



# MAGISTRATES COURT *of* TASMANIA

## CORONIAL DIVISION



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## **Record of Investigation into Death (Without Inquest)**

*Coroners Act 1995*

*Coroners Rules 2006*

*Rule 11*

I, Olivia McTaggart, Coroner, having investigated the death of Paul William Green

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

- a) The identity of the deceased is Paul William Green;
- b) Mr Green died as a result of inhalation of exhaust gases from a lawn mower, an action taken by him voluntarily with the intention of ending his life;
- c) The cause of death is carbon monoxide poisoning; and
- d) Mr Green died on 9 May 2017 at Devonport in Tasmania.

In making the above findings I have had regard to the evidence gained in the comprehensive investigation into Mr Green's death. The evidence comprises an opinion of the pathologist who conducted the autopsy; police and witness affidavits; medical records and reports; and forensic evidence.

Mr Green was born in the United Kingdom on 21 September 1950. He was 66 years of age at the date of his death. Mr Green immigrated to Australia in 1985 with his wife, Marion. The couple lived in New South Wales for a short period of time before moving to Western Australia where they lived for over 20 years. They moved to Tasmania in 2003 and lived together at 43 Raymond Avenue, Devonport until November 2016 when the relationship broke down and Marion moved out. Mr Green continued to live at the address until his death.

Mr Green was a retired electronic engineer. Whilst in the United Kingdom he held a position with the British military and subsequently worked in Australia in various jobs as an electronic engineer.

Mr Green suffered from longstanding physical and mental health conditions. Physically, he suffered a serious lung injury in 1973 as a result of a motor vehicle crash. This

resulted in chronic reduction of lung capacity. His mental health conditions included depression (with suicidal thoughts), anxiety and panic attacks. He was also diagnosed with post-traumatic stress disorder, attributed to his work with the British military. He consumed alcohol excessively to cope with his conditions.

The evidence in the investigation indicates that Mr Green did not have many friends or a strong support network. Over the years, he had attended doctors and mental health professionals and was prescribed antidepressant medication. However, in the two years before his death it appears that he did not undergo adequate treatment for his worsening mental health and alcoholism. It is clear that his conditions contributed to the breakdown in his marriage. His mental health further worsened after the separation and he posed a high risk of suicide.

In 2016 Mr Green was assessed and treated at North West Area Health Services after a suicide attempt by overdose of medication.

In 2017 Mr Green was taken to North West Area Health Services on three occasions by police. There were concerns from police and staff at the facility in relation to Mr Green's outlook on life due to the breakdown of his relationship, support network and continuous alcohol abuse. On all three occasions, Mr Green was discharged with follow-up by community mental health services.

Following Mr Green's separation from his wife, police records note numerous family violence incidents between them in 2017, including mutual Police Family Violence Orders and continual concerns regarding Mr Green's deteriorating mental health.

Mr Green was charged on a number of occasions with breaching the order against him. He appeared in court on 27 February 2017 and 14 March 2017. These charges were dismissed. However, on 10 April 2017 he was again charged with breaching the order against him. He was arrested, detained briefly, and then bailed to appear on 10 May 2017.

On 20 April 2017 Mr Green was taken into protective custody at the North West Regional Hospital by investigating police officers concerned about his declining mental health. One of the officers accompanying Mr Green was Constable Melle Zwerver, also the investigating officer in the coronial investigation.

Constable Zwerver stated in his affidavit, *"During this process I spoke with Paul at length and he appeared very concerned about his upcoming court appearance and the*

*possibility of incarceration. I informed Paul that it was unlikely and he should speak with his lawyer before doing anything drastic. Paul was fixated on the fact he would not go to jail and would rather die than go to jail'.*

On 10 May 2017 he failed to appear in court and a warrant was issued for his arrest.

On 11 May 2017 Mr Patrick Johnson, a friend of Mr Green, became aware that Mr Green did not attend court on 10 May. He attended Mr Green's residence as he was concerned for his welfare. He entered the home but could not locate Mr Green inside. He then entered the garage through the roller door and noticed a copper pipe connected to a lawn mower at one end with the other end placed through the window of Mr Green's vehicle. Mr Green was inside the vehicle. It was apparent that Mr Green was deceased. Mr Johnson contacted police.

Police investigations at the scene concluded that there were no suspicious circumstances and that Mr Green's death was consistent with suicide. Although a specific suicide note was not located, numerous papers had been laid out in the residence on the dining table including documentation written by Mr Green outlining plans for his estate, contact information for a number of his friends and family and a letter to his mother in the United Kingdom.

On 12 May 2017 an autopsy was conducted by pathologist Dr Rosa Devadas. Dr Devadas determined that the cause of Mr Green's death was carbon monoxide poisoning due to inhalation of exhaust gases from a lawnmower. Her conclusion was supported by toxicological testing of Mr Green's blood which showed fatal levels of carbon monoxide as well as a very high alcohol content.

Dr Devadas noted that contributing factors were psychiatric illness with mood disorder, in the context of recent multiple psychosocial stressors. I accept Dr Devadas's opinion regarding cause of death. I find that Mr Green intentionally took the actions described above to end his life by carbon monoxide poisoning.

The evidence reveals that there were numerous factors contributing to his decision. These included Mr Green's severe mental health conditions, pre-morbid obsessional personality, his chronic and extensive alcohol abuse and physical health issues. He had struggled greatly with the distress caused by these issues for many years. The separation from his wife and fear of a prison sentence appeared to be the final catalysts for his actions.

## **Comments and Recommendations**

In this case Senior Constable Zwerver has, in his report to me, thoughtfully expressed his opinion regarding the high risk of suicide presented by Mr Green and ways in which his death may have been prevented in the weeks before his death.

Firstly, he observed that a greater level of ongoing mental health support after his brief admission on 20 April may have prevented Mr Green ending his life.

Secondly, he commented in his report that previous records of diagnosed mental health and alcohol abuse issues were not readily available to police or mental health professionals when assessing Mr Green's risk of suicide. He suggested that improvements should be made to have information from health care and police services centralised to assist in the making of a well-informed decision regarding such risk.

I cannot, on the available evidence, make a finding in this case that, if a greater level of mental health support had been available to Mr Green, he would have survived. It is also speculative as to whether the outcome would have been different if more information from other sources had been available to police or mental health professionals in this case. It is possible that a more intensive treatment approach may have been adopted. On the other hand, Mr Green was reluctant to engage in treatment and, in his final weeks, appeared to be intent on taking his own life.

Nevertheless, Senior Constable Zwerver's observations have significant force in terms of suicide prevention generally. The more information available in centralised form to all those professionals dealing with persons at risk of suicide the higher the chance of appropriate support and successful treatment.

The Tasmanian Suicide Register (TSR), established in 2017, has been implemented within the Coroner's Office with the aim of better understanding suicide in Tasmania and to enable informed prevention strategies. This has occurred in response to the recognition of the need for more accurate and comprehensive information regarding suicide.

The TSR database is currently in development, focusing on all suicides occurring in Tasmania from 2012 onwards. Information is sourced from coronial investigations; examining the complex range of factors leading to suicide including access to services and the impact of a wide variety of individual and cumulative stressors. The TSR will be utilised by coroners in the future to better inform recommendations and prevention strategies.

The present investigation, sadly, involves a situation that coroners all too frequently encounter; being the suicide of an older male suffering mental health conditions, physical pain, substance issues, social isolation, and disengaged from adequate treatment and community support.

Some research in recent years has concluded that the suicide of older persons is an area of growing concern, particularly in light of the ageing population. It is also an area where there has been a scarcity of studies and research which could help formulate targeted prevention strategies<sup>1</sup>. Although I do not make formal recommendations in this case, I hope that, in the near future, detailed data extracted from the TSR will assist coroners in making effective recommendations for suicide prevention in cases involving the suicide of older persons and more widely, in appropriate cases.

I extend my appreciation to investigating officer, Senior Constable Melle Zwerver, for his comprehensive investigation and report.

I convey my sincere condolences to the loved ones of Mr Green.

**Dated:** 31 August 2018 at Hobart Coroners Court in the State of Tasmania.

**Olivia McTaggart**  
**Coroner**

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<sup>1</sup> Manthorpe, J., & Iliffe, S. (2010). Suicide in later life: public health and practitioner perspectives. [Review]. *International Journal of Geriatric Psychiatry*, 25(12), 1230-1238. doi: 10.1002/gps.2473; Jahn, D. R., Cukrowicz, K. C., Linton, K., & Prabhu, F. (2011). The mediating effect of perceived burdensomeness on the relation between depressive symptoms and suicide ideation in a community sample of older adults. [Article]. *Aging & Mental Health*, 15(2), 214-220. doi: 10.1080/13607863.2010.501064