Submission No 22

INQUIRY INTO CORONIAL JURISDICTION IN NEW SOUTH WALES

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Date Received: 11 July 2021

Submission: Upper House Inquiry Select Committee on the coronial jurisdiction in New South Wales – Lynda Newnam 11th July 2021

Reducing the rate of suicide deaths in NSW by 20% by 2023 is a Premier's Priority

see **https://www.nsw.gov.au/premiers-priorities/towards-zero-suicides**

> *"Every suicide is a tragedy and touches so many. Families, friends and communities across NSW are devastated by the impact of suicide, with an estimated 16 lives lost each week. No one should have to go through the grief of losing a loved one to suicide.*
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> *Suicide prevention is everybody's business and there is still much to do. Suicide is a complex problem and we all, as individuals, communities, the private sector and government need to take focused and coordinated steps to reduce it and provide greater support across the community……*
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> *A total of 937 people died by suicide in NSW in 2019, more than double the state's road toll that year.* ***Reducing the rate of suicide will require collaborative and compassionate action across the community****."*

Every case of suicide is provided to the Coroner and the total number make up approximately 10% of reported deaths - as quoted in https://www.smh.com.au/national/nsw/no-spike-in-nsw-suicides-in-2020-despite-covid-19-lockdowns-bushfires-20201109-p56cug.html I am making this submission as someone who has direct experience of one case as it has been processed over the past year. My son took his life at the end of May 2020.

My understanding of the coronial process prior to this had been informed by conversations and observations growing up in residences attached to Police Stations where my father was officer-in-charge. More recently, my son and I took an interest in how rock fishing deaths were addressed. We were both volunteers for a DPI fishing/habitat education program and resident within walking distance of identified 'hotspots.' We regularly distributed brochures and DVDs on the dangers of rock- fishing. It was obvious that measures, including strong warning signs, needed to be put in place, but it wasn't until around 6 years ago that concerted action was taken. In the case of the hotspots near us I understand the State agency which managed the land had objections to signs. I quote this because so often there are barriers not based on evidence but on narrow preferences.

Of the 937 people who died by suicide in NSW in 2019 (i.e. 18 per week not 16 as quoted in the Premier's Priority) some of those of 'senior years' may have preferred an 'assisted dying' alternative. This is not the place for such discussion however, I would make the point that it would be helpful if deaths were characterised in terms of risk and social loss. At 32 years the most likely cause of death for my son was suicide. Further, as a male in the age group 30-34, the risk factor was significantly higher than for females - approximately x4. Australian Bureau of Statistics figures are 26.1 Male to 6.2 Female per 100,000. https://www.abs.gov.au/statistics/health/causes-death/causes-death-australia/latest-

release In a few conversations with medical professionals I've noted a lack of awareness of actual statistics and hence risk factors. And even the Premier's target is lacking. A 20% reduction might be achieved in older age groups while youth suicide figures continue to grow. 'Traded lives' is a term used by some professionals in relation to COVID management.

The same ABS report, quoted above, revealed that the greatest cause of potential life lost in Australia in 2019 was not heart disease or cancer, but suicide. Despite ranking only 13th in the table of leading causes of death, when median age of death is taken into account, the true impact of suicide becomes evident. Suicide accounted for 115,000 years of potential life lost, far exceeding the 7,000 years lost to dementia and the 78,000 lost to ischaemic heart disease. Years of Potential Life Lost measures the gap between age at death and average life expectancy in Australia (currently 85 years for women and 79 years for men). In 2019, suicide was the leading cause of death among people aged 15 to 49, with a disproportionate number being males.

In the weeks since this Inquiry was established, I have received two pieces of correspondence from the Coroner's Court. The first, an email, was in response to a follow-up of previous email correspondence. The second piece arrived on the 30th June, by email and then later by post. This was a four-page document signed by a Registrar. I make two points here:

The four-page document contained sensitive material yet was posted as ordinary mail to my street address.

There was no mention of this Inquiry in the first or second pieces of correspondence.

From the four-page document: "*the Coroner thinks that it is not necessary to hold an inquest. This is because holding an inquest will not add any further information to what the Coroner already knows from the results of the police investigation and from the available medical evidence."*

Only a small number of deaths go to an Inquest and this is explained in documentation on the Coroner's website and for me was reinforced in email correspondence. My concern in requesting an Inquest was to highlight what I saw as a link between shutting down areas of society/economy and not putting compensatory supports in place, such as proactively requiring GPs to enquire about the effects of the shut-down and to monitor/step up monitoring the well-being of their patients on Mental Health Care Plans. As a consequence of the Shut Down Orders my son lost a number of essential routines including fitness, university study, work in music teaching as well as music performance and volunteering. While he couldn't teach music, perform, attend music labs, see friends and do his regular fitness routine it was, nonetheless, deemed appropriate to allow unlimited shopping for non-essentials in large retail stores in air-conditioned shopping centres. My son had been prescribed anti-depressants in late February. Prior to this no antidepressants had been prescribed rather he undertook the allowable 6 subsidised psychology sessions. At the late

March GP check, after shutdown, the dose was doubled, and he was sent off with scripts for 6 months. There was no follow up in April and/or May, which was the height of the shut-down in NSW when even beaches were barricaded. When I asked the GP whether South East Area Health had issued a protocol/instruction to increase monitoring of patients on Mental Health Care Plans, he was initially silent and then said, '*I hear your frustration'*. He added that it '*hadn't occurred to him'* and that this '*had only happened to him once before'*. I also said that as there was reduced demand for in-person clinic services why hadn't he used the time to check his Mental Health Care Plan patients. He said he had a lot of elderly patients to visit. I live near 9 Major Hazard Facilities and have taken an interest in Emergency Planning for over 15 years and have encountered resistance in meeting community preparedness requirements. I was also aware that Pandemics are covered in a Sub-Plan under the State's Emergency Plan and that community preparation is part of that. Since SARS 2003 it has been considered a likely event – a 'when' not an 'if'.

What follows is a brief summary of interactions in the process from late July 2020 to June 2021:

In late July 2020, an interview appointment for 1st August was set up by the Police Constable who attended the scene end of May and was subsequently assigned the case. Family members gathered for the interview. The Constable phoned on two occasions during the night to say he was delayed and then rescheduled to 2nd August. On the 2nd August he was delayed again. I had by this time written up a timeline based on research on telephone and bank records, thousands of emails and notes from a number of conversations plus images – in all 27 pages. I copied this to a USB. The Constable rang again to say he could not attend but sent officers already on patrol to collect my USB. I was concerned about the security of the USB and phoned and emailed on the following days to confirm that he had received it. I was advised the Constable was off duty and I left a message. I didn't get a response. I put this down to Police being exceptionally busy particularly with increased rates of DV. I rang the Coroner's Court on the 4th August and a staff member spoke to me about the process. I said I had provided a written account to Police. He suggested I could also provide it to the Court and that they would welcome anything I could provide at any time. This particular staff member I found to be thoughtful, reassuring and of practical assistance. I emailed the 27-page document and he stayed on the phone line to confirm receipt. I received a formal acknowledgement of receipt on the 19th August from another staff member.

On 3rd October I received an email from the Constable to say he had submitted his *Brief of Evidence* to the Coroner along with a *Request for Inquest* Form. I emailed the Coroner's Court requesting direction as to whether I should ask for an Inquest. I didn't receive a reply. On the 13th October, I submitted a request, which was 3 pages. It was primarily a condensed version of the previous with the benefit of 10 weeks of additional research. I asked for confirmation of receipt. I didn't receive a confirmation so followed up by email and after a subsequent email received confirmation that both the 27- page document and request were on file.

In late December, after the publication of a Sydney Morning Herald article that stated that suicides were lower during COVID I emailed again to ask whether my son had been included and if that were the case why had I not received a report. By this time, I was aware of other families who had lost young people during the shutdown. Their knowledge I suspected was not being captured in this process.

There was no correspondence between me and the Coroner's Court from late December 2020 to early June 2021. Then on the 8th June,2021, during a sensitive period following the anniversary, I emailed the Coroner's Court for an update. I said "*it is very upsetting waiting so long particularly given how the measures put in place for COVID impacted his wellbeing in April and May 2020. I thought there would be interest in case studies like this where critical supports were taken away and service for patients on Mental Health Care Plans reduced at the same time. How does the State get better at Health treatment and rolling out emergency measures if it doesn't look at these cases?"* I received a reply on 10th June to say the matter was currently under review "*as they undertake further investigations*" and that "*I am unable to give you a timeframe*". The question I posed regarding the collection of case studies and using these to inform better practices was not addressed and **nor was I advised of this Inquiry.**

On the 30th June I received the final correspondence. The account from the Coroner reads to me as a summary of what I provided from August onwards and except for the possibility of clarifying a point with the psychologist I can see no additional information that might have been collected let alone gaps identified and information analysed. I am not suggesting that other contacts were not made but I am not to know as the process does not allow this.

From a purely personal perspective I don't have an objection to the content, and I note that the tone is considerate and respectful. However, my reason for making a submission to your Inquiry and in pursuing threads identified in my own investigation is to provide a personal case study that considers social, institutional and professional inputs. If added to other case studies, it might ultimately feed into a better understanding of how well-being is addressed, and that applies particularly to professionals within the Health system but also to how principles are embedded within institutional practices. As individuals within a complex society we are obliged to operate at the 'mercy' of institutions and professionals and raise our young accordingly.

The Coroner occupies a special position in having the potential to better facilitate the collection of information. I would urge committee members to make recommendations that reflect this critical role.