MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

# Record of Investigation into Death (Without Inquest)

*Coroners Act* 1995
*Coroners Rules* 2006
*Rule* 11

**(These findings have been de-identified in relation to the name of the deceased, family, friends, and others by direction of the Coroner pursuant to s57(1)(c) of the Coroners Act 1995)**

I, Olivia McTaggart, Coroner, having investigated the death of PU

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

a) The identity of the deceased is PU

b) PU was born on 31 January 1976 and was aged 45 years at his death. He lived by himself in Wynyard and was a self-employed commercial fisherman. He had had numerous intimate relationships, including a short marriage, during his life but he did not have children. He was in good physical health, although he had a history of depression with suicidal ideation, multiple suicide attempts and excessive use of alcohol. He was under the regular care of his general practitioner who monitored his mental health and prescribed him medication. PU's self-harm and suicide attempts became more frequent in 2021, involving emergency department presentations on 19 January (likely deliberately piercing his mouth with an arrow), 6 February (attempted drowning) and 12 February (attempted gassing in his car).

On 21 February 2021 PU again attempted suicide, this time by medication overdose, and was admitted to the Spencer Clinic as a voluntary patient. Over the course of his next six days as an inpatient of the Spencer Clinic, he engaged well with treatment, his mood was reasonable, he denied suicidal ideation and was assessed as having reasonable insight and judgement. His treating health professionals adjusted his medication and commenced arrangements for PU to be admitted to the Bridge Program in April 2021 for alcohol detoxification. Referrals to other support services were also made during this time. Part of his treatment and discharge planning at the Spencer Clinic involved PU having day leave on 27 and 28 February 2021. He

successfully participated in day leave on 27 February and reported feeling safe when he returned to the Spencer Clinic that evening.

On 28 February 2021 PU left the Spencer Clinic at about 8.00am, having been collected by his brother. The plan was that he would return in the evening. He spent the morning with his brother consuming some beer, with his mother present, and then returned to his home mid-morning and consumed additional alcohol. During the morning, PU had a text message exchange with his girlfriend, TR, culminating in him indicating that he was suicidal and may hang himself. Other messages expressing suicidal ideation were sent by PU to another female. When his mother, LQ, arrived at his house as planned at 12.40pm, she found him hanging and apparently deceased in his garage.

After a full police investigation, I find that PU took the action of hanging himself with the intention of ending his life. There are no suspicious circumstances, and no other person was involved. He had likely consumed a moderate, but not large, quantity of alcohol before he took the action.

c) PU's cause of death was hanging.

d) PU died on 28 February 2021 at Wynyard, Tasmania.

In making the above findings, I have had regard to the evidence gained in the investigation into PU's death. The evidence includes:

- Tasmania Police Report of Death;
- Affidavits confirming life extinct and identification;
- Affidavit of the forensic pathologist regarding cause of death;
- Toxicology report from Forensic Science Service Tasmania;
- Hospital and general practitioner records for PU;
- Tasmanian Health Service Final RCA Report relating to PU's admission at the Spencer Clinic;
- Affidavit of Wayne Hyland, regarding his attendance at the scene of death;
- Affidavits of PU's mother, sister, and brother,
- Affidavits of four female friends of PU, including TR

- Affidavits of nine police officers who attended the scene of death or who had previous dealings with PU in the context of his episodes of self-harm on 19 January 2021, 6 February 2021, and 21 February 2021;
- Scene photographs; and
- PU's text messages and mobile phone data prior to his death.

**Comments and Recommendations**

An issue arose in this investigation as to whether PU should have been able to take day leave during his inpatient admission to the Spencer Clinic. An associated issue arose regarding whether his family members should have been formally notified by staff of the Spencer Clinic of his day release. Members of PU's family, primarily LQ, considered that the day release of PU was inappropriate in light of his level of risk. In relation to these questions, I have had particular regard to the Spencer Clinic records as well as an independent RCA report prepared in accordance with Tasmanian Health Service guidelines.

I comment initially that it is quite clear that PU was a voluntary patient with decision-making capacity. He was not involuntarily detained at the Spencer Clinic and was permitted to discharge himself at any time. Secondly, it was appropriate for the health professionals treating PU to plan for his re-entry into the community by providing day leave. He had been appropriately assessed as having a sufficiently low risk of self-harm to enable that to occur. Notwithstanding his previous suicidality, all indications during his admission were that he would be suitable for day leave. Finally, I note that TR was aware of his day release on 28 February as was his brother who collected him. He was also in the company of his mother shortly after leaving the facility on that day.

I do not consider that there is any further need to investigate the question of notifications to family members by the Spencer Clinic as I am satisfied that PU's suicide could not have been predicted on that day, that day release was appropriate and that he had sufficient support from family members and others.

Finally, I comment that this finding was ready for completion in July 2022. However, on 12 July 2022, a Notice of Appeal was filed in the Supreme Court by TR applying for an order that a public inquest be held. She took no steps to progress this appeal for a period of 18 months, despite attempts on my behalf to have the matter listed for mention or hearing.[1] Eventually, on 6 February 2024, a notice of discontinuance was filed by counsel for TR.

[1] As the investigating Coroner, I was named as respondent to the appeal and represented by counsel from the Office of the Solicitor-General.

The circumstances of PU's death are not such as to require me to make any recommendations pursuant to Section 28 of the *Coroners Act* 1995.

I convey my sincere condolences to the family and loved ones of PU.

**Dated:** 8 February 2024 at Hobart Coroners Court in the State of Tasmania.

**Olivia McTaggart**
**Coroner**