IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2021 003738

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Judge John Cain, State Coroner
Deceased:	Jorgen Bottern
Date of birth:	2 May 1935
Date of death:	15 July 2021
Cause of death:	1(a) CARBON MONOXIDE POISONING
Place of death:	Bolero Way, Cranbourne North, Victoria, 3977

INTRODUCTION

1. On 15 July 2021, Jorgen Bottern (known to family and friends as John) was 86 years old when he was found deceased in his motor vehicle on Bolero Way, Botanic Ridge.

2. At the time of his death, John lived at [redacted] Fig Court, Cranbourne North, with his daughter Sonja and her husband. John had lived with his daughter for the six years having recently moved to the property at Cranbourne North.

3. John immigrated to Australia from South Africa in around 1982 when he was 47 years old. He was married to Jane Bottern and together they had three children, [redacted], Sonja and [redacted] John worked as a Chartered Accountant and in other professions until he retired in around 2005.

4. In 2009, Jane sadly passed away from ovarian cancer. Jane's passing was a great loss to John, and he struggled in dealing with this loss. John continued to live independently until around 2016, when he moved in with Sonja and her husband.

5. In 2020, John suffered a stroke that left him with residual left side weakness. He worried about the risk of suffering a further stroke and if this were to occur, the impact it would have on his independence.

6. John attended General Practitioner, Dr Sanjay Suryavanshi from Carrum Downs Doctors who described John as *a strong minded fiercely independent and very polite gentleman*. John was initially reluctant to commence medication after his stroke, but he accepted that it was required to manage his condition.

7. In the two months prior to John's death, there was a decline in John's mental health. During this period, John received mental health care and treatment from Monash Health and continued to attend Dr Suryavanshi.

THE CORONIAL INVESTIGATION

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

9. 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.

10. 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.

11. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of John'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. Additional statements were obtained from medical practitioners who had provided treatment to John in the period leading up to his death.

12. This finding draws on the totality of the coronial investigation into the death of John, 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

13. On 19 July 2021, Jorgen Bottern, born 2 May 1935, was visually identified by his daughter, Sonja Bottern.

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

[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.

Medical cause of death

15. Specialist Forensic Pathologist Dr Matthew Lynch from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an examination on 19 July 2021 and provided a written report of his findings dated 20 July 2021

16. Toxicological analysis of post-mortem samples identified the presence of Carboxy haemoglobin (57%) but did not identify the presence of any alcohol or any commons drugs or poisons.

17. Dr Lynch provided an opinion that the medical cause of death was *carbon monoxide poisoning*.

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

Circumstances in which the death occurred

19. Following his stroke in 2020, John appeared to be settled even though he was worried about his health. However, from around May 2021, John's mental health appeared to decline. On 18 May 2021 the ANZ Bank notified Victoria Police that John had attempted to purchase an online 'Euthanasia Kit'.

20. Prior to contacting Victoria Police, the ANZ Bank had contacted John and queried the transaction as they thought it may have been fraudulent or an attempt to 'hack' his bank account. John confirmed with the ANZ Bank that he had initiated the purchase and that it was not suspicious or fraudulent. He advised the representative of the bank that he intended to take his own life. The ANZ Bank notified Victoria Police who in turn contacted John and Sonja.

21. Victoria Police attended John's home and arranged for him to be taken to the Frankston Hospital to be assessed under section 351 of the *Mental Health Act 2014* (Vic). John was assessed in the Frankston Hospital Emergency Department (**ED**) by Mental Health Clinicians, Mr Dwight Smith and later Mr Ali Tran.

22. The Mental Health Clinicians took a history and confirmed that John did have suicidal ideation but was not at immediate risk of harm. Mr Tran spoke to Sonja who expressed concern about the escalation of John's suicidal ideation and the proposal for his discharge without treatment.

23. Following consultation with the on-call psychiatrist a decision was made to keep John in the ED overnight and to reassess him the following day. On 24 May 2021, John was reassessed by the treating team, and it was concluded that he *[did] not meet Mental Health Act criteria as patient can be treated in a less restrictive setting*.

24. John was to be discharged with a plan to manage him in the community through the Monash Aged Person Intensive Community Mental Health Team. The suggested discharge support plan was:

    - daily follow up for risk assessment + longitudinal assessment for 1-2/52;
    - if team cannot contact Mr Bottern, will likely require welfare check;
    - Monash team to please also liaise with daughter Sonja;
    - support Jorgen to link with appropriate community supports e.g. Adult learning; program to meet like-minded people and foster interests;
    - neuropsychiatry review and work up for ?dementia given stroke last year and family's concerns around memory and driving; and
    - encourage engagement with psychology - currently hesitant.

25. The discharge plan was discussed with Consultant Psychiatrist, Dr Harish Chikana and it was decided that John could be discharged from the ED.

26. Following his discharge on 24 May 2021, John attended Dr Suryavanshi for a follow up appointment. John told Dr Suryavanshi that *he had nothing more to live for and did not want to be here anymore.* Dr Suryavanshi stated that John agreed to follow-up contact from the psychiatry team and was aware that he should call the crisis team if needed.

<u>Events of 14 and 15 July 2021</u>

27. On 14 July 2021, John made dinner, as it was his turn to do this, and told Sonja that he was going to see a movie. This was unusual as John did not often go out in the evening, but this did not raise immediate concern for Sonja.

28. John left the house at 8.00pm. John had not returned home prior to Sonja going to bed so she left the lights in the house for him when he returned. When Sonja awoke the next morning, the lights were still on, his car was not at the house and there was no sign of John. His bed had not been slept in.

29. At 6.30 am on 15 July 2021, workers at a construction site at Bolero Way arrived on site and noticed a car parked behind the power substation which they thought was unusual. On further investigation they noticed that the engine was running and there was a hose connected to the exhaust and placed in the window of the car. They discovered John in the drivers' seat of the car deceased. They turned the engine off and notified police. Ambulance Vitoria paramedics attended, and John was pronounced deceased.

ADDITIONAL INVESTIGATIONS

Family concerns

30. In December 2021, Sonja wrote to the Court expressing concerns in relation to the support and assistance that is available to older people who have expressed suicidal ideation. Sonja believes that there were inadequate supports available through the mental health system that were specifically directed to dealing with older people and that there needs to be more resources and a more targeted approach to addressing the needs of older people who are suffering mental health episodes and suicidal ideation.

31. On 15 June 2023, I met with Sonja to gain a better understanding of her concerns in the context of her father's death and to discuss what steps she considered may assist. The discussion with Sonja greatly assisted me in gaining a better understanding of the concerns she had and the sense of frustration she experienced knowing that her father needed support and assistance but was unable to access targeted care. I am very grateful to Sonja for taking the time to meet with me.

Review by Coroner's Prevention Unit

32. To assist me with considering the concerns raised by Sonja, I asked the Coroners Prevention Unit[2] (**CPU**) to inquire about work that had already been undertaken to address these issues, including whether the Royal Commission into Victoria's Mental Health System (**RCVMHS**) had examined this issue and if so, what recommendations had been made and what steps had been taken to implement any recommendations.

[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

33. Over the past decade (2013-2022), the average annual suicide rate in Victoria has followed a consistent pattern by sex and age group. The average annual suicide rate is lowest among those aged under 18 years (1.6 suicides per 100,000 population per year for males, and 0.8 suicides for females), and rises steadily with age to peak in the 45–54-year age group (23.8 per 100,000 per year for males, 7.8 for females). The average annual rate then declines with age from this peak to 15.1 suicides per 100,000 population per year for males aged 65-74 years, and 4.4 for females. Finally, there is a second peak among the oldest Victorians, with this peak being far more pronounced in males (31.2 per 100,000 population per year) than females (5.8) among those aged 85 years or older.

34. The CPU informed me that a recent study has been undertaken which was aimed at understanding why there is such a high suicide rate among men aged 85 years and older in Victoria.[3] The researchers examined suicides among old (aged 65-84) and older (aged 85 years and above) males and females which occurred in Victorian between 2009 and 2015, using detailed data drawn from the Victorian Suicide Register.[4] The main findings were that while the experience of physical ill health and pain were not more prevalent among older males, the older males were more likely to have experienced death of a partner and also had higher rates of organic mental illness (such as dementia) than old males or females.

35. The suicide rates for older people are significantly higher than other age groups but to date this has not been specifically addressed by any policy initiative identified so far.

Royal Commission into Victoria's Mental Health System

36. The CPU advised that the RCVMHS examined issues relating to older people in Victoria, and found that:

> *There is a substantial service gap for older Victorians. Victoria's population is ageing: during the next three decades, the number of Victorians aged 65 years and over is estimated to double, rising from*

[3] See King K, Schichthorst M, Millar C, Sutherland G and Too LS, "Understanding the Context of Suicides by Older Men Compared With Younger Old Men and Women: An Exploration of Coronial Data in Victoria, Australia", *Crisis*, 43(1), 2020, 67-71.

[4] The Victorian Suicide Register (VSR) is maintained by the Coroners Court of Victoria and contains information on all suicides investigated by Victorian coroners between 2000 and the present. VSR data is used to inform coroners' investigations, assist government organisations, and inform the public regarding suicide in the state. It also made available upon coronial approval for collaborative research projects to understand better the contexts in which suicides occur in Victoria and to identify opportunities for interventions to reduce suicide risk.

> *1.05 million (as of 30 June 2020) to 2.13 million by 30 June 2051. This means that Victoria will also likely see an increase in the number of older Victorians living with mental illness. Yet, currently, increasing demand and inadequate investment in services for older adults means that those who do seek support are often turned away.*[5]

37. Chapter 14 of Volume 2 of the RCVMHS *Final Report*, titled 'Supporting the mental health and wellbeing of older people',[6] focused in detail on mental illness and psychological distress in this group. The RCVMHS did not specifically address suicide prevention measures among older people, however noted that:

> *[…] the Commission is recommending a range of suicide prevention and response initiatives that build on the interim report's recommended expansion of follow-up care and support for people after a suicide attempt. Many of these initiatives will be available for older Victorians. The Commission is also recommending the development of a new suicide prevention and response strategy for Victoria that will consider where initiatives should be tailored or designed to the needs and interests of particular cohorts, including older Victorians.*[7]

38. In line with this, the RCVMHS recommended that a new Suicide Prevention and Response Office (**SPARO**) be created to coordinate a system-based approach to suicide prevention across government and community. SPARO is now operational and Victoria's new Suicide Prevention and Response Strategy (the **Strategy**) is at an advanced stage of development with a release date scheduled for late 2023.

39. I am hopeful, the Strategy will include specific suicide prevention initiatives explicitly targeted for older people.

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[5] Royal Commission into Victoria's Mental Health System, *Final Report: Summary and Recommendations*, Parliamentary Paper No. 202, Session 2018–21, p.12.

[6] Royal Commission into Victoria's Mental Health System, *Final Report, Volume 2: Collaboration to support good mental health and wellbeing*, Parliamentary Paper No. 202, Session 2018–21, pp.279-332.

[7] Royal Commission into Victoria's Mental Health System, *Final Report, Volume 2: Collaboration to support good mental health and wellbeing*, Parliamentary Paper No. 202, Session 2018–21, pp.295.

Other Inquiries and Interested Organisations

40. The CPU informed me that the Royal Commission into Aged Care Quality and Safety, which delivered its final report in February 2021, did not address suicide among older people in detail. However, it is possible that this is because suicide is a relatively rare event in aged care with the Court's data indicating that only about 5% of Victorians aged 65 years and older who recently suicided had resided in aged care.

41. The Council on the Ageing Victoria (**COTA**) has indicated an interest in this topic. COTA and Mental Health Victoria provided a combined submission to the RCVMHS, noting:

> '*Sadly, suicide prevention in older people is not given the attention it deserves. As people grow older, they and those around them may start to believe they have had a 'good innings' and a level of acceptance creeps in about physical and psychological symptoms and deterioration in quality of life. This may lead to potentially treatable physical and mental health conditions such as depression being ignored or inadequately managed thereby increasing the risk of suicide.*'[8]

42. The CPU also identified that Anglicare conducts the National Suicide Prevention for Seniors online course, described in a recent ABC news article as *what is believed to be the country's only national suicide prevention program for those working with, or caring for, older people*'.[9] The course targets aged care workers, retirement living staff, pharmacists, geriatricians, general practitioner practice staff (clinical and non-clinical) and anyone who supports older people, including unpaid carers and concerned family members. I am of the view that a course of this nature would appear to be a very important component of a suicide prevention strategy for older people.

Update from SPARO

43. In order to better understand the progress of the work being undertaken by SPARO and the likely time frame for release of the Strategy, the Court requested an update from SPARO.

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[8] Mental Health Victoria and the Council on the Ageing Victoria, *Supporting the mental health and wellbeing of older Victorians: A submission to the Royal Commission into Victoria's Mental Health System and the Royal Commission into Aged Care Quality and Safety*, July 2020, p.25.

[9] ABC Online, "Silent issue of suicide among older Australian men a growing concern, as advocates urge national conversation", 6 April 2023, <https://www.abc.net.au/news/2023-04-06/suicide-rising-among-older-australians/102180204>, accessed 30 June 2023.

44. SPARO advised that as part of the Strategy, six priority areas of action have been identified:

    a) build and support connected systems;

    b) build on and strengthen existing supports across the suicide prevention and response continuum;

    c) build and support a compassionate, trauma-informed workforce, strengthened by lived and living experience;

    d) reduce stigma and enable community wide action;

    e) drive whole of government collaboration and innovation; and

    f) build on and use data and our evidence based in delivery and evaluation.[10]

45. SPARO advised that these priority areas aim to reduce the rate of suicide equitably across all groups and communities.

46. SPARO also advised that:

    - older Victorians (people aged 65+ years) were identified as a demographic at an increased risk for suicide;

    - in acknowledgement of this, one of the 14 sector and community roundtables focused on suicide prevention and response issues related to 'adult and older males' and another focused on 'older persons', more broadly;

    - common issues identified were continuity of care, better understanding of signs of suicidal distress within the community, alcohol and other drug and pain medication misuse, and social isolation;

    - unique contributing factors that disproportionately impact older people identified were losing the ability the live independently, transition points (e.g., retirement and into residential aged care) and chronic pain; and

[10] Email from Bailey Nation-Ingle, A/State Mental Health and Wellbeing Promotion Advisor & Executive Director SPARO to Coroners Court of Victoria dated 6 July 2023.

- the Strategy will acknowledge that older Victorians, specifically older men, are a group that are disproportionately impacted by suicide.[11]

47. These initiatives are intended to benefit older Victorians include improving ways to navigate between support, care, and treatment systems; exploring ways to support people through transition points (such as engaging with aged care supports), and increased capability building in understanding suicidal distress in specific cohorts for frontline workers (including suicidal risks for older people).

48. The update provided by SPARO has been helpful in providing high-level information relevant to the Strategy. I await release of the Strategy to better understand the specific initiatives aimed to support older people and reduce their risk of self-harm.

49. Having considered this information, it is evident that there is a need for a comprehensive articulated strategy to address suicide in older people. It is not sufficient to leave it as part of a general suicide prevention strategy in Victoria. Any such strategy must provide services and support to the older person and also assist and support carers (paid and unpaid) to ensure that they are properly trained and equipped to provide appropriate care for the older person.

50. The Court will continue to monitor the suicide rates for older Victorians and publishes a suicide data report monthly. The implementation of the strategy will also be monitored by the court and where appropriate will be the subject of comment or recommendation.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Jorgen Bottern, born 02 May 1935.

    b) the death occurred on 15 July 2021 at Bolero Way, Cranbourne North, Victoria, 3977, from CARBON MONOXIDE POISONING; and

    c) the death occurred in the circumstances described above.

52. Having considered all of the circumstances, I am satisfied that Jorgen Bottern intentionally took his own life.

[11] Email from Bailey Nation-Ingle, A/State Mental Health and Wellbeing Promotion Advisor & Executive Director SPARO to Coroners Court of Victoria dated 6 July 2023.

I convey my sincere condolences to John's family for their loss.

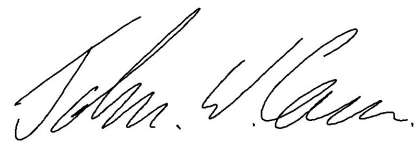
Pursuant to section 73(1B) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

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

Sonja Bottern, Senior Next of Kin

Senior Constable Wilson Smith, Coroner's Investigator

Signature:



JUDGE JOHN CAIN
STATE CORONER
Date:28 August 2023

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.