 30 December 1986, was visually identified by his father who signed a statement of identification.

25. Identity was not in dispute and required no further investigation.

Medical cause of death

26. Forensic Pathologist Dr Matthew Lynch from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination on 14 January 2019 and prepared a written report of his findings dated same. In preparing his report, Dr Lynch had regard to the Victoria Police Report of Death and a routine post-mortem computed tomography (**CT**) scan.

27. The post-mortem examination revealed incised injuries to the anterior aspect of both wrists in keeping with the reported history.

28. Toxicological analysis of post-mortem samples detected desmethylvenlafaxine, an anti-depressant drug, and doxylamine, an antihistamine. Delta-9-tetrahydrocannabinol, the active form of cannabis, was also identified.

29. Dr Lynch formulated the medical cause of death as *1 (a) Self inflicted incised injuries to wrists.*

30. I accept Dr Lynch's opinion.

RECOMMENDATION

31. As part of the coronial investigation, this matter was referred to the Mental Health and Disability team of the Coroners Prevention Unit (**CPU**) for review of HMI's clinical care and management in relation to his mental health. I received and considered the subsequent advice from CPU in this case.

32. CPU has advised, and I accept, that the clinical care provided to HMI was appropriate in the circumstances. Dr Sharifian focused on HMI's symptoms of depression, assessment for suicide risk and provision of support for withdrawal from cannabis, which was appropriate and responsive to the clinical picture presented.

33. However, noting that HMI was accompanied to the medical centre by his parents and by his partner, who had indicated during the consultation that HMI was experiencing paranoia (with

which HMI disagreed), there existed an additional opportunity to obtain and consider collateral information from a loved one in circumstances where they may have usefully added to the clinical picture presented by the patient.

34. The CPU opined that, while there is no suggestion that the care provided by Dr Sharifian was wanting, the circumstances of the consultation with HMI give rise to an opportunity for reviewing the advice provided to GPs around the utility of gathering collateral information to facilitate mental health assessments and treatment planning in circumstances in which family members are supporting the care of a loved one. This is particularly resonant given that general practitioners are often the first healthcare professional a person will consult for help with their mental health, as was the case for HMI.

35. With the aim of promoting public health and safety, pursuant to section 72(2) of the Act, I therefore make the following recommendation:

    a) I recommend the Royal Australian College of General Practitioners (**RACGP**) and the General Practice Mental Health Standards Collaboration (**GPMHSC**) consider incorporating into their educational material a focus on obtaining collateral information, where legally and ethically feasible, as a key step in facilitating comprehensive mental health assessment and treatment planning.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was HMI, born 30 December 1986;

    b) the death occurred on 10 January 2019 at Whittington, Victoria, 3219, from self inflicted incised injuries to wrists; and

    c) the death occurred in the circumstances described above.

37. Having considered all of the circumstances, in particular the lethality of the means chosen, I find that HMI intentionally ended his own life.

38. Pursuant to section 73(1B) of the Act, I order that this finding be published in a de-identified manner on the Coroners Court of Victoria website in accordance with the *Coroners Court Rules 2019*.

39. I convey my sincere condolences to HMI's loved ones for their loss.

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

Senior Next of Kin

Avant Law Pty Ltd, on behalf of Dr Majid Sharifian, Newcomb Medical Centre

Senior Constable Noah Beasley, Coroner's Investigator

Royal Australian College of General Practitioners

General Practice Mental Health Standards Collaboration

Signature:

Coroner Ingrid Giles

Date : 19 April 2024

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.