Coroners Act, 1996
[Section 26(1)]

Western  ***Australia***

RECORD OF INVESTIGATION INTO DEATH

Ref No: 14/16

I, Evelyn Felicia Vicker, Deputy State Coroner, having investigated the death of ***Radinka MIHAJLOVIC*** *with an Inquest held at Perth Coroners Court, Court 51, Central Law Courts, 501 Hay Street, Perth, on 19 & 20 April 2016 find the identity of the deceased was* ***Radinka MIHAJLOVIC*** *and that death occurred on 1 May 2012 on the train tracks at Maylands Train Station, Whatley Crescent, Maylands, as the result of Multiple Injuries in the following circumstances:-*

Counsel Appearing:

Mr T Bishop assisted the Deputy State Coroner
Mr E Panetta (instructed by MDA National) appeared on behalf of Dr Perica and Dr Rijks
Mr B Nelson and with him Ms R Paljetak (State Solicitors Office) appeared on behalf of the Inner City Community Mental Health Service (ICCMHS)

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INTRODUCTION

On 1 May 2012 Radinka Mihajlovic (the deceased) left a train at Maylands Train Station at 3.05 pm. A short while later, at 3.16 pm, the deceased was on the opposite platform at the train station when she jumped from that platform onto the train tracks in front of an oncoming train. She was observed by the train driver, however, there was not enough time for his emergency braking to be effective, before the train struck the deceased. She died at the scene.

The deceased was 47 years of age.

On 22 March 2012 the deceased had been placed on a Community Treatment Order (CTO) under the *Mental Health Act 1996* to be supervised by Dr Pauline Cole, Consultant Psychiatrist, at Inner City Community Mental Health Service (ICCMHS). The fact of the CTO made the deceased an involuntary patient for the purposes of compulsory medication while in the community. It was in place for three months to expire on 21 June 2012.

By the provisions of the *Coroners Act 1996* involuntary patients under the *Mental Health Act 1996* are "*persons held in care*" which mandates the holding of a public inquest (section 22(1) (a)). By section 25(3) a coroner holding that inquest must comment on the quality of the supervision, treatment and care of that person while in that care.

BACKGROUND

The Deceased

The deceased was born on 16 October 1964 in, the then, Yugoslavia. Her childhood was dominated by significant civil unrest in her country of origin, resulting in the Serbian/Croatian Civil War during the 1990's causing significant psychological trauma to most of the population. She had been married in Kosovo and had a son in 1992. Although she was divorced from her husband, he died prior to her leaving for Australia with their 7 year old son.

The deceased migrated from Bosnia to Western Australia in April 1999 with her son, but was seriously home sick and at one point tried to jump off a bridge in July 1999. She was restrained by friends and taken to the emergency department at Royal Perth Hospital (RPH).

Medical

The deceased was discharged from RPH on 16 July 1999 with an assessment of her attempt to jump from the bridge being as a result of a situational crisis and that the deceased "*did not want to kill herself*".[1] She was referred to a general practitioner at Maylands Medical Centre and prescribed antidepressant medication. She was also referred to the Transcultural Mental Health Centre (TMHC) co-located with RPH as a community support service.

[1] Ex 1, tab 9

The deceased consistently complained of physical symptoms as side effects of medication she was prescribed, although extensive investigations failed to reveal any physical basis for her symptoms. A cranial CT ordered in 2001 suggested an old infarct of the left caudate nucleus.

The deceased was eventually given a diagnosis of chronic post-traumatic stress disorder (PTSD) by the TMHC on 13 September 2002 by their psychiatrist, Dr Lester Szudej. It was felt the deceased's marked features of somatisation (physical symptoms expressing a mental health issue) were due to the deceased's lack of insight into her condition. She was medicated for her suspected mental health issues and also attended at the WA Vascular Centre and Pain Management Clinic at RPH for a known problem with her varicose veins.

The deceased remained with the Maylands Medical Centre and in December 2002 first saw general medical practitioner (GP) Dr Cornelius Rijks. He remained her GP until the time of her death. Her mental health issues continued to be managed by the TMHC and her medications were changed by her treating psychiatrists, on review, in an attempt to provide an effective response to her difficulties.

By August 2007 the deceased was treated with a combination of olanzapine, sodium valproate and citalopram

by consultant psychiatrist, Dr Salvatore Febbo.[2] Her mental state deteriorated significantly during 2007 and she had two acute admissions to RPH with acute psychosis with paranoid features. A cranial MRI disclosed no changes from her previous CT findings and this remained consistent until the end of her life. The deceased's RPH psychiatric notes indicate it was during 2007 the deceased's diagnosis changed from PTSD to one of bipolar affective disorder (BPAD), although Dr Rijks did not record a change in her treatment focus to BPAD until 2010.

In 2008 the deceased's main treating psychiatrist at the TMHC was Dr Slav Kostov and he changed her medication to sodium valproate (mood stabiliser), risperidone and depot flupenthixol (both antipsychotics). The deceased also had a 6 week admission to Graylands Hospital.[3] The TMHC did not have adequate resources for social worker input and community case management and Dr Kostov requested help from the ICCMHS. Dr Rijks made a referral to ICCMHS at roughly the same time and the deceased was then supervised in the community by Dr Keith Bender, who reduced her medications and withdrew her flupenthixol treatment.

In 2009 Dr Kostov found the deceased was requiring more and more community input and as a result of her behaviour and non-compliance with her medication due to her belief it

[2] Ex 1, tab 9
[3] Ex 1, tab 21

was causing physical symptoms, her care was completely transferred to ICCMHS. The deceased lost the benefit of Dr Kostov who had spoken her native language. He provided a letter to Dr Rijks explaining that some of the deceased's distress related to her wish to return to the former Yugoslavia because she was missing her family.[4]

During 2010 the deceased had two admissions to the psychiatric ward at RPH and it was in January 2010 a final diagnosis of BPAD with apparent psychotic symptoms was confirmed. Following hospitalisation the deceased was again referred to ICCMHS. Consistent non-compliance with medication was recorded due to her belief the medication was causing her physical symptoms such as severe nausea, diarrhoea and vomiting. There was further adjustment to her medication (antipsychotics: olanzapine and quetiapine) in 2010 due to additional side effects (weight gain) the deceased found unacceptable.

During this time the deceased received continuing support from ICCMHS in the form of a case manager, Jane Baijal, Dr Rijks believed was acceptable to the deceased. Her contact with Ms Baijal was originally weekly, then became fortnightly. [5]

The deceased continued to consult with Dr Rijks over reports of physical symptoms including chest pain and

[4] Ex 1, tab 11
[5] Ex 2

palpitations which she attributed to changes to her medication. In consultation with her psychiatrist at ICCMHS her GP started a schedule of increasing her doses of Epilim (valproate) as a mood stabiliser. He continued to investigate her physical symptoms but no basis could be found other than an ECG finding of a short run of atrial flutter. Follow up of this at RPH found no ischaemic or pulmonary embolism but did continue to identify episodes of atrial flutter, characterised as having a 4:1 block. The deceased appeared well with a pulse of 75.

In late 2010 Dr Rijks organised an echocardiogram and holter monitor which both reported as normal. A course of amitriptyline appeared to help her symptoms. The deceased's father died sometime in 2010 and this caused her great distress at being separated from her family during this time.

The deceased had another admission to RPH for hypomania in December 2010 and her treatment returned to quetiapine and valproate and her consultant psychiatrist, while an inpatient at RPH, remained Dr Kostov. A positive for the deceased.

The deceased was referred back to Dr Rijks and ICCMHS on discharge. Following the deceased's return to the community, her case manager, Ms Baijal considered herself to no longer be the deceased's case manager during 2011,

due to the deceased's wish to continue with a private psychiatrist to whom she asked to be referred by her GP. Ms Baijal stated the deceased specifically requested ICCMHS have no contact with her private psychiatrist, and ceased her contact with them.[6] However, there are comments in the reports of her GP,[7] private psychiatrist,[8] and the ICCMHS consultant psychiatrist, Dr Cole,[9] that the deceased remained a patient of ICCMHS between February 2010 and November 2011.[10]

Dr Cole confirmed the deceased as having an admission to RPH psychiatric unit between January and February 2010 with a referral to ICCMHS for follow up, and goes on to refer to her case manager throughout this period of management by ICCMHS, with two different registrar doctors. If her case manager during this period was not Ms Baijal there is no evidence from the papers as to who was her case manager, unless it was Jane Marshall.[11] This may be because different teams are responsible for different types of referral.[12]

Both Dr Cole and Ms Baijal describe a case manager as a member of one of the multidisciplinary teams providing intensive and frequent assessment, review and support to

[6] t 19.4.16, p49 & 78
[7] Ex 1, tab 10
[8] Ex 1, tab 9
[9] Ex 1, tab 11
[10] Ex 1, tab 11
[11] Ex 1, tab 10
[12] t 19.04.15, p51

clients that a medical practitioner alone is not able to provide.[13]

Dr Cole's review of the deceased's medical file with ICCMHS from February 2010 to 2011, prior to her involvement, noted three formal clinical case reviews of the deceased at which progressive risk assessments were undertaken. These involved the clinician identifying the severity of risk, including risk of harm to self and others. Dr Cole recorded the deceased was seen with an interpreter on some occasions for scheduled appointments, however was seen without an interpreter for home visits and ad hoc assessments.

Ms Baijal recalled being able to communicate with the deceased quite adequately for the purposes of her reviewing the deceased's general demeanour and compliance with medication. The deceased's risk assessment for self-harm was always quantified as low[14] and this corresponded with Dr Rijks' assessment that, other than her bridge jumping attempt, he was not aware of the deceased showing suicidal intent, only severe somatic responses to medication changes, with depression and agitation.[15]

Both ICCMHS and Dr Rijks referred to the deceased's holiday in the former Yugoslavia, native Bosnia, in early 2011. Dr Rijks assessed the deceased as being considerably

[13] Ex 1, tab 11, Ex 2 para 8-18
[14] Ex 1, tab 11
[15] Ex 1, tab 9, t 19.04.16, p14

more distressed on her return from Bosnia than she had been before her trip. He described the trip as having "*reinforced the losses she had undergone in changing home to Australia, and confronted with her waves of grief related to the death of her father in the previous year.*"[16] Her response to her trip was to cease her medications and Dr Rijks noted major preoccupation with her family and health causing her to be incoherent and agitated. He contacted ICCMHS personally on her return due to her distressed state and he then encouraged her to continue follow up with that service. He also, at her request, gave her a referral to a private psychiatrist, Dr John Perica.

The ICCMHS records the deceased's trip to her home country in 2011 and, that on her return to Australia in August 2011, the deceased confirmed she did not want further treatment from ICCMHS and wished to see a private psychiatrist. Although ICCMHS attempted to encourage her to use their services in conjunction with the psychiatrist they were unsuccessful and ICCMHS discharged her in November 2011 with ongoing care to be provided by her private psychiatrist and her GP. Ms Baijal was quite clear the deceased did not wish ICCMHS staff to have contact with her private psychiatrist.

Ms Baijal, in evidence, seemed to believe this occurred in 2010 but the ICCMHS records would imply this occurred in

[16] Ex 1, tab 9

November 2011. Certainly Dr Rijks was of the impression the deceased remained with ICCMHS for most of his contact with the deceased and he contacted ICCMHS on occasions during that time in the belief she was still in their care.

In Dr Rijks' August 2011 letter of referral for the deceased to Dr Perica, Dr Rijks states "*her treatment to date include engaging with Inner City Mental Health RPH. She is happy to continue this given the obvious advantages of emergency attendance when necessary, as well as access to a social worker*" Dr Rijks then goes on to list the deceased's contacts in the Inner City Mental Health team. Her mental health nurse was specified as Jane Marshall.[17]

Dr Rijks does not appear to have been aware of the fact the deceased had withdrawn from her contact with ICCMHS at any time, and his contacts with them were at times he considered the deceased needed additional community input. ICCMHS refers to those as re-referrals.

OCTOBER 2011 TO APRIL 2012

The deceased first saw Dr Perica on 6 October 2011 following her referral in August 2011. At that time she had been non-compliant with medications since her return from Bosnia. Dr Perica had the advantage of being able to speak

[17] Ex 1, tab 10

with the deceased in her native language and understand the culture of her community of origin.[18]

In evidence Dr Perica stated the deceased had put no prohibition on him communicating with ICCMHS or other practitioners. It appears her only concern was ICCMHS discussing her case with others. Dr Perica stated it was not unusual for patients of the deceased's background and culture to be very concerned with confidentiality.[19] Generally, the deceased seemed to be accepting of the need for Dr Rijks and psychiatrists in the public sector to communicate with each other and ICCMHS.[20]

Dr Perica also explained that patients with the deceased's background were uncomfortable with officials such as police, and involving police in the deceased's management when she was unwell was likely to cause her unnecessary agitation, preferably avoided if possible.[21]

Dr Perica diagnosed the deceased as suffering from bipolar disorder and post-traumatic stress disorder due to her exposure to severe traumatic events prior to her migration to Australia.[22] He continued contact with her for a total of 17 consultations up to her death and, in conjunction with Dr Rijks, continued with the deceased's medical care. Her medication was reinstituted as valproate and Seroquel but it

[18] t 20.04.16, p125
[19] t 20.04.16, p127
[20] t 20.04.16, p133
[21] t 20.04.16, p134
[22] Ex 1, tab 10

was evident to Dr Perica she was not compliant with her prescription regime. He added antidepressant medication to her normal medication, which she appeared to accept without reporting any significant side effects. Aside from his input to the deceased's medication, Dr Perica's main concern was to provide ongoing support and psychotherapy. There is no doubt the deceased had a very good relationship with both Dr Perica and Dr Rijks. There are fewer records of her acute physical symptoms in the reviews for this period of time.

In February 2012 the deceased again complained about side effects of her medication, although she also stated she was again non-compliant with her medication.

Both Dr Rijks and Dr Perica instituted investigations for her physical complaints. Dr Rijks assessed the deceased as having recurrence of her BPAD as a consequence of medication withdrawal with marked somatisation, and gave her a dose of mylanta and commenced diazepam to reduce her anxiety. He also sent correspondence to ICCMHS outlining his concern she was experiencing a relapse, along with his investigations which indicated iron deficiency.

Dr Rijks reviewed the deceased again on 17 February 2012 and was concerned enough to refer her to RPH ED. From RPH the deceased was transferred to Swan District Hospital

Psychiatric Ward, Swan Valley Centre (SVC) as a voluntary inpatient from 17 February 2012 to 12 March 2012.

Swan Valley Centre

The deceased was admitted to SVC under Dr Salam Hussain, Consultant Psychiatrist. On admission she was assessed with the help of an interpreter and found to be still very focused on her somatic complaints which she felt arose out of her medication. She had been non-compliant with her oral medications for two months because of the perceived side effects. She did not appear to associate her non-compliance with medication as being relevant to her elevated agitation. All investigations indicated her physical health was relatively normal and any symptoms with a clinical cause were managed.

During her time in SVC the deceased was mainly encouraged to comply with medication in an attempt to stabilise her agitation. She received multidisciplinary care and was commenced on the oral antipsychotic, olanzapine. Due to the deceased's confidence in her private psychiatrist, Dr Perica, the team at SVC considered her continued contact with Dr Perica to be important. Her continuing appointments with him were facilitated while she was an inpatient at SVC.

Despite the deceased's aversion to medication due to her perception it did her harm, it was evident she generally stabilised when she could be persuaded to take medication,

although she continued to complain of physical symptoms. The medication olanzapine was chosen because it was known to be effective in treating both psychotic symptoms and BPAD.[23] Dr Hussain suggested an injectable form of olanzapine which had become available in approximately 2009/2010. It was useful for the treatment of patients usually non-compliant with oral medication. One of the aims of her management during her time in SVC was to persuade her to be compliant with depot olanzapine. Although its administration required a period of monitoring post injection, it would have allowed the deceased to cease oral medication, and facilitated her compliance provided she could be persuaded it was effective.

The progress notes on 6 March 2012 indicate Dr Hussain attempted to persuade the deceased to have depot olanzapine. She was not cooperative, but later in the day she consented to the depot injection and there is a record she was provided with depot olanzapine while in a much more responsive and reactive mood. She refused to take any other medication if she was accepting of depot olanzapine.

The progress notes for 7 March 2012 indicate the deceased went to see Dr Perica, and she was booked for another appointment with him on 13 March 2012. Dr Perica did not report on her presentation to him on 7 March 2012.[24]

[23] t 19.04.16, p27
[24] Ex 1, tab 10

Dr Hussain next saw the deceased on 8 March 2012 and noted she presented with ongoing somatic complaints and showed a moderate to high level of distress to her physical complaints. Dr Hussain encouraged her discharge with depot medication. The plan was to persuade her to continue with depot olanzapine and refer her back to ICCMHS to continue with her community care, including administration of the depot olanzapine.

There is confusion between SVC and ICCMHS about the administration of the deceased's depot olanzapine once discharged from SVC. ICCMHS were not in a position to provide depot olanzapine due to the requirement for a period of monitoring post administration of the injection.[25]

The SVC progress notes clearly record a telephone call made on 9 March 2012 at 1.45 pm to the ICCMHS assessment team duty officer, Gordon Monroe. The SVC progress notes record the deceased's ICCMHS case manager as Ms Baijal, and that Mr Monroe agreed to provide the deceased with follow up management by ICCMHS. An agreed date for her next olanzapine depot injection was scheduled for 20 March 2012. That entry is signed by Dr Atad, Dr Hussain's registrar.

[25] t 19.04.16, p29

Dr Hussain was confident that entry would not have been made without there being a phone call and it would have followed discussion between them noting it was necessary ICCMHS could provide depot olanzapine.[26] A medication chart for olanzapine depot, with a fax receipt for 13 March 2012, appears in the deceased's SVC file. Dr Hussain stated that chart is usually faxed to the recipient service where the depot was planned to be administered.[27]

The corresponding electronic records[28] from ICCMHS do not show any entries for the deceased for either 8, 9 or 13 March 2012, but there is one for 15 March 2012 when the deceased was discussed at an intake meeting at which Mr Monroe and psychiatrist, Lynne Cunningham, were present. This was post the deceased's discharge on 12 March 2012. There is no indication as to how the deceased came to be discussed at the intake team's meeting on 15 March 2012.

The SVC integrated progress notes record a meeting between the deceased's treating team while in SVC, and the deceased and her son. The intention was the deceased have weekend leave in the care of her son, who was only 19 years of age, to see how she managed over the weekend.[29]

[26] t 19.04.16, p30
[27] Ex 1, tab 13
[28] Ex 12
[29] Ex 1, tab 13

The deceased's son in his statement interpreted the meeting in the following way;

> *"I was aware that mum had a lot of medical appointments all the time. She complained of physical pain regularly and of not wanting to take her medication. I don't know what medication she was on but I believe it was for her mental health issues as the doctors never found anything physically wrong with her.*
>
> *When I say the doctors never found anything wrong with her I am referring to a conversation I had with a doctor at Midland Hospital early last year who told me that mum was suffering from bipolar disorder and that she wasn't experiencing any physical pain."*[30]

The deceased returned to SVC following weekend leave on 12 March 2012 and was reviewed by Dr Atad and Dr Hussain. The deceased appeared to have managed well over her weekend leave but was still resistant to the concept of the intramuscular (IM) depot medication.

She reported being very stressed by certain aspects of her leave. She was assessed as suffering from mixed anxiety and depression with severe somatisation.

[30] Ex 1, tab 5, para 9 & 10

The plan was to discharge her outright that day to her home address with a taxi voucher, to be reviewed by her private psychiatrist, Dr Perica, on 13 March 2012. The plan noted her referral to ICCMHS and her case manager for future reference was Ms Baijal. According to the inpatient discharge letter she was next due to have her olanzapine medication administered by ICCMHS on 20 March 2013.[31]

Dr Hussain spoke with Dr Perica on the telephone about the deceased to ensure continuity of care once she was discharged. He was concerned the deceased was generally non-compliant with treatment and wished to ensure all those working on her behalf would be encouraging her compliance. Dr Hussain assessed the deceased as being very happy to continue with Dr Perica as her private psychiatrist. Dr Hussain considered Dr Perica's ongoing input to be essential for the deceased because she felt she could talk to him and it was not necessary for her to have an interpreter when seeing Dr Perica.[32]

In summary, the deceased was discharged from SVC on 12 March 2012 at 4.00 pm with the prospect of an appointment with Dr Perica the following day, and ongoing referral to ICCMHS for community management of her olanzapine depot.

[31] Ex 1, tab 13
[32] t 19.04.16, p24

There was no face to face discharge conference with all relevant parties.

POST DISCHARGE FROM SVC

Dr Perica saw the deceased on 13 March 2012. He described her as very agitated, teary and complaining of insomnia and epigastric pain. He reported she was unhappy about the depot olanzapine medication, despite it being a low dosage. He provided her with a script for olanzapine wafers to try at night. He was not due to see her again until 22 March 2012 and understood she was being cared for by ICCMHS as her community support service and would be given depot olanzapine on 20 March 2012.

The SVC discharge summary informed Dr Rijks the deceased's next depot was due on 20 March 2012 and was for 150mg, IM, olanzapine, fortnightly, to be provided by ICCMHS with reference to Gordon Monroe of the assessment team, with case manager Jane Baijal.[33] ICCMHS also received a copy of the discharge summary. There was also an email from SVC to ICCMHS on 13 March 2012 outlining the deceased's discharge plan which does not appear to have made an impression on any practitioner at ICCMHS,[34] because no one considered they were involved in the deceased's care at that time.

[33] Ex 1, tab 9 & 13
[34] Ex 2

SVC was under the impression Ms Baijal of ICCMHS was the deceased's ongoing case manager. ICCMHS saw the deceased's referral, although she had been referred in February 2012,[35] as a re-referral requiring she go through an assessment team to which Ms Baijal did not belong.

The outcome of those miscommunications was that the deceased was not assessed by the ICCMHS Acute Assessment Team Consultant Psychiatrist until 21 March 2012, although she had been discharged from SVC on 12 March 2012 with the requirement for depot olanzapine on 20 March 2012.[36]

INSTITUTION OF CTO

The deceased was seen at her home on 21 March 2012 by Dr Cunningham, Consultant Psychiatrist with the Acute Assessment Team ICCMHS, and a community mental health nurse from the same team. The ICCMHS notes indicate the deceased was *"uncooperative, mildly agitated, loud and mildly pressured in speech with persist discussion of her physical problems"* but denied suicidal ideation. Dr Cunningham diagnosed the deceased with BPAD with a possible differential diagnosis of delusional disorder.[37]

The deceased refused treatment and her judgement was classified as *"significantly impaired"*. She was considered to

[35] Ex 1, tab 11
[36] Ex 1, tab 11
[37] Ex 1, tab 11

be non-compliant with medication, which she clearly intended to be, although she could not have had her depot on 20 March 2012, because she was not seen on that date by those expected to provide it. Nor, under the discharge plan from SVC, was she required to take oral medication while receiving depot olanzapine.

Dr Cunningham initiated a plan to commence the deceased on a community treatment order (CTO) due to her non-compliance with medication. The plan was to trial her on oral medication. If she complied then she would not be required to take depot medication, however, if she did not comply then the CTO would require the administration of a depot anti-psychotic, probably risperidone. The CTO made the deceased an involuntary patient for the purposes of enforced medication while in the community under the *Mental Health Act 1996*. The deceased was not prescribed any medication, either oral or depot at that assessment.

Community treatment order

Mental Health Act 1996
Sections 49 (3) (b), 52 (b), 62 (2) (b), 63 (2) (b) and 67
Form 10

Patient	Family name: MIHAJLOVIC Other names: RADINKA Alias: Address: 4/6 FOGERTHORPE CRESCENT MAYLANDS Postcode: 6051 Date of birth: 16 Oct 1964 Patient reference no.: 1002291401
Psychiatrist making order	Name: Hyame Cunningham Practice address: Inner City Adult Mental Health Clinic Murray St Perth Postcode: 6000 If patient is on leave of absence, name of the medical practitioner or authorized mental health practitioner on whose opinion the psychiatrist is relying:
Supervising Psychiatrist	Name: Hyame Cunningham Practice address: Inner City AMHC Murray St Perth Postcode: 6000
Responsible practitioner	Name: Jane Baigal OT. Practice address: Inner City AMHC Murray St Perth Postcode: 6000
Treatment plan	Radinka must attend the Clinic regular for medical review and accept regular depoo medication
Duration	Date order finishes: 31/06/12 Time order finishes: 23 00 am / pm
Directions for reporting	
Order	**I have examined the patient and, having regard to section 26 of the *Mental Health Act 1996*, believe that the patient should be made, or should continue to be, an involuntary patient. I am satisfied that the criteria for granting a community treatment order in respect of the patient are satisfied and therefore order that the patient be treated in the community in accordance with this order.** Signature of psychiatrist: Date: 22/03/12 Time: 10 00 am / ~~pm~~

Exhibit 1, Tab 18 – Community Treatment Order 22 March 2012

[Back of Form 10]

Confirmation of order (If required)	Name of confirming psychiatrist or practitioner: Dr Bukky Akinyemi Occupation of confirming psychiatrist or practitioner: Medical Practitioner **I have reviewed this order and am satisfied that the patient should be made an involuntary patient and should be treated in the community in accordance with this order. I therefore confirm the order.** Signature: Date: 22/03/12 Time: 10.30 am / pm

NOTES FOR THE PSYCHIATRIST

Criteria for making a person an involuntary patient	A psychiatrist may only make a person an involuntary patient if the psychiatrist has examined the patient and believes that — • the patient has a mental illness requiring treatment; • the treatment can be provided through a community treatment order and is required to be so provided in order to — ○ protect the health or safety of the patient or any other person; ○ protect the patient from self-inflicted harm (being serious financial harm, lasting or irreparable harm to an important personal relationship, or serious damage to the reputation of the patient); or ○ prevent the patient doing serious damage to any property; • the patient has refused or, due to the nature of the mental illness, is unable to consent to the treatment; and • the treatment cannot be adequately provided in a way that would involve less restriction of the freedom of choice and movement of the patient than would result from the patient being an involuntary patient.
Criteria for making a community treatment order	A psychiatrist may only make a community treatment order respect of a patient if the psychiatrist is satisfied that — • treatment in the community would be consistent with the objectives of — ○ protecting the health or safety of the patient or any other person; ○ protecting the patient from self-inflicted harm (being serious financial harm, lasting or irreparable harm to an important personal relationship, or serious damage to the reputation of the patient); or ○ preventing the patient from doing serious damage to any property; • suitable arrangements can be made for the care of the patient in the community; • a medical practitioner or mental health practitioner who is suitably qualified and willing to do so will be available to ensure that the patient receives the treatment outlined in the order; and • a psychiatrist who is willing to do so will be available to supervise the carrying out of the order. A community treatment order cannot be made against a patient to whom section 25 of the *Criminal Law (Mentally Impaired Defendants) Act 1996* applies. If the patient is on leave of absence the treating psychiatrist may make a community treatment order on the basis of an opinion to that effect given by another medical practitioner or an authorized mental health practitioner (section 63).
Treatment plan	A psychiatrist must include in a community treatment order — • the treatment that the patient is to receive while subject to the order; • details of where and when that treatment is to be given; and • such other matters relating to the treatment as it is appropriate to specify.
Duration of order	A community treatment order has effect until — • the order lapses — ○ at the time specified in the order which must be not more than 3 months from when it was made; or ○ if the order is extended, at the time specified in the extension order (Form 12); • an extension of the order (Form 12) ceases to have effect because a second opinion was requested and either — ○ did not confirm that the extension should have been made; or ○ was not obtained within the time required; • the order is revoked (Form 11); • it is ordered that the patient is no longer an involuntary patient (Form 8); or • the patient is admitted to an authorized hospital as an involuntary patient.
Reporting of progress	A psychiatrist may include in a community treatment order directions to the responsible practitioner and the supervising psychiatrist as to reporting of the patient's progress.
Confirmation	A community treatment order must be confirmed by another psychiatrist, or if another psychiatrist is not readily available, by a medical practitioner authorized by the Chief Psychiatrist, within 72 hours of it being made unless — • the order is made by a psychiatrist who is examining the patient after the patient has been referred for examination by a psychiatrist (Form 1 or 5); or • the patient is already detained in an authorized hospital as an involuntary patient.

Exhibit 1, Tab 18 - Community Treatment Order 22 March 2012

Dr Perica next saw the deceased on 22 March 2012 and the deceased reported to Dr Perica she had been seen by her case manager the previous day but had not been given the depot injection. This indicated a lack of understanding on the part of the deceased as to what was actually happening with her community mental health care. It was not clear from the evidence how frequently interpreters were used to assist with the deceased, nor a clear procedure as to how that would be arranged.

Once assessed by the Acute Assessment Team the deceased was to be transferred to the ICCMHS Continuing Care Team. Her supervising psychiatrist for her CTO was to be Dr Stephanie Cole, and care was transferred to Dr Cole on 29 March 2012 with the allocation of her previous case manager, Ms Baijal.[38] It was envisaged Dr Cole would not see the deceased until 20 April 2012, almost 6 weeks into a 3 month CTO.[39] During that time the deceased was un-medicated.[40]

[38] Ex 1, tab 11 & 18
[39] t 20.04.16, p164
[40] t 20.04.16, p159

Variation or extension of community treatment order

Mental Health Act 1996
Sections 76 and 79
Form 12

Patient

Family name:
Other names:
Alias:
Address:

Date: . . . . .
Time: . . . . .
J08;24205
MIHAJLOVIC, RADINKA
4/6 FOGERTHORPE CRESCE
MAYLANDS
6051
HO
F
DOB:16/10/1954

Postcode: _ _ _ _

Date of birth: _ _/_ _/_ _ Patient reference no.:

Supervising psychiatrist

Name: Hyme Cunningham
Practice address: Inner City Amhc
Murray St Perth
Postcode: 6000

Community treatment order

Name of psychiatrist who made community treatment order: Hyme Cunningham

Date order made: 22/03/12 Time order made: 10 am/pm

Date order expires: 21/06/12 Time order expires: 2300 PM am/pm

Transferee responsible practitioner (if required)

Name: Dr Pauline Cole
Inner City Amhc
Practice address: Murray St Perth
Postcode: 6000

Variations to treatment plan (if required)

—

Variations to directions for reporting (if required)

—

Extension (if required)

Date extension ends: _ _/_ _/_ _ Time extension ends: am / pm

Exhibit 1, Tab 18 – Transfer of Supervision of CTO to Dr Cole on 29 March 2012

Variation of order [Tick one or both boxes as appropriate]	☑ **Responsibility for ensuring that the patient is treated in accordance with the community treatment order is transferred to the medical practitioner or mental health practitioner set out above.** ☐ **The terms of the community treatment order in respect of the patient are varied as set out above.** ☐ **The community treatment order is extended until the date and time set out above.** Signature of psychiatrist: Date: 29/03/12 Time: 15:00 ~~am~~ / pm

NOTES FOR THE PSYCHIATRIST

Extension	A psychiatrist may extend a community treatment order for up to 3 months. A community treatment order cannot be extended more than once.
Second opinion	A patient whose community treatment order is extended may, in writing, request a second opinion. If a request is made the psychiatrist extending the order must arrange for a second opinion to be obtained within 14 days. If the second psychiatrist does not agree with the extension, or the opinion is not obtained within 14 days (other than because the patient does not attend for examination) the extension ceases to have effect and the community treatment order ceases to be in force.
Information	A psychiatrist varying or extending a community treatment order must give a copy of the variation or extension order to the patient.

Exhibit 1, Tab 18 - Transfer of Supervision of CTO to Dr Cole on 29 March 2012

The deceased's case was discussed at the Continuing Care Team meeting on 3 April 2012, some three weeks following her discharge from SVC with the assumption she would be receiving ongoing depot olanzapine.

Dr Cole, consultant psychiatrist, first reviewed the deceased on 4 April 2012 to assess her and commence the deceased on appropriate medication.[41] Dr Cole believed waiting until 30 April 2012 for assessment to medicate while subject to a CTO to be inappropriate.

Dr Cole had briefly reviewed the deceased's file prior to her meeting. She was seen without an interpreter which, Dr Cole stated, had been usual practice for *"ad hoc"* assessments. In Dr Cole's view the deceased demonstrated a reasonable understanding of English and could express herself. Dr Cole commenced the deceased on risperidone dissolving tablets and asked Ms Baijal to assist with monitoring the deceased's compliance and review her by visiting her at her home address. Dr Cole wished to assess the deceased's compliance with oral risperidone before commencing depot risperidone injections.

The deceased provided Dr Perica with a copy of her CTO information on 5 April 2012, but it did not disclose the medication with which the deceased was to be treated by ICCMHS. It was his assumption the CTO was in place

[41] t 20.04.16, p159

because of her non-compliance with oral medication, but he assumed she would be continuing with depot olanzapine.[42] The deceased explained to Dr Perica she had been given oral risperidone, but he did not understand the depot medication she was to receive in the future would be risperidone and not olanzapine. In evidence, Dr Perica did not have any difficulty with the fact she was given risperidone, but was not informed of her medication by ICCMHS, nor was it on the CTO.

Dr Cole, in her report, refers to Ms Baijal as being the deceased's continuing case manager and that the deceased had emphasised to Ms Baijal she did not wish for there to be an exchange of information from ICCMHS to Dr Perica.[43] Dr Perica indicated the deceased had put no such restriction on his communications although he was very aware of the matters which the deceased considered required confidentiality.

The practitioners at ICCMHS did not consider the deceased to be at significant risk of self-harm or suicide and consequently there was no discussion about breaches of confidentiality in respect of her involuntary treatment on the CTO. The ICCMHS did have communication with Dr Rijks and there had never been any discussion of suicidality. This was confirmed by Dr Rijks in evidence.[44]

[42] t 20.04.16, p138
[43] Ex 1, tab 11
[44] t 19.04.16, p14

Dr Cole was expecting the deceased's case manager, Ms Baijal, to be monitoring her compliance with oral risperidone, however, Ms Baijal indicated her relationship with the deceased during the 2012 referral was not comfortable.[45] She had to communicate with the deceased through the door and was not allowed into the house.

Dr Cole indicated that initially all she was looking for was some compliance in the hope full compliance would follow over time.[46]

In evidence Ms Baijal could not recall looking at the discharge summary from SVC once she became the deceased's case manager in 2012, following institution of the CTO, nor did she recall whether there was a medication chart for the deceased.[47] Ms Baijal understood the deceased had been started on depot risperidone, but was also provided with quicklets to bring her risperidone levels up to a therapeutic level.

Ms Baijal referred to her notes and said she checked the deceased's compliance by way of telephone calls and the deceased was fairly honest in saying whether she had taken her medication as prescribed. It does not seem there was consistent checking of the medication itself other than

[45] Ex 2
[46] t 20.04.16, p168-9
[47] t 19.04.16, p60

questioning about compliance with medication although the progress notes do indicate some checks on the doses.[48]

The deceased saw Dr Rijks on 27 April 2012 with respect to follow up for her iron deficiency and weight loss. The deceased was happy to continue with medication for her iron deficiency and discussed her general physical health. Dr Rijks found the deceased's pulse and blood pressure to be normal, her chest was clear and her urine analysis normal. Dr Rijks envisaged ongoing two weekly reviews of the deceased in the alternate week to that in which she saw Dr Perica. Dr Rijks' view on 27 April 2012 was the deceased was not behaving erratically or displaying any disillusions or fanciful thoughts. He did not consider her to be demonstrating any appearance of suicidality or panic attacks or loss of control.

During that consult Dr Rijks telephoned Dr Perica with the deceased present and they discussed Dr Perica's intention to restart the deceased on low dose Zyprexa (olanzapine) once her CTO had expired. The two doctors discussed the deceased's ongoing physical investigations and her referrals to nephrology and gastroenterology at RPH in an effort to reassure the deceased her complaints about physical symptoms were being taken seriously.[49]

[48] t 19.04.16, p62
[49] Ex 1, tab 9

Similarly, when the deceased saw Dr Perica for appointments during that time she continued to complain risperidone was causing her muscular aches and a tremor.[50] Dr Perica did not understand she was non-compliant with oral risperidone and understood her to have had depot olanzapine.[51]

Dr Cole next saw the deceased on 30 April 2012 with an interpreter. Dr Cole considered this to be the deceased's first scheduled formal CTO appointment, almost seven weeks after her discharge from SVC with SVC's understanding the deceased would be provided with ongoing fortnightly depot olanzapine.

Dr Cole assessed the ICCMHS file entries from Ms Baijal and other practitioners involved in the deceased's care. She noted the deceased's general non-compliance with oral medication and ongoing somatic complaints to the exclusion of all else. While presenting as a low risk of suicide and violence the deceased was still indicating serious physical pain as a result of medication, although non-compliant. The deceased wanted to reduce her oral medication and explained via her interpreter she was not taking her medications as prescribed.

Ultimately, Dr Cole decided the deceased needed to be provided with depot medication. Dr Cole considered the

[50] t 20.04.16, p142
[51] t 20.04.16, p138

deceased had an ongoing mental illness as defined in the *Mental Health Act 1996* which impaired her judgement due to her lack of insight into her problems and the risk of serious harm to her relationships and reputation as a result of that illness going untreated. For that reason she felt it necessary to compel the deceased's compliance with medication by way of depot. The deceased is recorded as having 25mg intramuscular risperidone at 1.50 pm on 30 April 2012.[52]

Other than the initial unscheduled review of the deceased on 4 April 2012, the consultation on 30 April 2012 was the only involvement of Dr Cole with the deceased as her supervising CTO consultant psychiatrist.

Following the deceased receiving her depot risperidone on 30 April 2012 she attended on Dr Rijks, informally, and asked how her referrals to RPH were progressing. She confirmed with Dr Rijks she had her depot injection and had been reviewed by the supervising consultant psychiatrist. Dr Rijks told the deceased it was premature for him to harass RPH over the referrals which would occur in their own time. From Dr Rijks' note it would seem the deceased was again focused on her physical difficulties, but there was nothing out of the ordinary in his assessment of the deceased on 30 April 2012, despite it being informal.

[52] Ex 1, tab 11 & 18

1 MAY 2012

The deceased had an appointment to see Dr Perica on 1 May 2012. In Dr Perica's opinion the deceased was the most agitated, tearful and hopeless on that date that he had ever seen. She was extremely distressed, not wishing to go home and expressing suicidal thoughts. Dr Perica was extremely concerned for her safety and believed she should be admitted as an inpatient to RPH, as her normal inpatient facility. He cancelled the rest of his patients for the day to enable him to concentrate on the deceased and contacted ICCMHS in an attempt to facilitate her admission to hospital with familiar practitioners.

The deceased was obviously agreeable to this because she agreed to Dr Perica also contacting her neighbours to advise them she was to be admitted to hospital and would not return home that day.

Dr Perica rang ICCMHS expecting the deceased's case manager would be in a position to assist him transfer the deceased to RPH psychiatric unit in a way which would reduce her anxiety and fear of external agencies.[53] Dr Perica was not immediately able to contact Ms Baijal because she was out visiting a client, but the duty clinician advised Ms Baijal Dr Perica had been attempting to contact her.

[53] t 20.04.16, p144

Ms Baijal called Dr Perica and he asked she collect the deceased from his premises to take her to RPH. Ms Baijal needed further information. Dr Perica was dissatisfied with the response to his request and again rang ICCMHS and spoke with Dr Cole. Dr Perica indicated to Dr Cole he was expecting the deceased to be collected from his rooms because she was sobbing and had asked "*for an injection to kill her because of her physical symptoms*".[54] This would seem to express Dr Perica's concern the deceased was expressing suicidal thoughts.

Both Dr Cole and Ms Baijal indicated to Dr Perica that if he had concerns for the deceased's welfare the appropriate course of action was for him to admit her to hospital via an ambulance,[55] which to Dr Perica meant the involvement of the police.[56]

While Dr Cole and Dr Perica were on the telephone, Ms Baijal went to see Dr Cole and they discussed the best course of action. Dr Cole agreed Ms Baijal and the duty clinician would attend Dr Perica's offices and attempt to persuade the deceased to go with them, if she was reluctant to leave.[57] Dr Cole agreed she would provide an urgent assessment to consider whether the deceased required admission. Both Dr Cole and Ms Baijal refer to a base line

[54] Ex 1, tab 11 & t 20.04.16, p145
[55] t 20.04.16, p172
[56] t 20.04.16, p152
[57] t 20.04.16, p171

assessment, although Dr Perica disputed this was his expectation. He wanted Dr Cole to review the deceased because she had seen her the previous day for her depot medication and had a better idea of how she was presenting by comparison to the previous day.

Unfortunately, these exchanges, while done in the deceased's best interest from Dr Perica's perception, and while ICCMHS was attempting to assist the deceased, resulted in a significantly undesirable situation with all the treating clinicians/practitioners becoming extremely distrustful of one another and their respective perspectives.[58]

Dr Perica stated in evidence he had cancelled his clients for the rest of the day in the expectation he would be needed to provide input for the deceased with Dr Cole later in the day.[59]

The deceased was taken voluntarily from Dr Perica's offices and was reviewed by Dr Cole, with Ms Baijal completing a brief risk assessment. Ms Baijal did not view the deceased as expressing suicidal ideation and she did not recall the deceased being concerned about her medication because of its physical effects. Ms Baijal recalled the deceased being really focused on the depot injection and believing it was making her physically ill.

[58] t 20.04.16, p157
[59] t 20.04.16, p146

Dr Cole reported the deceased as complaining the depot medication had given her a headache and cough and prevented her sleep. She did not want the next depot injection scheduled for 14 May 2012, but did not speak to Dr Cole of suicide. Dr Cole asked her directly about suicidality and reported the deceased as not answering the question directly, but still talking about her physical symptoms and wishes not to have depot medication.[60] Dr Cole considered the deceased to be preoccupied with her physical ailments and emotional discomfort. Dr Cole believed the deceased was agitated as to the depot injections but not actively suicidal. Dr Cole believed the deceased was merely responding to her agitation about her somatic complaints as a result of the depot medication.

In an effort to reassure the deceased Dr Cole informed her she could refuse the depot injection on the next occasion and she would not be forced to comply, but she would need to comply with oral medication and monitoring by way of blood tests.[61] Apparently the deceased agreed to this option. The deceased was provided with a script for risperidone tablets at her preference. Dr Cole hoped this would address the deceased's fixation about the CTO and depot medication, and contain any low risk of suicide which might exist. In her written report Dr Cole also considered that, as

[60] t 20.04.16, p174
[61] t 20.04.16, p179

Dr Perica had chosen not to admit the deceased, he did not consider there to be a real risk of suicide.[62]

It does not appear the deceased was asked whether she wished a voluntary admission to hospital to assist her. She was sent home with a prescription for risperidone tablets. ICCMHS intended to follow up by way of telephone the following day, and neither Dr Perica nor her son were advised she was returning home following a fairly intense day.

The deceased left ICCMHS at approximately 2.45 pm to travel home.

MAYLANDS TRAINSTATION

The evidence from witnesses at the Maylands train station indicated the deceased arrived on the Midland line platform at Maylands train station at about 3.05 pm. This was her home train station. At approximately 3.15 pm the deceased was on the opposite platform roughly 14 metres from the north eastern end. She was seen to jump off the platform quite deliberately, onto the tracks, crouch down and then kneel forwards in front of the oncoming train. The train driver activated the emergency brake, however there was not enough time for that to be effective before the train collided with the deceased. She died at the scene.

[62] Ex 1, tab 11

The train was brought to a stop and the incident investigators and emergency services contacted. Evidence from witnesses made it clear it was a deliberate act on the part of the deceased.[63]

POST MORTEM EXAMINATION

The post mortem examination of the deceased was carried out by the Chief State Forensic Pathologist, Dr Clive Cooke on 3 May 2012.[64]

The examination showed severe multiple injuries with widespread abrasions and lacerations on the external body, with internal injuries comprising fractures of the skeletal frame, bruising of the lungs and kidney and a laceration of the spleen.

It was Dr Cooke's opinion the deceased had died as the result of multiple injuries.

Initial toxicological screening did not detect any common drugs or alcohol, prescription or otherwise in the deceased's system at the time of her death.

In view of the administration of 25mg of depot risperidone on 30 April 2012 the ChemCentre was asked to requantify the result. This took time due to the lack of a current

[63] Ex 1, tabs 4, 6, 7 & 8
[64] Ex 1, tabs 19 & 20

standard for risperidone and a concern the relevant samples had been stored for some time.

On 21 December 2016 a repeat analysis indicated risperidone was still not detectable in the blood mortuary admission preserved sample (BMAPS) or any other samples, but 9-hydroxyrisperidone (paliperidone) was detected at approximately 0.003mg/L in the BMAPS.[65]

Interpretation of this result is probably suggestive of the administration of a first injection of slow release risperidone, with 9-hydroxyrisperidone being a metabolite of risperidone, and the literature indicating there is initially only a very small drug release (<1%) which does not build to optional plasma levels for some weeks. It is usual to supplement first injections with oral administration of the drug to achieve higher plasma levels in the short term.[66]

CONCLUSION AS TO THE DECEASED'S MANNER AND CAUSE OF DEATH

I am satisfied the deceased was a 47 year old woman, native of Bosnia but in Western Australia since 1999, who suffered from BPAD and PTSD. Her mental illnesses were exhibited by persistent somatic symptoms which the deceased was convinced were caused by the medications used to control her illnesses.

[65] Report received from ChemCentre on 21.12.2016 dated 21.12.2016
[66] Communication from ChemCentre Chemist 22.12.2016

The deceased's care in Australia was managed through both the public and private mental health systems, but was unfortunately hindered by the deceased's concern with confidentiality restricting full and appropriate communication between the public system where it comprised ICCMHS, and her private practitioners, consultant psychiatrist Dr Perica and her GP, Dr Rijks. The deceased did not appear to have a problem with SVC discussing her management with Dr Perica, and Dr Atad (SVC) believed she had appropriately communicated relevant facts to ICCMHS to facilitate their proper care of the deceased. It does not appear ICCMHS ever attempted to contact SVC, another branch of the public system.

Due to the deceased's somatic complaints there was a general reluctance on her behalf to comply with medication. This resulted in SVC considering it appropriate the deceased be treated by way of depot medication, to avoid her requiring daily oral medication. She was provided with depot olanzapine on 6 March 2012 with the expectation she would be provided with her next depot injection on 20 March 2012 by ICCMHS. The plan agreed to by the deceased was that she would not be required to take oral medication if having depot.

Unfortunately, there was no effective discharge planning around the deceased's discharge from SVC. There was a plan but it was a plan about which the relevant parties were

either not clear, or confused. No attempt was made by ICCMHS to clarify SVC's reasoning or intention.

Due to the lack of relevant communication surrounding the plan there was misunderstanding about the medication to be used and the deceased did not receive ongoing depot, nor could she be compelled without consent. She was not even seen by anyone on behalf of ICCMHS until after her depot olanzapine had been due, although one day should not have had a significant effect.

When assessed by the ICCMHS Acute Assessment Team consultant psychiatrist on 21 March 2012 the deceased was considered to be needing medication. She was assessed as needing to be placed on a CTO to ensure her compliance with medication and risperidone was considered the appropriate medication. She was placed on a CTO effective from 22 March 2012 but still not provided with any form of medication pending her scheduled review by her supervising psychiatrist on 30 April 2012.

The deceased was seen earlier by the consultant psychiatrist supervising her CTO, on 4 April 2012, and it was again explained to her she would be given risperidone depot if she was non-compliant with oral medication. The intention was to trial her on oral medication, and then move to depot risperidone, if she continued to be non-compliant. The deceased was quite openly non-compliant.

The deceased was given her first depot medication pursuant to the CTO on 30 April 2012. She was again fixated on her physical symptoms following that injection as indicated by her contact with Dr Rijks that afternoon.

The deceased had a difficult night overnight from 30 April 2012 to 1 May 2012. This she blamed on the depot medication. By the time she attended her appointment with Dr Perica later that morning she was extremely distressed and conveying a strong wish to die. He had no doubt she was a real suicide risk. This was a practitioner who had a good rapport with the deceased and with whom she was honest. He certainly had more understanding of the deceased than any practitioner at ICCMHS.

The events of the rest of 1 May 2012 reflect a serious disjunct in communication between the public and private mental health system.

Dr Perica, in an attempt to deal with the deceased in the least restrictive way due to his understanding of her cultural background, sought to enlist the help of ICCMHS, as her supervising community mental health provider, with the deceased's voluntary admission to RPH psychiatric ward. The exchange caused Dr Perica distress, and caused ICCMHS to view the deceased's admission as non-essential, following their own assessment, because Dr Perica had not

forced the issue as an involuntary admission on his own assessment. The whole point was to make it voluntary.

Once reviewed by her supervising ICCMHS psychiatrist the deceased was allowed to go home on the understanding she would not again be forced to have a depot injection, but would be required to comply with oral medications by way of monitoring blood levels.

The deceased was discharged to return home.

By the time the deceased left ICCMHS and reached Maylands station she had formed a plan to throw herself in front of a train. The deceased waited for an oncoming train, jumped in front of it with an intention to end her life and was killed. As a result of the multiple injuries she received the deceased died immediately.

I do not believe the deceased was psychotic at the time but lacked insight which caused her to be distressed and frustrated with her perception she would never receive relief from her physical symptoms, while she was medicated. This, despite the fact the actual levels recorded in her system at death would have been highly unlikely to have precipitated any symptoms, and she complained of physical symptoms even when non-compliant with medication.

I find death occurred by way of Suicide.

COMMENTS ON THE SUPERVISION, TREATMENT AND CARE OF THE DECEASED WHILE ON A COMMUNITY TREATMENT ORDER

The case of the deceased was reviewed by Dr Adam Brett, Consultant Psychiatrist, on behalf of the Coroners Court. Dr Brett's report refers to the significant misunderstandings which occurred between ICCMHS and the deceased's other carers in the community. He referred to the need for a coordinated care framework for the treatment of mentally ill persons in the community.[67]

It is essential there be appropriate continuity of care and this can only, in my view, be effectively achieved by the appointment of a person to coordinate and understand all the different aspects of each patient's care. Whether this person be called a care co-ordinator, community liaison worker or individual case manager matters not, it is the concept which is important.[68] This is especially important where the patient by way of age or culture, is significantly more vulnerable than the usual level of vulnerability for those with mental health issues and difficult family support.

There needs to be a distinction made between a patient's privacy and the actual fact of treatment requirements. The fact of treatment requirements should not be able to be

[67] Ex 1, tab 21
[68] General comments and recommendations into the "Mental Health Deaths April 2008" p28-29 and recommendations 6, 9, 10 & 12. Inquests 5/06, 6/06, 44/06, 3/07, 32/05 & 5/07.

withheld from the person appointed as a coordinator and that coordinator needs to be ongoing through different phases of a patient's management. That is involved, not in the patient's private concerns, but in the patient's practical requirements for coordinated management and treatment between different facilities and practitioners. Effectively, an ongoing case manager with specific handover requirements for any change in treatment or practitioner while a patient is in the mental health system, public or private.

Realistically review of this particular case needs to extend to the deceased's management before the imposition of the CTO on 22 March 2012.

It is accepted the deceased had a long history of mental health illnesses in the form of post-traumatic stress disorder later diagnosed as bipolar affective disorder. Her illness expressed itself by way of her belief in serious physical complaints arising out of medication used in an attempt to control her illness.

Historically, the deceased had responded well to psychiatrists with whom she could communicate in her own language with an understanding of the culture from which she had come. With her management by the TMHC, originally located in RPH, the deceased also had a GP with whom she communicated well and reported she was generally more compliant with medication at that time.

However, it became obvious the deceased required more care within the community than TMHC could provide and she was transferred to ICCMHS. Her relationship with this service seems to have been reasonable while there was still some input from TMHC. It became less effective once the deceased no longer had input from a psychiatrist with whom she could communicate in her own language. I do not believe this was a language problem but more of a cultural nature. The deceased does not appear to have believed her CMHS *"understood"* her in emotional terms.

Following the deceased's return from Bosnia in 2011 she sought referral to a culturally appropriate psychiatrist from her GP and withdrew herself from contact with her case manager at ICCMHS and requested ICCMHS have no contact with her new, private psychiatrist.

There was no follow up by ICCMHS with the deceased's GP or notification to her GP they considered ICCMHS were no longer involved with the deceased's ongoing care, nor an approach by ICCMHS to persuade either Drs Rijks or Perica to keep them informed about practical aspects of her care. I understand there is no room in the public system for this to occur, but it is what a CMHS should be resourced to do.

It is clear the deceased's GP, Dr Rijks, and her psychiatrist, Dr Perica, believed the deceased was still involved with

ICCMHS and Dr Rijks contacted ICCMHS whenever he had concerns about the deceased's ongoing mental health care.

It was as a result of Dr Rijks' concern the deceased was admitted to RPH emergency department on 17 February 2012 following which she was transferred to SVC as a voluntary patient until her discharge on 12 March 2012.

Despite the, admittedly disjointed, known difficulties with the deceased's compliance with medication there was no round table discussion with the deceased and all those providing input to her ongoing care on discharge. While there had been a meeting with her son, prior to her weekend leave, it is clear he did not really understand his mother's difficulties and it was an inappropriate expectation of a 19 year old son brought up in a different culture. He did not have the benefit of a round table discussion with SVC, ICCMHS, Dr Rijks and Dr Perica to enable him to understand some of the issues surrounding his mother's ongoing care.

It is apparent from the deceased's discharge into the care of ICCMHS following her inpatient stay at SVC there were the beginnings of serious miscommunication. ICCMHS are adamant they had not, and never would have, agreed to depot olanzapine for a patient in March 2012. Irrespective of the relevance of that issue, an ongoing community coordinator would have understood and discussed that

issue prior to discharge so all would know what a workable plan could envisage.

On discharge the deceased was referred to ICCMHS, but it was seen as a new referral which required she progress through assessment prior to being placed in continuing care. This caused difficulties in communication because her past care was not suitably connected with her current community situation and there was no continuity in her management/treatment from SVC to ICCMHS, both public sector facilities.

The situation with her discharge from SVC reflected a lack of appropriate discharge planning. There was no coherent involvement of all those caring for the deceased in the community in the discharge planning. There was a miscommunication about ICCMHS' ability to continue the depot medication, olanzapine, on which she had been commenced by SVC. This would not have occurred had ICCMHS been part of a coordinated discharge conference.

In addition, the practical lack of continuity in the deceased's care, firstly on release from SVC to ICCMHS, and secondly once assessed by the Acute Assessment team and placed on a CTO before the scheduled review by a supervising psychiatrist on behalf of the continuing care team, makes the fact of a CTO effectively pointless. It was only Dr Cole's

appropriate concern which saw the deceased reviewed and provided with medication earlier.

This resulted in a period of "*non-compliance*" with medication, although the deceased had not been provided with medication she could take, other than Dr Perica supplying her with olanzapine quicklets informally, because he understood she was being medicated with olanzapine depot.

In view of the deceased's known reluctance to take medication the subject of a CTO should have been appropriately addressed as part of her discharge planning before 12 March 2012. A coordinated conference with the deceased and her carers would have assisted the deceased's son understand the issues involved. As it was he believed there was nothing significantly wrong with his mother. This undoubtedly led to frustration in the household between mother and son as to her ongoing "*symptoms*".

An appropriately coordinated discharge conference prior to the implementation of the discharge plan for the deceased may have prevented the fatal breakdown of continuity seen in this case. At least all relevant parties would have been in the same space as to the deceased's difficulties.

The failure to have an appropriate discharge conference prior to finalising an appropriate plan led to serious

misunderstandings between Dr Perica and ICCMHS as to their relevant roles in the care of the deceased once back in the community.

While I accept it was a systems failure and not an individual failure, I am not in a position to say the deceased's supervision, treatment and care was appropriate while subject to the CTO imposed on 22 March 2012. Nor can I say optimal supervision, treatment and care would have necessarily prevented her death. Voluntary admission to hospital on 1 May 2012 may have prevented her death on that date.

Recommendations over the last ten years have focused on an appropriate community care plan with a coordinator understanding all aspects of a patient's care and able to coordinate an appropriate plan in the community which also accommodates the need for admissions and continuing care from time to time.[69]

These types of recommendations for the discharge of mentally ill patients back into the community have been made consistently by various organisations, including prior coronial recommendations, for at least 10 years.

[69] I note the South Metropolitan Health Service Mental Health strategy and leadership unit released a care coordination framework in 2012 which details a workable strategy for mental health care in W.A. – Ex 1, tab 21

RECOMMENDATION No.1

PATIENTS WITH MENTAL HEALTH ISSUES WHICH REQUIRE TREATMENT IN EITHER THE PUBLIC OR PRIVATE HEALTH SYSTEM BE PROVIDED WITH A COMMUNITY LIAISON PERSON (COORDINATOR) WHO UNDERSTANDS THE TREATMENT/ MANAGEMENT PLAN IN PLACE FOR THAT PATIENT AND IS IN A POSITION TO ENSURE PROPER COORDINATION OF THE PATIENT'S CARE BETWEEN ALL RELEVANT FACILITIES AND PRACTITIONERS.

RECOMMENDATION No.2

DISCHARGE PLANNING FROM A FACILITY, OR REFERRAL FROM ONE MENTAL HEALTH PRACTITIONER TO ANOTHER, ALWAYS INCLUDE THE NOMINATED COMMUNITY LIAISON PERSON, IN PERSON, AT ANY CONFERENCE WHEN THE DECEASED AND THEIR COMMUNITY CARERS ARE PRESENT TO ENSURE UNDERSTANDING AND CONTINUITY OF MANAGEMENT FOR THE PATIENT.

RECOMMENDATION No.3

THE ISSUE OF PATIENT CONFIDENTIALITY NOT TO INCLUDE THE FACT OF TREATMENT AND MANAGEMENT AS BETWEEN A COMMUNITY LIAISON PERSON AND OTHER MENTAL HEALTH PRACTITIONERS, ONLY THE CONTENT OF PRIVATE DISCLOSURES.

E F Vicker
Deputy State Coroner
5 January 2017