IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2019 003365

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Darren J. Bracken
Deceased:	Mr P[1]
Date of birth:	9 July 1947
Date of death:	1 July 2019
Cause of death:	1(a) EXSANGUINATION FROM INCISED WOUNDS TO THE NECK AND WRIST
Place of death:	Mount Eliza

[1]This Finding has been de-identified by order of Coroner Darren Bracken to replace the names of the deceased and their family members with psuedonyms.

INTRODUCTION

1. On 1 July 2019, Mr P was 71 years old when his wife, Ms J found him dead on the loungeroom floor of the house they shared in Mount Eliza.

THE CORONIAL INVESTIGATION

2. Mr P death was reported to the Coroner because it was a 'reportable death' pursuant to the *Coroners Act 2008* (the Act). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury. Mr P's death was at least unexpected and resulted from an injury.

3. The role of a coroner is to independently investigate reportable deaths to establish, if possible, the identity of the deceased, the cause of death, and its 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.

4. Under the Act, coroners also have the important functions of helping to reduce the number of reportable deaths, promoting public health and safety and facilitating the administration of justice by making comments or recommendations about any matter connected to the death under investigation.

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

Circumstances in which the death occurred

5. Mr P had a medical history of Bipolar Disorder, alcohol addiction, Cirrhosis of the liver, Portal Hypertension, and a Gastrointestinal bleeding from Oesophageal varices and depression. Mr P saw Doctor Kosenko who was practising at 'The Ti-Tree Family Doctors Clinic' in Mount Eliza and psychiatrist Dr Peter Graf.

6. In 2016 Mr P stopped seeing Dr Graf and his care, incorporating prescription of anti-depression medication, was assumed by Dr Kosenko. At this time Mr P's mood was said to be stable and his medication was being reduced.

7. In 2017 Mr P further reduced his medication and in June 2017 stopped taking it.

8. In the following months Mr P reported to Dr Kosenko that he felt well and was experiencing no symptoms of depression. Mr P was then too reducing his alcohol intake.

9. In 2018 Mr P reported periods of stress and 'feeling down' and in January 2019 drinking too much again. He was worried about the effect his drinking would have on his health. He was undergoing counselling and being reviewed monthly by Dr Kosenko. Mr P last saw Dr Kosenko in early June 2019 when Dr Kosenko noted that he appeared physically stable and did not report any psychological symptoms or concerns. Mr P saw another doctor, at the Ti-Tree Clinic, in company with his daughter on 19 June 2019, Dr Khong. Mr P had been showing signs of increased stress, his drinking had increased, and he was said to be worried about family finances, perhaps unnecessarily. Mr P had mentioned suicide to family members but denied intent and didn't discuss it in detail with doctors. Dr Khong's impression was that Mr P had increased his alcohol intake and there was associated anxiety and lowered mood as well as an erroneous perception that he was in 'financial difficulties'.

10. Ms J awoke at 4.45am on 1 July 2019 to find her husband not in the bed that they shared. She shortly located him lying on the floor in the loungeroom, a not unusual occurrence and she thought he was asleep. At 6.45am Ms J became concerned when Mr P was still lying on the floor in the loungeroom. She checked him and found him cold to touch and unresponsive (Ms J had worked as a nurse). Ms J could not find a pulse and called an ambulance which arrived shortly afterward and paramedics pronounced Mr P dead. Police were called and arrived shortly afterward.

11. Senior Constable Williams examined Mr P's body and found lacerations across his throat and on his left wrist and two 'Stanley knife' blades under blood on the floor near to where Mr P lie.

Identity of the deceased

12. On 1 July 2019 Ms J identified the deceased as her husband of more than 40 years, Mr P, born 9 July 1947.

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

Medical cause of death

14. On 2 July 2019 Dr Yeliena Fay Barber, a specialist forensic pathologist practising at the Victorian Institute of Forensic Medicine (**VIFM**), conducted an external examination of Mr P's body and in a resultant report dated 5 July 2019 opined that the cause of his death was exsanguination from incised wounds to the neck and wrist.

15. The toxicology report revealed the presence of treatment medications.

Coroners' Prevention Unit Review

16. I sent the investigation file in relation to Mr P's death to the Coroners' Prevention Unit[1] for review. The Coroners' Prevention Unit considered that when Mr P consulted Dr Khong on 19 June 2019 that he was appropriately and comprehensively assessed. On 25 June 2019 Dr Khong checked results of tests from samples taken on 19 June and entered the results into the Clinic's records system so that the results could be discussed with Mr P. In such circumstances, the Clinic was expected to generate a telephone call from a nurse to Mr P to make an appointment for the results to be discussed. For reasons that remain unknown, this did not occur, although Dr Khong was of the view that Mr P had an appointment on 1 July 2019. The Coroner's Prevention Unit considered that a proactive approach to ensuring a subsequent timely review would have been reasonable.

17. The Victorian Suicide Register records that suicide rates among men is significant. It is higher than females and the general population and increases as they age. People who die from suicide have often seen their general practitioner between, within six weeks and 12 months of their deaths. The Coroners Prevention Unit recommended that I make a recommendation to the Australian College of General Practitioners highlighting the risk of suicide in older men promoting proactive follow-up or, in circumstances where such follow-up is not able to be arranged a timely referral to tertiary service.

[1] 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.

FINDINGS AND CONCLUSION

18. A finding of suicide is of great moment and can impact upon the memories of a deceased person held and treasured by those who knew and loved them. It can reverberate through generations of a family. Such a finding should only be made based on compelling evidence and not from inexact proofs, indefinite testimony or indirect inferences.

19. It is often difficult to determine what may have precipitated a person's decision to end their life. The decision is sometimes influenced by issues known only to the deceased person. I am unable to state with any certainty, the reason or reasons for Mr P choosing to take his own life.

20. I note that Mr P had a history of suicidal ideation and mental ill health. Further, Mr P may have been worried about family finances albeit unnecessarily.

21. I am satisfied, having considered all of the available evidence, that Mr P intentionally took his own life, that there are no suspicious circumstances and that no further investigation into his death is required.

22. Pursuant to section 67(1) of the *Coroners Act* 2008 I find:

    a) That the identity of the deceased was Mr P, born 9 July 1947.

    b) That Mr P died on 1 July 2019 at Mount Eliza, Victoria from exsanguination from incised wounds to the neck and wrist and

    c) that his death occurred in the circumstances described above.

RECOMMENDATION

Pursuant to section 72(2) of the Act, I recommend that:

1. The Royal Australian College of General Practitioners highlight to its Fellows and members the higher prevalence of suicide by males than females in the community and in particular the increase in prevalence as men age. That the College recommend to its Fellows and members the desirability of proactive timely follow-up of males who present

with suicide ideation, a history of such ideation, indicators of depression or a history of suicide attempts and that if a timely follow-up is unavailable refer such patients to an appropriate service which can facilitate such a timely follow-up.

Pursuant to section 73(1A) 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:

Ms J, Senior Next of Kin.

Senior Constable A Williams, Coroner's Investigator.

President Royal Australian College of General Practitioners, Dr K Price.

Signature:

DARREN J BRACKEN

CORONER

Date : 14 July 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.