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, Simon Cooper, Coroner, having investigated the death of FR

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

a) The identity of the deceased is FR;

b) FR died as a result of inhalating the exhaust from a petrol generator, actions undertaken by her alone, voluntarily and with the express intention of ending her own life;

c) The cause of FR's death was carbon monoxide intoxication; and

d) FR died on 28 July 2020 at Cockerill's Road, Boyer, Tasmania.

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

- The Police Report of Death for the Coroner;
- Affidavits establishing identity and life extinct;
- Report – Dr Christopher Lawrence, Forensic Pathologist;
- Report – Forensic Science Service Tasmania;
- Affidavit – Kai Peersmann, sworn 31 December 2020;
- Affidavit – Lawrence Springborg, sworn 15 December 2020;
- Statutory Declaration – Valery Kullrich, made 30 July 2020[1];
- Affidavit – Valery Kullrich, sworn 31 December 2020;
- Statutory Declaration – Adrian Slee, declared 31 July 2020;
- Affidavit – Adrian Slee, sworn 31 December 2020;

[1] This statutory declaration, and that of Mr Slee, was made in relation to the missing person report.

- Affidavit – Nouman Miandad, sworn 1 August 2020;
- Affidavit – John Rowbottom, sworn 10 December 2020[2];
- Affidavit – Andrew Lewis, sworn 17 December 2020[3];
- Affidavit – Sergeant Alastair Watson, Crime Scene Examination Section, Forensic Services, Tasmania Police, sworn 12 August 2020 (and scene photographs);
- Email – Detective Senior Constable Adam Hunter, Criminal Investigation Branch, Bridgewater, Tasmania Police;
- Forensic evidence - including handwritten suicide note and vehicle fingerprint analysis;
- Medical Records – Collins Street General Practice, Tasmania;
- Medical Records – Tasmanian Health Service;
- Final Root Cause Analysis Report (RCA) – Tasmanian Health Service;
- Medical Records – Inglewood Medical Centre, Queensland;
- CCTV footage and electronic door lock records – St Ives Apartments; and
- Tasmania Police Missing Person Report and Enquiry Records.

Introduction

FR was born on 27 September 1992 at Inglewood Hospital, Queensland.

She suffered poor mental health for much of her life.

FR had a lengthy and well documented history of treatment for depression and anxiety which included medication and multiple admissions for inpatient treatment. There is evidence of frequent articulation of suicidal ideation, intent and planning, as well as actual suicide attempts.

In 2018, FR attempted suicide in Tasmania by carbon monoxide poisoning in her car. Following her attempt she was admitted to the Royal Hobart Hospital and spent time as a patient in the secure mental health unit.

Treatment - immediate lead up to death

On 4 July 2020, FR's GP referred her to Tasmanian Health Service Community Mental Health Services (MHS). The referral sought assistance from MHS for FR in light of her low

[2] The content of this affidavit suggest the deponent is (or was) a member of Tasmania Police.
[3] The content of this affidavit also suggests Mr Lewis was a police officer at the relevant time. The practice of police officers swearing affidavits in Coronial matters and failing to identify that they are (or were) in fact serving police, as well as omitting any reference to their rank, has become increasingly common of late. It is very unhelpful and should cease.

mood and suicidal ideation. Records indicate that the MHS Hobart Crisis Assessment and Treatment Team (CATT) attempted to contact FR on 5 and 6 July, without initial success.

On 9 July, FR called the CATT service requesting to see a psychologist, with whom she had a pre-existing therapeutic relationship. The THS records indicate that CATT did not 'have the capacity to return [FR's] call'.

Despite not making any contact with FR, THS records indicate her case was discussed at the CATT multi-disciplinary team meeting the following day. The minutes of that meeting indicate that it was recognised that she was at high risk of self-harm and that she had 'conservative' parents in Queensland[4].

No contact was made with FR following that meeting.

However, her case was discussed again, at another multi-disciplinary team meeting on 13 July. At that meeting the records indicate that it was decided, rather than actually doing anything or even contacting FR, her case would be discussed again on 15 July. On 13 July FR herself made contact with the CATT, asking, not unreasonably, what was happening with her referral and indicating that she considered she would benefit from support in the form of case management. The records indicate that the clinician to whom she spoke discussed with FR contacting Centrelink and a housing support service.

Two days later, on 15 July, FR's case was discussed, again, at yet another multi-disciplinary team meeting. On this occasion the records indicate that the fact that FR had changed her address was noted and her case was therefore to be transferred to the Clarence and Eastern CATT.

On 17 July, the CATT records indicate that an attempt was made to contact FR to inform her of the transfer (noting that in the two weeks since her referral FR had not actually seen anyone from the MHS). The records indicate that a message was left for FR to call back, her file was 'couriered' to Clarence and she 'was discharged from the white board'.[5]

The next relevant event, following an unsuccessful attempt to speak with FR on 18 July 2020, was the actual establishment of contact with her on 19 July. The records indicate that FR

[4] It is unclear to me just what the relevance of FR's parents' assumed political and/or social views might have been, in terms of her being provided the treatment she both obviously needed and, as a sick member of the community, was clearly entitled to. The fact that it was recorded at all seems to suggest that some or all members of the multi-disciplinary team present at the discussion considered it significant in some way. I observe that unfortunately in my 10 years as a coroner I have had occasion to review CATT records many times. Never once do I recall reference to a patient's parents as 'liberal', socially or politically, or indeed *any* reference to the presumed political leaning of *any* members of a patient's family. I suppose that there may be an explanation for the entry of which I am unaware.

[5] 'Discharged from the white board' seems to mean, I think, her name was rubbed off.

"requested practical assistance for psychosocial stressors and her fear of relapse into crisis which would require admission". The records go on to indicate that the CATT to CATT transfer was to be initiated and include a confirmation that FR's case would be discussed at yet another multidisciplinary team meeting. And so it was on 20 July 2020 that, for the fourth time, FR's case was discussed at a multidisciplinary team meeting. Following the meeting, a clinician from the CATT multidisciplinary team left a message on her phone requesting a return call.

A discussion occurred between a CATT clinician and FR on 21 July 2020. Various matters such as Social Security, housing, relationship and financial counselling appear to have been discussed and FR was advised she would be discharged as a patient the next day.

FR's records indicate that, for the fifth time, and still without actually ever having been seen by anyone, her case was discussed at a CATT multidisciplinary team meeting on 22 July 2020. She was discharged as a patient. Less than a week later she took her own life.

Circumstances of death

In the immediate lead up to her death FR was living in a motel but also staying with her aunt, Ms Valerie Kullrich at Clifton Beach. On the morning of Tuesday 28 July 2020 she left her aunt's address. No witness saw her alive after that time, although she did buy a petrol generator that day from a hardware store at about 10.00 am.

On Thursday 30 July, deeply concerned for her niece, Ms Kullrich reported FR missing. An immediate investigation was commenced by Tasmania Police.

It is apparent that sometime between 10 am on 28 July 2020 and the early hours of Saturday, 1 August 2020, FR drove her Daihatsu sedan to light bushland about 120 m west of Cockerill's Road, Boyer near New Norfolk. There she sealed the underside of the dashboard with blue plastic and black gaffer tape, evidently to prevent petrol fumes from escaping from the car. FR then started the petrol generator in the vehicle with the windows sealed and all vents blocked, inhaled the fumes generated and died.

Her body was found by police after her vehicle was located by security guard.

Investigation

Uniform, Forensic and Criminal Investigation Branch officers all attended the scene and carried out a thorough investigation. Nothing that was found at the scene suggested the involvement of any other person in FR's death or that there were any circumstances of

suspicion associated with it. Amongst other things a suicide note was located in the vehicle. The hand writing was subsequently identified as being that of FR.

Her body was removed from the vehicle and transported to the Royal Hobart Hospital where it was formally identified by her aunt. Following formal identification an autopsy was carried out by experienced forensic pathologist Dr Christopher Lawrence. Dr Lawrence did not find any signs of violence or injury which could have caused or contributed to FR's death. He said in his report that her body had pink lividity consistent with a history of exposure to carbon monoxide. Samples taken at autopsy were subsequently analysed at the laboratory of Forensic Science Service Tasmania. That analysis showed carboxyhaemoglobin at 84% saturation, well within the reported fatal range.

I am satisfied that the cause of FR's death was carbon monoxide intoxication due to the voluntary and intentional inhalation of exhaust from a petrol generator.

The circumstances surrounding FR's involvement with the CATT was reviewed carefully and comprehensively by the Tasmanian Health Service. The final RCA report was detailed in its analysis and clear in its recommendations. I endorse those recommendations.

Conclusion

I am quite satisfied that after a lengthy history of mental illness, namely depression and anxiety, which included suicidal ideation, plans and attempts, FR took her own life.

At the time of her death, FR had recently been discharged as a patient from the State Mental Health Service without ever actually having been seen by anyone from that service. This is despite the mental health service receiving a referral from a general practitioner and having complete access to her recent history of treatment as an inpatient following a suicide attempt.

It is not unfair to say that the extent of the "treatment" FR received was that her case was discussed on five occasions at multidisciplinary team meetings, her name was rubbed off a whiteboard and her file transferred by courier from one CATT office to another.

In short, I consider that there was no proper attempt to establish a therapeutic relationship with her and that in real terms FR received no treatment whatsoever, at a time she plainly needed it.

In investigating deaths coroners necessarily have the benefit of hindsight. They must be very conscious of the fact that those making decisions at about the time of death do not have that same benefit. Keeping that firmly in mind, I still consider that it should have been abundantly

plain that FR was in need of help and discussing her case at a myriad of team meetings did nothing in any meaningful sense to actually support her.

Comments and Recommendations

Although it will be apparent that I have reached the view that FR was very poorly served by the State Mental Health Service, there seems to me little point in recommending, in effect, that healthcare professionals should do their jobs properly. Therefore I do not consider it appropriate to make any formal comments or recommendations pursuant to section 28 of the *Coroners Act* 1995.

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

Dated: 24 July 2023 at Hobart in the State of Tasmania.

Simon Cooper

Coroner