LOCAL COURT OF NEW SOUTH WALES

Coronial Jurisdiction

Inquest:	**Inquest into the death of Mark Richard GLEESON**
Hearing dates:	17-18th June, 2014
Date of Findings:	18thJune, 2014
Place of Findings:	Wollongong Local Court
Findings of:	Magistrate Geraldine Beattie, Deputy State Coroner
Findings:	I find that Mark Richard Gleeson died on or about 21st December, 2011 in the rail corridor near the corner of Railway Parade and Governors Lane, Wollongong, New South Wales from respiratory depression and failure caused by the interaction of prescribed medications and alcohol.
File number:	2011/412936
Representation:	Ms Ward, Counsel Assisting the Coroner, i/b Ms Haider of Justice Legal Mr Barnes i/b M. Woodward (Tresscox) for Dr Abujam Mr Jackson i/b J. Kamaras (Avant) for Dr Oldham Ms Berberian i/b H. Allison (Crown Solicitor's Office) for the Illawarra Shoalhaven Local Health District

INQUEST INTO THE DEATH OF Mark Richard GLEESON

FINDINGS

1. Overview

Mark Richard Gleeson was only 39 when he died from respiratory failure due to the combined effect of alcohol and a number of prescribed medications between the late afternoon of 21st December, 2011 and 9.30am the following morning, when his body was found next to a railway hut in the railway corridor near the corner of Railway Parade and Governors Lane, Wollongong.

He leaves behind his loving and devoted parents, Janice and Ivor Gleeson, his brother, Warren Gleeson, and his 14 year-old son, Connor Gleeson, who lives with his mother, Michelle Henry.

Mark had a lengthy history of admissions to mental health units, as well as problems with gambling and drug and alcohol abuse. In the three months prior to his death he had been admitted as a voluntary patient to Macquarie, Wollongong, Goulburn, and Cumberland Hospitals. He had also entered drug and alcohol rehabilitation at Peppers (Wagga Wagga) and Oolong House (Nowra), but only remained at each facility a very short time before attending hospital with mental health issues.

The day after he arrived at Oolong House on 19th December, 2011 Mark was taken to Shoalhaven Hospital with concerns about hearing voices telling him to kill himself. He was transferred to Wollongong Hospital Mental Health Unit on 20th December, where he was assessed and admitted as a voluntary patient. The following day Mark was further assessed by Dr Abujam and Dr Oldham, was not content with the proposed treatment plan and their refusal to prescribe him higher doses of valium, and discharged himself against medical advice. He planned to travel via Sydney to Melbourne to see his son for Christmas. On discharge from Wollongong Hospital at 2.30pm on 21st December, Mark was dispensed seven days' prescription medication.

Tragically, Mark's family were unaware that he was no longer at Oolong House, let alone had been admitted to and self-discharged from the mental health unit.

At about 9.30am on 22nd December, 2011 Mark's body was found in the railway corridor, less than 600m from Wollongong Hospital. He was still wearing his hospital identification band. Lying near his body were empty packets of his prescribed medications: Olanzapine, Quetiapine and Clonazepam.

Autopsy revealed that Mark had heavily congested lungs, suggestive of his having died from respiratory depression and, ultimately, respiratory failure.[1] Toxicological analysis showed a, "cocktail of prescribed medications including antipsychotic and anxiolytic agents"[2] as well as alcohol. The pathologist is of the opinion that Mark died from "drug interaction/overdose causing respiratory depression and respiratory failure."[3] This opinion is supported by Prof. Dawson, expert in pharmacology and toxicology, who also noted that the levels of quetiapine and olanzapine detected in Mark's post mortem blood were consistent with the amounts of those medication that he had been dispensed and which were missing from the packets found near his body.[4] Several of the drugs Mark had taken were at elevated lethal or borderline fatal levels individually and, taken with alcohol would have had a cumulative effecting leading to respiratory depression and death.

This inquest has focussed on the circumstances of Mark's final discharge from Wollongong Hospital, his having been given a week's supply of prescribed medication, why his family was not advised he had left Oolong House and been again admitted to Wollongong Hospital, and whether Mark intentionally took his own life.

2. The Nature of an Inquest

The primary statutory role of a Coroner is to seek answers to the following questions: Who died? When and where did he die? What was the cause of death? What was the manner of the death? The answers to the first three questions are

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[1] Autopsy report dated 2.2.12, ex.1, p.2.
[2] Ibid.
[3] Ibid.
[4] Ex.2, p.87.

straightforward and not in issue. The focus of this inquest has been upon the manner in which Mark died.

An inquest is not adversarial in nature; the proceedings are neither criminal nor civil. It is not the function of the Coroner to make formal findings of negligent behaviour. Nor is an inquest a Royal Commission with power to investigate matters more widely. If any specific or systemic failings are identified, any commentary or findings are done so merely in the context of determining the manner and cause of death.

These findings are not an exhaustive summary of all the documentary and oral evidence. I have, however, taken into account all the evidence and the submissions of the parties.

3. Social and Mental Health History

Mark was born on 16th March, 1972. He had a long, although unfortunately episodic and unsuccessful, engagement with the mental health system that dated back until at least 2008. There is a consistent theme in his medical records as well as his mother's detailed statement, of anxiety, drug and alcohol abuse, gambling addiction, and thoughts of self harm. His ability to cope with these issues appears to have significantly deteriorated in the final months of 2011.

On 19th September, 2011 he was admitted as a voluntary patient to the Parkview Unit at Macquarie Hospital. He is described as "intoxicated and expressing thoughts of self harm...this is in the context of a several month history of depressive features, progressively worsening over the last 2 weeks characterised by decreased mood, thoughts of worthlessness, amotivation and suicidal ideations."[5] He had two incidents of attempted self harm whilst on unescorted leave during this admission: on 8th October he was reported to have consumed six beers and 25 x 5mg Diazepam tablets; on 17th October he consumed 10-12 beers and started gambling, then felt guilty and began to lacerate his forearms with his credit card. After attending a police station he was transferred to Ryde Emergency Department for review. He was

[5] Ex.2, tab 20, p.565

assessed as suitable for drug and alcohol rehabilitation at William Booth and was due to take up a bed there on 31st October, but failed to return to Macquarie Hospital from leave on 30th October.

Mark then caught a train to Waterfall, slept in bushland, and walked to Wollongong, presenting at Wollongong Hospital on 31st October stating, "he doesn't know what's going on, thoughts of self harm."[6] By 1st November he denied thoughts of self harm and was admitted to the mental health unit as a voluntary patient. He told the psychologist, "that sometimes he feels like he's being watched by someone and like people are calling his name. He is anxious about this as he's never experienced this before."[7] Arrangements were subsequently made for Mark to attend drug and alcohol rehabilitation at Peppers, in Wagga Wagga. The letter from Wollongong Hospital to that facility states, "his psychiatric diagnosis is a severe major Depression with transient psychotic features but ongoing prominent anxiety and symptom limited panic attacks...He has an underlying vulnerable personality with low and fragile self-esteem with ongoing feelings of guilt about his current dependent relationship with his parents."[8]

Mark arrived by train at Peppers Rehabilitation Facility on 14th November. However, five days later he was taken to Wagga Wagga hospital, "hearing voices which are telling him to kill himself denies plan, denies self harm."[9] He was transferred to Chisholm Ross mental health unit at Goulburn Hospital on 20th November, where it was noted, "It is difficult to be certain about the cause of his paranoid beliefs and auditory hallucinations. I suspect it is related to a mild chronic psychosis (though the main differential diagnoses would be a drug induced state or pseudo-hallucinations related to cluster B personality traits)."[10]

On 25th October Mark transferred to Cumberland Hospital, where he spent a further three weeks. A letter from Dr Stanek states, "Mark's main problem is substance abuse...he is currently not psychotic but depressed and doesn't need further inpatient

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[6] Ex.2, tab 19, p.382.
[7] Ibid., p.477.
[8] Ibid., p.401.
[9] Ex.2, tab 18, p.375.
[10] Ex. 2, tab 17, p.347.

treatment."[11] His parents then arranged for him to attend drug and alcohol rehabilitation at Oolong House, Nowra, and drove him there on 19th December. On admission, Mark nominated his mother as his next of kin and provided her telephone number on the admission forms.[12] Mr and Mrs Gleeson expected Mark would remain there for a number of weeks and that he would call them on Christmas Day. However, this was the last time Mark's parents saw him alive.

Mrs Gleeson, with her husband and son, Warren, spoke movingly at the conclusion of the evidence. She described her son's wonderful sense of humour and loving nature, and how he loved the outdoors. Mrs Gleeson also noted, above all, Mark's love of his family and, especially, his son, Connor. The photograph Mr Gleeson handed me of Mark and Connor shows his happy smile and protective love of his son. The tragic manner of Mark's early death is clearly a burden the Gleeson family and Ms Henry continue to carry and he is sorely missed and loved by them all.

4. The Events of 20th-21st December, 2011

On 20th December, the day after his admission to Oolong House, Mark told staff he was hearing voices telling him to kill himself, and he was taken to Shoalhaven Mental Health and then to Shoalhaven Hospital. He told the mental health nurse, "worried going to harm myself because voices telling me to...voices to harm himself – slit his wrists, thoughts of self harm + suicide – some finger scratching on inside forearms."[13]

He was transferred to Wollongong Hospital, where he was admitted to the mental Health Unit as a voluntary patient. For the first time documented in any of the records in evidence, Mark declined to nominate anyone as his primary carer.[14] Entries on his risk assessment checklist include, "hopelessness/despair, expressing high levels of distress, command hallucinations, paranoid ideation about others."[15]

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[11] Ex. 2, tab 15, p.222.
[12] Ibid., p.188.
[13] Ex. 2, tab 14, p.164.
[14] Ex. 2, tab 13, p.92, p.96.
[15] Ibid., p.119.

The Career Medical Officer in Psychiatry, Dr Abujam, assessed Mark at about 11.30am on 21st December. She made very detailed notes of this assessment including, "Was c/o [complaining of] extreme anxiety, feeling suspicious + hearing voices, feeling that others are aware of his thoughts and can read his mind, derealisation/depersonalisation kind of phenomenon as if he is not real and watching himself from outside."[16] Dr Abujam described in her oral evidence how Mark wanted her to increase his prn Valium from 10mg to 80mg, but she negotiated this down to 20mg. Her notes further state she found, "no formal thought disorder, ?paranoid delusion, ?thought broadcasting phenomenon, thoughts of self harm...?auditory hallucinations...Impn [impression] ?first episode of psychosis (late onset), independent of substance, ?personality issues, ?depression/anxiety issues, poly-substance abuse, past h/o [history of] gambling problem/addiction (no forwarding address right now."[17] In evidence she explained that this was simply her provisional diagnosis, and that the last five issues she had noted pointed to the possibility of personality disorder.

Dr Abujam asked the Chief Psychiatrist, Dr Oldham to further review Mark with her. She again made a detailed note of that examination at about 12.30pm: "reports he is feeling very low, it doesn't matter whether I live or die, but I need help...hears voices all the time, feels others can read his mind...tells he will do it properly if he plans to die...got upset when informed to limit his prn medication. Got further upset while discussing the goals of his inpatient treatment. Impression – personality disorder. Patient request for discharge as he has concerned that he doesn't think he can receive help here and that moreover he is a voluntary patient. He doesn't have a discharge destination...Reports maybe he'll go to Melbourne."[18]

In evidence, Dr Oldham explained how the reference to hearing voices was not an hallucination but, rather, Mark giving a lucid and coherent account of his harsh and self-critical thoughts, of his being angry with himself for disappointing his parents. He considered that Mark did not feel helpless, but that he had a plan to see his son

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[16] Ibid., p. 148.
[17] Ibid., p. 149.
[18] Ibid., pp. 150-151.

and felt ready to take some responsibility for his life, although he was not yet ready or willing to involve others in his world. Dr Oldham's treatment plan was for Mark to remain on the ward and talk about his plans and reasons to stay sober, or alternatively to return to Oolong House. To effectively address his personality disorder would require commitment to long term therapy such as dialectical behaviour therapy. However, the way Mark asked for a large amount of benzodiazepam on top of his other medication made Dr Oldham feel that Mark saw his hospital admission as a way of getting other drugs. When Mark's request was refused, it was a turning point and Mark decided he was not going to get what he wanted there and wanted to leave.

There was a delay in a social worker attending the ward and Mark refused to wait any longer. He was then discharged from Wollongong Hospital at 2.30pm. He was given the crisis contact number, information about emergency accommodation, and seven days' supply of his prescription medication: 14 tablets of Olanzapine (Xyprexa) 5mg, 42 tablets of Quetiapine (Seroquel) 200mg, 7 tablets of Clonazepam (Benzodiazepam) 2mg and 14 tablets of Sodium Valproate 500mg.

At about 9.30am the following morning Mark was found deceased by a member of the public next to a relay hut in the rail corridor not far from Wollongong Hospital. The empty medication packets and his hospital identification band led police to make enquiries with Wollongong Hospital and Oolong House and, ultimately, to contact Mrs Gleeson.

5. Consideration of Issues

As indicated above, this inquest has focussed on the following issues:

a) Why did Mark leave Wollongong Hospital on 21st December, 2011?
b) Why was his family not advised he had left Oolong House and been admitted to Wollongong Hospital?
c) Why was he given a week's supply of prescribed medication?
d) Did Mark intentionally take his own life?

I shall now consider each of these issues in turn.

a) Why did Mark leave Wollongong Hospital on 21st December, 2011?

Mark's decision to leave Wollongong Hospital appears to have been prompted by the (appropriate) refusals by Dr Abujam and Dr Oldham to significantly increase his prn dose of Diazepam. Once Mark was aware his medication was not going to be increased, the proposed treatment plan was not acceptable to him, and he requested discharge, "as he was concerned that he doesn't think he can receive help here."[19] Dr Oldham gave evidence of how he had outlined his treatment plan for Mark, and that he wanted him to stay, so he could have conversations that would help him make a commitment to long term treatment. A bed was available and Dr Oldham told Mark he was welcome to stay. Dr Abujam was also worried about Mark because of his vulnerability to drug, alcohol and gambling issues. Indeed, she spoke to Mark in his room after the consultation with Dr Oldham concluded and offered to telephone Oolong House for him to confirm if his bed was still available. However, Mark refused this offer.

Dr Oldham explained to Mark the consequences of discharge against medical advice and the risks he faced, in particular that Mark would be vulnerable given his history of drug, alcohol and gambling issues if he were not in treatment and that this would be exacerbated by it being the Christmas holiday season. He described Mark as being competent to make his decision to leave, that he understood the treatment he was being offered, and that he was able to weigh the decision in his mind and communicate it. However, Mark was committed to his own plan of travelling to Melbourne to see Connor.[20]

Mark was a voluntary patient in the mental health unit. He could not be involuntarily admitted or detained unless he was a mentally ill or mentally disordered person and there was no other available care of a less restrictive kind, consistent with safe and effective care. Dr Oldham explained that Mark showed no signs of being mentally ill or mentally disordered, and no signs of being at immediate risk of harm to himself or

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[19] Ex. 2, tab 13, p.151.
[20] Ex. 2, tab 6, p.52, par. 11.

others. Indeed, as Dr Oldham did not consider that Mark met those *Mental Health Act 2007* criteria, he was required to let Mark leave.[21]

Dr Oldham's concerns were for Mark's mid to long term progress. He explained how Mark was finally showing signs of accepting responsibility for his actions and the impact they had on others. In that context, detaining Mark against his will carried the real risk of making him worse by giving him even less confidence in himself. Tellingly, Dr Oldham concluded his evidence with the comment that, "If I didn't feel he was safe to manage himself, I couldn't discharge him because I could not feel he would be safe."

A/Prof. Robertson, who was engaged as an expert to review and comment upon Mark's care and treatment at Wollongong Hospital, was of the view that Dr Oldham had methodically evaluated Mark's competence in relation to treatment refusal and his ability to formulate an alternate management plan. He was satisfied that Dr Oldham and Dr Abujam had exercised an appropriate duty of care in addressing Mark's mental state and that his clinical care was of a reasonable standard.[22] His oral evidence supported Dr Oldham's assessment and planned treatment for Mark and he agreed that what Dr Abujam and Dr Oldham did in managing Mark's decision to discharge was reasonable on the evidence available to them at the time, and that they had no choice other than to let him go.

I am therefore satisfied that it was appropriate in all of these circumstances for Mark to be allowed to leave Wollongong Hospital.

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[21] The relevant provisions are found in Chapter 3 of the *Mental Health Act, 2007*. They state:

12 General restrictions on detention of persons

(1) A patient or other person must not be involuntarily admitted to, or detained in or continue to be detained in, a mental health facility unless an authorised medical officer is of the opinion that:

(a) the person is a mentally ill person or a mentally disordered person, and

(b) no other care of a less restrictive kind, that is consistent with safe and effective care, is appropriate and reasonably available to the person.

(2) If an authorised medical officer is not of that opinion about a patient or other person at a mental health facility, the officer must refuse to detain, and must not continue to detain, the person.

(3) An authorised medical officer may, immediately on discharging a patient or person who has been detained in a mental health facility, admit that person as a voluntary patient.

[22] Ex. 2, tab 11, p.77.

b) Why was Mark's family not advised he had left Oolong House and been admitted to Wollongong Hospital?

Mark was taken to Oolong House by his parents and, on admission, nominated his mother as his next of kin and provided her telephone number.[23] However, no-one from Oolong House contacted Mrs Gleeson to let her know that Mark had been taken to Shoalhaven Hospital and that he had been discharged from the rehabilitation facility. The Chief Executive Officer of the Oolong Aboriginal Corporation has since advised that Mark did not request that his family be contacted in relation to his progress or discharge. As there was no written consent to contact family, it was not their normal practice at that time to notify family in such circumstances. To the organisation's credit, this practice has now changed and families are contacted where consent is given.[24]

The clinicians at Wollongong Hospital were bound by the provisions of the *Mental Health Act 2007*, which enables a patient to nominate a primary carer.[25] If a patient chooses to not nominate a primary carer, clinicians are generally required to give effect to that choice. On 20th December, for the first time in any of the records contained in Exhibit 2, Mark declined to nominate his mother (or anyone) as his primary carer.[26] Dr Abujam further explained that if his family had contacted the hospital in these circumstances she would have to have revisited this nomination with Mark before they could be given any information about him.

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[23] Ex. 2, tab 15, p.183.

[24] Ex. 2, tab 10, pp. 65-66.

[25] 72 Nomination of primary carer

(1) A person may nominate a person to be the person's primary carer for the purposes of this Act.

(2) A person may nominate persons who are excluded from being given notice or information about the person under this Act and may revoke or vary any such nomination.

(3) A person who is over the age of 14 years and under the age of 18 years may not exclude the person's parent by a nomination under subsection (2).

(4) A nomination, variation or revocation is to be made in writing and may be given to an authorised medical officer at a mental health facility or a director of community treatment.

(5) A nomination remains in force for the period prescribed by the regulations or until it is revoked in writing.

(6) An authorised medical officer or a director of community treatment is, in carrying out his or her functions under this Act or the regulations, to give effect to a nomination or a variation or revocation of a nomination, if notified of the nomination, variation or revocation.

(7) An authorised medical officer or a director of community treatment is not required to give effect to a nomination, or a variation or revocation of a nomination, if the officer or director reasonably believes:

(a) that to do so may put the patient or nominated person or any other person at risk of serious harm, or

(b) that the person who made the nomination, variation or revocation was incapable of making the nomination, variation or revocation.

[26] Ex. 2, tab 13, pp.92, 96.

The clinicians were also restricted by privacy legislation and duties of confidentiality between a doctor and patient.

It is clear from the evidence that Dr Abujam and Dr Oldham did all they appropriately could to get Mark to change his mind about family contact. Dr Oldham, in speaking to Mark about his vulnerability if he left, suggested he at least allow them to let his family know what was happening, but Mark shook his head and said, "No." Dr Oldham candidly stated in evidence that, "I was tempted" to contact the family against Mark's will, but felt it would totally destroy what little therapeutic relationship they had established with him, as well as Mark's capacity to engage with any other clinicians in future.

Dr Abujam, in her subsequent conversation with Mark in his room, offered to telephone his family and ask them to collect Mark from the hospital. However, Mark told her he had been trouble for his family and did not want to trouble them any further.

A/Prof. Robertson endorsed the position taken by Dr Oldham and Dr Abujam, stating that the situation would not allow them to legally contact Mark's family.

I therefore find that it was appropriate, although tragically unfortunate, that Mark's family were not notified of his discharge from Oolong House and his admission to and discharge from Wollongong Hospital.

c) Why was Mark given a week's supply of prescribed medication?

When Mark discharged from Wollongong Hospital he was given sufficient prescribed medication for seven days. This was in accordance with standard NSW Health procedure that prescriptions on discharge should not exceed seven days, and common practice at Wollongong Hospital hereby patients were usually given a week's supply of medication.[27]

At the time of his discharge on 21st December, the Christmas holiday period was fast approaching and with it, associated difficulties in seeing a general practitioner to

[27] Evidence of Dr Oldham, 17.6.14.

obtain a further prescription for ongoing medication. Additionally, Mark was intending to travel away from the local area and interstate and appears to have led a somewhat chaotic and disorganised lifestyle when not in formal care, no doubt increasing the difficulty in finding a doctor to continue his medication.

Further, Mark was placed on that same medication regime during his three-week admission to Cumberland Hospital in November. Dr Abujam, who had only seen Mark for one day, therefore acted appropriately in not making any change to his medications. As she explained in evidence, it was not appropriate to cease Mark's high dose of antipsychotic medication; that needed to be done slowly and in a secure environment. Indeed, she had a duty of care to provide sufficient medication so as not disrupt the continuity of his pre-existing medication regime. She further noted that in her experience many patients had relapses because they were unable to get their medication or see a doctor, and then overdosed when they ultimately obtained their medication again.

When Dr Abujam's evidence was put to Dr Oldham he agreed with her comments and supported her decisions. He also noted how they were "really surprised" to hear that Mark had died and that he had not come across a person overdosing on discharge medication before. Significantly, he stated words to the effect of, "If I considered only two days' medication was appropriate, I'd never discharge the patient, because I would have thought that the person was not safe with medication." Dr Oldham or Dr Abujam stated that if they had any inkling that Mark would take all his medication at once they would have reassessed the voluntary nature of his admission.

In his report of 29th January, 2014, A/Prof. Robertson expressed concern about, "the dispensing of a lethal amount of psychotropic medication to the deceased."[28] However, when taken through each of the factors contributing to the decision to give Mark a week's supply of medications on discharge, A/Prof. Robertson stated, "I would have been compelled to make the same decision, given the way the Mental Health Act is set up."

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[28] Ex. 2, tab 11, p.77.

While hindsight and the knowledge of what happened to Mark less than twenty hours after he left the hospital make us question the wisdom in giving him such a large supply of medication on discharge, I accept that the decision to do so was properly informed and appropriate in all of the circumstances at the time.

d) Did Mark intentionally take his own life?

Before making a finding of suicide, a coroner should apply the *Briginshaw*[29] standard, and be comfortably satisfied that this is the case on the balance of probabilities. The Briginshaw standard of proof was clearly explained in *Neat Holdings Pty Ltd v Karajan Holdings Pty Ltd*:

> "The ordinary standard of proof required of a party who bears the onus in civil litigation in this country is proof on the balance of probabilities. That remains so even where the matter to be proved involves criminal conduct or fraud. On the other hand, the strength of the evidence necessary to establish a fact or facts on the balance of probabilities may vary according to the nature of what it is sought to prove. Thus, authoritative statements have often been made to the effect that clear or cogent or strict proof is necessary 'where so serious a matter as fraud is to be found'. Statements to that effect should not, however, be understood as directed to the standard of proof. Rather, they should be understood as merely reflecting a conventional perception that members of our society do not ordinarily engage in fraudulent or criminal conduct and a judicial approach that a court should not lightly make a finding that, on the balance of probabilities, a party to civil litigation has been guilty of such conduct."[30]

It is clear from the available evidence that Mark took the alcohol and prescribed drugs that ultimately claimed his life. However, it is less clear that he intended this result.

Previously, on 8th October, 2011, while on unescorted leave from Macquarie Hospital, Mark reported he had consumed six beers and ingested 25 x 5mg Diazepam tablets. On 17th October, 2011, when again on unescorted leave, he consumed 10-12 beers, started gambling, then felt guilty and began to lacerate his forearms with his credit card.[31] When taken from Oolong House to Shoalhaven Hospital on 19th December, 2011, Mark told the mental health nurse he was, "worried going to harm myself

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[29] *Briginshaw v Briginshaw* (1938) 60 CLR 336.
[30] (1992) 110 ALR 449.
[31] Ex.2, tab 20, pp.564-565.

because voices telling me to...voices to harm himself – slit his wrists, thoughts of self harm + suicide – some finger scratching on inside forearms."[32]

However, there is no clear evidence of Mark intending, after discharge from Wollongong Hospital, to take his own life. To the contrary, there is evidence more suggestive of Mark having recklessly taken all his prescribed medication. Mark told Dr Abujam as well as the clinical psychologist at Cumberland Hospital[33] that his prescribed level of medication was too low to have the desired effect. On discharge from Wollongong Hospital he had a plan to travel interstate to see his son, whom he had not seen for a long time, for Christmas. Further, Dr Abujam and Dr Oldham stated that Mark had no plan to self-harm and was at low risk of suicide.

Dr Oldham explained how it is common for patients to express *thoughts* of self harm but that very few had actual plans to carry this out, and that Mark's comments recorded in the medical notes of 19th-21st December, 2011 were generalised and reflective of his self-critical thoughts rather than any plan to end his life. He also noted that Mark was taking a positive step in accepting responsibility for his past behaviour, and that he was beginning to make amends with his plan to see his son. When taken to Mark's account of his drug use on admission to Oolong House,[34] Dr Oldham commented that Mark was taking a cocktail of drugs, anything he could get his hands on, and displaying recklessness in doing so, particularly in taking the drugs with alcohol and not knowing how each drug interacted with the other.

Dr Abujam explained that when Mark answered "yes" to questions about thoughts of self harm, it was a vague response to the questioning, indicative of ongoing chronic thoughts of self harm, but not of his having any plans to carry it out. She also commented on how impulsivity increases with the intake of alcohol and that maybe this had a role in Mark wanting to take all his prescribed drugs.

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[32] Ex.2, tab 14, p.164.
[33] Ex.2, tab 16, p.282.
[34] 2 cartons beer per day, 1g amphetamine every second day, 1g ice 5 days per week, and 2-3g cocaine 2 days per week. He last used these substances 6 weeks prior to his admission to Oolong House. Ex. 2, tab 15, pp.188-189.

A/Prof. Robertson noted that it was common in patients with borderline personality disorder to "blow hot and cold" and to make impulsive, ill-advised decisions. This adds considerable weight to arguments that Mark did not deliberately intend to take his life when he consumed his prescribed medication.

Thus, in the absence of clear evidence of an intention at the time to take his own life, I am not satisfied to the requisite standard that Mark deliberately took his own life.

6. Conclusion

This has been a very sad case. Mark was still a young man when he died and it is clear from the evidence before this inquest that he was much loved and had many good qualities and attributes, while at the same time struggling with his demons of apparent personality disorder, and drug and alcohol abuse. Mark's parents, Janice and Ivor Gleeson, never gave up on him despite his complex history and sought to support him through and between his various hospital admissions and to facilitate his admission to drug and alcohol rehabilitation. Their presence with other family members during this inquest has been further testimony to their love for their son and concern to better understand the sad circumstances of his death.

It is also clear from the written and oral evidence that both Dr Oldham and Dr Abujam were very caring, thoughtful and considerate and showed an impressive degree of commitment in their care and treatment of Mark.

7. S.81(1) Findings

As a result of considering all of the documentary evidence and the oral evidence given at inquest, I make the following findings in relation to this death.

Identity of deceased: Mark Richard Gleeson.

Date of death: on or about 21st December, 2011.

Place of death: the rail corridor near the corner of Railway Parade and Governors Lane, Wollongong, New South Wales.

Cause of Death: respiratory failure as a result of the interaction of prescribed medication and alcohol.

Manner of Death: accidental.

8. Recommendations

Coroners have power, pursuant to s.82(1) of the *Coroners Act 2009*, to make recommendations connected with a death investigated by inquest. For the reasons set out in these findings, I decline to make any recommendations.

SIGNATURE

Signature	
Name	Geraldine Beattie
Capacity	Deputy State Coroner Wollongong
Date	18th June, 2014