MAGISTRATES COURT TASMANIA

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CORONIAL DIVISION

Record of Investigation into Death (Without Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Olivia McTaggart, Coroner, having investigated the death of Luke Trevor Young

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

a) The identity of the deceased is Luke Trevor Young.

b) Mr Young was born in Sydney on 28 November 1978. At the time of his death, he was aged 42 years and was in receipt of a disability pension. He lived with his father, Trevor Young (referred to as "Trevor") at Doctors Rock, Tasmania.

Mr Young suffered from significant mental and physical health conditions for most of his life. His diagnoses included bipolar affective disorder, ADHD, depression, hepatitis C, cirrhosis of the liver, type II diabetes, hypertension, sleep apnoea, alcohol dependency and iron deficiency. From about the age of 11 years, Mr Young began engaging with illegal drugs and abusing alcohol. By the age of 15 years, he had been expelled from school and did not engage in any further formal schooling. Over the following 25 years, Mr Young's life was marked by cycles of alcohol and drug abuse, often leading to instances of attempted suicide or violence towards his father, who cared for him. At times, such cycles would be followed by periods when Mr Young would engage with mental health services and his mental health would improve. Mr Young spent extensive time living interstate and the evidence in the investigation discloses a substantial medical history in New South Wales and Queensland.

In 2014, Mr Young intentionally stabbed himself in the abdomen with a kitchen knife in a suicide attempt. In 2015, in another suicide attempt, he drove a vehicle off the road whilst not wearing a seatbelt. In both instances, Trevor was able to obtain assistance for his son.

In March 2020 Mr Young and his father moved from Queensland to Doctors Rocks in Tasmania. It was hoped the move would be a fresh start. By April 2020, Mr Young had commenced seeing his local general practitioner and was referred to a consultant psychiatrist in Hobart, Dr Ross Kirkman, as there was no psychiatrist readily available for consultations on the North West coast.

On 22 June 2020 Mr Young consulted Dr Kirkman for the first time. He told Dr Kirkman that he thought of suicide every day and had done so for many years. He described having cut himself, overdosed on heroin and also overdosed on quetiapine (his prescription medication) a week before that consultation. Dr Kirkman confirmed Mr Young's diagnoses of bipolar II and ADHD (combined type), assessed appropriate medications and provided prescribing instructions to Mr Young's regular general practitioner. Dr Kirkman subsequently reviewed Mr Young and his prescription medications on 4 August 2020 and 2 September 2020. Of note, Dr Kirkman was particularly concerned that Mr Young's lack of sleep due to sleep apnoea was impacting upon his unstable mental state and encouraged him to persist with the CPAP machine to aid sleep. The records indicate that over the following months Mr Young did not present for two sleep study appointments and that he no longer wished to see Dr Kirkman. His general practitioner commenced the referral process to another psychiatrist.

From the time of arriving in Tasmania in March 2020 until his death in February 2021, Mr Young was treated and managed by general practitioner, Dr Nimali Samarabandu. In this 11 month period, Dr Samarabandu saw Mr Young on 50 occasions in respect of his numerous health conditions, including overseeing his mental health treatment. Dr Samarabandu noted that Mr Young was compliant with his medication.

On 28 January 2021 Mr Young received a text from a fines enforcement agency in Queensland indicating that his driver's licence would be suspended if he did not satisfy outstanding fines. He suffered a serious anxiety attack upon receiving this news, and an ambulance was called to assist him. The following day, Mr Young and his father attended the North West Regional Hospital and doctors assessed Mr Young as being sleep-deprived and suffering from insomnia. In the following days, Mr Young complained to his father that the sleeping pills he was prescribed were of little to no effect, that he was sick of taking his medications and that nothing was working.

At 6.30pm on 2 February 2021 Trevor went to check on Mr Young in his caravan on the property and heard him snoring. He returned later in the evening to check him again, and heard him still snoring. Trevor was aware of his son's sleep apnoea and left him to sleep. At around 7.05am the following morning, being 3 February 2021, Trevor went to check on his son and when he couldn't immediately see him, went back inside the main property to look for him. When Mr Young could not be located inside, Trevor returned to check the caravan again. At that time, Trevor found Mr Young lying face down on the floor of the caravan with a large quantity of medication on the table. Police and ambulance were called but Mr Young could not be revived and was pronounced deceased.

c) I am satisfied, having particular regard to the autopsy and toxicological findings, that Mr Young died as a result of mixed prescription drug (sertraline, amlodipine, lamotrigine, quetiapine) toxicity. I find that he took an excessive quantity of his prescription medications whilst he was alone in the caravan and with the specific intention of ending his life. There were no suspicious circumstances surrounding his death.

d) Mr Young died between 2 and 3 February 2021 at Doctors Rocks in Tasmania.

In making the above findings, I have had regard to the evidence gained in the comprehensive investigation into Mr Young'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 of Forensic Science Service Tasmania;
- Medical Reports for Mr Young from the Royal Brisbane and Women's Hospital, Wynyard Medical Centre, North West Regional Hospital and Dr Kirkman;
- Affidavit of Trevor Young, father of Mr Young;
- Affidavits of three attending and investigating police officers, together with photographs; and
- Mobile phone records.

Comments and Recommendations

Unfortunately, Mr Young suffered severe mental illness and chronic suicidality over many years. These issues were complicated by alcohol and drug dependence and numerous physical health conditions. In light of Mr Young's multiple suicide attempts during the course

of his life, his prognosis was likely poor. However, it is appropriate to make comment in this case about what I consider to be a gap in the delivery of optimal mental health services to him.

In May 2020, Dr Samarabandu referred Mr Young to the Adult Community Mental Health Services North West in Burnie. The referral was declined on the basis that Mr Young's circumstances did not fit the criteria for the Crisis Assessment and Treatment Team ('CATT') input and he should be referred to a private psychiatrist. Subsequently, he was referred to Dr Kirkman who, being a Hobart-based psychiatrist, consulted Mr Young via teleconference. Dr Kirkman provided appropriate treatment and advice to Mr Young within the constraints of COVID-19 regulations and his proximity from the north-west coast of Tasmania. When Mr Young requested a new psychiatrist in December 2020, he was referred to a mainland-based psychiatry practice specialising in providing care via teleconferencing. Trevor said that son attended two teleconference consultations with a Melbourne-based psychiatrist before his death but they were each less than six minutes in duration and, in his view, achieved very little.

I commend Dr Samarabandu for her care and treatment of Mr Young before his death. She made all appropriate referrals to assist Mr Young on improving his mental state. I note that she offered Mr Young the opportunity of referral to a psychologist but Mr Young did not wish to accept such a referral.

In the investigation, I received reports from both Dr Samarabandu and Dr Kirkman. In his report, Dr Kirkman stated as follows;

> *"In a 'best case scenario' circumstances Mr Young would have been intensely case managed on a weekly or fortnightly basis by a local Adult Mental Health multidisciplinary team. However, it is my understanding that there is no such service in the North West or the North regions of the state. Because of the lack of community services, and because I am a bulk billing practitioner, many GPs refer patients such as Mr Young to me. Unfortunately, it's not feasible or possible for me to provide intensive case management but I guess in this situation there were few options available."*

Dr Kirkman went on to say that in many instances of a similar nature patients seen by the local CATT are often passed back to him quite rapidly even though he is not in a position to *"case manage from afar"*. Dr Samarabandu agreed fully with Dr Kirkman's concerns, indicating that there is a big shortage of psychologists and psychiatrists in the North West area. She commented that the waiting lists are very long and there is an inability to meet the demand.

Whilst Mr Young's death perhaps could not have ultimately been prevented, intensive community case management to treat his mental health conditions was required and may well have assisted him. Such a service was not available to Mr Young and should be considered in plans for mental health services for the North West region, if it does not already for part of such plans.

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

I acknowledge Mr Trevor Young's devotion to helping his son over many years. I convey my sincere condolences to the family and loved ones of Mr Young.

Dated: 20 April 2023 at Hobart in the State of Tasmania.

Olivia McTaggart
Coroner