FORM 37

Rule 60(1)

REDACTED FINDING INTO DEATH WITH INQUEST

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

Court reference: 4272/08

Inquest into the Death of Ms P

Delivered On:	14 April 2011
Delivered At:	Coroners Court Level 11, 222 Exhibition Street Melbourne Victoria 3000
Hearing Dates:	13 and 14 December 2011
Findings of:	Coroner K M W Parkinson
Representation:	Mr John Boothby for North Western Mental Health Services Mr Stanley for Dr Michael O'Gorman
Place of death/ Suspected death:	St Vincent's Hospital Victoria Parade, Fitzroy
PCSU:	Senior Constable D Dimsey

FORM 37

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REDACTED FINDING INTO DEATH WITH INQUEST

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

Court reference: 4272/08

In the Coroners Court of Victoria at Melbourne

I, K. M. W. PARKINSON, Coroner

having investigated the death of:

Details of deceased:

Surname: P
First name: Ms
Address: Oak Park, Victoria 3046

AND having held an inquest in relation to this death on 13 and 14 December 2010 at Melbourne

find that the identity of the deceased was Ms P
and death occurred on 22 September 2008

at St Vincent's Hospital, Victoria Parade, Fitzroy, Victoria 3065

from
1a. MULTI ORGAN FAILURE
1b. HYDROCHLORIC ACID INGESTION

In the following circumstances:

1. An inquest was conducted into the death of Ms P on 13 and 14 December 2010. The following witnesses gave evidence in the proceeding: Mr Alan Spurr, Registered Nurse North Western Community Assessment and Treatment Team; Dr Michael O'Gorman; Dr Naomi Thomas, treating psychologist; Dr Lukamar Pathumanabham, Medical Officer North Western Mental Health Service and the investigating police officer, Senior Constable Craig Jarvis. North Western Mental Health Services (a part of Melbourne Health group) was represented in the proceeding by counsel.

2. Ms P was 30-years-old. She was born in the Philippines on 8 October 1977 and was one of seven siblings. She had come to Australia originally to undertake post graduate university studies and was the mother of a three year old boy. She shared custody of her son, week about with the child's father. Ms P was usually employed as an IT business systems analyst. She lived at Oak Park.

3. Ms P did not have any significant medical history, however had recently been receiving counselling for anxiety and depression. In the months prior to her death she had been struggling with depressive illness, anxiety and had suffered from insomnia.

4. She had described difficulties in employment, having left a long term employment and of struggling with a new position. In the previous years she had experienced the breakdown of a long term relationship and more recently another relationship had been unsatisfactory. She was also finding it difficult to adjust to the shared custody arrangement of her son and experiencing financial difficulties.

5. Although she had attended a general medical practitioner on 15, 18 April and 29 June 2008, she first reported mental health difficulties when attending at a medical appointment on 3 September 2008. As a result the attending GP, Dr Kwiatek, undertook a mental health assessment and made a referral to psychologist, Dr Naomi Thomas.

6. Dr Thomas saw Ms P on 4, 11 and 16 September 2008. She reported to the GP on 11 September that Ms P suffered from severe major depressive disorder and marked sleep disturbance and advised that she would require long term follow up. Dr Thomas also recommended that the GP consider medication for insomnia if appropriate. On 14 September Ms P consulted her regular GP, Dr Michael O'Gorman, for follow up treatment.

7. At the appointment on 16 September 2008, Dr Thomas reports that she was settled, denied suicidal ideation and had commenced taking Temazepam for sleep as prescribed by Dr O'Gorman. Dr Thomas reports that she appeared to engage in therapy and a further appointment was scheduled for 25 September 2008.

8. On 18 September 2008, Ms P's brother was advised that she was behaving unusually at a friend's premises and that she was distressed and indicating an intention to harm herself. Her friend took her to the Northern Hospital (Austin), where she was assessed by the emergency mental health team and referred for community care by North West CAT team.

9. At approximately 5.00pm on 18 September 2008, family members contacted Dr Thomas seeking an urgent consultation as a result of concerns as to Ms P's deteriorating mental health and concerns for her safety. Dr Thomas's evidence was that this contact identified that there had been a serious deterioration in Ms P's mental health in the days prior to her suicide. Her

evidence was that she became aware of this deterioration as a result of a telephone call from Ms P's friend on 18 September at approximately 5.00pm. Ms P was described as distressed and crying on the floor. She refused to speak to Dr Thomas on the telephone. Dr Thomas determined that the situation required crisis intervention and advised that the CAT team be contacted. She then made arrangements to follow up the progress of that contact.

10. Northern CAT team attended at the home and assessed her as appropriate to remain in the community and that she would be referred to her local mental health service, North West, the following morning.

11. Dr Thomas's evidence was that she spoke to the assessment team when they were in attendance at the home of Ms P's brother, on the evening of 18 September 2008, at approximately 9.05pm. Dr Thomas believes that she conveyed to them the clinical background, including her assessment of the deterioration in Ms P's condition. An assessment was made that Ms P was appropriate to remain in the community at her brother's home that evening.

12. She was referred to North East CAT team on 19 September 2008. Telephone contact was made with her on the morning of the referral. It was arranged that Ms P would attend upon her GP, as she was concerned to obtain medication to assist her with sleep difficulties and a GP appointment would result in an earlier assessment and prescribing if appropriate.

13. She attended upon Dr O'Gorman on 19 September 2008. Dr O'Gorman's evidence was that Ms P had apparently deteriorated since his last consultation. He was advised by Ms P and her brother, that there had been contact with the Northern Mental Health CAT team the previous day as a result of suicidal ideation; that the CAT team continued to be involved in her care and that an appointment had been made with the North East CAT team for later that day. Dr O'Gorman assessed that the level of her anxiety was such that he felt he ought to concentrate first on addressing that issue and once the anxiety was under control, address the underlying depression. He prescribed Oxazepam an anti anxiety medication.

14. It does not appear that the expected CAT team attendance took place that day and that the only contact was by telephone later in the evening after more critical events had intervened. At approximately 6.00pm, Ms P had reported to her brother that she had taken one of the tablets but was still unable to sleep. Approximately one hour later, she appeared to him to be incoherent and he established that she had taken all 25 of the Oxazepam tablets. She was transferred to the Austin Hospital by ambulance, where she was admitted overnight. The Austin Hospital clinical notes record that she had taken an overdose of benzodiazepine. Her brother stated that he was advised the initial assessment had indicated that she required to be treated as an inpatient, however later that afternoon (20 September 2008), he was telephoned and advised that she did not need a psychiatric admission and would be discharged to care in the community.

15. It appears from the notes of the assessment undertaken by Austin Hospital clinicians that Ms P's explanation as to her intention in taking the overdose of medication was accepted. Her explanation had been that the overdose was 'accidental' in the context of trying to medicate herself to sleep, and that she did not really intend to kill herself.

16. The ongoing approach to management in the community also appears to have been guided by an acceptance of this explanation, however the clinical notes and reports from family and friends in the period continue to refer to concerns as to Ms P having suicidal thoughts or family being concerned as to her risk of self harm.

17. She was discharged to the care of the North West Mental Health Services on 20 September 2008. She left the hospital with her brother and stayed at his home for the evening. She was seen at her brother's home by clinicians from the North West Community Assessment and Treatment team at approximately 19:40hours.

18. A review appointment was arranged at the Broadmeadows Psychiatric Unit on Sunday, 21 September 2008. Ms P attended for the appointment with her brother and was assessed by Dr Pathumanabham, the duty medical officer. Dr Pathumanabham diagnosed major depression and prescribed the antidepressant Mirtazepine 15mg nocte and a hypnotic Zopiclone 7.5mg nocte. In view of her past overuse of medication, a limited number of doses were supplied to prevent further overuse. Dr Pathumanabham appears to have accepted that the overdose of 18 September was unintentional and this appreciation of the nature of the overdose appears to have guided the approach of the clinicians in their assessment of Ms P.

19. Dr Pathumanabham stated that a review of the CAT team notes and a risk assessment undertaken at that interview indicated that Ms P did not have any current suicidal thoughts or intent, there was no past history of suicide attempt, there was no family history of suicide and that she did not have any psychotic thoughts, that she felt supported by the management plan and she agreed to the follow up plan. She was not admitted for more intensive in patient intervention and left the mental health service to return home to meet her child, who was being returned to her care that day. It is clear that the mental health service were aware that Ms P would be at home alone caring for the child.

20. A follow up appointment was made for review the following day. A telephone call to check on her welfare was arranged and I am satisfied was made to Ms P at her home at approximately 7.15pm on 21 September, 2008. Notes made by the clinician during that call record that Ms P advised she was 'fine' and that the child could be heard by the caller to be playing in the background.

21. At 1.20am the following morning, Monday 22 September 2008, a call was made by Ms P to 000 emergency services, advising that she had drunk a corrosive substance. When police arrived Ms P was in the lounge room, an open and empty half litre container of hydrochloric acid in proximity. Her son was located lying in bed in the second bedroom.

22. Ms P was being overcome by the effects of the substance, but was still able to communicate with the police officers. She advised that she had drunk the acid as she wished to die. During this time she attempted to cradle her child. Police and ambulance officers established that the child had not been harmed and had not himself ingested the substance.

23. Ms P was transferred by ambulance to St Vincent's Hospital, Melbourne, where she was admitted to the Intensive Care Unit. She had suffered critical corrosive injuries and her prognosis was not favourable. She died on 22 September 2008, at 11.25am.

24. An inspection was undertaken by Dr Sarah Parsons, Forensic Pathologist with the Victorian Institute of Forensic Medicine who reported that the cause of death was 1(a) multi organ failure and 1(b) hydrochloric acid ingestion. Dr Parsons reported that Ms P had suffered significant chemical burns to face, mouth and throat and multi organ failure.

Assessment, Diagnosis and Treatment in the period 18 September to 21 September, 2008

25. The evidence was that because she was no longer exhibiting suicidal ideation at the Northern Hospital, it was appropriate that she be discharged after the overnight in patient admission and that the Community Assessment team clinicians were satisfied that suitable arrangements were in place for her to receive treatment in the community setting.

26. As best as can be understood from the evidence of the clinicians, Dr Pathumanabham, Psychiatric Medical Officer and Mr Spurr, Registered Psychiatric Nurse, and the notes, the decision to continue community care was based upon the fact that she denied she was intending to harm herself, she was co-operating in future treatment proposals and because she was going to be receiving her child home from his father. It was assumed that she would act protectively towards the child and that this would in turn be protective of her. It also appears that there was an assumption that Ms P had been assessed by a psychiatrist or at least a psychiatric registrar when in the emergency department. There is no evidence of this having occurred. Dr Pathumanabham agreed in evidence (T95.24) that in hindsight and having regard to all factors, which subsequently became known, Ms P's level of risk of self harm was much higher than that assessed.

27. I am satisfied that there was a deficiency in the detail of information conveyed to the North West CAT team, in particular Dr Pathumanabham and a lack of recognition of the significance of the clinical information as to deterioration provided by Dr Thomas to the North East CAT team.

28. As Dr Pathumanabham stated (T86 -90) that he was not aware of the deterioration in the previous few days as described by Dr Thomas and the fact that there had been two prior mental health and hospital attendances with suicidal intent or ideation. His evidence suggests that this would have altered his approach to the assessment and to the decision as to whether she required an in patient admission, although Dr Pathumanabham also observed that the availability of mental health beds was very limited and that this was a constraint upon his being able to admit Ms P. He stated (T95.1):

> *"The availability of beds, in patient beds and the resources. I think where to draw the line is difficult because whether they can manage at home, whether they can manage in hospital. You have to balance between the resources available so you cannot keep all the depressed patients in the hospital, at the same time you cannot leave anyone who is at risk at home. So its difficult to draw the line but if there are more resources available then we could have kept her in the hospital. The pressure for the beds could be the reason for her to be managed at home".*

29. I am conscious of the limitation upon resources available to clinicians in the mental health field. The evidence satisfies me that the clinicians were attempting to provide care and treatment within the limits of the resources available to them. The circumstances were complicated by the fact that Ms P had no prior mental health history and that the onset of the decline was sudden and unexpected, even to the treating clinical psychologist, in the context of her clinical history. This contributed to the mental health clinicians being deceived as to the acuity of her mental health status.

30. There was a clear deficiency in the information available to the assessing clinician and in particular Dr Pathumanabham, in determining the appropriateness of Ms P being treated in the community. A more fulsome understanding of the course of her illness may have alerted him to the severity of the decline as identified by Dr Thomas.

31. There was a complicated community assessment or intervention process which resulted in Ms P being seen by three different community mental health teams in three days and a passing of responsibility for her care from one mental health team to another depending upon where Ms P was physically located when a crisis arose in that period.

32. This resulted in a lack of availability of information as to her progress and an inability to integrate or convey information from one source to another. Had there been care provided by one community mental health team in the period, instead of three, that team may well have been able to garner more complete information from all sources including hospital notes and the clinical psychologist, better co-ordinate the care delivery and identified the decline which was occurring and intervened to provide hospitalisation. In that sense, despite the acuity of the illness, the death may have been prevented.

33. I am satisfied that the care and management provided by the General Practitioner and the Psychologist was reasonable and appropriate in the circumstances.

34. I find that Ms P died on 22 September 2008, as a result of multi-organ failure as a result of ingesting hydrochloric acid and that the injuries were self inflicted and intentional.

COMMENTS:

Pursuant to section 67(3) of the **Coroners Act 2008**, I make the following comment(s) connected with the death (including any notification to the Director of Public Prosecutions under Section 69(2) of that Act):

35. It is clear from the evidence in this proceeding that there had been attempts made by public mental health services to engage with Ms P and to provide her with appropriate mental health treatment and support. However, it is also apparent that the clinical decision making was constrained by the multiplicity of teams involved in the care and the lack of appropriate mental health beds being available to patients in crisis.

36. The seriousness of Ms P's clinical condition was not readily apparent and not able to be fully assessed within the limited time frames available for diagnosis and observation in the community. The diagnosis suffered from the absence of an examination by a psychiatrist at any stage in the process and by the lack of co-ordinated and complete diagnostic information being available to the assessing clinicians. The multiplicity of mental health services and division of responsibility between areas and consequent handover from one service to another adds to the complexity of care delivery and the potential for accurate or complete information about a patient to be overlooked. It is not within the scope or capacity of an inquest to fully interrogate the manner of service delivery in mental health in Victoria, however, it seems that this level of complexity of provision of first line services is problematic.

37. I am satisfied that there was a failure to integrate all of the clinical information which was available in relation to Ms P, which may have enabled a proper and accurate diagnosis of her mental health status and in particular her risk of self harm. There was a lack of inquiry of the GP and the psychologist in relation to clinical history and a lack of follow up with either.

38. It does not appear that Ms P was assessed by a psychiatrist at any time during any of her admissions or during the period in which care was provided by the mental health team. It would seem that an assessment by a specialist psychiatric clinician ought to be an appropriate and necessary step before a decision is made that a patient is to be safely discharged into the community, particularly when they are to be at home without a responsible adult being present.

39. One further matter is appropriate for comment as a matter relevant to public health and safety. In this case there was no notification made to the father of the child or to child protection services as to any protective concerns after the first attempt by overdose nor at any time until after the final act, which resulted in Ms P's hospitalisation and ultimate death.

40. Ms P was at home with the child without anyone present to directly provide care or supervision. The child was received back into her care in a context where the mother had just one day previously taken an overdose. The assessment that the child was protective for the mother whatever the degree, is not necessarily appropriate for application in the reverse. The child was on the premises and in the presence of the mother when she ingested the poison, which ultimately took her life.

41. It is unacceptable that a child should be placed in the circumstance that this child was placed. The child's interests were entirely disregarded. There is no evidence that any consideration was made of the protective interests of the child. The only consideration made in relation to the child was as to his value in contributing to the safety of the mother. The priority and assessment was misguided and had the potential to result in serious harm to the child.

RECOMMENDATIONS:

Pursuant to section 72(2) of the **Coroners Act 2008**, I make the following recommendation(s) connected with the death:

1. That the Secretary, Department of Health review mental health service practices in relation to the transfer of management of patients as between the regional mental health services with a view to ensuring provision of accurate and current health status information.

2. That the Secretary, Department of Health review the level of supervision and follow up care required to be in place prior to a mental health patient being discharged to community care.

3. That the Secretary, Department of Health review the process and appropriateness of telephone assessments being undertaken by CAT teams of a mental health patient in the absence of prior direct contact with the assessor and that self reporting of 'well being' not be regarded as a reliable measure of safety in this context.

4. That the Secretary, Department of Health and the Secretary Department of Community Services review mental health service practices in relation to the discharge and supervision of mentally ill persons, where they have care and responsibility for children under the age of 16 years and ensure that adequate supervisory mechanisms, including appropriate protective notifications are in place.

5. I direct that a copy of these findings be provided to: The Honourable Mr David Davis MLC Minister for Health (Victoria); The Honourable Ms Mary Wooldridge MP, Minister for Community Services Victoria; The Secretary, Department of Health (Victoria); The Secretary, Department of Human Services (Victoria), The Child Services Commissioner, Mr Bernard Geary; The Northern Mental Health Service, The North East Mental Health Service, The North West Mental Health Service, The Chief Psychiatrist Dr Ruth Vine.

Signature:

KIM M. W. PARKINSON
CORONER

4 May 2011