FORM 37

Rule 60(1)

FINDING INTO DEATH WITH INQUEST

Section 67 of the ***Coroners Act 2008***

Court reference: 1670/07

Inquest into the Death of JODI JOY McPAUL

Delivered On:	22nd December, 2009
Delivered At:	Melbourne
Hearing Dates:	18th August, 2009, Coronial Services Centre, Southbank
Findings of:	PARESA ANTONIADIS SPANOS
Representation:	Dr Elizabeth Brophy, on behalf of Peninsula Health/ Frankston Hospital Senior Constable Kelly Ramsey
Place of death:	Mornington Peninsula Hospital, 2 Hastings Road, Frankston 3199

FORM 37

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FINDING INTO DEATH WITH INQUEST

Section 67 of the Coroners Act 2008

Court reference: 1670/07

In the Coroners Court of Victoria at Melbourne
I, PARESA ANTONIADIS SPANOS, Coroner

having investigated the death of:

Details of deceased:

Surname: McPAUL
First name: JODI
Address: 36 Lomica Drive, Hastings 3915

AND having held an inquest in relation to this death on 18th August, 2009
at Southbank
find that the identity of the deceased was JODI JOY McPAUL
and death occurred on 3rd May, 2007

at Mornington Peninsula Hospital, 2 Hastings Road Frankston 3199

from
1a. HYPOXIC BRAIN INJURY
1b. PLASTIC BAG ASPHYXIA
2. SCHIZOPHRENIA

in the following circumstances:

BACKGROUND AND PERSONA CIRCUMSTANCES[1]

1. Ms Jodi Joy McPaul was a thirty-three year old single woman who resided with her mother Mrs Noeleen McPaul at 36 Lomica Drive, Hastings. Ms McPaul had a young son who lived with his father interstate and she had limited contact with him, largely as a result of her psychiatric illness. She started experiencing the symptoms of psychiatric illness in her late teens, was eventually diagnosed with Schizophrenia and had a long history of engagement with psychiatric services, most recently through Peninsula Health. Ms McPaul's mother cared for her, supported

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[1] This finding is based on all the material the product of the coronial investigation of Ms McPaul's death, that is the brief compiled by Senior Constable Tim Collins from Frankston Police, the evidence of those witnesses who testified at inquest and any exhibits tendered and submissions made by or on behalf of parties. I do not purport to summarise all the material in this finding but only refer to it in such detail as appears necessary on the basis of forensic significance and narrative clarity.

her through her illness, associated psychosocial difficulties and advocated for her with psychiatric services..

ADMISSION AS AN INVOLUNTARY PATIENT - 29 MARCH 2007

2. Ms McPaul's illness had proved difficult to treat over the years, in part because she experienced many undesirable side-effects, and in part because she deeply resented having to succumb to any treatment. The result was that she received less than optimum doses of medication in order to avoid the unacceptable side-effects, so her symptoms were at best alleviated or reduced, but generally always present to some extent. Even within this context, her illness appeared to have deteriorated over the two year period to January 2007 and she presented a significant management challenge due to the severity of her illness, her lack of insight, her completes psychosocial circumstances and the ongoing stress of estrangement from her son. Ms McPaul's clinical course of this period was characterised by frequent relapse and a recent suicide attempt in November 2006.

3. On 29 March 2007, Ms McPaul's Community Treatment Order (CTO) was revoked and she was admitted to the Adult Acute Inpatient Unit (Ward 2 West) at Frankston hospital, as an involuntary psychiatric patient. Her admission was precipitated by a worsening of her illness with an increase in auditory hallucinations, a belief that she was receiving threatening phone calls on her mobile, a fear that she and her mother would be captured and tortured, and a feeling that the world was not a good place in which to live. At the time of her admission, she had some ideas of not wanting to live and talked about writing a will, but on direct questioning, had no suicidal ideation, intent or plan.

4. Prior to her admission, Ms McPaul was prescribed Olanzapine ("Zyprexa" an antipsychotic) 22.5mg daily, Fluepenthixol (an SSRI antidepressant) 20mg fortnightly by intramuscular injections and occasional Diazepam (an anxiolytic) and Temazepam (a hypnotic/sedative). The intention on admission was to consider a change of medication to Amisulpride ("Solian" and antipsychotic). This change was introduced as a topic for discussion topic so as win Ms McPaul's cooperation. The possibility of electroconvulsive therapy was also discussed. Ultimately, Ms McPaul refused to change to the new oral medication "Solian" and, as at the time of her death, the plan was to increase Flupenthixol to 40mg.[2]

5. From the time of admission, Ms McPaul's risk assessment was such that she was allowed supervised leave with her mother. She went out on leave on a number of occasions including over the Easter weekend. On 16 April 2007, staff noted some deterioration in her mental state when she returned from leave and also noted that she appeared cyanotic at times. This was investigated

[2] Exhibits "A" and "B" and Dr Newton's evidence at transcript pages 3-7, 19.

by a medical review and no cause found. By 23 April 2007, there were further reports that Ms McPaul spent much of the day praying when she was on leave and that, for her, this was an indicator of increased risk of self-harm. On direct questioning, however, she continued to deny any suicidal ideas of self harm.[3]

1ST MAY 2007 - DISCOVERY OF MS McPAUL - CODE BLUE

6. Shortly after 3.00pm on 1st May 2007, Registered Psychiatric Nurse Ms Julia Payne who was nursing Mc McPaul that day realised she was missing and went looking for her. She searched her bedroom, communal areas and the dining room before looking in the visitor's toilet next to the communal living room. She found her at 3.20pm, locked in the toilet which she was able to open from the outside. Ms McPaul was slumped over in a crouched position. Her head was covered in a black plastic bag which had been secured at the back of her neck with the same knitting wool she had been knitting with earlier. Ms Payne immediately tore the bag from Ms McPaul's face and called a Code Blue.[4]

7. Medical staff came in response to the Code Blue. Immediate resuscitative measures included cardiopulmonary resuscitation, the administration of adrenaline and intubation. Ms McPaul was taken to the Intensive Care Unit where she was cooled. Investigation by CT scan of the brain showed cerebral oedema with swelling and bilateral basal ganglia infarcts. The diagnosis of hypoxic brain injury was made, and in light of her poor prognosis, the decision taken in consultation with her mother was to withdraw active treatment and to treat her palliatively. Ms McPaul was pronounced deceased at 6.50pm on 3rd May 2007.

PURPOSES OF A CORONIAL INVESTIGATION

8. The primary purpose of a coronial investigation is to ascertain, if possible, the identity of the deceased person, how death occurred, the cause of death and in particular the need to register the death - effectively the date and place where the death occurred.[5] In order to distinguish 'how' death occurred from the 'cause of death', the practice is to refer to the latter as the medical cause of death, incorporating where possible the mode or mechanism of death, and the former as the context or the background and surrounding circumstances. These expressions encompass matters sufficiently proximate and relevant to the death, and not merely matters which might form part of a narrative preceding or culminating in death.

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[3] See 2 above.
[4] Ms Payne's statement dated 7 December 2007 was part of Exhibit "K" balance of the coronial brief where she describes the position as " ...slumped over in a crouched position, which I later thought may have been a praying position as she was kneeling with her hands together." - paragraph 21.
[5] Section 19(1) of the Coroners Act 1985, "the Act".

9. Involuntary psychiatric patients are accorded a special status under the Coroners Act 1985. By definition their deaths are "reportable" irrespective of the cause,[6] and if they are admitted involuntary patients at the time of their death, the coronial investigation must encompass an inquest.[7] In this way, the legislation recognises the vulnerability of people in State care and the appropriateness of a transparent and independent coronial investigation of their deaths, and implicitly invites appraisal of the relevance, if any, of their status as a person held in care and the adequacy of the care provided.

10. A secondary purpose of any coronial investigation arises implicitly from the power to report to the Attorney-General on a death that a Coroner has investigated; to comment on any matter connected with the death, including public health or safety and the administration of justice; and to make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety and the administration of justice.[8] Whilst the current legislation does not explicitly refer to the purpose of such coronial reports, comments or recommendations, the implicit purpose, certainly the generally accepted purpose, is the prevention of similar deaths in the future. [9]

FINDINGS AS TO UNCONTENTIOUS MATTERS

11. In relation to Ms McPaul a number of the matters required to be ascertained, if possible, were uncontroversial. I find that she was Jody Joy McPaul born on the 24th August 1973, late of 36 Lomica Drive, Hastings, and that she died in the Intensive Care Unit of Frankston Hospital, at 6.50pm on the 3rd May 2007.

12. Nor was the cause of death controversial. There was no autopsy as I allowed the family's objection to autopsy pursuant to Section 29 of the Coroner's Act 1985. However, Senior Forensic Pathologist Dr Noel Woodford from the Victorian Institute of Forensic Medicine conducted an external examination, reviewed the medical records and medical deposition from Frankston Hospital and the circumstances as reported by the police, and provided a detailed report of his findings. Dr Woodford advised that it would be reasonable to attribute the cause of death to "*hypoxic brain injury secondary to plastic bag asphyxia*" with "schizophrenia" noted as a significant condition/illness not directly related to the cause or mechanism of death.

13. Dr Woodford recommended post-mortem toxicological analysis, preferable of specimens taken at the time of asphyxiation/arrest, and such analysis was undertaken on a specimen taken at

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[6] Paragraphs (i) and (iaa) of the definition of "reportable death" in Section 3 of the Act.
[7] This is the effect of paragraph 17(1)(b) mandating inquests in certain circumstances and paragraph (c) of the definition of "person held in care" in section 3, that is "a patient in an approved mental health service within the meaning of the Mental Health Act 1986.
[8] Section 21(1), 19(2) and 21 (2) of the Act re reports, comments and recommendations respectively.
[9] This is to be contrasted with the Coroners Act 2008 which refers to "prevention/preventable deaths" in its Preamble and section 1 purposes.

Frankston Hospital at 3.50pm on the 1st May 2007. The results showed no alcohol or other commonly encountered drugs or poisons, and lend support to the proposition that Ms McPaul was not taking her medication as prescribed, despite being an admitted involuntary psychiatric patient at the time.[10]

14. I find that the cause of Ms McPaul's death was a hypoxic brain injury secondary to plastic bag asphyxia, with schizophrenia noted as a significant condition/illness not directly related to the cause or mechanism of death.

HOW THE DEATH OCCURRED

15. In the circumstances of Ms McPaul's death, ascertaining how her death occurred necessarily involves some evaluation of the adequacy of the treatment of her psychiatric illness. It should be stressed that the fact of her suicide, in and of itself, should carry no adverse finding or comments about the adequacy of treatment. It is trite to say that people can and do intentionally take their own lives, some when they are tin the community either receiving treatment or not, others when they are acutely unwell and/or in an inpatient setting, whether as voluntary or involuntary patients. The association between suicide and the diagnosis of schizophrenia should not be laboured.

16. Ms McPaul has exhibited self-harming behaviours and had attempted suicide previously.[11] Most recently, in November 2006 when she took an overdose of medication. As in other instances, this appeared to be an act in furtherance of her spiritual beliefs (or delusions) rather than an act of annihilation. In terms of the formal assessment of her risk of suicide during her last admission, it was chronic rather than acute, and gave rise to ongoing difficult in treating her. The need to develop and maintain good rapport and therapeutic engagement required unobtrusive clinical management and garnering her co-operation, particularly with the choice of medication. On the other hand, the treating team were mindful that Ms McPaul was at chronic rather than acute risk, that her quality of life and level of functioning would be detrimentally affected by a highly restrictive approach. Such an approach might be required to ensure her safety, but paradoxically, would be likely to increase her risk, particularly the risk of an impulsive act of suicide. To add to the complexity, Dr Newton testified that however closely Ms McPaul was

[10] The first toxicology report dated 25th May 2007 showed no alcohol or common drugs or poisons - Olanzapine, and for that matter Diazepam and Temazepam, are routinely screened for. Antipsychotics are not routinely screened for, and a request for screening for Fluvoxetine was made in May 2009, in the course of preparation for inquest. The second toxicology report dated 16th June 2009 revealed Lignocaine, consistent with therapeutic emergency administration, but no Fluvoxetine. The toxicologist included a rider in the second report - "some of these drugs over time may have degraded during storage, hence limiting the detection of these drugs."

[11] Dr Newton's evidence at transcript pages 30-4, comments made by her mother at transcript pages 43-44 and following. The observations that Ms McPaul would be self-destructive shortly before her fortnightly depot injection Flupenthixol is also consistent with a relatively low therapeutic dosage to help reduce side-effects and the re-emergence of her illness as the level of her medication waned.

observed, the treating team were mindful that they would not be able to completely reduce the risk.[12]

17. Within this context of chronic risk, Ms Payne made a number of observations of Ms McPaul on the 1st May 2007, which alerted her to some deterioration in her mental state.[13] According to her statement, she had ongoing concerns for Ms McPaul, and had voiced these on previous occasions. Sometime between 1.00-2.00pm Ms Payne voiced her concerns during the afternoon handover. She recalled seeing Ms McPaul at about 2.50pm in the common room, and saw her hand back her knitting needles and wool to the nurses' station. Other staff had seen Ms McPaul at around 3.00pm in the corridor and in the dining room at 3.10pm. There was nothing in her behaviour at these times to alert them to any increased risk for her safety.[14]

18. Whilst the medical records bear out any number of similar observations of Ms McPaul during her last admission, it requires the benefit of hindsight to make the connection between such observations on the 1st May 2007 and her subsequent actions in taking her own life. Dr Newton's evidence on this point was appropriately reflective and cogent -

> *"in general, I don't think that we would change that approach of trying to look at quality of life and maximising function and socialisation with Jodi if we had a second chance. I think that in the three days before her death, she was - her symptoms and distress, were worsening again. And if I could do it again, we'd pick that up an act sooner, on that. But again, because she had this fluctuating illness, it's easy to go back from an end point and say look at what was happening, but looking forward, I don't think it was as clear cut as that, from a clinical point of view."*[15]

19. As I understood her position, Ms Hawkins, Ms McPaul's mother who attended the latter half of the inquest, was not critical of risk assessment or the adequacy of observations of her daughter during her admission, but of the philosophical underpinnings of psychiatry generally, and of the choice of Flupenthixol which she believed was responsible for the deterioration of her daughter's mental state. She advocated for a more holistic approach to the treatment of psychiatric illness,

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[12] See Dr Newton's evidence at transcript page 11 and following. I have paraphrased here what I understood to be the gist of his evidence about the chronic nature of Ms McPaul's suicide risk. Ms Hawkins, Mc McPaul's mother, made comments which were consistent with this assessment of her daughter as a person who could not be stopped if she embarked on a course - transcript page 52.

[13] " ... Behaviour fixed stare, pleasant and co-operative. Speech - slow monotone. Rate Volume Tone. Mood - flat - Affect - blunted ..." excerpt from the medical record in Exhibit "K" the balance of the brief.

[14] Ms Payne's statement was part of Exhibit "K" the balance of the brief, which also includes an excerpt from the medical record.

[15] Transcript page 12.

incorporating aspects of natural or alternative remedies aimed at correcting imbalances of certain substances in blood/urine.[16]

20. As I endeavoured to explain at inquest, these strongly held views were not matters I would be able to investigate or answer definitely, without straying beyond the reasonable scope of a coronial investigation.[17] Such evidence as was available on these issues came from Dr Newton who confirmed that Ms McPaul's choice of taking certain vitamin supplements was not interfered with during her admission; that although there is a disorder which mimics schizophrenia and relates to cryptopyrroles it was not the illness from which Ms McPaul suffered; and although Flupenthixol (like Olanzapine) had a side-effects profile, it was neither more nor less acceptable on the balance and in general than other medications and does not cause suicide.[18]

CONCLUSION

21. Based on the totality of material available to me, I find that the psychiatric treatment provided to Ms McPaul, as an involuntary admitted patient of Peninsula Health during her last admission, was appropriate, and further find that, regardless of such treatment, she intentionally took her own life.

COMMENT MADE PURSUANT TO SECTION 19(2) OF THE CORONERS ACT 1985

22. At inquest, I heard evidence of an internal review or "root cause analysis" conducted at Peninsula Health about Ms McPaul's death, and of subsequent changes to certain documentation and procedures. A number of exhibits were tendered by way of illustration of these changes which I do not propose to detail.[19] I note that one outcome of the root cause analysis was the recognition of plastic bags as "contraband" so as to heighten awareness of their potential as a means of asphyxiation, and another was to make clearer the connection between a change in the assessed suicide risk and the frequency of observations. While these changes certainly have the potential to improve outcomes for other patients, I am not persuaded that the outcome would have been different for Ms McPaul, who had been sighted as recently as only ten minutes before Ms Payne discovered her asphyxiating.

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[16] Transcript page 41 and following. Specifically in relation to her daughter she was concerned that her psychiatric illness might have been caused by or at least related to coenzyme Q10 deficiency, or four times higher than normal levels of cryptopyrroles, zinc depletion.

[17] Transcript page 50.

[18] Transcript page 46.

[19] See for example transcript pages 11-15, 22 and following esp 28, 38 and Exhibits "C", "D", "E", "F", "G", "H", "I" and "J".

DISTRIBUTION OF FINDING

The family of Ms McPaul
Director of Psychiatry, Peninsula Health
Chief Executive Officer, Peninsula Health
Chief Psychiatrist for Victoria, Dr Ruth Vine

Signature:

Paresa Antoniadis Spanos
Coroner

Date: 22/12/09