# OFFICE OF THE STATE CORONER

# FINDINGS OF INQUEST

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| CITATION: | **Inquest into the death of Melissa Maree BLAKE** |
| TITLE OF COURT: | Coroner's Court |
| JURISDICTION: | Maroochydore |
| FILE NO(s): | COR 183/07(5) |
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| FINDINGS OF: | Ms B Callaghan, Coroner |
| CATCHWORDS: | CORONERS: Inquest – suicide, drowning, Mental Health Service, whether treatment appropriate |

**IN THE MATTER OF:** **AN INQUEST INTO THE DEATH OF MELISSA MAREE BLAKE**

Preliminary matters

I deliver my findings pursuant to S45 of the Coroners Act 2003. In this matter there is no doubt that Ms Blake died as a result of drowning on 16.1.07 at 24 Panorama Cres. Buderim. She committed suicide whilst under the care of Sunshine Coast District Mental Health Services Network.

The purpose of the inquest was to establish whether or not the treatment given to Ms Blake was appropriate and whether alternate treatment should be recommended in similar circumstances. In making my findings I am not permitted, under the Act, to express any opinion on any matter that is outside the scope of the inquest, except in the form of a recommendation which would in my opinion be designed to prevent the occurrence of a death.

The findings I make here are not intended to determine or influence any question or issue of liability in any other place.

The evidence in the inquest has been adduced from witnesses and exhibits which have been tendered before me. This along with other material on file represents the total of the material adduced before me.

Circumstances leading to Ms Blake being under care of Community Health

Ms Blake had a miscarriage some 2 weeks prior to her GP Dr Mark Bown referring her to the Mental Health Service of the Sunshine Coast Health Service for assessment. She had presented to Dr Bown as withdrawn/scared and expressing thoughts of suicide. She was convinced that she had a serious illness. The family had expressed concern to Dr Bown that Ms Blake was suicidal and they were caring for her 24hours per day. Initially Dr Bown had tried to have Ms Blake treated under the private health system with a specific psychiatrist but was unable to obtain an early appointment – subsequently it was decided to have Ms Blake treated in the public system. Ms Blake

had been seeing a clinical psychologist post miscarriage who diagnosed Obsessive Compulsive Disorder and anxiety.

Treatment by Sunshine Coast Health Service

On 11.12.06 Ms Blake was assessed by Ms Joan Reid, Clinical Nurse – this assessment occurred over the telephone at 6.00pm. At the time Ms Blake was on Lexipro (anti depressant - 10 milligrams /day), and had been on this drug for 16 days. She was also on stillnox and had been so for the previous 2 months. Ms Blake expressed a willingness to be involved in CATT (Community Assessment and Treatment Team). She was referred for further assessment.

The following day she was assessed at her home by Dr. Adam Fish (Principal House Officer and medical practitioner) and Peter Bradford (Clinical Nurse Consultant and primary care coordinator). Ms Blake was assessed as having a major depression, agitated with perhaps psychotic features.

Plan was to cease lexipro, allow for 1 day wash out and then commence Ms Blake on mirtazapine (antidepressant) (30mg) with daily home visits to monitor for emerging psychotic systems. Fish's report on this visit was that both the patient and her family were opposed to the possibility of hospital treatment and keen for treatment to be offered in the community despite frank discussions of the potential risks. It was also felt that Ms Blake did not meet the criteria for involuntary assessment or treatment under the Mental Health Act at the time as there was no evidence she would not be compliant with the treatment.

This plan was implemented. Ms Blake's condition was monitored daily by various health professionals. Fish visited Ms Blake at her home on 12.12.06. 15.12.06, 28.12.06 and 5.1. 07. Dr Redman, psychiatrist visited Ms Blake at her home and reviewed the treatment of her on 18.12.06 and 25.12.06. Redman made the decision to change Ms Blake's anti-psychotic medication to olanzapine to be taken 5mg at night and a further 5mg as needed. Redman also determined that there was a need for twice daily home visits. Redman sought a second opinion from Dr Miles, specialist

psychiatrist. Prior to this time Fish had been discussing Ms Blake's treatment with Miles.

Miles saw Ms Blake on 19.12.06 and 21.12.06 at her home. He agreed with Redman's assessment. He was uncertain as to whether there were any psychotic features but "*on balance ... felt that Melissa may have had very 'low grade evolving' psychotic features and ... suggested that her dosage of olanzapine should be increased to 10mg per day*". This plan was then followed.

Clinical notes of the period from 20.12.06 show a gradual improvement in Ms Blake's condition and on 21.12.06 following the advice from Miles the home visits were reduced to once per day. Ms Blake continued to improve.

On 25.12.06 Redman, after discussions with Bradford felt it would be appropriate to increase the dosage of mirtazapine to 45mg per day. This was to be confirmed by Fish when he next reviewed Ms Blake on 28.12.06. On this date the mirtazapine was increased to 45mg per day and the olanzapine was decreased to 5mg per day. This was following a discussion between Fish and Miles. By this stage Ms Blake had raised the concern she had over her weight gain which had been attributed to olanzapine.

Ms Blake continued to improve after the decrease in the olanzapine and by Fish's home visit on 5.1.07 it seems there had been significant improvement in her condition. Ms Blake continued to be concerned about her weight gain. Fish discussed with Miles reducing the olanzapine dosage to 2.5 – 5mg at night as required. Miles concurred with this and the olanzapine was reduced to an as needs basis.

That weekend Ms Blake was going away with family to northern NSW and there was to be no home visits until the following Monday. Evidence is that Ms Blake had no access to any olanzapine over that weekend. On the Monday following the weekend Ms Blake advised Bradford that during the weekend the mornings had been good but her mood had deteriorated during the afternoons. She expressed the opinion that her decline over the weekend could be linked to the cessation of olanzapine.

The olanzapine was reintroduced on 9.1.07 – dosage was 2.5mg at night. On 11.1.07 Fish, who was unable to attend a home visit with Ms Blake on that date because he was running late had a phone conversation with Ms Blake who expressed the opinion that she felt that she had gone backwards since the cessation of the olanzapine and she had not improved since the reintroduction of it at 2.5mg. Fish decided that Ms Blake could take 5mg of olanzapine until she was medically reviewed.

Daily home visits continued with some improvement on 13.1.07 and 14.1.07. On 15.1.07 clinical notes indicate that Ms Blake was having a bad day. Ms Couche, social worker had visited Ms Blake at her home on that date and discussed with her organising another medical review. Couche considered the suicide risk was moderate but did not believe that there was an immediate risk because Ms Blake discussed plans for the next day. Ms Blake had stated to Couche that she wanted some space and Couche suggested that she might go for a walk on the beach with her husband the next day. When questioned on this Couche stated that she and Ms Blake talked about her getting out of the house and she recalled discussing this with some member of the family. The next day Ms Blake committed suicide.

Report and evidence of Dr F T Varghese

I had Dr FT Varghese, consultant psychiatrist prepare a report for me on Ms Blake's treatment. He concluded that Ms Blake suffered from an episode of psychotic depression with both somatic delusions and self-deprecatory delusions. He reported that the risk of suicide with this illness was very high and was something which had to be assumed. Varghese stated that the condition suffered by Ms Blake would have responded very well to ECT (electroconvulsive therapy) however it could be treated with medication. He felt that it was unwise to attempt to treat such a serious condition with a high death rate in an outpatient setting unless around the clock monitoring could be provided.

His report noted that the Mental Health Act stipulates that treatment be provided in the "*least restrictive*" alternative and this would put the treating team in an invidious position in the case where a patient such as Ms Blake was not refusing treatment in a

community setting and the family felt that they could provide supervision with respect to issues of risk. It was Varghese opinion that the *"legal requirement for the 'least restrictive' alternative only applies if the appropriate treatment is in fact providable in the least restrictive environment ... I would take the view that in psychotic depression of this kind, community treatment is in fact not providable unless the resources to provide such treatment are available"*.

On the question as to whether the level of care for Ms Blake was appropriate having made the decision to manage her illness in the community Varghese was of the opinion that it was. Ms Blake was seen on a daily basis (except for the 2 days when she was travelling in northern NSW) and sometimes twice per day as well as telephone reviews. She was assessed by consultant Psychiatrist (Redman) on 2 occasions in the home and a second opinion was provided by Miles, Psychiatrist also in her home. Ms Blake was also seen intermittently by Fish, Principle House Officer, Psychiatric Registrar as well as allied health staff – social worker, psychologist and nurses.

Varghese's opinion was that in the absence of ECT, the appropriate treatment for psychotic depression was an antidepressant combined with an antipsychotic drug. The anti-depressant was mirtazapine and the antipsychotic was olanzapine. Varghese commented that the olanzapine appeared to have been effective in ameliorating the psychotic symptoms and ceasing it without a consultant opinion or better still a consultant assessment was questionable (it was Fish's decision to cease the olanzapine to an as needs basis). He also commented that given the obvious deterioration in the patient's condition (after ceasing the olanzapine) it was surprising that Ms Blake was not reassessed by a consultant and the treatment plan reviewed. The olanzapine was recommenced by Fish. In his evidence Varghese stated when asked about the decision to cease or put her on olanzapine on an as needs basis that it was not something he would do but whether it was unreasonable would depend on the clinical situation at the time. He believed that Ms Blake suffered from psychotic depression and anti depressants alone were not effective and as a patient improves they should remain on the anti-psychotic for 3 months.

Varghese raised the issue as to whether it was appropriate to treat a person so seriously ill as Ms Blake in the community but conceded that one could not actually put a person on an ITO unless they were unreasonable refusing treatment which was not the case with Ms Blake.

The other issue that Varghese raised was the use of tick box protocols to assess suicide risk. He was of the view that clinical assessment is the most appropriate way of assessing suicide risk. I did not find that there was any problem with the assessment of suicide risk in this case.

Evidence of Dr Lawrence

Dr Lawrence, specialist psychiatrist was of the view that the treatment of Ms Blake was appropriate in the circumstances. On the question of ECT treatment Lawrence stated "*ECT, I think is the treatment of choice for a person suffering from a severe psychotic depression, with a high level of suicidal risk. I don't think I would jump in necessarily with that option without having, perhaps, started the patient on an antidepressant drug first ... and at least seeing the response, but that opinion would be influenced by the level of the – and severity of the psychotic features and the suicidal risk or general ... status medically of the patient.*" (Transcript p64 l22 – 30)

Lawrence's assessment of the notes was that not only Fish but also Redman and Miles were not convinced of the extent or severity of the psychotic features.

In evidence Lawrence stated that weight gain was a significant issue with olanzapine. She stated that it was an effective drug but overall it does cause some weight gain and it certainly can cause a very rapid weight gain which is very concerning and it would be unwise for that to be allowed to continue.

Lawrence's view was that hospitalisation should be left to the professional people to evaluate on a case by case basis.

Issues to be considered

In this case I find the issues that I must consider are

- Whether or not Ms Blake should have been admitted to hospital
- Whether or not Ms Blake should have been given ECT treatment
- Whether the support and information given to the family was adequate
- Change in the medication
- Whether lithium should have been prescribed

Whether or not Ms Blake should have been admitted to hospital

Neither Ms Blake nor her family wished for Ms Blake to be admitted to hospital and this is made very clear in the clinical notes. This issue is discussed with the family by Redman. It is also discussed with Ms Blake and Mrs Blake by Bradford. Mrs Blake initially in her evidence stated that this was not the case – she can recall Bradford discussing it with her but not anybody else. In her later evidence she agreed that she had a discussion with Fish and that she was prepared to look after her daughter at home. It is some time since these discussions would have taken place and Mrs Blake has been through the trauma of her daughter's death – it is not surprising that she has little recollection of discussions that were held at the time. Fish and Redman made contemporaneous notes of what discussions were held and these notes indicate that hospitalisation was discussed. I accept the evidence of the notes. In light of the unwillingness to have Ms Blake hospitalised, if the professionals treating Ms Blake were of the opinion that hospitalisation was necessary then Ms Blake would have had to have been admitted pursuant to S117 of the Mental Health Act which deals with involuntary treatment for non-compliance with treatment. This is not what the situation was – Ms Blake was willing to take whatever drugs were prescribed, she cooperated fully with the CATT team – there was no question of her being non-compliant with her treatment. In view of this cooperation then I am of the opinion that Ms Blake should not have been involuntarily admitted to hospital.

I am also of the opinion that there should not be a recommendation that hospitalisation should occur when somebody suffers with depression with psychotic features. This must be left to the treating specialists and be judged on a case by case basis. In looking back over the notes concerning Ms Blake, the treating specialists

were not sure at the beginning as to any psychotic features in Ms Blake's illness. Fish, Miles and Redman were all uncertain as to any psychotic aspect to her illness but it seems they erred on the side of caution and prescribed an anti-psychotic drug. The severity of the illness can only be judged by the treating health professionals and whether or not to hospitalise can only be done by these people.

Whether or not Ms Blake should have been given ECT treatment

ECT is clearly Varghese's preferred treatment when faced with a severe depression with psychotic features. Varghese had the benefit of hindsight when determining the illness suffered by Ms Blake was psychotic depression – this was not clear to the treating professionals when first dealing with Ms Blake. Lawrence was of the view that one would commence with drugs and then if this did not work then look at ECT treatment.

ECT is quite an invasive treatment and is just one of the tools available to treating health professionals. The call as to whether or not ECT should be recommended must be made by the treating psychiatrist. In this case it does not seem that ECT was discussed with the family – I can find no fault in that. Ms Blake was being treated in the community under a medical practitioner and 2 psychiatrists. They proposed drug treatment and this I find to be appropriate in the circumstances that existed at the time.

Whether the support and information given to the family was adequate

The level of treatment is well itemised in the clinical notes and the various reports that have been presented to this Inquest and I have referred to various aspects of that treatment in this decision. The level of home visits is appropriate in my opinion. Initially it was once per day, increased to twice per day and then decreased to once per day once improvement commenced up to 8.1.07. During the period up to 8.1.07 Ms Blake was regularly seen by mental health professionals including psychiatrists, medical practitioner, specialist mental health nurses, psychologists and social workers. The visits were at different times of the day and were by different people. There has been some criticism of this by the legal representative of the family and yes it would result in varying moods being displayed however I do not see how this

differs from what would have occurred if she had been in hospital. She would not have been seen by the same doctor or nurse or other mental health practitioner nor would it necessarily have been at exactly the same time every day. What was important was that after each visit detailed notes were taken – so detailed in fact that we are able to get a clear picture of what was occurring with Ms Blake and how she was responding to the treatment. These notes were of a very high standard.

Mrs Blake did complain of being shut out of the process, particularly by Fish when he requested he speak to Ms Blake alone. There are confidentiality and privacy matters that Fish must consider. Of course he and all other persons involved in the treatment of Ms Blake would want to talk with her on her own and this I find to be entirely appropriate.

Where I do have concerns is in the discussions with the family with regard to the risk of suicide and what their responsibilities were should Ms Blake not be hospitalised. The Blake family were not professionals yet I have the impression that many of the CATT team presumed the Blake's understood the level of supervision needed of Ms Blake. I accept that Redman spoke at length with Mrs Blake on 18.12.06 about the risk of suicide and explained the need to keep a particular watch on the 4 – 5 day after commencing treatment because of the higher level of energy. Fish's notes re visit of 12.12.06 state that the family was supportive – there is no indication that Fish spoke to the family of their need to stay vigilant. His notes of 15.12.06 state "very supportive family who are currently ensuring that Melissa is not left alone" and his notes of 28.12.06 state "family still ensuring that someone is always with Melissa". In his oral evidence Fish stated that he would see the patient and other members of the team would do "more of the family work". (Transcript page61 line38). On 2 occasions clinical nurse Debbie Dale attended with Fish and there is no indication in her notes that she had any discussion with the Blake family re suicide risk On her final attendance at the home of the Blake's on 12.1.09 her notes state "*suicidal ideation has increased in past 3 days ... her risk has increased in past 24 hours and requires close monitoring & consideration of utilising hospitalisation is ongoing*". Yet there was no indication that this was discussed with the family – it might have been but the notes do not suggest that it was. In her evidence Dale can recall Fish speaking with Mrs Blake but did not hear the conversation. Dale's evidence was that

she had no direct contact with the family including when she visited on her own on 11.1.07. Bradford clearly spoke to Mrs Blake and other members of the family about the risk of suicide and he did this on a regular basis. Bradford was the primary care coordinator until he went on leave on 10.1.07. Clinical nurse Lennox became involved in the treatment of Ms Blake on 4.1.07. He home visited on 4.1.07, 12.1.07, 13.1.07 and 14.1.07. In his evidence he did not recall having any session with the family and he did not know whether he would have spoken to them about the risk of suicide.

All of this is unsatisfactory in my view – it seems that there is no plan where the family is spoken to on a regular basis with regard to suicide risk and this is not good enough when the family are an integral part of the treatment of the patient when they are being treated in the community. The family needs to be made aware of the risk of suicide and the need for close supervision and exactly what this means. This needs to be reinforced on each home visit, needs to be part of the plan and the clinical notes should indicate that this has been done.

I find that the document which is Exhibit 23 is not adequate in explaining these issues. It does not for instance go into what is needed to be done if one is required to constantly monitor a person at risk of suicide and I do not think that a brochure could ever adequately explain what is required. I am of the view that a person needs to do this and then this can be backed up by a brochure.

**I recommend that a professional health worker be responsible for ensuring that the family understands the risk of suicide, explains fully the role the family is to play in helping to prevent a suicide and reinforces this on a regular basis.**

The level of treatment from 8.1.07 I find not to be adequate. When Ms Blake's mood deteriorated to the extent it did Ms Blake should have been medically reviewed sooner rather than later. Certainly she should have been assessed by a psychiatrist at that time. Ms Blake was out of Queensland from 5.1.07 – she deteriorated over that weekend. She was home visited by Bradford on 8.1.07. His notes indicate that her mood was depressed and she was expressing concern that changes in her mood may

be linked to cessation of olanzapine. On the following day Bradford received a phone call from Ms Blake, tearful and distressed. She reported increasing negative thoughts and re-emergence of thoughts that she had been a bad person. Following this phone call Bradford had a discussion with Miles and Fish re reintroducing low dosage of olanzapine. Bradford was a very able and caring registered psychiatric nurse but he did not have the power to prescribe olanzapine. That had to be done by a medical practitioner and one should have seen Ms Blake as soon as possible after it became evident that her situation had deteriorated. This did not occur, however the medication was recommenced obviously following the report from Bradford. Whilst I am critical that this did not occur I am not inclined to make a recommendation. Ms Blake was being treated in the public hospital system in her home – there must be enormous pressures on the time of the practitioners running this service and that it seems is what occurred here.

The other comment I wish to make concerns the clinical notes which had included in them the plan of action and the medication to be given. Whilst the clinical notes were very good I would suggest that the plan and medication be itemised separately with an indication as to who was responsible for each individual part of the plan. This would ensure that the plan was properly followed. A copy of the plan also ought to be given to the family carers – this would ensure that the family who are part of the treatment plan are fully aware of what is to be done, will allow them the opportunity of ensuring that it is done and would also have the added benefit of ensuring the family stay focused on the seriousness of the illness and their role in the treatment. This I believe would prevent the situation of a patient running out of a medication which is what occurred here on 5.1.07.

**I recommend that the plan for treatment of a person in the community including medication to be given to that person be itemised in the clinical notes separately with an indication as to who is to be responsible for carrying out the plan. I recommend a copy of the plan be given to the family carers.**

<u>Change in the medication</u>

As at 19.12.06 Ms Blake was on 10mg of Olanzapine and 30 mg Mirtazapine. On 25.12.06 mirtazapine was increased to 45mg and Olanzapine remained at 10mg. She improved steadily. The levels of dosage of these medications were as per the directions of Redman and or Miles. On 28.12.06 discussion was had between Miles and Fish to reduce the olanzapine to 5mg and this was done the following day. Ms Blake continued to improve until 5.1.07. On this date Fish contacted Miles and discussed with him the issue of Ms Blake's olanzapine dosage and suggested reducing the dosage to 2.5mg – 5mg at night as required. Ms Blake for some time had been complaining of weight gain and so Fish following discussions with Miles took the decision to decrease the dosage to an as needs basis. However, it was not really on an as needs basis as Ms Blake ran out of olanzapine on 5.1.07 and Fish should have been aware of this as the clinical notes of the visit on 4.1.07 clearly state it.. She was going away that weekend and did so without any olanzapine. On both days over the weekend her mood seems to be okay in the mornings but deteriorated each afternoon. By the 8.1.07 Ms Blake was expressing concerns that the changes in her mood may be linked to the cessation of the olanzapine and on 9.1.07 she phoned the CATT team (Bradford) tearful and distressed and reported negative thoughts. Bradford contacted Miles and discussed the reintroduction of the olanzapine and it was decided that it would be introduced at 5mg over 2 days. On 11.1.07 the reintroduction of the olanzapine had not halted the feelings of going backwards and Fish over the phone gave the instructions to increase the dosage to 5mg per day. During this period, that is the period from 8.1.07 to 11.1.07 during which time Ms Blake's condition had deteriorated, she had not seen a medical practitioner or been reviewed.

In considering whether or not it was appropriate to decrease and then cease the olanzapine I have to consider all of the circumstances that existed at the time. Firstly Miles, Redman and Fish were not certain as to the psychotic features of Ms Blake's illness but decided to put her on the olanzapine just in case. During the period up to the 5.1.07 Ms Blake continued to improve and during this period the anti-depressant mirtazapine had been increased and the olanzapine had been decreased. Ms Blake had been complaining of weight gain reasonably regularly – it had been an issue since 27.12.06. In light of all of these circumstances it was in my view reasonable for those medical practitioners who were overseeing Ms Blake's treatment to make the decisions they did – they could have easily concluded that the improvement in Ms

Blake's condition was due to the mirtazapine not the olanzapine as her condition continued to improve when the dosage of olanzapine was reduced.

It was not reasonable for them to make the decision to leave her on the olanzapine on an as needs basis and then leave her with no olanzapine should she need it. This problem was made worse by the fact that Ms Blake was away for the weekend and out of contact with the CATT team.

It is in my view impossible to recommend any particular guidelines for the treatment of somebody in Ms Blake's position. It has to be managed on a case by case basis by the specialist overseeing the person's illness.

Whether lithium should have been prescribed

The answer to this is no.

This was raised with Varghese as the family had raised it with the coroner. Varghese in his report deals with it and states that "*very few psychiatrists would have used lithium in the acute phase of her psychotic depression. Lithium may have been justified at a later date if it had been only partial response to the anti-depressant and anti-psychotic despite adequate dosage and adequate time, in which case it could be used as an adjunct to increase the effectiveness of the anti-depressant. Lithium has not been shown to have any anti-psychotic effect on its own or as an adjunct to anti-psychotic drugs*"

Dr Lawrence did not recommend its use either.

Coroner's findings

Ms Blake died by committing suicide by drowning at her home on 16.1.07. At the time of her death she was suffering from a serious mental illness and was under the case of Sunshine Coast District Mental Health Service at Nambour Hospital and was being treated for her illness in the community.

Pursuant to S46 Coroners Act I make the following recommendations:-

**I recommend that a professional health worker be responsible for ensuring that the family understands the risk of suicide, explains fully the role the family is to play in helping to prevent a suicide and reinforces this on a regular basis.**

**I recommend that the plan for treatment of a person in the community including the medication to be given to that person be itemised in the clinical notes separately with an indication as to who is to be responsible for carrying out the plan. I recommend a copy of the plan be given to the family carers.**

All proceedings before this Court are sad proceedings. I express my sympathy and condolences, and that of the Court to the family and relatives of Ms Blake in their sad loss.

Bernadette Callaghan
Coroner