



MAGISTRATES COURT of TASMANIA
CORONIAL DIVISION



Record of Investigation into Death (With Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Christopher Paul Webster, having investigated the death of Brock Alleine Vince with an inquest held at Hobart in Tasmania

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

- a) The identity of the deceased is Brock Alleine Vince;
- b) The circumstances of Mr Vince's death and possible contributing factors are discussed in this finding;
- c) Mr Vince died as a result of drowning in a bathtub at his flat at 104a Harrington Street, Hobart. At the time of his death, he was intoxicated by a combination of drugs and alcohol;
- d) The date of death was between 19 January 2014 and 20 January 2014; and
- e) Mr Vince was born on 1 December 1978 and was 35 years old when he died. He was unemployed, being previously employed in the Information Technology Industry. He was a single man.

On 3 October 2016, Coroner S Cooper completed an investigation into the death of Mr Brock Vince and made certain findings as to the cause of death of Mr Vince.

Subsequent to the publication of those findings, Dr Weidmann, through his solicitors, made an application under s 58 of the *Coroners Act* 1995 for the findings of Coroner Cooper to be re-examined and if appropriate that the inquest into the death of Mr Vince be re-opened.

I (Coroner Webster) re-examined the inquest, and for reasons which I published, determined to re-open the matter and to hold a new inquest.

A number of pre-inquest conferences were held before me, which involved the interested parties, and an inquest was held on 11 October 2017.

At the pre-inquest discussions, the interested parties generally agreed that the re-opened inquest should not re-canvas much of Coroners Cooper's findings, which were not in dispute, but should consider the following additional matters:

- a) Whether the prescribing of the medication Seroquel (aka Quetiapine), by Mr Vince's treating psychiatrist, Dr Weidmann, was appropriate and contributed to Mr Vince's death; and
- b) Whether Mr Vince should have been admitted into St Helens Private Hospital earlier and whether failure to admit him into that hospital earlier contributed to his death.

Circumstances Leading up to Death

Mr Vince was born 1 December 1978 and was the son of Gregory and Diane Vince. He suffered mental health problems throughout his life and had significant issues related to substance abuse and depression.

He suffered obsessive compulsive and panic disorder and alcoholism. Mr Vince was treated by a GP and Dr David Weidmann, a consultant psychiatrist, who treated Mr Vince for a number of years. The treatment by Dr Weidmann included the prescribing of Seroquel.

On 15 January 2014, Mr Vince was in a distressed state and indicated to friends and family that he considered he needed to go back to hospital. His father made telephone calls over the next few days to Dr Weidmann and St Helens Hospital to have Mr Vince admitted to hospital but was unsuccessful.

On 17 January 2014, Mr Vince attended the Royal Hobart Hospital. The hospital notes record that Mr Vince presented to the Department of Emergency Medicine complaining that he had a breathing problem. He told staff that he had been binge drinking for a week and he was going into St Helens Hospital that day.

On 19 January 2014, Mr Vince was seen at his home by a friend and his parents and he was again clearly distressed. He contacted St Helens Hospital, which confirmed that he would be admitted the next day.

It appeared to his friend that Mr Vince had been drinking and there was a smell of alcohol in his flat.

At 9.30pm on 19 January, his friend left the flat. Mr Vince was not seen alive again.

At 10.00am on 20 January 2014, a Property Agent was called to Mr Vince's unit due to water entering adjoining premises and Mr Vince's body was found in the overflowing bath.

Medication, a laptop, and several hand written notes (which could be interpreted as suicide notes) were found at the premises and seized by police.

Dr C A Lawrence, the State Forensic Pathologist, conducted an autopsy. He concluded that Mr Vince's death was caused by drowning following combined drug and alcohol intoxication.

The drugs found in Mr Vince's system were consistent with therapeutic levels but his alcohol level was high, namely 0.237g/100ml of blood.

Dr Lawrence was of the opinion that due to the alcohol levels the sedative effect of the drugs were enhanced.

Findings

I am satisfied that Mr Vince took his own life and no other person was directly involved in his death.

The evidence provided by St Helens Private Hospital, which I accept, was that it is a Private Hospital with no emergency services, and it could have only accepted Mr Vince if his admission was authorised by the patient's "privately treating Doctor" and that the hospital was prepared to admit Mr Vince whenever his admission was authorised by Dr Weidmann. It had made arrangements for him to be admitted on 20 January 2014 being the date that Dr Weidmann had authorised Mr Vince's admission.

Dr Weidmann gave evidence at the inquest.

His evidence was that due to his self-imposed limits on his workload he considered that he had too many patients under his treatment to allow admission of Mr Vince to St Helens Private Hospital prior to 20 January 2014.

That is, given the number of hours that he, Dr Weidmann, was working in January 2014 and the number of patients already under his care at St Helens Hospital (10-12) he could not safely admit Mr Vince to his care at St Helens Hospital until 20 January 2014.

Dr Weidmann gave evidence that after 30 years of practice as a psychiatrist he had deliberately reduced his workload.

Dr Weidmann's reason for not admitting Mr Vince due to his workload is supported by Dr A J Bell in his report to the Coroner dated 12 April 2017 in which he states:

"this is an acceptable and necessary for patient safety reason for not admitting Mr B Vince"

I accept the evidence of Dr Weidmann.

It is not unreasonable for Dr Weidmann to impose limits upon the number of patients he can treat in hospital, particularly if he thinks that by accepting that person as a patient he will not be giving that patient appropriate safe treatment.

I accept that Dr Weidmann was in the best position to know what numbers of patients he could safely handle. Certainly the doctor could not be accused of accepting too many patients simply to recover the fees that would have been payable for the extra patients.

It is a fact of life that a person is rarely seen by a doctor immediately but has to wait for the earliest available appointment. In an ideal world, there would be no delay between a patient wishing to see their doctor and actually seeing that doctor. We do not live in an ideal world. The delay in admission of Mr Vince to St Helens Hospital was not unreasonable.

Doctor Weidmann has been criticised for the use of Quetiapine or Seroquel.

The doctor's evidence was that he had treated Mr Vince with this medication over 3-4 years without problem, that the medication was used widely for psychiatric patients such as Mr Vince and that he was not aware of the side-effects of increased suicidal tendencies.

I accept the evidence of Dr Weidmann, a consultant psychiatrist with over 30 years standing, particularly as there is no evidence from a medical professional to the contrary. Neither Dr Bell nor Dr Lawrence, who provided reports to the Coroner, criticised the medication prescribed to Mr Vince. I agree with the submissions made by Dr Weidmann's solicitors that the document tendered at the hearing (which purported to be distributed by Astra Zeneca) should be given little or no weight as its authorship is not known and the authenticity or contents could not be tested in cross-examination.

Recommendations

In the circumstances of Mr Vince's death, I have no recommendations to make pursuant to section 28 of the *Coroners Act* 1995.

I convey my condolences to the family and friends of Mr Brock Vince.

Dated 15 March 2018

Christopher Webster

Coroner