**CORONERS COURT**
**OF NEW SOUTH WALES**

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| **Inquest:** | Inquest into the death of RC |
| **Hearing dates:** | 17-19 October 2016, 27 February 2017 |
| **Date of findings:** | 28 February 2017 |
| **Place of findings:** | State Coroners Court, Glebe |
| **Findings of:** | **Magistrate Teresa O'Sullivan, Deputy State Coroner** |
| **Catchwords:** | CORONIAL LAW – Cause and manner of death<br>Suicide risk assessment |
| **File number:** | 2014/116079 |
| **Representation:** | Sergeant Paul Bush, Sergeant Assisting<br><br>Mr Patrick Rooney for the South West Sydney Local Health District |
| **Non-publication order** | S. 75 (2)(b)(i) and (ii) No publication of the identity of the deceased person |

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| **Findings:** | **Identity of deceased**:<br>The deceased person was RC<br><br>**Date of death**:<br>RC died on 15 April 2014<br><br>**Place of death**:<br>He died at Buttercup Reserve, Corner of Kurrajong Road and Cembra Way, Mount Annan<br><br>**Manner of death:**<br>The death was intentionally caused by RC shooting himself in the head with the intention of ending his life<br><br>**Cause of death:**<br>The medical cause of the death was a gunshot wound to the head |

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*The Coroners Act 2009* (NSW) *in s81 (1) requires that when an inquest is held, the coroner must record in writing his or her findings as to various aspects of the death.*

*These are the findings of an inquest into the death of RC.*

## REASONS FOR DECISION

# The Inquest:

Section 81 (1) of the Coroners Act 2009 (NSW) requires that when an inquest is held, the coroner must record in writing his or her findings. These are my brief findings in relation to the death of RC.

## *Background:*

RC was 53 years old at the time of his death. He was married to KF in 1999 and they had a child, M together in 2006. RC was suffering from depression when K and RC met in 1996. K believes his depression relates to bullying that he suffered during high school. RC's father passed away in 2004 and his mother in 2009, these events made his depression worse. In 2012 RC and K separated.

In August 2013 he was admitted to Campbelltown Hospital and as a result of his depression he underwent a course of electro shock therapy. He was released into the care of the Campbelltown Community mental health team (CoHMET).

## *Contact with RC on 13 April 2014:*

On 13 April 2014 at 2200, RC's friend, George, rang CoMHET and spoke to Mental Health Nurse, Rumbi Muzirma. He reported, amongst other things, finding a note in RC's house outlining his finances and then apologising. Nurse Muzirma spoke to RC. RC denied to Nurse Muzirma that it was a suicide note and stated that he had been drinking. He also admitted to Nurse Muzirma that he had been non-compliant with medications. RC was offered hospital admission but he declined this.

During Nurse Muzirma's conversation with RC and George, she indicated that if RC was not willing to attend the Centre she would be obliged to notify the police. George suggested taking RC to his house overnight.

A plan was decided upon whereby RC would spend the night with his friend George and that George would bring RC to Brown St, Community Health Centre for his planned appointment the next day with Ms Bridgford.[1]

[1] Brief of evidence, ex 1, Tab 13

On 14 April 2014 RC was driven by Alex to attend his review at 1100 with Clinical Psychologist, Ms Bridgford. Alex was not present during the review carried out by Ms Bridgford.

During the review with Ms Bridgford, RC reported having had a bad week and that his birthday had made him miserable. He admitted to drinking a bottle of wine each day for the past week and noted that his mood had declined. He denied any suicidal thoughts or any intent to self-harm. RC was asked if he wished to talk of anything else and he said that he was "fine". RC answered most questions with yes or no responses. The next psychology appointment with Ms Bridgford was scheduled for 28 April 2014.

During the drive back to RC's house, Alex asked RC a number of questions about the review. He also asked RC if Ms Bridgford asked him about the note. RC said that it was more like a lecture and that he was not asked anything about the note.

Later on 14 April 2014 at 1320 Ms Bridgford received a call from Alex asking why she had not raised the suicide note in her review of RC. Alex explained that RC was drinking 2 litres of alcohol per day, living on weight reduction drinks and stated that RC is "managing information" and he was aware that RC hadn't told him everything that was discussed in the session. Alex agreed to send his brother George to the next appointment. Alex requested more intensive follow up because he believed that RC's risk of suicide had increased.

After receiving the phonecall from Alex, Ms Bridgford took RC's file to CoHMET to enquire about the phonecall and search for any progress notes about the call. Ms Bridgford states that a CoHMET worker found a loose leaf progress note in the tea room. She took the page to the CoHMET Nurse Unit Manager (NUM), Jon Murphy for investigation regarding the missing information and the file.[2]

The CoHMET file contains a note from J Murphy NUM dated 14 April 2014 at 1400 indicating that Ms Bridgford had not known about the suicide note. He also indicated that RC had not conveyed suicidal thoughts or plans to Ms Bridgford that day, but that RC has stopped taking his Lithium. It was noted that his case manager was currently unavailable. He noted in the file that there was an appointment scheduled with Dr Gupta on the coming Thursday, 17 April 2014. The plan that was outlined was:
"(1) Phone call this evening to monitor MS [mental state] / Risk;
(2) Offer HV [home visit] if required;
(3) Continue to monitor over next few days."[3]

[2] Brief of evidence, ex 1, Tab 12
[3] Brief of evidence, ex 1, Tab 18

There was no record of a discussion about firearms by any staff member of the Centre or CoMHET at any time. RC was not discussed on 14 April 2014 with Dr Gupta.

Ms Bridgford contacted Alex by telephone on 14 April 2014 at 1430 to explain procedures and to discuss the plan. Alex reportedly agreed and was pleased. Alex advised that RC is not truthful about his level of drinking. It was also noted that RC denies suicidal ideation except that he has said to Alex that suicide remains an option.

## *Contact with RC on 14 April 2014:*

On 14 April 2014 at 1835 a CoMHET staff member Iryna Warianka made a phone call to RC who stated that he was at home watching news and that he "feels settled" and has "been drinking wine" tonight "half bottle, not planning to have anymore". She also indicated that RC "sounds flat, can't identify why he is not doing well, however adamant he has no suicidal ideations".[4]

RC stated that he did not know why Alex was raising concerns about him. RC was accepting of follow-up from CoMHET and confirmed that if he was not coping he would call the service. It was recorded that RC was "reactive, appropriate on the phone, nil current risk identified, able to guarantee safety tonight." The plan was to contact him by phone again the following day.[5]

## *The events of 15 April 2014:*

On 15 April 2014 both George and Alex tried to contact RC by phone. On each occasion they were unsuccessful. At 1235 George contacted CoMHET reporting that he had been unable to contact RC and that he was concerned due to the "suicide note" already mentioned and that RC had been abusing alcohol for the last six days. George stated that he was frustrated with the response he received and called the police.[6]

Narellan police visited RC's house and conducted a search. His body was later discovered at Buttercup Reserve, Mt Annan.

## *Was Campbelltown Community Mental Health (CoHMET) aware that RC possessed a firearm?*

The suggestion that RC was in possession of a firearm and further that the CoHMET team were notified comes from the evidence of Alex in his statements provided in the

[4] Brief of evidence, ex 1, Tab 16
[5] Brief of evidence, ex 1, Tab 18
[6] Brief of evidence, ex 1, Tab 11

brief of evidence. [7] Alex also maintained in oral testimony he had informed CoHMET of the presence of a firearm.

It appears that Alex was frustrated with the responses he was receiving from CoHMET when he expressed his concerns about RC. In answer to a question during this inquest, Alex stated, "It got to the point where I felt that these guys really had to act so I was throwing everything at them to get them to act."[8] Alex also stated in oral evidence "he was just dismissive about it and that, you know, got up my nose and I pushed a bit and made him aware of a fact that, you know, that he had a gun."[9]

During the conversation between Alex and RC in the drive from CoHMET to RC's house there is only one mention of a firearm in passing and no direct questioning about the possession of a firearm by RC. Alex agreed that during a conversation that he recorded between RC and himself after RC's appointment at CoHMET that the firearm was not mentioned.[10]

No mention of a firearm is recorded in the medical notes prior to RC's death. Leanne Bridgford was adamant that she was not told or informed of the possession of a firearm by RC in her conversations with Alex. A short note is made after his death on the basis of information from Police.

There is no doubt that Alex cared about RC, was a strong advocate for RC and that he was concerned about his safety. However, on the evidence before me, I cannot be comfortably satisfied that CoHMET was informed that RC was in possession of a firearm.

## *Progress note created on 13 April 2014:*

George P contacted CoHMET after he found a note at RCs's house.[11] The note details financial arrangements and starts with the name "Kim" and ends with the word "sorry". He was concerned that it was a suicide note and relayed that information to the CoHMET mental health nurse, Rumbi Muzirwa.

Rumbi Muzirwa gave evidence that when she received the phonecall she tried to find RC's file but was unable to. Ms Muzirwa made a note on a blank progress sheet and placed the note on the table in the meeting room. She stated this was common practice for handover at CoHMET. Ms Muzirwa contacted RC and spoke to him and discussed going to hospital for treatment. After discussions with RC and George it was agreed that RC would stay with George and attend CoHMET the following day for a scheduled appointment.[12]

[7] Brief of evidence, ex 1, Tab 8,9
[8] (p38) Transcript 17/10/2016
[9] (p40) Transcript 17/10/2016
[10] (p36 –p37). Transcript 17/10/2016
[11] Brief of evidence, ex 1, Tab 22
[12] Brief of evidence, ex 1, Tab 13

Ms Muzirwa also states that she informed her co-worker, Henna Leechburch-Auwers, of the note and the need for follow up on the following day as RC was due for a consultation with Leanne Bridgford. Ms Leechburch- Auwers agrees that RC's case was discussed between them but states that there was no discussion of follow up on the next day.[13]

It was not controversial that the note was misplaced and was not with the file when Leanne Bridgford spoke with RC the following day. There is some disagreement between Ms Muzirwa and Ms Leechburch-Auwers about what happened. As far as this inquest is concerned, the unfortunate fact is, the file note was missing when RC was being assessed by Ms Bridgford the next day. Ms Bridgford was unaware of the existence of the suicide note when she saw RC.

It is also noted that there is a factual dispute as to the extent to which Ms Bridgford was concerned after being contacted by Alex P about the concerns he had with Mr Cachia and her finding of the misplaced progress note. It is not essential to resolve that factual dispute for the purposes of this inquest.

In answer to the issue of the misplaced progress note, the LHD relies upon the changes made at the Centre that are reflected in the documentation and evidence provided by Mr John Pullman and Mr Scott Fanker.[14] Mr Pullman has outlined a number of improvements that have been made since RC's death. They include better staffing levels, transfer of care meetings and clearer handover procedures and an improved electronic medical records system. It appears that, in part, these changes have been made to assist in preventing the misplacement of any written progress notes in the future and that is a good thing.

## *The experts:*

Two expert psychiatrists provided evidence to this inquest, namely, Dr Matthew Large and Dr Glen Smith. Relevantly, the outcome of concurrent expert evidence was that each of the experts agreed on many issues save for the decision made by Centre staff to contact RC by telephone on the evening of 14 April 2014 (as part of an assessment of his mental state) rather than attend upon his home for a face-to-face assessment and therefore the timing of any further assessment by a senior mental health practitioner.

Dr Large maintained that it was reasonable to postpone any further clinical assessment, after Ms Irenya Warianka (Registered Psychologist) contacted RC, to a later date. It was noted that a further appointment was already scheduled with Dr Gupta to occur on 17 April 2014 and that Ms Warianka had assessed RC to, amongst other things, be "settled" during her phone call with him on the evening of 14 April 2014. She did not consider that RC required a home visit and had no cause for concern arising from her telephone call with him.

[13] Ex 3
[14] Ex 3

Dr Large also considered the fact that RC did not ask for or want a home visit and it would have been intrusive to attend on him at home and not necessary in the circumstances.

Dr Smith, on the other hand, was of the view that due to the combination of risk factors (RC's history, increased drinking, stopping medication and finding the suicide note), a comprehensive face to face assessment by a senior clinician was warranted on the evening of 14 April 2014.

It was also a point of agreement that if RC was known to possess a firearm the response would have been to contact police to attend.

In broad terms the experts were asked to comment upon whether or not the care and treatment provided by the Centre's CoMHET was in accordance with NSW Health Policies and Guidelines. Dr Large indicated that they were guidelines, with discretion to be used by clinicians. Dr Smith agreed and indicated that the guidelines were a guide only.

It would appear that the decision regarding what type of contact or action should have occurred on the evening of 14 April 2014 is very much a matter of judgement and discretion. In hindsight it would have been preferable for there to have been a face to face meeting with RC where the suicide note could have been viewed and further plans put in place.

It is noted that since RC's death there has been an increase in staffing levels at CoMHET which has allowed more home visits to occur. [15]

## *Autopsy Report*

The Autopsy report prepared by Dr Szentmariay states that the direct cause of RC's death was a gunshot wound to his head.[16] At autopsy Dr Szentmariay notes, "external examination showed the presence of dots of blood on the right thumb". This clearly suggests that RC pulled the trigger of the firearm.

## *Manner of death:*

On the evidence before this inquest it is clear that RC intended to end his life when he pulled the trigger of the gun on 14 April 2014 at Buttercup Reserve, Mount Annan.

I would like to thank the officer in charge of the investigation, Constable Melissa Gates. I would also like to thank the Police Advocate Assisting me, Sergeant Paul Bush.

Finally, I offer my sincere condolences to RC's family and friends who cared for him deeply.

[15] Ex 3
[16] Brief of evidence, ex 1, Tab 5

## Findings required by s81(1)

As a result of considering all of the documentary evidence and the oral evidence heard at the inquest, I am able to confirm that the death occurred and make the following findings in relation to it.

### *The identity of the deceased*

The deceased person was RC

### *Date of death*

He died on 15 April 2014

### *Place of death*

He died at Buttercup Reserve, Corner of Kurrajong Road and Cembra Way, Mount Annan

### *Cause of death*

The medical cause of the death was a gunshot wound to the head

### *Manner of death*

The death was intentionally caused by RC shooting himself in the head with the intention of ending his life

I close this inquest.

**Magistrate Teresa O'Sullivan**
**Deputy State Coroner**

**Date 28 February 2017**