



MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

Record of Investigation into Death (Without Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Andrew McKee, Coroner, having investigated the death of James Robert Sowden

Find, pursuant to Section 28(1) of the Coroners Act 1995, that:

- a) The identity of the deceased is James Robert Sowden;
- b) Mr Sowden died as a result of self-inflicted incised and stab wounds to his neck and incised wounds to his wrists;
- c) Mr Sowden's cause of death was self-inflicted incised and stab wounds to his neck and incised wounds to his wrists; and
- d) Mr Sowden died between 28 and 29 March 2018 at Westbury, Tasmania.

In making the above findings I have had regard to the evidence gained in the comprehensive investigation into Mr Sowden's death. That evidence includes:

- The Police Report of Death;
- An opinion of the forensic pathologist who conducted the post-mortem examination;
- Toxicology report prepared by Forensic Science Services Tasmania;
- Relevant police, family and witness affidavits;
- Records maintained by the Launceston General Hospital;
- Records maintained by the Deloraine Medical Practice;
- Forensic evidence; and
- Final RCA report dated 21 December 2018.

Background

Mr Sowden was born in Sydney on 22 June 1952 and was aged 65 at the date of his death. He was married to Denise Sowden and their marriage had produced three children, Daniel, Robert and Adam.

Mr Sowden resided with his wife and two eldest children at 2 Dexter Street in Westbury. Mr Sowden was Mrs Sowden's full time carer as a result of her suffering a brain aneurysm.

Mr Sowden was self-employed as a builder until his retirement in 2005.

Mr Sowden's Medical History

Records maintained by Mr Sowden's general practitioner would indicate that he had previously been diagnosed with:

- a) Lumbo sacral back pain
- b) An enlarged prostate and elevated PSA
- c) Tension headaches
- d) Tenosynovitis of peroneus brevis/longus in the right ankle

According to the RCA (Root Cause Analysis) Final Report, on 13 February 2003 Mr Sowden was referred to the Launceston General Hospital (LGH) Emergency Department (ED) by his general practitioner with symptoms of paranoid ideation and hearing "voices." Mr Sowden was assessed by a psychiatrist and diagnosed as suffering from a depressive episode.

He was assessed as safe for discharge and discharged home with a follow up by his general practitioner. He was prescribed medication and a letter was provided by the attending psychiatrist to his general practitioner.

On 15 May 2003 Mr Sowden was taken to the LGH ED pursuant to a Mental Health Order. Mr Sowden was assessed by a psychiatrist. He was accompanied by his father. Both Mr Sowden and his father expressed the view he did not have a psychiatric disorder and Mr Sowden declined the offer of an inpatient admission. Mr Sowden was discharged with a comprehensive letter provided to his general practitioner from the attending psychiatrist.

Circumstances Surrounding the Death

As part of the coronial investigation into Mr Sowden's death, all of his three sons and his brother in-law, Kevin McMillan, swore affidavits.

It is clear from the affidavits, and medical records that Mr Sowden's mental health was declining in the weeks preceding his death.

Police records indicate that Officers of Tasmania Police attended 2 Dexter Street on 3 March 2018 in relation to a family dispute. Mr Sowden was spoken to and he alleged that Daniel Sowden had made threats towards him.

The situation resolved by Daniel Sowden removing himself from the family home for a period of time.

In the week preceding his death Mr Sowden was staying with his sister and brother in law.

Mr Sowden self-identified that he was feeling depressed and anxious. He attended his general practitioner and was prescribed medication. His brother in-law indicated that whilst Mr Sowden was staying with them he had what he described as an adverse reaction to the medication he was prescribed. The medication caused him to become paranoid. He suffered a number of panic attacks and became distrustful of Mr and Mrs McMillan. He asserted they were trying to poison him. During his stay Mr Sowden drove himself to the LGH. Mrs McMillan was required to drive Mr Adam Sowden to the hospital to collect Mr Sowden as he would not drive home. Mr Adam Sowden found his father sitting in his car in the carpark.

As a result of his paranoia Mr and Mrs McMillan requested Mr Sowden return to his own home. On the day before his death Mrs McMillan attempted to take Mr Sowden to his general practitioner. He refused to enter the premises of his general practitioner as he believed he was being trapped.

Mr Adam Sowden saw his father standing outside the pharmacy in Westbury with Mrs McMillan. Mrs McMillan was attempting to contact Mr A Sowden as he drove past the pharmacy. He returned to the pharmacy and asked what was going on. His Aunt told him that she had taken his father's medication back to the chemist. Mr Sowden was being paranoid and was refusing to get back into Mrs McMillan's car.

Mr A Sowden and Mrs McMillan convinced Mr Sowden to get back into Mrs McMillan's car and follow Mr A Sowden to Mr Sowden's home. Upon arrival at Dexter Street Mr A Sowden entered the premises to visit with his mother.

Mr Sowden remained outside, pacing up and down the patio. He was observed to pick up a rock from a garden bed and an old hammer. He then commenced to strike himself to the head with the hammer. Mr A Sowden immediately removed the rock and hammer from Mr Sowden. Other family members provided assistance to Mr Sowden. Mrs McMillan called an ambulance and requested the assistance of Tasmania Police.

Mr Sowden was taken into protective custody by Officers of Tasmania Police pursuant to the *Mental Health Act 2013* and transported by them to the LGH ED.

Mr Sowden underwent assessment at the hospital. Mr Sowden was physically examined. No abnormalities were detected. He was medically cleared and then voluntarily referred to the CATT team for review.

Mr Sowden was reviewed by the CATT registered nurse.

A history was taken. Mr Sowden denied any past or current suicidal ideation.

The CATT registered nurse noted no previous psychiatric admissions.

The CATT registered nurse discussed Mr Sowden's presentation with the consultant psychiatrist on call. The outcome of that discussion was that:

- a) Mr Sowden was to be discharged home in the company of a supportive son;
- b) The CATT was to organise a medical appointment with the CATT psychiatrist;
- c) The CATT was to provide a support call the next day; and
- d) The ED doctor was to prescribe Quetiapine in accordance with the consultant psychiatrist's instructions.

Mr Sowden was discharged at 10.30pm. He returned to his home. Upon arrival at his home Mr Sowden had a shower and went to bed.

The following morning, 29 March 2018, Mr Sowden was located deceased by his son, Daniel. Mr Sowden had used a broken shard of a mirror to self-inflict fatal wounds.

Post-Mortem Examination

A post-mortem examination was conducted by forensic pathologist Dr Donald Ritchey. Dr Ritchey provided the following opinion as to Mr Sowden's cause of death:

"The cause of death of this 65 year old man, James Robert Sowden, was incised and stab wounds of the neck and incised wounds of both wrists. Significant contributing factors were depression with anxiety and autoimmune thyroiditis.

Individuals with thyroid disease are at an increased risk of depression and depressed individuals with thyroid disease are at increased risk of exacerbation of their depressive symptoms."

I accept Dr Ritchey's opinion as to Mr Sowden's cause of death.

The Final RCA (Root Cause Analysis) Report

As a result of Mr Sowden's death, the Tasmanian Health Service (Adult Community and Older Persons Mental Health Services, North – Statewide Mental Health Services) conducted an RCA and produced a report. The report was endorsed by Dr B Elijah and Ms N Dymond on 21 December 2018.

The RCA report identified system improvement opportunities and recommendations as follows:

- Description: The high level of risk pertaining to the mode of suicide attempt and identified triggers.

Recommendation: Risk assessments of acutely suicidal patients who have attempted suicide by a lethal mode, a medical psychiatric assessment is conducted.
- Description: The importance of gathering collateral history of first presenters for mental health assessment with identified high risks.

Recommendation: Clinical staff are reminded of the importance of collateral history gathering
- Description: Lack of assessment of decision making ability.

Recommendation: It is clinically important to evaluate a person's mental decision-making capacity every time a key treatment decision needs to be made. It is imperative when conducting a mental status examination there is a focus on attention, mood, thinking (form and structure) memory and cognitive function.
- Description: Handover from clinician to on call Psychiatrist. Lack of face to face medical assessment.

Recommendation: As Consultant on call relies on a clinician providing accurate assessment to make treatment decisions. It is important to maintain and communicate, using the structured handover tool ISOBAR. It is possible to provide access of DMR to consultants on call which may aid in clarification of the client history presentation and risk and any medical assessment that has occurred in ED prior to making treatment decisions.
- Description: CATT MDT processes.

Recommendation: When clients are reviewed in CATT MDT, it is vital that the discussion is fully documented so that formal documentation exists, including rationale

for decisions made. This ensures that the plan is consistent, easily interpreted and available to all involved in care.

6. Description: Risks involved and need for close observations not explained to family and patient as part of the discharge planning.

Recommendation: All Clinicians ensure family are aware of risks and need of observation and gaining their agreement to a risk management plan prior to the discharge.

7. Description: Risk assessment skills.

Recommendation: Risk assessment skill training to be considered as a mandatory training requirement for SMHS.

I am satisfied that the recommendations have been considered and acted upon.

Based on the investigation by attending police officers I am satisfied there are no suspicious circumstances surrounding Mr Sowden's death.

As a result of the investigation undertaken by Officers of Tasmania Police I am satisfied that Mr Sowden acted alone when he inflicted injuries upon himself with a shard of broken mirror.

Comments and Recommendations

I note that a review involving the circumstances surrounding Mr Sowden's death has been conducted by the Tasmanian Health Service (Adult Community and Older Persons Mental Health Services, North – Statewide Mental Health Services).

I am satisfied the recommendations of the RCA final report have been considered and acted upon.

I do not need to make any recommendations as a result of Mr Sowden's death.

I convey my sincere condolences to Mr Sowden's family and loved ones.

Dated: 26 July 2021 at Hobart in the State of Tasmania.

Andrew McKee
Coroner

