FINDINGS and RECOMMENDATION of
Coroner Simon Cooper following the holding of an inquest under the *Coroners Act* 1995 into the death of:

KT

Contents

Record of Investigation into Death (With 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, youths 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 KT, with an inquest held at Hobart in Tasmania, make the following findings.

Hearing date

5 December 2023.

Counsel

C Lee – Counsel Assisting

Introduction

1. During the night of 17 and 18 July 2021, KT died at her home in a suburb in Hobart in Tasmania. Her death was unexpected and as such was reported under the *Coroners Act* 1995.

2. Because of concerns I had about some of the circumstances surrounding her death, in particular the treatment she received from a psychologist in the immediate lead up to her death, and that psychologist's apparent lack of cooperation with the coronial investigation, I decided that it was desirable that an inquest should be held.[1]

3. The witnesses who gave evidence at the inquest were:

   (a) Mr Peter Nelson (Psychologist); and

   (b) Detective Senior Constable Paul Cooper (Investigating Officer).[2]

4. In addition, the evidence of other witnesses was received in affidavit form (without the witnesses being called), and documentary and other evidence was tendered. The complete list of exhibits is annexed to this finding and marked with the letter A.

[1] See section 24(2) of the *Coroners Act* 1995.
[2] Detective Senior Constable Cooper and I are not related.

5. As a result of the evidence tendered at that inquest I make the following formal findings pursuant to section 28(1) of the *Act*:

   (a) The identity of the deceased is KT;

   (b) KT died in the circumstances set out further in this finding;

   (c) The cause of KT's death is insulin and mixed drug toxicity, the result of actions undertaken by her alone, voluntarily and with the express intention of ending her own life; and

   (d) KT died, aged 47 years, during the night of 17 and 18 July 2021 in a suburb in Hobart in Tasmania.

Background

6. KT was mother to five children, one of whom, her daughter RM, suffered from insulin dependent diabetes.

7. KT's physical health was a problem for her. She suffered asthma and bad back pain. In addition, KT's mental health was poor; she suffered depression for which she was treated. It is clear that her mental health fluctuated and in the lead up to her death, stress due to relationship difficulties caused it to decline.

8. Evidence was led at the inquest which showed that KT had a mental health history that included suicidal ideation (2007) and an attempt at suicide by carbon monoxide poisoning in her car (2008). Particularly relevant in the context of KT's death was the evidence of a suicide attempt approximately six weeks before her death.[3] Following that incident, KT sought treatment from her general practitioner and was referred to a clinical psychologist, Mr Peter Nelson, whom she had seen in the past.

9. Between 2 June 2021 and 13 July 2021, KT saw her GP on at least seven occasions. She was prescribed fluvoxamine[4] and a mental health plan was prepared. Her medical records include mentions of suicidal ideation on several occasions. She also saw Mr Nelson for psychological support at least twice during the same period, including on the last day of her life. I will return to Mr Nelson later in this finding.

[3] Exhibit C 12.

[4] Fluvoxamine is a SSRI drug commonly used to treat depression.

What a coroner does

10. Before considering the circumstances of KT's death, it is necessary to say something about the role of the coroner, and what she or he does and does not do.

11. When conducting an inquest (which is a public hearing),[5] a coroner performs a role very different to other judicial officers. The coroner's role is inquisitorial. An inquest might be described as a quest for the truth, rather than a contest between parties to either prove or disprove a case. The coroner is required to thoroughly investigate the death and answer the questions (if possible) that section 28(1) of the *Coroners Act* 1995 asks. These questions include who the deceased was, how they died, the cause of the person's death and where and when the person died. This process requires the making of various findings, but without apportioning legal or moral blame for the death.[6] The job of the coroner is to make findings of fact about the death from which others may draw conclusions. A coroner may, if she or he thinks fit, make comments about the death or, in appropriate circumstances, recommendations to prevent similar deaths in the future.

12. It is important to recognise that a coroner does not punish or award compensation to anyone. Punishment and compensation are for other proceedings in other courts, if appropriate. Nor does a coroner charge people with crimes or offences arising out of a death that is the subject of investigation.

13. As was noted above, one matter that the *Coroners Act* 1995 requires, is a finding (if possible) as to how the death occurred.[7] 'How' has been determined to mean "by what means and in what circumstances",[8] a phrase which involves the application of the ordinary concepts of legal causation.[9] Any coronial inquest necessarily involves a consideration of the particular circumstances surrounding the particular death so as to discharge the obligation imposed by section 28(1)(b) upon the coroner.

14. The standard of proof at an inquest is the civil standard. This means that where a coroner makes findings of fact, she or he must be satisfied on the balance of probabilities as to the existence of those facts. However, if an inquest reaches a stage where findings being made may reflect adversely upon an individual, it is well-settled that the standard applicable is that expressed in *Briginshaw v Briginshaw*, that is, that the

[5] Section 3 of the *Coroners Act* 1995.
[6] *R v Tennent; Ex Parte Jager* [2000] TASSC 64.
[7] *Coroners Act* 1995, section 28(1)(b).
[8] See *Atkinson v Morrow* [2005] QCA 353.
[9] See *March v E. & M.H. Stramare Pty. Limited and Another [*1990 – 1991] 171 CLR 506.

task of deciding whether a serious allegation against anyone is proved should be approached with a good deal of caution.[10]

15. Finally, I observe that a coroner has a duty, "wherever appropriate, to make recommendations with respect to ways of preventing further deaths and on any other matter that the coroner considers appropriate".[11] It is settled law that there are limits to the making of recommendations; recommendations must arise out of, or enjoy a clear evidentiary nexus to, the findings at the inquest and avoid "*philosophical self-indulgence*".[12]

Circumstances of death

16. The evidence at the inquest satisfies me that the domestic relationship KT was in at the time of, and in the years leading up to her death lacked stability with KT and her children moving in and out of her domestic partner's home on several occasions.

17. Her partner was made the subject of a Police Family Violence Order in March 2016 for a period of 12 months. The order had expired by the time of KT's death.

18. There is also evidence that KT was involved in a casual sexual relationship with another man in the lead up to her death.

19. KT was described as a good employee, but in the months leading up to her death she had significant periods of absence on the basis of ill health.

20. On Saturday 17 July 2021, KT kept an appointment with her psychologist Mr Nelson. She also visited the man with whom she was engaged in a casual sexual relationship. Later still, she exchanged text messages with family and friends and used her mobile telephone to search medical articles on insulin overdoses.[13]

21. Shortly before midnight, KT used her daughter RM's insulin pens to intentionally inject fatal doses of insulin into her own body.

22. Her domestic partner found her body the following morning and called emergency services.[14]

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[10] (1938) 60 CLR 336 (see in particular Dixon J at page 362).
[11] See section 28 (2) of the *Coroners Act* 1995.
[12] *Chief Commissioner of Police v Hallenstein* [1996] 2 VR 1 at page 7 per Hedigan J.
[13] Evidence at the inquest indicates that KT's mobile telephone had been used on 13 July 2021 to search for similar information.
[14] Exhibit C 12.

Investigation

23. Police and ambulance officers were on the scene within a matter of minutes of being called. There was nothing that could be done for KT as she was clearly deceased and had been for some hours. An inspection of her body revealed clear evidence of puncture marks on the outer right thigh and inner left thigh. Empty boxes of diazepam and fluoxetine along with empty packets of oxycodone and other drugs, as well as five empty insulin syringes were located, photographed[15] and seized by investigating officers.

24. Nothing was located at the scene by attending police that gave rise to the suspicion of any person's involvement in KT's death.[16]

25. Her body was formally identified at the scene[17] and then transported by mortuary ambulance to the Royal Hobart Hospital.

26. At the Royal Hobart Hospital, the Tasmanian State Forensic Pathologist, Dr Andrew Reid, conducted an autopsy. Following that procedure, Dr Reid prepared a detailed report which was tendered at the inquest.[18] Dr Reid did not find any evidence of injury or of a sudden natural cause of death. A CT scan was performed as part of the autopsy and the report specifically noted no evidence of traumatic injury. Dr Reid carried out rapid serology testing for vitreous biochemistry, insulin and C-peptide levels. That testing showed a low glucose concentration and a raised insulin concentration. Dr Reid expressed the view, which I accept, that those findings were consistent with exogenous insulin overdose.

27. Toxicological analysis of samples taken at autopsy was carried out at the laboratory of Forensic Science Service Tasmania. Alcohol (0.047 g/100ml), oxycodone, fluvoxamine, naloxone and ibuprofen were all found to have been present in those samples.[19]

Mr Peter Nelson

28. KT first saw Mr Nelson, a practising clinical psychologist, in December 2016. The evidence was between that date and the date of her death he saw her on 16 occasions, including on the last day of her life.

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[15] Exhibit C 20A.
[16] Exhibit C 19, paragraphs 7, 8 and 11.
[17] Exhibit C 3.
[18] Exhibit C 5.
[19] Exhibit C 6.

29. After KT's death an order was issued pursuant to section 59 of the *Coroners Act* 1995 for Mr Nelson to provide his file, so far as it related to KT's treatment, to the coroner's office. That order was made on 29 July 2021 and served the same day. The order required Mr Nelson to provide documentation within one month. It was not complied with.

30. On 4 February 2022, Mr Nelson was sent a follow-up email in relation to the order. He did not reply.

31. On 7 June 2022, a coroner's associate spoke to Mr Nelson. Mr Nelson told the associate, Senior Constable Barnes, he would send the requested material by the "end of the week". He did not do so.

32. On 15 July 2022, nearly a year after he had been served with the order requiring production of his file to assist in the investigation in relation to his patient's tragic death, Mr Nelson was spoken to by another coroner's associate. In that conversation he told the associate – Constable Olivia Pearce-Tomes - that he did not have the records and that he would send an email over the weekend confirming that information. He did not send an email that weekend or at all. This was the first occasion upon which Mr Nelson had indicated that he was unable to locate KT's file.

33. On 3 August 2022, another email was sent to Mr Nelson requesting the records. Mr Nelson replied, confirming he did not have those records.

34. Apart from what might be thought to be a professional obligation to assist a coroner in relation to the investigation of the death of any patient, I observe that the failure to comply with an order for the production of documents is an offence.[20]

35. Mr Nelson's failure to comply with the order when initially served, and failure to advise that he was unable to locate his file unnecessarily hampered and delayed the investigation of KT's death.

Conclusion

36. The evidence at the inquest satisfies me to the requisite legal standard that the cause of KT's death was mixed drug toxicity. I am also satisfied that there are no suspicious circumstances associated with her death. The actions which caused KT's death were undertaken by her alone, voluntarily and with the express intention of ending her own life.

[20] Section 66 of the *Coroners Act* 1995.

37. I am affirmatively satisfied that the treatment she received from her general practitioner and psychologist was appropriate.

Recommendations, comments and final remarks

38. Counsel Assisting, Mr Lee, submitted that it was appropriate that I consider sending a copy of my findings to the Australian Health Practitioner Regulation Authority in relation to Mr Peter Nelson's conduct so far as it relates to his file management of KT. I think such an approach is entirely appropriate. I direct accordingly.

39. I conclude this matter by offering my sincere and respectful sympathies to the family of KT on their loss.

Dated 18 January 2024 at Hobart, in the State of Tasmania

Simon Cooper

Coroner

Annexure A

LIST OF EXHIBITS

Record of investigation into the death of KT

No.	TYPE OF EXHIBIT	NAME OF WITNESS
1	POLICE REPORT OF DEATH	Const Simone VAN DAM
2	LIFE EXTINCT AFFIDAVIT	Dr Nathan WARNER
3	ID AFFIDAVIT – POLICE	Const Simone VAN DAM
4	ID AFFIDAVIT – MORTUARY	Anthony CORDWELL
5	POST-MORTEM REPORT	Dr Andrew REID
6	TOXICOLOGY REPORT	Neil MCLACHLAN-TROUP
7	MEDICAL RECORDS	Claremont Village Medical Centre
8	AFFIDAVIT	Peter NELSON
9	HOSPITAL RECORDS	RHH
10	AT RECORDS	Ambulance Tasmania
11	AFFIDAVIT – SNOK	RB
12	AFFIDAVIT	PL
13	AFFIDAVIT	RM
14	AFFIDAVIT	EO
15	AFFIDAVIT	LD
16	AFFIDAVIT	NM
17	AFFIDAVIT	Const Calvin COLES
17A	BODY WORN CAMERA FOOTAGE	Const Calvin COLES
18	AFFIDAVIT	Const Simone VAN DAM
19	AFFIDAVIT	Snr Const Paul COOPER
20	AFFIDAVIT	Snr Const Lauren McMahon
20A	PHOTOS	Snr Const Lauren McMahon
21	PHONE RECORDS	Tasmania Police
22	FVMS	Tasmania Police
23	AFFIDAVIT	Const Olivia Pearce-Tomes

24	**PROPERTY RECEIPTS**	**THS, Tasmania Police**
25	**MISCELLANEOUS PAPERWORK**	**Misc**