QUEENSLAND COURTS

OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Dianne Judith Bowling**
TITLE OF COURT:	Coroners Court
JURISDICTION:	Brisbane
FILE NO(s):	2011/3711
DELIVERED ON:	18 July 2014
DELIVERED AT:	Brisbane
HEARING DATE(s):	20 May 2014, 7 July to 9 July 2014
FINDINGS OF:	John Lock, Deputy State Coroner
CATCHWORDS:	**Coroners: inquest, mental health, case management, community and family input**

REPRESENTATION:

Counsel Assisting:	Ms M Zerner i/b Office of the State Coroner
Metro North Hospital Service:	Mr J Allen of Counsel

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Introduction

Dianne Judith Bowling was aged 59. Dianne also used a preferred name of Deanne. In this inquest decision I have adopted her formal birth name.

Dianne was on a disability pension with her financial affairs managed by the Public Trustee Office. Dianne had a very lengthy history of mental health issues and had been receiving treatment from psychiatrists over many years. She suffered from mood swings, depression and alcohol abuse. The formal diagnosis was Bipolar 1 Disorder. She was prescribed a number of medications. Dianne was under the care of the Prince Charles Hospital Mental Health Service (PCMHS), as well as receiving support from a number of community agencies and her brother, Christopher Edward Baker.

On 30 October 2011, a carer from Commonwealth Respite Services was visiting Dianne for a regular fortnightly appointment. When she received no answer to her knocking on the door she followed procedure and contacted Dianne's next of kin. The carer picked up Dianne's brother, Christopher Baker. They found Dianne in her bedroom lying on her bed neatly covered with a small blanket. It was reported that a number of empty medical prescription packets were found. Dianne was not breathing. Ambulance officers were called but she was clearly deceased when they arrived.

The cause of death was determined to be 'mixed drug toxicity'.

The investigation

Given Dianne's long-term mental health history, an intentional taking of her own life could not be excluded on those facts. Her history indicated that on a number of occasions she had taken impulsive overdoses of prescribed medications, usually when she was experiencing an exacerbation of her psychiatric symptoms. Her current medications included thyroxine, metoprolol, olanzapine, quetiapine, sodium valproate and temazepam. All these drugs were found in her system and one at a toxic level.

Equally, the history and circumstances could suggest this was an overdose of medication taken in the context of a recent exacerbation of mental health symptoms but without an intention to take her life. In that respect the finding remained undetermined.

Concerns were also raised by her brother, Christopher Baker and a carer advocate about the treatment and care provided by the PCMHS.

The concerns raised included:

a. a case manager overruling a GP's request in 2010 that she be admitted (referred to the HQCC for investigation)

b. recurrent emotional problems in the few days prior to her death

c. community groups, family and friends having grave concerns for her mental state and the hospital ignoring the signs and symptoms

d. the substantial number of drugs found in Dianne's system with issues expressed concerning the issuing of prescriptions for medication, security, control and accountability

e. issues concerning a staff member advising he was only looking after Dianne for a short time and did not want to stand on anyone's toes.

A coronial investigation commenced including requests for a report from the PCMHS and statements from medical and nursing staff engaged in Dianne's care, as well as respite carers and support workers from other agencies. The medical records and policies and procedures of the mental health service were obtained and examined. An independent expert report was obtained from Dr Jill Reddan.

The inquest issues

Given the concerns raised, and after reviewing the material gathered during the investigation, a decision was made to hold an inquest. The issues for the inquest were settled at a Pre-Inquest hearing as follows:

a. the findings required by section 45 of the Coroners Act namely the identity of the deceased person and how and what caused her death

b. whether the assessment and treatment of the deceased by the PCMHS, including the Community Mental Health Team was appropriate and adequate in the four weeks leading up to the deceased's death

c. the adequacy of the policies and procedures of the Prince Charles Hospital (PCH).

Autopsy results

An autopsy examination found significant coronary atherosclerosis involving two major arteries to the heart and dilation of the heart chambers consistent with dilated cardiomyopathy. The lungs showed moderate to severe changes of emphysema.

Toxicology testing found the presence of multiple drugs of prescription including metoprolol, olanzapine, quetiapine, valproic acid and temazepam and oxazepam.

It was considered that the cause of death was due to mixed drug toxicity. The concentration of metoprolol (an antihypertensive drug) was at a potentially fatal level on its own. Its toxic effects include coma, hypotension, bradycardia,

seizures and metabolic acidosis. The presence of coronary atherosclerosis and emphysema would have contributed to her death.

The evidence

I have received very helpful comprehensive submissions from Counsel Assisting, Ms Zerner. These set out the relevant facts and summarise the material placed before the inquest as well as the oral evidence. Mr Allen of Counsel submitted brief submissions, given there was little controversy about the matters raised by Ms Zerner, other than on some limited issues. I do not intend to repeat all of the evidence before me or the facts as set out by Ms Zerner.

Personal history

Dianne's brother, Christopher Baker provided a statement to police and gave evidence at the inquest.

Dianne was one of four children with three brothers.

Dianne resided in a housing commission unit and had been there for approximately 14 years. Christopher resided in the Stafford area close to where his sister resided and provided her with long term dedicated and compassionate support.

Christopher first became aware of his sister’s mental health issues approximately 35 years ago. The first signs he saw were that she suffered badly from mood swings, depression and alcohol abuse.

She had married on three occasions and he believed she suffered considerable physical and mental abuse in those marriages.

The last marriage ended approximately 15 years ago, having lasted for about five years. Mr Baker was of the view the relationship was very abusive and she may have suffered a lot of mental trauma. This husband was a former psychiatric patient whom she had met at the mental health unit at the PCH.

During the course of this marriage they resided at Kingston and he recalls his sister being hospitalised on a number of occasions at Logan Hospital, one of which was for a self harm related incident and possibly a drug overdose. Christopher assisted his sister in filing for divorce and in finalising their financial affairs.

In the last 14 years he recalls his sister had been a patient at the PCMHS on countless occasions for various lengths of time, depending upon the severity of the mental health illness and episodes.

Over the last 10 years the frequency and severity of the mental health episodes became more intense. She had numerous outpatient appointments with psychiatrists and other allied health officers checking on her welfare, and was supported by community organisations including Commonwealth Respite

Services, Burnie Brae Respite organisation at Chermside and Adina, a mental health support service.

Dianne's financial affairs were taken over by the Queensland Public Trustee in January or early February 2011. Prior to this, his sister's finances and investments had been handled by Christopher. However, after he suffered a stroke in October 2010, and upon advice by Dr Relan, a psychiatrist, the financial affairs were taken over by the Public Trustee.

Dianne was in receipt of a disability pension and all monies were paid to the Public Trustee. The sum of $300 per fortnight was paid to her Bank of Queensland account for everyday expenses.

Dianne was at times very demanding and difficult, particularly when she was unwell. Despite this, and as well as providing care to his son and elderly father, it is evident that Mr Baker has provided dedicated and compassionate support to his sister over a very long period.

I accept over such a long period, Mr Baker would have been well attuned to assessing Dianne's state of mind and wellness and I accept his evidence when he said Dianne was highly agitated and seemingly more depressed at the time leading up to her death.

Concerns from family about PCMHS in 2010

It is apparent there had been previous concerns expressed by Christopher Baker in 2010 about an earlier case manager at the hospital. A complaint had been made to the Health Quality and Complaints Commission (HQCC).

Concerns expressed included that the case manager, an occupational therapist, failed to listen to family members and carers who had concerns about her current mental health and deterioration.

The complaint noted that her GP, Dr Jennifer Duncombe faxed a letter to the hospital requesting Dianne be assessed as she was becoming increasingly paranoid, was spending money irrationally, and had given away possessions. When the occupational therapist interviewed the patient she stated she was fine but the next day she suffered a psychotic episode and was admitted to a mental health unit where she spent the next several months. The concerns were that the occupational therapist exceeded her jurisdictional authority in overriding the GP's request for urgent review by a psychiatrist.

The Executive Director of Medical Services at the PCH, Dr Ayres provided a response to the HQCC. This indicated the case manager was apologetic that her professional demeanour and clinical judgement had been perceived in a negative manner. It was conceded the case manager had contacted the consultant to discuss the current medication regime but she did not discuss any of the family's concerns. The case manager believed the behaviour exhibited by Dianne did not differ from her previous behaviour patterns or presentations. She acknowledged the importance of discussing and escalating clinical concerns expressed by families with more senior medical

staff. The case manager was no longer employed with the PCH. It was noted that she was a new practitioner and the PCH reviewed allocation processes for case managers to ensure that the more complex cases are assigned to advanced professionals.

The independent medical adviser to the HQCC reviewed the records and other information. The adviser was of the view that it was inappropriate that family input was not taken into consideration. Although a GP requesting admission does not compel the facility to admit if the assessment does not make this warranted, it was reasonable to expect that if a GP was concerned enough to request an urgent mental health assessment this would be by an experienced clinician. A junior occupational therapist might have been far less experienced than a GP.

The medical adviser noted the hospital's submission that the service has now reviewed the allocation of case managers to ensure that more complex clients are assigned to advanced practitioners. The medical adviser said this was considered appropriate although it was surprising it was not already in place.

The HQCC consulted with the Occupational Therapists Board of Australia with a recommendation that the complaint be referred to it. The Board declined to accept the complaint for further action.

In conclusion the HQCC closed the complaint. The reasons advanced for this was that it was apparent the occupational therapist had acknowledged the complaint and modified her practice accordingly. The hospital had also taken steps to address systemic issues arising from the complaint. In view of these factors it was decided that no further action be taken in relation to the complaint.

Given those findings, this issue was not further examined at the inquest.

Mental Health History

A report was requested from the PCMHS. This was provided by Dr Pankaj Relan. Dr Relan also gave evidence at the inquest.

The report confirmed that Dianne had a long-standing history of more than 40 years of suffering from mental illness. She required multiple inpatient admissions on at least 20 occasions, predominantly during manic or hyper manic or depressive episodes including high levels of anxiety and psychotic symptoms. Her first episode of mania occurred at age 16 and she required an inpatient admission of seven months. The hospitals included Logan, Princess Alexandra, Royal Brisbane and the PCH.

During inpatient admissions as well as during treatment in the community she was provided with multiple psychotropic medications. These were provided usually in combinations and it would appear that most of these medications would provide her symptomatic relief for a period of time and then she would experience an exacerbation of psychiatric symptoms. On occasions in the past she had been administered treatments with electroconvulsive therapy.

There were three reported suicide attempts. This included an overdose of lithium and thyroxine in October 1992; an overdose of risperidone, temazepam, lithium and thyroxine in December 1999; and an overdose of the thyroxine, nitrazepam and sodium valproate in April 2009.

As a result of the overdose in 1999, Dianne required six weeks in intensive care. Her recovery was complicated by aspiration pneumonia and a small stroke causing some frontal lobe brain damage and resultant ongoing memory deficits.

A CT scan of her head in November 1999 found a small area of watershed infarction. Scans in 2008 and 2009 were reported to exhibit an old frontal lobe infarct with mild cerebral atrophy.

Dianne first started attending the mental health service at the PCH in the year 2000. She had a few inpatient admissions and continued to receive follow-up assessments and treatments at the Chermside Community Mental Health Clinic.

Dr Relan stated it was considered Dianne had a fragile and difficult to treat illness. Over time it was assessed her ability to comprehend and perform complex tasks in general was basic and limited. Further, the episodes of exacerbation of symptoms were becoming more frequent and were requiring longer inpatient admissions.

Of particular importance to this case were the well recognised signs of her becoming unwell. It was observed that when she became anxious she would start to feel depressed and agitated and her ability to comprehend and appropriately understand questions or commands would further reduce significantly. During these times she would exhibit more restless behaviours instead of being able to explain about her own depressed and anxious mood. Dr Relan noted Dianne's responses during those times would be in short sentences and characterised by statements like *'I don't know…. Something is wrong'.* She would also tend to appear somewhat lost and not able to express herself or perform simple day to day activities which she would usually be able to do. She would begin to become somewhat confused and vague, along with worsening of her anxiety and paranoia.

In September 2010, a Crisis Management Plan was developed in the context of her cognitive issues, mental illness and previous cerebral infarction. This plan highlighted the background history, strengths, protective factors, typical presentations and support mechanisms. The plan provided Dianne with support networks to contact during times of crisis or need. In addition her brother was provided a copy of the plan and it was also appropriately shared amongst various care providers involved in her care.

After her discharge from hospital in November 2010, Dianne was followed up regularly at outpatient appointments and also regular reviews by her case manager. During times of crisis or exacerbation of symptoms, the reviews

would be more frequent. She also received regular care from other service providers including Burnie Brae and Commonwealth Respite Care during the week.

In 2011 she had two admissions to the mental health unit, the first being between 8 and 31 March. Her last admission to a mental health unit was for one month from 17 June 2011 to 15 July 2011. Both of these admissions were in the context of gradual worsening of her mental state characterised by increased anxiety, feeling confused, depressed, ambivalent and somewhat paranoid. She was experiencing disturbed sleep. Mr Comley, her regular case manager, explained these admissions were made in a planned way and were not reactive to a crisis.

It was apparent over time that such episodes of exacerbation of symptoms were becoming more frequent and would require a longer duration of inpatient admissions.

Her current medications included thyroxine 100mg mane, metoprolol 50mg BD, olanzapine 15mg nocte, quetiapine 275mg nocte, sodium valproate 700mg mane and 1000mg nocte and temazepam 10mg nocte.

During mid-2011 she underwent a psychological and occupational therapy assessment to better understand her cognitive abilities, cognitive deficits and her functional ability. The issue of moving to a low care facility was raised.

Dianne was assessed to have moderate cognitive deficits but a reasonable functional ability. An occupational therapist found that her physical and mental health status was such that she was able to live independently and safely with moderate-high levels of support from the community and her brother and that her cognitive deficits did not impact significantly on her ability to perform the activities of daily living. It was during this time that the treatment team was successful in securing the Public Trustee Office to manage her finances however an application for appointment of the Adult Guardian for other decisions was dismissed by the Queensland Civil Administration Tribunal.
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In addition to her brother, Dianne had support from agencies in the community, her psychiatrist, a case manager, representatives from Burnie Brae, Community Respite and Suncare and she also attended other respite centres from time to time.

Prior to discharge from hospital it is reported Dianne stated she preferred to stay at home and have someone visit her. In any event, on discharge Dianne did attend three nights of respite at Adina (a respite facility).

Mr Baker does not agree that Dianne did not want to access respite services but agrees that with her access to money controlled by the Public Trustee, money may have become an issue. The evidence of her case manager, Mr Comley as set out in his case notes, refers to her reluctance to access respite services, and I accept this was the case and he was seeking to encourage her. Money does appear to be a matter she raised with Mr Comley.

Crisis Management Plan

One of the confusions in this case was the currency of the Crisis Management Plan that had been developed and which plan was being considered in the months before Dianne's death. There were a number of such plans on the record and it took some time during the inquest to work out what plan/s were in force. That in itself is a problem as the clinicians obviously should all be literally working from the same page and it is unclear if they were.

There appears to be another Crisis Management Plan operating between 16 December 2010 and 10 March 2011 and another overlapping plan from 28 October 2010 and 28 October 2011. This plan appears to have been signed off by Dianne and the hospital. Sheryn O'Grady, who was employed with Commonwealth Respite as a senior support facilitator is referred to as a support service on both these plans.

The medical records also contain a draft plan ('draft' is watermarked all over it), which was purported to commence on 17 June 2011. On that plan it is noted Sheryn O'Grady's involvement was suspended. In the document it notes that the service was suspended at this time however re-referral can be made to consider/initiate respite services.

RN Gulliver says he examined her Crisis Management Plans that were filed on her chart. He says there were two including one dated to commence on 16 December 2010 and to be reviewed on 10 March 2011 and one which appears to commence on 17 June 2011. This latter plan had been signed by Dianne but not yet endorsed by the treating team. He said he was given this plan by Paul Comley at the handover. The particular copy of this plan, that is the one signed by Dianne alone, cannot be found on the medical records themselves.

Importantly RN Gulliver noted the later Crisis Management Plan clearly stated that Sheryn O'Grady from Suncare had 'suspended involvement' with Dianne and he was mindful of this and the amount of information he shared with her during his interactions.

The evidence before the inquest was unclear as to why Ms O'Grady had some 'suspended involvement'. This information was not known to her at the time. Her organisation was still involved with Dianne in the September/October 2011 period. It could have been because it was not uncommon for there to be cycles where they were not involved. Ms O'Grady's organisation had an unsigned copy of a previous Crisis Management Plan.

Whatever is the case, RN Gulliver not unreasonably interpreted 'suspended involvement' in its pejorative sense, and it is likely this impacted on his interactions with Ms O'Grady at crucial times. This will be considered later in the decision. I make no adverse finding about RN Gulliver's reliance on this plan. Given he had a full case load it should not be his responsibility to search the files and work out what plans were in force. That should be self evident, and it wasn't.

In any event, the recent plans importantly note that during the last two admissions when Dianne started to become unwell, she became somewhat confused, edgy and more vague in addition to worsening anxiety and paranoia. Usually her responses during those times were in short sentences and generally characterised by statements like *'I don't know, something is wrong'.*

The plans set out a brief history of Dianne's mental health history. Importantly it noted that when Dianne starts to experience anxiety and depressive symptoms, her cognitive deficits tend to become more prominent and she appears vague, lost, paranoid, unable to express herself in simple words and unable to even perform simple daily tasks which she could otherwise have done easily.

The plans noted that Dianne had significant professional support structures in place and all people involved in her care would receive a copy of the plan. It noted that it was highly probable that one of the professional support persons looking after her might be able to pick up on the above-mentioned signs of onset of exacerbation of symptoms of mental illness. It was also expected the professionals who noticed the initial signs of becoming unwell would inform the mental health case manager about the noticed symptoms or concerns. Upon receiving information the case manager would either assess the patient or organise an urgent assessment, if required.

Dr Reddan was of the view Dianne's Crisis Management Plan was well-intentioned but misguided. The intent was very sound but it contained a lot of information that someone wishing to access or read it quickly would have to wade through before getting to the practical advice.

She considered the plan should have been simplified and modified for the purposes of the community support agencies or the non-government organisations. She noted however, the plan did provide guidance about what should be considered a sign of relapse and it did provide for what may be considered the next step in her management. However, she says it really had no ultimate role in her overdose and death.

Dr Reddan considers that the documentation and policy surrounding the new *Acute Management Plans* results in a much more focussed document. This is meant to be a succinct clinical document, accessed through CIMHA to provide clinical information to emergency medicine, acute treatment services and other mental health practitioners where a patient presents to a hospital or via a telephone call requiring an intervention.

It is also noted the hospital district has introduced a *Crisis Intervention Plan* that specifically provides information and/or strategies to assist the Queensland Police Service and the Queensland Ambulance Service to manage and/or resolve a mental health crisis in the community. Dr Reddan was also supportive of this documentation.

Events of the months leading up to death

The admissions in March and June 2011 occurred in the context of Dianne suffering a number of symptoms over a number of weeks and on each occasion the admissions were planned in response to her deteriorating health. The presenting symptoms included increased anxiety, poor short-term memory, broken sleep, poor concentration and a feeling that she was becoming unwell.

At the time of discharge in July 2011, Dianne agreed to three nights respite at Adina but otherwise wanted to return to her own home.

On 20 July 2011, her case manager Paul Comley attended on a home visit. He found there were no concerns regarding her mental state and he arranged repeat prescriptions.

On 26 July, Dr Relan reviewed Dianne and he assessed her as being relatively stable. Paul Comley did a home visit with an occupational therapist on the same day and again noted no issues regarding mood or anxiety.

On 12 August 2011, Paul Comley went on a home visit where her mood was assessed as stable. She reported she was sleeping well.

On 30 August 2011, Dr Relan noted she was relatively stable and current treatment would continue.

On 2 September 2011, Paul Comley took Dianne to an outpatient appointment. She refused an offer of further respite.

On 14 September 2011, Paul Comley made an unannounced attendance at her home. There was some anxiety initially and she advised she had difficulty sleeping. She was encouraged to access respite services.

On 16 September 2011, Christopher Baker telephoned Paul Comley and provided information which Paul Comley noted may be early indicators of a deteriorating mental state. He planned to visit on 20 September 2011 and this appointment took place. He assessed her as being relaxed and calm and Dianne was not exhibiting any signs of a deteriorating mental state. Dianne stated she was taking her medication and she was sleeping normally. She was again encouraged to access respite services. He says he telephoned Mr Baker to provide him with feedback.

On 29 September 2011, Paul Comley had a home visit and updated her crisis plan which Dianne signed. He assessed her as being a little anxious but managing daily activities. She reported two nights of poor sleep. She declined respite care. He told her he was going on leave and provided her with the interim case manager's details.

On 30 September 2011, Paul Comley completed a Consumer Care Review Summary. This review was for the purpose of an upcoming three monthly

team case review of Dianne's case. He also provided a brief handover to RN Gulliver. Mr Comley says his handover consisted of:

a. highlighting recent issues including noting her stable mental state, diagnosis, frequency of contact and the usual approach to engaging with Dianne

b. providing a copy of the most recent case review

c. advising of the need to provide transport to outpatient appointments and the date, time and treating doctors for her next appointment.

RN Gulliver recalls Mr Comley specifically referring to the Crisis Management Plan which showed Ms O'Grady's suspended involvement. Paul Comley does not recall specifically referring to the Crisis Management Plan but says there were documentation and case notes on the chart and on the mental health database (CIMHA).

RN Gulliver says he was informed Dianne would contact the service if she had any problems. She had several support services already in place and had frequent contact with them. He was told she only wanted minimal contact with mental health services and if she did not contact the service, he was to contact her to see if she needed any extra support. RN Gulliver states that his level of involvement with Dianne became more than he expected.

Mr Comley stated Dianne was not reluctant to contact the service but needed a particular approach to get her to engage. He does not recall saying she only wanted minimal contact but may have said contact between appointments may be sufficient.

Paul Comley says that on 3 October 2011 he contacted Christopher Baker and advised him he was going on leave and RN Gulliver would be the interim case manager.

Dr Relan reviewed Dianne on 4 October 2011. There were still some sleep issues but he found she remained relatively stable and there did not appear to be any exacerbation of her symptoms or any change or deterioration.

It is evident Dianne's condition began to deteriorate after 4 October 2011.

On 10 October 2011, Wendy Him, a support worker from the Burnie Brae Centre (where Dianne attended for day respite), noted she was unsettled, unhappy, distant, slow to respond to questions and Dianne advised she did not feel right.

Wendy Him says she reminded Dianne she was free to call her or visit her at any time if she needed assistance or a chat. Wendy Him says she informed her supervisor, Deborah Underdown, of her concerns.

Wendy Him telephoned Dianne on 11 October 2011 by way of a welfare check. Dianne said she was feeling a little anxious. Dianne was making arrangements to see a physiotherapist and have some blood tests, and this provided some reassurance to Ms Him on the basis she was making plans. Dianne was told she could contact her at any time.

Deborah Underdown from Burnie Brae Centre stated that in the period September to October 2011 she only had one personal contact with Dianne. At that time she seemed distant and quiet and made limited conversation. She reported this along with feedback from Wendy Him to Dianne's brother and to her relief case manager, Richard Gulliver from the PCMHS in a telephone call on 11 October 2011.

The community workers were concerned that the observations about Dianne's behaviour could have indicated deterioration in her mental state and as they were not a clinical service or clinically trained they felt the behaviour should be acknowledged and reported to the appropriate persons. Ms Underdown recalls RN Gulliver was abrupt on the telephone and she felt she was not listened to as her feedback was not clinical in nature.

RN Gulliver states that he acknowledges there may have been concerns communicated on 11 October 2011 about Dianne's deteriorating mental health by another supporting agency but he cannot recall the exact nature of this conversation. He did not document this particular contact at the time as there was no clinical relevance and the informer was 'expressing the difficulties of the personality of the client'.

In any event, RN Gulliver contacted Dianne on 12 October and he says this allowed him to assess and respond to the concerns that may have been communicated.

Contact was by way of a follow-up visit. It was documented that Dianne was polite, warm and welcoming. She was not anxious and was appropriate in behaviour. She was not thought disordered. She showed no signs or symptoms of psychosis. She had no thoughts of self harm or suicide. The note in the record was comprehensive and the plan was to follow her up next week.

Sheryn O'Grady was employed with Commonwealth Respite as a senior support facilitator. She coordinated non-clinical case coordination and respite to support Christopher Baker. The focus of the support was to provide Mr Baker with a break from his caring role, whilst providing direct support to Dianne.

Ms O'Grady had direct contact with Dianne when she attended a Suncare family fun day on 16 October 2011. She recalls Dianne was apprehensive about the crowd of people that were in attendance. Wendy Him recalls Dianne saying she was still feeling unwell. Linda McNee, also a Suncare community worker, said Dianne advised she was not sleeping well at night and was feeling anxious. Ms McNee provided feedback in an email stating there was a

need to follow this up as there were signs she was becoming mentally unwell. Ms McNee had also noted concerns on 17 September 2011 when Dianne had expressed that something on the television was giving her a special message.

Ms McNee stated the behaviours she saw in October 2011 were similar albeit less intense than the behaviours for which she was voluntarily hospitalised earlier in the year.

These events were passed on to the various care agencies and then to Dianne's case manager.

On 18 October 2011, RN Gulliver spoke to Dianne on the telephone to confirm a follow-up appointment for the following day. She mentioned she was not sleeping well but could not say why.

On 19 October 2011, Sheryn O'Grady telephoned Dianne after receiving feedback from Ms McNee that Dianne was not sleeping well, was feeling anxious and was presenting with symptoms that she may be becoming unwell.

Dianne told her she was waking at three in the morning worrying about things and was unable to get back to sleep. Ms O'Grady had already contacted RN Gulliver the day before to enquire if he could visit.

With Dianne's consent Ms O'Grady again telephoned RN Gulliver to ensure that her needs were responded to appropriately. She had worked alongside Dianne for a number of years and although she was not a clinician she considered that her observations and communication with Dianne had enabled her to gain insight into Dianne's cyclic patterns of behaviour, early warning signs and observations in her decline in mental health condition, awareness and overall deterioration. She believed Dianne was exhibiting early warning signs of unwellness during October 2011.

Ms O'Grady says she advised RN Gulliver there was a need for him to meet with Dianne that day as she appeared to be excessively worrying. She says the feedback from RN Gulliver reflected some negativity and clinical exclusivity, was dismissive in nature and lacked an appropriate response even when it came to reflecting on the current Crisis Management Plan and despite being presented with the facts. In particular she says RN Gulliver said that Dianne could not dictate when case managers see her as she was not a priority as he had several other dangerously unwell clients that were to be prioritised before he could get to see her. He told her he had other top priority patients booked in for that day. She strongly suggested that RN Gulliver discuss the case with the team leader.

Wendy Him had taken Dianne out for a hairdressing appointment. Wendy said that Dianne was distant, slow to respond to conversation and stated she was feeling unwell and didn't feel right. Wendy contacted Christopher Baker and she also called Sheryn O'Grady at his request. Sheryn O'Grady advised Wendy she had already telephoned RN Gulliver and he was 'rather unhelpful

and belligerent'. She said she was unhappy and disappointed with his response.

Wendy Him passed this information onto Ms Underdown who then spoke to RN Gulliver. He told her she was the third person to phone that day. Those calls were clearly from Ms O'Grady, Mr Baker and Ms Underdown. Ms Underdown says RN Gulliver said 'they were 'professional and knew what they were doing and were going to see her and had backup appointments with her psychiatrist if required'. Ms Underdown told RN Gulliver she just wanted to let him know how concerned they were, particularly as Dianne had a Crisis Management Plan in place and particularly as she was identifying that she didn't feel well.

Ms Underdown says in her statement the response from the relief case manager was to advise that the service was monitoring Dianne, they were the 'experts' and would act accordingly if they assessed Dianne to be at risk. They thought the relief case manager seemed reluctant to consider non-clinical information or information from non-clinical stakeholder feedback. In evidence Ms Underdown agreed that the words used may have been 'professional' rather than 'expert'. The feeling that he was dismissive was based on his tone and the brevity of the conversation; not any actual words used.

RN Gulliver says later in the morning he had a message to contact the respite service requesting that he see Dianne sooner. He told the respite carer that he had other priority clients booked to be visited that day and was intending to see her the next day.

At noon he received a telephone call from Mr Baker who mentioned that support workers informed him they believed Dianne was going downhill and that he had spoken to his sister and felt she was hiding a lot of issues.

In any case, RN Gulliver in fact telephoned Dianne to inform her that he would try and see her later that day at around 1pm if all went well.

At 1pm RN Gulliver had a home visit with Dianne. She appeared tired but well-dressed and appropriate in behaviour. Dianne mentioned she had attended a physiotherapy appointment the previous day and found the travel getting there nerve racking. She also mentioned she had gone out with Burnie Brae on Monday but had not liked the place they went to. She mentioned that she found some of these appointments overwhelming at times. He gave her some strategies to assist with her sleeping.

RN Gulliver stated it was clear that Dianne continued to have anxiety issues but there were no thoughts of self harm or suicide. She was not agitated or paranoid and there were no signs or symptoms of psychosis. He endeavoured to bring forward her psychiatric appointment to Tuesday, 25 October 2011 but she told him she had an inspection of a house that day and the later appointment on 8 November was okay. He planned to follow-up on 26 October 2011.

On 24 October 2011, Dianne attended Burnie Brae. Wendy Him says Dianne told her she was still not good and was not feeling right. She appeared distant and had a vacant look on her face when she made eye contact, was very slow to respond to questions and her facial expressions did not change at any time. She says she reported her observations to Deborah Underdown although there are no records regarding this incident. Ms Him concedes that if there had been significant concerns these would have been recorded and perhaps Dianne was only the same as she had seen her before.

The medical records note an entry for 26 October where Dianne had called to check if RN Gulliver was attending that day. She appeared to be tired and worrying about not sleeping. She was asked if she had any issues or concerns, and she mentioned a member of her family was going into hospital but denied this was the cause of her sleep deficit. Again, there was no evidence of thought disorder and she was not paranoid, manic or psychotic. There were no thoughts of self harm or suicide. An arrangement was made for an emergency appointment with her psychiatrist on 27 October.

RN Gulliver picked up Dianne the next day for the doctor's appointment where she presented as anxious and requiring constant reassurance. She did not want to be admitted or have her medication increased.

RN Gulliver recalls receiving a telephone call from the respite carer asking for an update as to whether Dianne attended her doctor's appointment the day before, which he confirmed and reported her presentation in the session was positive.

The last appointment with a psychiatrist was on 27 October 2011 with a relieving registrar, Dr Clavijo. Dr Clavijo's statement says he was asked to fill in for Dr Relan at his outpatient clinic.

He was a psychiatric registrar having held the position for three years. He states he was given a brief summary of her mental illness and current clinical presentation by her case manager, RN Gulliver and the main concern was a complaint about not sleeping, which had been persistent for some time. Dr Clavijo also had access to the file and Crisis Management Plan.

On review Dianne told him she had been waking up at 3am, but on further questioning she agreed she would go back to sleep easily. She denied any current stressors. She said she was going out as usual and participating in the activities she had enrolled in. She denied low mood but was feeling anxious. She was specific about this anxiety not stopping her from socialising, which Dr Clavijo noted was a symptom of relapse in her management plan.

On examination she was mildly anxious but denied suicidal ideation or any delusions. Her main concerns were her insomnia and the number of tablets she was on.

Dr Clavijo stated his assessment was of a patient with a well-documented history of bipolar affective disorder who presented as being stable but

somewhat preoccupied with her sleep patterns, which he thought at the time could be an early sign of relapse.

Dianne was advised to increase Seroquel 275mg to 300mg at night to assist with her sleep. A follow-up appointment by her case manager was organised and possibly an appointment with Dr Relan in the following week if she was still over preoccupied with her sleeping pattern.

Dr Clavijo can recall having a low degree of concern about the risks of suicide or harm to others. He organised the follow-up appointments.

Dr Clavijo was aware of the current management plan and his own personal clinical assessment was that there were no indications her condition was deteriorating. Her complaint of insomnia was subjective and she admitted that even though she was waking up early she could return to sleep without major difficulties. Her daily activities had not changed, which according to her history was one of the significant signs of deterioration. She had plans and was looking forward to attending the usual social commitments in the following days. He discussed the plan with Dr Relan on 28 October 2011. In general it was noted Dianne continued to experience difficulty with sleep but there did not appear to be any worsening in her other psychological aspects or functioning.

After the appointment RN Gulliver says Dianne was reluctant to adhere to an increase in Seroquel because she believed she was on too much and had no signs of psychosis. He says Dianne was happy, laughing and joking as they travelled home and she gave no indication that she was either upset or anxious.

On 28 October 2011, Sheryn O'Grady spoke to RN Gulliver to check on the outcome of the assessment. She says RN Gulliver advised he was unable to suggest other strategies without stepping on Paul Comley’s toes. She says she discussed the Crisis Management Plan, which clearly documented that other allied health support can become involved including involvement with the Mobile Intensive Rehabilitation Team (formerly MIST).

RN Gulliver says they discussed the complexity of the case but nothing in the conversation concerned him and so he did not keep a case note or put in place any additional actions prior to his planned contact with her on 31 October 2011. He disagrees with Ms O'Grady's recollection of the conversation. He denies he was unable to provide any alternative strategies to help cope with Dianne's current level of stress and anxiety, or that he said he did not want to step on Paul Comley's toes. He says he advised that Dianne attended the appointment with her psychiatrist and that she appeared happy with the outcome of the appointment. He says he recalls Ms O'Grady commenting on the difficulty she had been experiencing while working with Dianne and that she found it difficult to find carers who would have long-term relationships with her due to her challenging behaviour.

He denied Ms O'Grady raised MIST as a possibility. He said this was not mentioned in her Crisis Management Plan so this would never have been a viable option due to referral processes and she would not have met the entry requirements.

There is clearly a dispute between Ms O'Grady and RN Gulliver as to the content of this conversation and other conversations. In evidence Ms O'Grady said her view that RN Gulliver was dismissive was based on the language he was using, which she interpreted as downplaying the concerns and not validating the feedback by an action.

Ms O'Grady did complete relatively contemporaneous notes in her database system. She gave evidence that once entered an entry cannot be edited other than by another entry added in. Given the adverse outcome for Dianne was still to come, there is no reason why she would not be reflecting in her notes a reasonably accurate version of events, and to that extent I accept her evidence generally as to the content of conversations she had with RN Gulliver.

However, RN Gulliver's attitude to these conversations was clouded by the Crisis Management Plan he was working from, which noted Ms O'Grady's 'suspended involvement' and he did not want to breach the client's confidentiality. He felt he could not reveal too much to alleviate her concerns.

I accept generally the evidence of Ms Underdown and Ms O'Grady that indicate RN Gulliver gave an impression of being dismissive of them during his conversations with them.

In evidence he said that Non Government Organisations (NGOs) do not have the training that clinicians have to get to the bottom of the problems facing a patient. He had concerns, probably quite rightly, with simply accepting information over the telephone, which may have been simply bogus or complete hearsay.

He also accepted he was rushed at this time with other high acuity patients and he could have sounded dismissive. He said in evidence he 'was not really the case manager' and 'needed to be careful with other patients'; an issue said by the NGO workers that he raised in his conversations with them.

All that being said, RN Gulliver did in fact take action by seeing Dianne urgently, bringing forward psychiatric assessments, and although he may have given an unfortunate impression to the NGO workers, I do not find any of his actions or inactions contributed to the outcome.

Dianne's brother Christopher spoke to her on 26, 27 and 29 October 2011 about her recent appointment with her psychiatrist and medication issues. At the time she sounded depressed. He suggested she look forward to an outing she was taking with a support worker from the Commonwealth Respite Service on 30 October 2011 and to watching a favourite Elvis Presley movie later that day. He said he felt it would be okay to wait until Monday. He told

Dianne to get through the weekend and he would take her to the emergency department on Monday.

On 30 October 2011, Ms McNee rang Dianne's brother asking why Dianne was not responding. He went to her address with Ms McNee and was able to enter through an unlocked security screen and front door. This surprised him, as his sister was security conscious and would usually have both doors locked. He also found the keys to the front door in full view on a piece of furniture. This was also out of character.

Mr Baker found his sister in her bedroom lying on her bed neatly covered with a small blanket. She was already deceased.

Critical Incident Review

A critical incident review was conducted by the hospital in conjunction with other stakeholders from the community. The review indicated that Commonwealth Respite Service and Burnie Brae had some concerns about Dianne in the weeks before her death and felt she was deteriorating with some signs of increasing anxiety and being vague that were non-specific but had been seen previously.

Expert Report of Dr J Reddan

Dr Jill Reddan provided a report to the coroner. Dr Reddan is a Consultant Psychiatrist with extensive experience in both private and public mental health services as well as providing expert reports.

Dr Reddan said in her opinion RN Gulliver was appropriately experienced to take over case management for the four weeks whilst the usual case manager was on leave. She stated she was unable to comment on the adequacy of the handover to RN Gulliver as she was not aware of what was said. However, she says the documentation for the case was adequate for RN Gulliver to reasonably quickly come up to speed with Dianne's case.

She made the observation that a change in case manager and/or treating doctor creates a discontinuity in patient care and always creates cracks through which patients may fall. She says there are always subtleties about a patient, which cannot be adequately conveyed by the written word. Dr Reddan stated it needs to be kept in mind mental health staff can vary in their capacity to convey, by written word, nuance and subtlety.

Dr Reddan said that whilst RN Gulliver's communication with the non-government organisations was not ideal, at some level he did process the concerns raised as demonstrated by his discussions concerning Dianne with the attending medical staff; accessing an early appointment with a psychiatrist; and by visiting her in her home a day earlier than he had planned.

Dr Reddan was of the view RN Gulliver did escalate the concerns to her treating doctor and did adhere to the Crisis Management Plan. There was certainly an increase in contact with Dianne when concerns were raised about her.

Dr Reddan is of the view that Dianne's presentation to Dr Clavijo did not warrant admission. She stated that his documentation and approach to her case was reasonable given the information available to him at that time. Dr Clavijo states he discussed the matter with Dr Relan the next day but this was not documented in the records. It was definitely planned for Dr Relan to see her early the next week.

Dr Reddan stated that the clinical history and her presentation did not indicate that the Acute Care Team should have become involved and in any event, it is likely that Dianne took the overdose some time on 29 October which probably would have been before the Acute Care Team would have scheduled to visit or call her.

Dr Reddan also opined that medication management was consistent with most clinical practice guidelines and was common practice amongst conservative psychiatrists.

Dr Reddan stated it was unclear from the notes when Dianne was first prescribed metoprolol however she had been taking it for years. It was likely given her history of hypertension that this was originally prescribed for this and it is unlikely the prescription was initiated by mental health staff.

Dr Reddan stated she was unclear why Dianne was prescribed two different anti-psychotic drugs, olanzapine and quetiapine but she stated that over the years the doses had not been excessive or very high.

Sodium valproate is an anti-epileptic drug but it is commonly used in mood disorders, particularly Bipolar. Dianne had been prescribed lithium years before and it was somewhat unclear as to why this was not continued. However Dianne was extremely resistant to any changes in her medication, causing her considerable anxiety. Although Dr Reddan considers that overall lithium is the preferred drug for bipolar she was not critical of Dr Relan for continuing sodium valproate and stated this was what the vast majority of psychiatrists would have done when taking over the case.

The unresolved question was whether Dianne should have been prescribed an antidepressant in view of the history. Dr Reddan noted there were arguments both for and against.

Dr Reddan noted that the question as to who should be prescribing psychotropic medication and how often and in what quantities is always difficult. She noted that Dianne's overdosing previously had been restricted to only three occasions in a woman who had a very lengthy history of Bipolar Disorder. In addition, talk of suicide or suicidal threats was not a major feature of Dianne's case. Thus restricting the number of people prescribing to her, or the frequency or the amount of tablets provided was not indicated in her case. Indeed, the risk of being overly restrictive is that the wrong message can be given to the patient, worry the patient or place more of a burden on the patient and the services. This could increase the risk the patient will cease taking

medication and it was known that medications improve the patient's quality of life, and reduces the incidence of relapses, morbidity and mortality.

Dr Reddan stated that procedures, policies or work instructions can be a support or guide to good practice in health care, but they are never a substitute for good training, supervision and common sense.

Dr Reddan however was critical of some of the hospital's policies, in particular 'Navigating the Metro North Mental Health Service-TPCH'. Specifically it recommended some behaviours or practices which Dr Reddan considered should not be recommended. For instance, it suggests that if someone has a mental health concern about an individual they are supporting, they are to decide whether the concern is an emergency or not. In Dr Reddan's view, asking a community support worker to decide whether a situation is an emergency or not is not within their training or expertise. To suggest that the individual must present to their closest Emergency Department or to ring 000 is basically suggesting to the support worker that it is still their problem. It is delegating to support workers, an assessment and decision which are difficult for even experienced mental health staff.

Dr Reddan considered that Emergency Departments are the last place that mental health patients should be directed to unless there is no other option. Telephoning 000 was essentially putting the responsibility on to the Queensland Police Service or the Queensland Ambulance Service.

Dr Reddan considered that a much better policy was titled 'Communicating with the Mental Health Service – TPCH'. She considered this was a far more sensible document in that the community support worker is encouraged to ring the principal service provider. She was concerned about communicating by generic e-mail accounts given these may not be accessed for hours or days at that time.

Dr Reddan stated that the overall procedure for case management was lengthy and very comprehensive but, by necessity, it is important that such policies or procedures not be overly prescriptive, as one of the essential roles and assets of a case manager is flexiblity.

Dr Reddan stated it was unclear from the material how frequently patients were discussed in a multidisciplinary team meeting or at a case review although there were comprehensive care plans documented in the file. She considered it was likely that those care plans were modified after each team meeting. She considered the multidisciplinary team meeting was crucial. She stated it was unclear to her how brief notes from those meetings were documented. She considered it was a crucial omission when the Consumer Integrated Mental Health Application was developed it did not have a clear drop-down menu for multidisciplinary team meetings or case reviews.

Dr Reddan stated that it would be good practice for a relieving case manager to, where possible attend a case review about the patient prior to taking over their care. She stated it was next to impossible to develop a procedure or a

policy about handovers during absences of a psychiatrist, registrar or case manager. How extensive any handover should be depends on the patient and it is likely to be simplified if the documentation about the patient is good.

Dr Reddan stated it was clear from the material that Dianne suffered from Bipolar 1 Disorder as well as a Generalised Anxiety Disorder. The lifetime risk of suicide in individuals with Bipolar 1 is considerably higher than it is in individuals with schizophrenia, the latter of which is usually a more severely impairing condition. The rate of completed suicide in patients with Bipolar 1 is considerably greater than that of the general population.

In Dianne's case the number of suicide attempts she had previously made was fairly low compared to many other patients with Bipolar 1.

Dr Reddan noticed in the 12 months to two years prior to her death Dianne was experiencing more episodes of melancholic depression. She says efforts were made by the treating team to improve the quality of her life and to reduce the risk of relapse by increasing her community supports. She says whilst appropriate, at the same time there was a risk too many people may have been stressful to Dianne. She also noted Dianne's reluctance to attend respite and to undergo ECT.

Response by the PCH to issues raised by Dr Reddan

Dr Jacinta Powell is the Clinical Director of Metro North Mental Health. She provided a statement recording her response to the issues raised by Dr Reddan.

In 2011 there were a number of ways patients could access medication. For a small number of patients, they would attend their GP who would prescribe medication with input from psychiatric medical staff. However, most patients would either be given a prescription by the treating doctor at the service to take to their local chemist or it would be dispensed by the hospital pharmacy.

Ms Bowling was quite committed to managing her own medications and was aware of what she was taking when she needed new prescriptions. She obtained her medication by taking the prescriptions to a community pharmacy.

Dr Powell considered that given the history of overdoses were limited to three episodes in 1992, 1999 and 2009, it would not have been practical to limit her supply of medication over many years and if attempted would almost certainly have resulted in her running out of medication and becoming unwell. It would also have limited her autonomy and increased her dependency on others for care.

Dr Powell also provided a response with respect to be matters raised by Dr Reddan in her report concerning the documents titled ‘Navigating the Metro North Mental Health Service’ and 'Communicating with the Mental Health Service-TPCH’.

Both these documents were developed in 2011 in response to feedback from external agencies which found it difficult to understand how the mental health service operated or how best to raise issues of concern and communicate with the most appropriate person.

Dr Powell does not agree with Dr Reddan that a support worker or carer could not understand a prompt to consider if there was an emergency or not. She was of the opinion that on balance it would be better if such workers or carers err on the side of caution and called for immediate help for emergency services rather than delay by contacting a case manager who may not be immediately available or a mental health clinician who may not know the person.

Dr Powell noted the concerns about having a person taken to the emergency department as an option of last resort and agreed that whilst it should only occur when there was no other option, in the event of an emergency this is the safest point of initial assessment.

Dr Powell stated that the PCMHS has mental health clinicians in the emergency department around the clock. Their role is to assist people with suspected mental illness from the point of triage, through medical clearance and then they are generally taken through to the mental health service assessment area for further treatment and possible admission. Assessment generally happens in parallel with an emergency department assessment or instead of such an assessment following initial triage. She stated that this ensures the safety of patients and staff across a variety of presentations that present via emergency services and avoids the problem of a long waiting time in the emergency department.

Dr Powell stated that only emergency services such as police and ambulance are required to take patients to the emergency department. People who bring themselves in or come with carers or support workers are able to come directly to the mental health service assessment area between 8am and 9pm Monday to Friday and 9am to 5pm on weekends and can see mental health clinicians for assessment, bypassing the emergency department.

Dr Powell noted that Dr Reddan was supportive of the document ‘Communicating with the Mental Health Service-TPCH’ but was critical of the use of generic e-mail accounts. The document was written specifically for non-government and community support organisations. The use of a generic e-mail account was a deliberate decision by the service and came about in response to specific communication issues identified by teams. The generic e-mail accounts are accessed each morning by the intake worker for each team and monitored over the course of the day. Prior to implementation of generic e-mail addresses, when a message or e-mail had been left for an individual case manager there were sometimes delays particularly when a case manager was unexpectedly away on sick leave or out of the office.

Dr Powell stated that although the criticisms were not supported, there is always scope for improvement and these documents have been placed on the

agenda for an interagency meeting that is to occur shortly, to review the currency and utility of the documents and include consideration of the concerns raised.

Over the last two years the service has developed a prospectus approach to education, training and communication with the community, non-government organisations, consumers and carers.

'The Recovery Support Services Courses and Resources Prospectus' for July to December 2014 has recently been published electronically and will be distributed to agencies. A workshop available to consumers, carers and support agencies is scheduled for 30 July 2014 entitled 'Navigating the mental health service and accessing support systems within the community'.

Conclusions on the issues

How and what caused Dianne's death

The issue raised here is whether or not the ingestion of a toxic level of metoprolol by Dianne was with an intent to take her own life or whether it was simply a case of misadventure or accident.

There had been three previous occasions when Dianne overdosed with her prescribed medication and which, at least in the medical records, were considered suicide attempts. These events occurred in 1992, 1999 and 2009.

Dr Reddan noted that the number of suicide attempts was fairly low compared to many other patients with Bipolar 1. Dr Reddan noted the lifetime risk of suicide in individuals with Bipolar 1 is considerably higher than that of the general population and higher than those suffering from even more severely impairing mental health conditions.

It is evident that Dianne had been experiencing more frequent episodes of unwellness including melancholic depression.

It is also evident that over the month of October 2011 Dianne was deteriorating and her brother, the community workers and Dr Relan had noticed a change in her condition which was thought to be an early sign of a relapse.

Although there is no evidence that Dianne was expressing suicidal ideation, there is also no evidence that she was known to be reckless or indifferent to compliance with taking her medication. In fact, the evidence supports that Dianne was careful and attentive to taking her medication. It is noted metoprolol was prescribed by her GP to treat her long term hypertension and she would have been well aware of how much she was to take.

In conclusion, I find it is more likely than not that Dianne took a fatal level of metoprolol with intent to take her own life and in the context of some deterioration in her mental health. I suspect she knew she was relapsing and

knew where this was heading with another probable admission to hospital in the near future.

Whether the assessment and treatment of the deceased by the Prince Charles Hospital Mental Health Service, including the Community Mental Health Team was appropriate and adequate in the four weeks leading up to the deceased's death

Dianne was suffering from a long-term chronic mental illness of Bipolar 1 Disorder, generalised anxiety and probable melancholic depression compounded by cognitive deficits. At times her behaviour could be difficult and demanding.

Dianne's brother, Christopher Baker, provided very compassionate care and support. Dianne also had the benefit of other support from a number of community organisations who also provided some respite for her brother.

Since 2000 the principal management of her mental illness was conducted by the PCH. Dianne had a case manager assigned to her as well as a Crisis Management Plan.

The plan provided guidance about what should be considered a sign of relapse and what should be considered to be the next step in management. A number of community support staff who had been providing care to Dianne were aware of the possible signs of relapse and identified some of these in the month and weeks leading up to her death.

Dr Reddan was critical of some aspects of the complexity of the plan itself but considers it had no ultimate role in the overdose and death.

There was also clearly some confusion on the face of the medical records as to what particular plan was current. RN Gulliver was working from a plan which may have impacted on how he interacted with some of the community workers when they contacted him to advise of the possible signs of relapse.

Ultimately, how he interacted with the community workers played little part, as he did act by conducting an earlier home visit and arranging earlier psychiatric appointments. All this was performed in a timely manner.

Dr Reddan was not critical of the assessments by the case manager or Dr Clavijo and was of the opinion that the care provided to Dianne was reasonable and appropriate in the circumstances.

It is evident that Dianne was relapsing and becoming more unwell. Her cyclic history was of a pattern of relapse evolving over time and not suddenly. At the last assessment just prior to her death, it was not considered that she required an immediate admission to hospital. With the benefit of hindsight, it is possible she was more unwell than she was assessed. Dr Reddan stated that it is difficult to be able to predict when someone may suicide and patients may simply change their minds without any indication this was about to happen.

The evidence does not support any adverse finding should be made concerning the assessment, care and treatment provided by the mental health service to Dianne in the months and weeks leading up to her death.

The adequacy of the policies and procedures of the Prince Charles Hospital

Concerns have been identified regarding the Crisis Management Plan. Dr Reddan considered it was well intentioned but too complex.

Further, the evidence supports a finding that in this case the distribution of the plan was confused and less than ideal in that there appears to have been a number of signed and unsigned plans that were different to the one that presumably was finally approved and signed by all the appropriate parties.

It is clear however, that the reliance on the particular plans may have contributed to some of the interactions with community agencies but did not play a part or contribute to Dianne's death.

Dr Reddan agrees that the documentation and policies surrounding the new Acute Management Plans are much better and more focused.

The policy supporting the introduction of Acute Management Plans notes that the Acute Management Plan is to be saved in CIMHA and the Emergency Department Information System (EDIS) so that the most current plan is accessible to all mental health acute care teams, Department of Emergency Medicine and psychiatry services across the state. Provided that is the case then no further comment or recommendation appears to be necessary.

I assume that to ensure the efficacy of the new policy, a system of audits of compliance has been put in place. If not, then it should be.

Dr Reddan was also critical of aspects of some other procedures and in particular the one titled ‘Navigating the Metro North Mental Health Service – TPCH’. The hospital disagrees with that view but has agreed that as there is always scope for improvement further interagency meetings will occur shortly to review the currency and utility of the documents and will include consideration of the concerns raised.

In that respect no further recommendation is considered necessary.

Findings required by s. 45

Identity of the deceased – Dianne Judith Bowling

How she died – Dianne died by intentionally ingesting various prescribed medications and in particular a toxic level of her antihypertensive medication metoprolol. Dianne had been suffering from a long-term debilitating mental illness and in the month prior to her death was experiencing a

relapse and deterioration in her mental well-being.

Place of death – 7 / 34 Leiper Street Stafford Qld

Date of death– 29 October 2011

Cause of death –

1(a) Mixed drug toxicity
2 Coronary atherosclerosis

I close the inquest.

John Lock
Deputy State Coroner
Brisbane
18 July 2014