QUEENSLAND COURTS

# OFFICE OF THE STATE CORONER

## NON-INQUEST FINDINGS OF THE INVESTIGATION INTO THE DEATH OF ALISON RUTH COPELAND

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| CITATION: | **Investigation into the death of Alison Ruth Copeland** |
| TITLE OF COURT: | Coroners Court |
| JURISDICTION: | Brisbane |
| FILE NO(s): | 2013/4151 |
| FINDINGS OF: | John Lock, Deputy State Coroner |
| CATCHWORDS: | Coroners: Death in care, mental health and physical disabilities, access to suitable residential placements for people under 65 |

## Background Medical and Social History

Alison Ruth Copeland was aged 55.

Her past medical history included that of subarachnoid haemorrhage in 1995, caused by a cerebral aneurysm. This had resulted in right-sided hemiparesis, aphasia and right sided hemisensory loss. Alison suffered from double vision, limited mobility (usually mobilising with a cane) and used a motor scooter to mobilise longer distances. Her marriage broke down after her injury.

There was also a history of hiatus hernia, gastric reflux and depression. She was on a number of medications including those consistent with depression

Alison had been employed as an administration officer in the Department of Education for 20 years.

The past history of aneurysm had caused cognitive impairment, speech problems, blurred vision and blindness. Her history indicated she had made 10 previous attempts to end her life with the first attempt occurring in 1997 following her injury. The past attempts had been by varying means including by overdose, cutting her wrists, gassing herself and intending to drive her scooter into a canal.

## Issues concerning attempts to obtain access to a high needs nursing facility

Alison had been on a waiting list for a Blue Care aged nursing care facility for a number of years but had been informed that this would become available soon.

Care was being provided by Bayside Mental Health Service. The service stated that its focus of care was to support her through the process of entry to the nursing care facility as well as linkage to and coordination of other services in the interim and carer's support for Alison's sister.

Alison's mental state was said to have been stable for many months prior to this. However, her sister states her mental state fluctuated often due to the level of frustration she experienced between periods of hopefulness and disappointment. There were occasions when she would become trance-like after bouts of extreme upset, repeating things like ‘no more’ over and over.

Alison was last seen by her case manager on 7 November 2013. Her mental state at the time appeared to have been good. It was stated she was appreciative of the visit. The case manager considered the conversation was logical and rational and insight was reasonable regarding managing ongoing frustration. It was considered there was a low-risk of self harm at the time of the visit as she was future oriented and hopeful. There was a chronic medium risk given her past history and ongoing frustration with placement and her physical condition.

The plan at the time of this assessment had been closure to the service with ongoing follow-up with Blue Care and her GP and extensive communication with these services. The case manager had arranged to see Alison one more time prior to closure of the case.

## Internal hospital review

It was noted that Alison suffered significant frustration as a result of the period of time she had been waiting for an aged care bed. Despite intensive efforts and liaison by her case manager and carer with agencies such as Disability Services Queensland and residential aged care facilities, it had not been possible to find a suitable placement for her.

She had multiple comorbidities that had led to physical disability and the need for a placement in an aged care facility. She also suffered from depression and adjustment disorder and her physical disability was a major cause of her mental health symptoms.

The review noted that the difficulties in finding a placement for a consumer under the age of 65 years and with high care needs, was highlighted in this case.

## Concerns of family

In 2005, Alison's sister moved into a dual living home to better care for her as Alison's physical abilities deteriorated. There was ongoing depression with numerous suicide attempts.

In February 2011, she was admitted to the Belmont Private Hospital due to erratic and psychotic behaviour. An appointment was made by the hospital social worker with Disability Services Queensland (DSQ).

For the next two years the family describes a series of delays and failures within DSQ to progress any assistance. The family had received significant support from Bayside Mental Health Services who made every effort to find the assistance that was required to provide support to Alison.

Initial contact with DSQ directed them to obtaining an Aged Care Assessment Team (ACAT) assessment as being a faster option than through DSQ. However Alison's age was initially considered to be an impediment for such an assessment.

Subsequently, Alison was admitted into Causuarina Lodge and was there for 18 months whilst appropriate high care accommodation was sought.

Complaints were made to the Health Quality and Complaints Commission in relation to DSQ which advised that it had no jurisdiction. Subsequently complaints were made through the Disability and Communities Complaints Unit. Complaints escalated to the Ombudsman's office, the local Member of Parliament and the Minister. Various apologies were provided but no further practical solution ever resulted.

The family agreed that much more needs to be done about appropriate housing for younger persons suffering from disability and this issue was at the very core of Alison's recent suicide.

## Events of 18 November 2013

Her sister told police that she saw Alison at 7am on 18 November 2013 and initially she appeared to be fine. They then had a verbal argument as Alison wanted her sister to spend more time with her. She was swearing and screaming and yelling ‘let me go I hate my life’. She said this on several occasions. Her sister then gave Alison temazepam to help her sleep and checked on her twice that evening. Early the next morning, the sister went downstairs and found Alison in her room with a plastic bag over her head. She was clearly deceased.

## Autopsy examination

An autopsy examination has confirmed the cause of death was due to plastic bag suffocation.

Toxicological analysis found multiple drugs of prescription, which were mainly therapeutic and slightly above therapeutic concentration including temazepam, mirtazapine and venlafaxine (antidepressants), amlodopine (antihypertensive), paracetamol, promethazine (antihistamine).

The cause of death was due to asphyxia following plastic bag suffocation. The presence of multiple drugs including benzodiazepines and antidepressants could have caused drowsiness and enhanced loss of consciousness leading to death.

## Response by DSQ

DSQ noted that the records indicated Alison waited approximately three months before undergoing an assessment of need by a departmental officer. It was noted that the Department makes every effort to complete an assessment in the shortest possible time frame.

However, in 2011 a wait of three to four months in the South East region was not uncommon as a result of available staff resources. In addition, a new process of intake and assessment had commenced and Queenslanders with a disability were actively encouraged to self refer for an assessment and this resulted in high demand.

DSQ advised that since 2011 efforts have been made to reduce the wait time for disability services assessment. The current average is now six weeks unless there are identified high risk factors in which case an urgent assessment will be made.

Departmental officers are now guided to identify high needs requiring an immediate emergency response by various internal policies and risk assessment tools.

DSQ advise that once an individual seeking assistance is assessed, their disability support needs are listed on a statewide register. Assessment does not automatically equate to access to support and services. Services are offered when a funded vacancy is identified, or additional resources (additional funding) becomes available.

Alison was assessed to have high needs in that accommodation arrangements were considered unsustainable in its present form. She was accordingly placed on the register. Data for this period indicated there were 67 individuals across the state recorded on the register waiting for out-of-home accommodation support funding. As of 6 May 2014, 394 individuals were recorded on the register as awaiting out-of-home accommodation support.

The Department investigated internally the complaint of Alison's family. It was identified that it had not been made sufficiently clear to the family that an assessment of high support needs does not equate to prioritised service delivery. It is now the practice of departmental officers to be very clear when communicating the outcome that being assessed as suitable does not guarantee identified supports will be received. Due to demand exceeding supply, an applicant may only be linked to specialist supports if and when the appropriate supports become available.

DSQ also advised that the Department will assist individuals and families to explore other avenues including through other agencies. In that regard an ACAT assessment was suggested as another alternative to assist in exploring out-of-home accommodation options that provide high care. An ACAT assessment was undertaken in August 2011 noting Alison was eligible for admission to a nursing home and subsequently she was transferred to Casuarina Lodge Rehabilitation Centre whilst awaiting a suitable placement. Alison's family has acknowledged that ACAT specifically deal with clients over 65 and are not a part of the DSQ, nor have the same assessment process. The family consider that ACAT should be commended for caring enough to assist outside of their jurisdiction, not once, but twice, and despite an extensive waiting list.

In March 2013, the family sought reassessment of her needs to include in-home support until placement in aged care. DSQ reviewed and updated the register of need with recommendations for in-home support and accommodation support, to be provided as resources became available.

DSQ states it made contact with ACAT on a number of occasions to check on her waiting status and to help progress placement. Further contact in April 2003 also resulted in ACAT agreeing to reassess Alison for aged care respite while waiting for the nursing home placement.

DSQ noted that under section 8 of the Disability Services Act, it is recognised there are finite resources available and a need to distribute resources fairly with regard to the state's priorities. The process to access specialist disability services is guided by policies to ensure it is consistent, transparent and responsive while managing finite resources effectively and equitably across the state.

In May 2013, the Queensland Government agreed with the Australian Government to full implementation of the National Disability Insurance Scheme (NDIS) to take place between 1 July 2016 and 30 June 2019. Under the NDIS, the current state-based schemes will change to a national scheme. For housing, the provision of accessible and affordable accommodation options will continue to be the responsibility of the State while NDIS will fund reasonable and necessary home modifications to private dwellings on a case-by-case basis.

It is the view of the Department that as a result of the nationwide reforms it is intended that people with a disability will receive a more timely and comprehensive response to their support needs.

The Department extended its sincere apologies to the family.

## Conclusion

Alison had suffered from a significant physical disability since 1995 as a result of bleeding into her brain from an aneurysm. There were resultant significant mental health consequences with multiple attempts at suicide over the years. Attempts were being made to have her cared for in an appropriate high needs care facility however there were significant problems in finding such a facility.

A review by the Bayside Mental Health Service noted that this case highlighted the difficulties in finding suitable facilities for persons under the age of 65 who require high need care.

DSQ accepts there were delays in an initial assessment and limited funding resources available to provide immediate accommodation needs for Alison once the assessment was completed.

DSQ states the intention of the NDIS, in conjunction with the State Government, is to provide more timely and comprehensive responses to those who require disability services in the future.

The NDIS does not commence for a further two years and does not apply to housing.

The problem of insufficient appropriate accommodation support for disabled people under 65 is likely to remain an issue.

DSQ has noted the number of individuals awaiting ‘out-of home’ accommodation support increased from 67 in August 2011 to 394 as of May 2014. At the time of her death, Alison had already been waiting for 18 months and her family have continued concerns that if she was still alive the situation would likely have remained unchanged.

## Publication of Findings

This investigation has considered a number of issues concerning the availability of out-of-home accommodation support for those under the age of

65 with high needs. Alison's family has been consulted and agreed this was an issue of public interest warranting publication of the findings pursuant to s. 46A of the *Coroners Act 2003*.

## Findings required by s. 45

**Identity of the deceased** – Alison Ruth Copeland

**How the person died** Alison had been suffering from multiple neurological and physical disabilities requiring constant care. Efforts were being made to find a suitable placement for her high needs but there were considerable difficulties in finding such placements for people under 65. She has taken her own life in the context of ongoing depression and frustration with her life difficulties and residential circumstances.

**Place of death** – 100 Morris Circuit Thornlands QLD 4164

**Date of death**– 18 - 19 November 2013

**Cause of death** – 1(a) Plastic bag suffocation

John Lock
Deputy State Coroner
Brisbane
28 July 2014