**Coroners Act 1996**

**[Section 26(1)]**

***Western Australia***

# ***RECORD OF INVESTIGATION OF DEATH***

*Ref No: 12/14*

*I, Sarah Helen Linton, Coroner, having investigated the death of* ***Helen Barbara MINETT*** *with an inquest held at the* ***Perth Coroner's Court, Court 51, CLC Building, 501 Hay Street, Perth*** *on* ***24-27 March 2014****, find the identity of the deceased person was* ***Helen Barbara Minett*** *and that death occurred on* ***28 September 2009*** *at* ***142 Apsley Road, Willetton*** *as a result of* ***multiple drug toxicity in a woman with coronary artery atherosclerosis*** *in the following circumstances:*

**Counsel Appearing:**

Kate Ellson assisting the Coroner
Melanie Naylor (Tottle Partners) appearing on behalf of Dr Wild

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## INTRODUCTION

1. Helen Barbara Minett (the deceased) was a 55 year old lady with a complex medical history. She suffered abuse during a traumatic childhood, which had led to many of her health problems.[1]

2. The deceased suffered from a large number of medical conditions and had undergone more than one major abdominal surgical procedure.[2] She suffered from chronic pain and was receiving regular doses of opioids and other drugs of addiction in the form of morphine, codeine, buprenorphine and diazepam, in an attempt to manage her pain.[3]

3. The deceased also had significant mental health issues and had a long history of suicidal ideation. She had first attempted suicide as a teenager in New Zealand,[4] and later many times as an adult.[5]

4. From August 2004 until her death, the deceased's general practitioner was Dr Felicity Wild, a member of St Luke's GP Medical Group. The deceased had a close relationship and very regular contact with Dr Wild during that period.

5. On the morning of 28 September 2009 the deceased overdosed on a large quantity of oral morphine hydrochloride solution (morphine mixture), while alone at home. The deceased rang a friend after the overdose, which led to Dr Wild being contacted.[6]

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[1] Exhibit 1, Tabs 6 and 11.
[2] Exhibit 1, Tab 10.
[3] Exhibit 2, Tab 29.
[4] Exhibit 1, Tab 6.
[5] Exhibit 1, Tabs 6 and 10.
[6] Exhibit 1, Tab 7.

6. Dr Wild attended the deceased's home later that morning. Initially, the deceased was drowsy but ambulatory. She later fell into a heavily sedated sleep with slow respiration. Dr Wild decided to leave the deceased at home and not telephone an ambulance nor take her to hospital herself, as she thought the deceased would recover from the overdose spontaneously based on past history.[7] That did not occur.

7. In the early afternoon the deceased's husband, Mr Minett, returned home and Dr Wild left the deceased in his care. The deceased was asleep and unresponsive at this time.[8]

8. When Mr Minett went to bed at 9.30pm that evening, the deceased was still alive, but heavily sedated. At approximately 12.30am the following morning, Mr Minett awoke and checked the deceased. He found her not breathing and cool to the touch. After telephoning a friend and then Dr Wild, he telephoned an ambulance.[9]

9. Ambulance officers attended but found no signs of life.[10]

10. A post-mortem examination was conducted by forensic pathologist Dr McCreath on 2 October 2009.[11] The cause of death was determined by Dr McCreath to be multiple drug toxicity in a woman with coronary artery atherosclerosis.

11. An inquest was held from 24 to 27 March 2014 in the Perth Coroner's Court. The primary issues for investigation were whether the deceased ingested the fatal amounts of drugs with the intention of taking her own life, whether the decision of Dr Wild not to request an ambulance was appropriate in the circumstances, and whether her failure caused or contributed to the death of the deceased.

[7] Exhibit 1, Tab 10; Exhibit 2, Tab 28.
[8] Exhibit 1, Tab 10; Exhibit 2, Tabs 19 and 28.
[9] Exhibit 1, Tab 6; Exhibit 2, Tab 19.
[10] Exhibit 1, Tab 12.
[11] Exhibit 1, Tab 14.

12. The documentary evidence adduced at the inquest was substantial. It included a police report with various witness statements obtained as part of the investigation, the St John Ambulance patient care record and notes, the deceased's Fremantle Hospital records, the clinical records from St Luke's GP Medical Group, the handwritten medical records of Dr Wild and a handwritten diary of the deceased, written in the last year of her life.

13. Oral testimony was provided by Mr Minett, Sheree Minett, Margaret Bartlett, Joyce Plumb, Sergeant Berens, First Class Constable Holtom, Dr Dunjey, Dr Mansfield, Professor Joyce, Professor Winterton, Wayne Boisson and Dr Wild.

## THE DECEASED'S EARLY YEARS

14. The deceased was born in 1954 in New Zealand and spent her formative years there. As an adult, the deceased disclosed memories of sexual, physical and emotional abuse by family members and others while growing up in New Zealand.[12] Those events had a lasting impact upon her, both physically and psychologically, resulting in her first suicide attempt (the first of many) at the age of 16 years.[13]

15. The deceased met Clement Minett when she was 16 years old. They became friends first, and later formed a relationship and married in 1982.[14] They had two sons together, born in 1983 and 1984.[15]

16. After the birth of her sons, the deceased had the first of a number of major surgeries, being a hysterectomy and oophorectomy (against a background history of polycystic ovaries). Further surgeries were performed in New Zealand for a variety of reasons, including a vertical banded gastroplasty in 1991 for obesity.[16]

[12] Exhibit 1, Tabs 6, 11; Exhibit 2, Tab 19.
[13] Exhibit 1, Tab 6; Exhibit 2, Tab 19.
[14] Exhibit 2, Tab 19.
[15] Exhibit 3, Tab 4.
[16] Exhibit 2, Tab 17.

17. As for her mental health, there is no record of the deceased having any psychiatric review while in New Zealand. She was, however, treated for episodes of depression related to stressors of ill health on two occasions.[17]

18. In 1996 the Minett family moved to Perth. The move was, in part, designed to provide the deceased with some psychological reassurance that she was safe from her childhood abusers.[18]

19. The deceased was by all accounts a fun and caring woman who made friends easily. She apparently settled in well following the move to Western Australia, and took an active interest in the local community. She became a member of the Riverton Baptist Community Church and also joined a related women's group called Women Interested in Growing and Sharing (WINGS), eventually joining the leadership team of that group.[19]

20. The deceased also joined the WA State Marching Team and volunteered as part of a Restorative Justice program that involved visiting prisoners.[20]

21. However, it was apparent to those close to her that the deceased's health continued to deteriorate.[21]

## ST LUKE'S GP MEDICAL GROUP

## DR LACHLAN DUNJEY

22. St Luke's GP Medical Group is a medical practice in Morley. It is known as a Christian practice and, accordingly, often attracts patients with a Christian belief system who are seeking a general practitioner who

[17] Exhibit 2, Tab 17.
[18] Exhibit 1, Tab 6.
[19] Exhibit 1, Tab 7; Exhibit 2, Tab 21.
[20] Exhibit 3, Tab 1.
[21] Exhibit 1, Tabs 6 and 10.

shares their belief system.[22] It would seem the deceased was such a person.

23. The deceased first attended the St Luke's GP Medical Group on 1 August 2000, when she saw Dr Lachlan Dunjey.[23] The deceased presented with suicidal thoughts triggered by flashbacks and memories of her childhood abuse.[24] The deceased raised with Dr Dunjey her fear that she had multiple personality disorder (MPD) or some type of possession.[25]

24. What was formerly known as MPD is now known as Dissociative Identity Disorder (DID). According to the DSM – IV Criteria, the essential feature of DID is the presence of two or more distinct identities or personality states that recurrently take control of behaviour, resulting in amnesic periods. The alternative identities frequently have different names and characteristics that contrast with the primary identity. It reflects a failure to integrate various aspects of identity, memory and consciousness. Individuals with DID frequently report having experienced severe physical and sexual abuse, especially during childhood.[26] It seems it is a controversial diagnosis, not widely accepted in psychiatric circles, and hence does not fit well within the public mental health system.[27]

25. There is a connection between DID and PTSD, as it is usual that a person with DID would have experienced traumatic stress, which has caused the dissociation. As acknowledged by Dr Dunjey, a practitioner who did not believe in DID would be likely to diagnose a patient as suffering from PTSD rather than DID.[28]

26. Dr Dunjey diagnosed the deceased with depression and sought to manage her condition with medication. He advised her not to attempt to probe into her memories

[22] ts 59 (Dr Dunjey).
[23] Exhibit 2, Tab 15; Exhibit 3, Tab 3.
[24] Exhibit 2, Tab 15.
[25] Exhibit 2, Tab 15; Exhibit 3, Tab 3; ts 61 (Dr Dunjey).
[26] Exhibit 9.
[27] ts 53 (Dr Mansfield); ts 75 (Dr Dunjey).
[28] ts 58 (Dr Dunjey).

until her depression was controlled and she was not suicidal.[29]

27. While under Dr Dunjey's care, the deceased attempted suicide on at least one occasion. On 1 October 2000, the deceased was admitted to Fremantle Hospital after attempting suicide by taking a drug overdose.[30] She was referred by the hospital to Bentley Mental Health Service for out-patient management. It seems that the deceased coincidentally was treated by Dr Dunjey's brother, Dr Malcolm Dunjey, who was a psychiatric medical officer at Bentley Hospital.[31] Dr Malcolm Dunjey held the view of many psychiatrists that he did not believe in MPD/DID as a diagnosis, and he told the deceased of his view.[32] The deceased was given a working diagnosis of PTSD.[33] This encounter apparently reinforced in the deceased's mind that she would not find assistance with mainstream mental health services in Perth.[34] She stopped seeing Bentley Health Service after May 2001.

28. The deceased continued to explore her belief that she might have MPD/DID, rather than, or in addition to, PTSD. On 23 March 2001 the deceased told Dr Dunjey that she had read a book about MPD and on 2 April 2001 she told Dr Dunjey that she was aware of 'alters' or alternative personality states, and had started a 'map' depicting these.[35] Dr Dunjey did not explore these issues with the deceased.[36]

29. In relation to her physical health, Dr Dunjey referred the deceased for various scans and tests in November 2000 relating to fainting episodes or collapses, and she was also referred for vaginal repair, apparently to correct significant incontinence.[37]

[29] Exhibit 2, Tab 15; Exhibit 3, Tab 3; ts 61 – 63, 76 (Dr Dunjey).
[30] Exhibit 4, Tab 4; Outpatient Notes; Exhibit 2, Tab 15; ts 62 (Dr Dunjey).
[31] Exhibit 1, Tab 7; Exhibit 2, Tab 15.
[32] Exhibit 2, Tab 21 [19]; ts 134 - 135 (Plumb, J).
[33] Exhibit 1, Tab 11.
[34] ts 135 (Plumb, J).
[35] Exhibit 2, Tab 15.
[36] ts 67 (Dr Dunjey).
[37] Exhibit 2, Tab 16.

## DR MANSFIELD (NEE SMITH)

30. Another GP in the St Luke's practice at that time was Dr Leonie Mansfield (formerly Dr Smith, as she was known at that time). Dr Mansfield had a particular interest in DID and Dr Dunjey regarded Dr Mansfield as a more appropriate practitioner to manage the deceased's care for that reason, and also because she was female. Accordingly, in August 2001 Dr Dunjey relinquished his care of the deceased to Dr Mansfield.[38]

31. Dr Mansfield first met the deceased on 25 August 2001 and she later became her regular patient.[39] Dr Mansfield noted that the deceased had three main medical issues while in her care, as well as the ongoing issues with her mental health.

32. The deceased had gastro-intestinal issues, dating back to a vertical band gastroplasty in the early 1990's. In 2002 she was vomiting at least once a day due to food getting stuck. A gastroscopy showed only a 1 cm gastric outlet. Accordingly, she was referred to Mr Leon Cohen, a general surgeon and endoscopist, who performed a Roux-en-y gastric bypass in October 2002 to provide a larger opening from her stomach.[40] Following the surgery, the deceased required iron and vitamin supplements and developed chronic constipation.[41]

33. In February 2002, the deceased suffered acute urinary retention, requiring the use of an indwelling catheter for a few days. She continued to have episodes of retention, which were associated with her bouts of chronic constipation, and in July 2003 she again had significant retention that left her with a non-functioning bladder. She was subsequently required to self-catheterize several times a day, which left her subject to urinary tract infections, requiring repeated courses of antibiotics.[42]

[38] Exhibit 2, Tab 15; ts 67 (Dr Dunjey).
[39] Exhibit 2, Tab 16; ts 40 - 41 (Dr Mansfield).
[40] Exhibit 2, Tab 16; Exhibit 3, Tab 2.
[41] Exhibit 2, Tab 16.
[42] Exhibit 2, Tab 16.

34. The third main medical issue was treatment for suspected cardiovascular disease, based upon her strong family history of heart disease.

35. As to her mental health, Dr Mansfield considered that the deceased had a very clear diagnosis of DID,[43] maintaining that she fit the DSM-IV criteria for DID perfectly.[44] She did not, however, refer her for psychiatric treatment for this disorder, as the deceased was reluctant to see anyone else and Dr Mansfield's previous experience when treating patients with DID was that there were no psychiatrists in Perth who had any acceptable outcomes dealing with this disorder.[45] Dr Mansfield did, however, receive advice from one psychiatrist to attempt the use of a beta blocker, Inderal. She prescribed the beta blocker to the deceased in June 2002.[46] Other than that, Dr Mansfield did not consider there was any other treatment available to the deceased for her DID.

36. Dr Mansfield told the court that in the period she treated the deceased she was not aware of any suicide attempts by the deceased, although she was aware of her suicidal alternative personality, referred to as "Susie".[47] There was, however, an event involving a suspected drug overdose by the deceased on 7 September 2003. On that occasion, Dr Mansfield attended the deceased's home as the deceased's friends were concerned that she would not wake. Dr Mansfield monitored her condition until she awoke after three hours, and then left her in the care of friends.[48] At that stage, the strongest medication the deceased was prescribed was Panadeine Forte.[49]

37. The deceased also reported various assaults during this time, but she did not permit Dr Mansfield to collect evidence of these assaults, nor report them to police.[50]

[43] Exhibit 2, Tab 16.
[44] ts 42 (Dr Mansfield).
[45] ts 42 (Dr Mansfield).
[46] Exhibit 3, Tab 3.
[47] ts 43 (Dr Mansfield).
[48] Exhibit 2, Tab 16; ts 45 (Dr Mansfield).
[49] ts 45 (Dr Mansfield).
[50] Exhibit 2, Tab 16.

38. Dr Mansfield's last consultation with the deceased was on 17 June 2004, after which Dr Mansfield left the St Luke's practice.[51] Prior to leaving, Dr Mansfield arranged for another GP at the practice, Dr Wild, to take over the deceased's care.[52] Dr Wild knew the deceased from a Christian group already, but did not know the deceased well at that time.[53]

## DR WILD

39. Dr Wild assumed management of the deceased's medical care in August 2004.[54] Dr Wild accepted the deceased's diagnosis of DID as valid, although she had little experience with the condition prior to treating the deceased.[55]

40. According to the clinical notes, the deceased consulted Dr Wild approximately 106 times at the clinic.[56] This figure does not include those occasions on which Dr Wild spoke to the deceased by telephone, or saw her at her home or elsewhere. Most of those occasions were documented in separate medical notes contained in exercise books.[57] It is apparent from those notes that from an early stage the deceased was generally in daily contact with Dr Wild, via a telephone call from Dr Wild to the deceased each evening, and this continued until her death.[58] Dr Wild described the calls as an informal extension of the therapeutic relationship.[59]

41. As Dr Wild described it, her role was primarily as the deceased's doctor, but she also at times acted in the capacity of her carer, spiritual counsellor and simply as a friend.[60] The changing nature of the relationship from simply doctor/patient to more personal involvement is

[51] Exhibit 1, Tab 16.
[52] ts 44 – 45 (Dr Mansfield).
[53] Exhibit 2, Tab 30, Flag 1 [3].
[54] Exhibit 1, Tab 10.
[55] ts 299 (Dr Wild).
[56] Exhibit 1, Tab 10.
[57] Exhibit 7B.
[58] Exhibit 2, Tab 30, Flag 1 [7]; Exhibit 7B.
[59] Exhibit 1, Tab 10.
[60] Ts 316 (Dr Wild).

revealed in the content of the notes in the exercise books.[61]

42. In the period that Dr Wild managed the deceased's care, it is apparent that the deceased had a large number of serious medical issues. They included the intermittent chronic urinary retention and constipation noted by Dr Mansfield.[62]

43. On 9 January 2006 the deceased underwent surgery for creation of a defunctioning loop ileostomy to help relieve her chronic constipation and associated abdominal pain. This resulted in the creation of a stoma.[63] The surgery appeared to be successful, but the deceased later developed a number of bowel obstructions that required hospitalisation. As a result, she underwent further surgery on 30 October 2006 performed by Mr Cohen, in the form of a total colectomy and proctectomy.[64]

44. At the same time the deceased was undergoing the gastrointestinal procedures, she was being treated for pain related injuries by Consultant Rheumatologist, Dr Andrew Taylor. Dr Taylor arranged that Dr Wild was authorised to prescribe buprenorphine patches and morphine mixture to manage the deceased's pain.[65] She was authorised to take 8 mls per day of a 10mg/ml morphine mixture, which equated to a total dose of 80mg per day.[66]

45. Despite the procedures performed by Mr Cohen, the deceased was hospitalised at Fremantle Hospital due to a bowel obstruction on 8 July 2008, for which she underwent a laparotomy, requiring to be taken to the theatre twice in the same day due to complications. She was taken to the ICU post operatively and it was thought she suffered a cardiac event while there. She was finally discharged on 18 July 2008.[67] She was admitted again

[61] Exhibit 7B.
[62] Exhibit 1, Tab 10.
[63] Exhibit 3, Tab 2.
[64] Exhibit 3, Tab 2.
[65] Exhibit 3, Tab 3.
[66] Exhibit 3, Tab 3.
[67] Exhibit 3, Tab 4.

to Fremantle Hospital due to a bowel obstruction on 27 January 2009.[68]

46. The deceased also suffered chronic dehydration due to high output from her stoma and was admitted to Fremantle Hospital in March 2009 for that reason.[69]

47. On 19 November 2008 the deceased was reviewed at the Fremantle Hospital Pain Medicine Unit by Dr Stephanie Davies. She was prescribed Pregabalin (Lyrica) and her ongoing use of Fentanyl patches and 80 mg per day of morphine mixture was supported, although it was suggested the deceased should consider reducing her opioids by 10% of her daily dose. A change to Norspan patches was also suggested as a future option.[70] At the time of her death the deceased was booked to see Dr Davies again at the Pain Medicine Unit in order to obtain another prescription of Pregabalin.[71] Her main current pains at that time were located in the left upper quadrant of her abdomen and in her left lower back, radiating into her thigh.[72]

48. On 23 January 2009 the deceased saw a Renal Physician, Dr Robyn Kirwan, due to chronic renal impairment.[73] The deceased had previously been admitted to hospital with acute renal failure in association with withdrawal from benzodiazepines and opiates.[74] Dr Kirwan reviewed the deceased and in May 2009 he referred her to urologist Dr (Jessica) M.A. Yin for review. He was concerned that she was retaining urine again, which might lead to chronic renal failure resulting in her requiring weekly dialysis in hospital.

49. The deceased also suffered recurrent angina, noted by Dr Wild in her report as one of the deceased's most

[68] Exhibit 3, Tab 4.
[69] Exhibit 3, Tab 4.
[70] Exhibit 3, Tab 4.
[71] Exhibit 3, Tab 3; ts 295 (Dr Wild).
[72] Exhibit 3, Tab 3.
[73] Exhibit 2, Tab 18; Exhibit 3, Tab 4.
[74] Exhibit 2, Tab 18.

significant physical issues in 2009.[75] She was taking medicine daily for her heart condition.[76]

50. In addition to her physical health issues, the deceased also continued to experience mental health problems while under Dr Wild's care. Dr Wild noted that the two major aspects of her psychiatric health during this period were her attempts at suicide and suicidal ideation generally, as well as her DID.[77] Dr Wild's clinical notes document the deceased's struggle with suicidal thoughts from January 2005 until her death. Although the deceased sometimes expressed a contemplation of committing suicide by hanging or some other means, and had self-harmed by cutting herself, it appears that her actual suicide attempts only ever involved overdoses of medication.[78]

51. It is apparent that the deceased deliberately overdosed on her prescribed medication many times. Dr Wild's notes document overdoses on numerous occasions.[79] Many of the overdoses involved large quantities of medication, particularly morphine mixture.[80] According to Dr Wild, the deceased appeared to experience little effect from the overdoses,[81] although it seems that Dr Wild did not attend the deceased on these occasions and her information about them came from reports.[82]

52. The most recent suicide attempt, prior to her death, was in May 2009. The deceased was reported to have taken 500 mg of morphine mixture combined with amitriptyline, Panadeine Forte and Norspan (buprenorphine). At that time Dr Wild noted that the deceased was cared for by friends and slept maybe four hours. Afterwards, she told Dr Wild "I'd do anything to kill myself."[83]

[75] Exhibit 1, Tab 10; ts 291 (Dr Wild).
[76] Exhibit 1, Tab 10.
[77] Exhibit 1, Tab 10.
[78] Exhibit 1, Tab 10; Exhibit 7A.
[79] Exhibit 1, Tab 10; Exhibit 7A.
[80] Exhibit 1, Tab 10; Exhibit 7A.
[81] ts 298 (Dr Wild).
[82] ts 298 (Dr Wild).
[83] Exhibit 1, Tab 10; Exhibit 7A; Exhibit 7B (Book 38).

53. The deceased also described feeling suicidal in mid-August 2009, although no suicide attempt was recorded.[84]

54. Dr Wild noted that the deceased had been trialled on antidepressant medication when she first consulted Dr Dunjey, but it did not appear to have been particularly beneficial and, indeed, the deceased reported it had made her more suicidal.[85] Dr Wild did prescribe the antidepressant Citalopram at one stage, but the deceased refused to continue taking it.[86]

55. According to Dr Wild, the deceased's DID was a significant challenge to the management of her health.[87] Although Dr Dunjey had never experienced the deceased in an altered state,[88] both Dr Mansfield and Dr Wild reported to have experienced the deceased switching to her 'alter' personalities on various occasions.[89] Indeed, on the occasion that the deceased declined to continue taking Citalopram, the refusal was apparently given by one of the 'alter' personalities.[90]

56. Similarly to Dr Mansfield, Dr Wild did not attempt to refer the deceased to a psychiatrist or any mental health services for her DID. This was because Dr Wild understood from the deceased that she was opposed to the idea of referral as it was unlikely another therapist would accept her diagnosis of DID and, on that basis, the deceased did not believe she would benefit from the public mental health system.[91] Further, the deceased did not have private health insurance and would, in any event, have also struggled in the private health sphere to find a therapist who could manage her well, given her other medical complications.[92]

[84] Exhibit 1, Tab 10; Exhibit 7A; Exhibit 7B (Book 38).
[85] Exhibit 1, Tab 10.
[86] Exhibit 1, Tab 10.
[87] Exhibit 1, Tab 10.
[88] ts 67 (Dr Dunjey).
[89] Exhibit 2, Tab 16; ts 43 (Dr Mansfield).
[90] Exhibit 1, Tab 10.
[91] Exhibit 1, Tab 10; ts 300 (Dr Wild).
[92] Exhibit 1, Tab 10; ts 301 (Dr Wild).

57. As mentioned earlier, the deceased had a history of reporting assaults, which she did not wish reported to the authorities. Dr Wild also recorded the deceased's reports of assaults and noted that she could not discount the possibility that the deceased was self-harming when dissociated, rather than being a victim of abuse.[93]

## THE DECEASED'S CARERS

58. Separate to the medical care provided to the deceased by her various GP's, the deceased also had a number of other people in her life that assisted with her care.

## JOYCE PLUMB

59. Joyce Plumb met the deceased through WINGS. From about 2000 they became very friendly.[94] At some stage the deceased began to share her memories of her childhood with Mrs Plumb.[95] Mrs Plumb is not a qualified counsellor,[96] however, she adopted a role for the deceased as a nonconventional counsellor,[97] undertaking what she described as 'prayer therapy'.[98] She was also sometimes involved in assisting with some of the deceased's physical care[99] and attending medical appointments with her.[100]

60. Mrs Plumb claimed to have first-hand experience of the deceased's various alternative personalities.[101] In particular, Mrs Plumb had experience with one alternative personality she named Susie, as she was associated with the deceased's suicidal tendencies.[102]

61. Mrs Plumb was aware that the deceased had attempted suicide on a number of occasions and often provided

[93] Exhibit 1, Tab 10.
[94] Exhibit 2, Tab 21.
[95] Exhibit 2, Tab 21.
[96] Exhibit 1, Tab 7 [6].
[97] Exhibit 1, Tab 7 [6]; Exhibit 2, Tab 21 [18] – [19]; ts 300 (Dr Wild).
[98] Exhibit 2, Tab 21 [48] – [51].
[99] ts 118 (Plumb, J).
[100] ts 120 (Plumb, J).
[101] Exhibit 1, Tab 7; Exhibit 2, Tab 21 [14].
[102] Exhibit 1, Tab 7 [16]; ts 126 (Plumb, J).

support to her on those occasions.[103] She had also experienced occasions when the deceased overdosed on her medicine in an attempt to induce sleep, rather than to take her life.[104]

62. It was Mrs Plumb's evidence that the deceased had made a 'lasting request'[105] not to be put into the public health system if she attempted suicide.[106] Mrs Plumb believed those closest to the deceased were aware of the request.

## MARGARET BARTLETT

63. Margaret Bartlett met the deceased through the Riverton Baptist Community Church in about 2000.[107] From approximately 2005 the deceased moved in with Mrs Bartlett and her family. Mrs Bartlett acted as her full-time carer, for which she was paid a small allowance.[108]

64. As the deceased's carer, Mrs Bartlett was actively involved in the deceased's medical care, and generally had control of the deceased's medication.[109]

65. Mrs Bartlett was aware of occasions when the deceased apparently overdosed on her medication. On these occasions, the deceased would sleep it off. Mrs Bartlett believed these overdoses to be accidental.[110]

66. However, Mrs Bartlett also experienced what she believed to be the deceased's alternative personalities, arising from her DID.[111] Mrs Bartlett was aware that at least one of those personalities had made comments about self-harming, and she considered it possible that one of the deceased's alternative personalities might be suicidal.[112]

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[103] Exhibit 1, Tab 7 [17]; Exhibit 2, Tab 21; ts 127, 138 (Plumb, J).
[104] Exhibit 2, Tab 21 [38].
[105] ts 142 (Plumb, J).
[106] ts 142 – 144 (Plumb, J).
[107] Exhibit 2, Tab 22 [1].
[108] Exhibit 2, Tab 22 [10] – [11].
[109] Exhibit 2, Tab 22 [46] – [48].
[110] Exhibit 2, Tab 22 [42]; ts 149 – 150 (Bartlett, M).
[111] Exhibit 2, Tab 22 [24] – [27]; ts 156 (Bartlett, M).
[112] Exhibit 2, Tab 22 [55] – [56].

67. Mrs Bartlett gave evidence that she was aware of the deceased's wish not to be sent to hospital, to avoid being put into the public mental health system.[113] However, Mrs Bartlett denied talking about the deceased's request with other people,[114] in particular Mrs Plumb.[115] Mrs Bartlett did, however, indicate that in an emergency she would call Dr Wild, rather than an ambulance, although she did not know why.[116]

## SHEREE MINETT (NEE VERON)

68. Sheree Minett married the deceased's husband, Clement Minett in December 2012.[117] Prior to that, she was known as Sheree Veron.

69. Mrs Minett came to know the deceased through WINGS and the Riverton Baptist Church and they became friends.[118] Later, Mrs Minett took on a carer role for the deceased. Although Mrs Minett is a qualified carer, her role of caring for the deceased was unpaid and involved generally assisting her but did not include administering her medication.[119]

70. Mrs Minett was aware of the deceased having other personalities or alters, but she had not experienced one expressing suicidal ideation and was not aware of any actual suicide attempts by the deceased.[120] She had, however, experienced occasions when the deceased had taken more than her normal dose of medication. On those occasions, the deceased would sleep it off.[121]

71. Mrs Minett did not give any evidence of an understanding with the deceased not to call an ambulance if she overdosed. She indicated in her statement that if she had ever been concerned about the

[113] ts 150 - 151, 154, 155 (Bartlett, M).
[114] ts 151 (Bartlett, M).
[115] Ts 159 – 160 (Bartlett, M).
[116] ts 152 (Bartlett, M).
[117] Exhibit 2, Tab 20 [7]; .ts 80 (Minett, S).
[118] Exhibit 2, Tab 20 [4] – [7].
[119] Exhibit 2, Tab 20 [3]; ts 81 - 84 (Minett, S).
[120] Exhibit 2, Tab 20 [41]; ts 90 – 91 (Minett, S).
[121] Exhibit 2, Tab 20 [37] – [38]; ts 92 - 93 (Minett, S).

deceased's breathing she would have called an ambulance.[122]

## CLEMENT MINETT

72. As mentioned above, the deceased and Clement Minett were married in 1982 and had two sons together. The relationship was happy initially, but became troubled after they moved to Perth and the deceased's physical and mental health deteriorated. They had periods of marital separation in the last years of the deceased's life.[123] Mr Minett also continued to work away from home often, which resulted in further periods where they lived separately from each other.[124]

73. When Mr Minett was at home and the deceased was living at the marital home, Mr Minett provided the deceased with assistance with her physical care.[125] However, as mentioned previously, Mrs Bartlett usually managed the deceased's medication.[126] Mr Minett only rarely handled medication for the deceased.[127]

74. As to her mental health issues, Mr Minett had some limited knowledge of her traumatic childhood experiences, but the deceased did not generally discuss these matters with him. She reserved much of her disclosure for Joyce Plumb.[128] He had, however, observed the deceased's alternative personalities at times and accepted her diagnosis of DID.[129]

75. In relation to her suicide attempts, it was generally agreed by the witnesses that the deceased sought to conceal them from her husband and this was possible as he was not part of her close support team.[130] He was aware that she sometimes took an extra dose of

[122] Exhibit 2, Tab 20 [38].
[123] ts 10 – 11 (Minett, C).
[124] ts 11 (Minett, C).
[125] ts 11 - 12 (Minett, C).
[126] ts 19 (Minett, C).
[127] ts 20, 22 (Minett, C).
[128] ts 14 - 15 (Minett, C); ts 140 - 141 (Plumb, J).
[129] Exhibit 1, Tab 19 [21] – [22].
[130] ts 24 (Minett, C), 120, 141 (Plumb, J), 309, 328 (Dr Wild).

morphine mixture, and when he was aware it had occurred he noted that she appeared to sleep it off.[131]

76. Mr Minett observed the deceased becoming progressively weaker in the last year of her life,[132] and in a lot of pain.[133] She eventually had to give up the Marching Team as she couldn't cope with its demands any more.[134] She was also no longer able to do household chores.[135] He did not see any indications that she may have been thinking of taking her life, although given her desire to conceal her suicide attempts from him, it is unlikely the deceased would have expressed suicidal thoughts to her husband.[136]

## SEPTEMBER 2009 - GENERALLY

77. In the last month of her life, the deceased's physical health continued to deteriorate. September 2009 was a particularly bad month health-wise and Dr Wild described the deceased's state of health at that time as "disastrous".[137]

78. As mentioned earlier, the deceased had been referred to a urologist, Dr Yin. Dr Yin saw the deceased on 7 September 2009 and noted that she would require an anatomical assessment as well as urodynamic studies.[138] This did not occur before her death.[139] The deceased was reportedly very apprehensive about these investigations as they were invasive and unpleasant[140] and also triggered memories of her abuse.[141]

79. Dr Kirwan, who had referred the deceased to Dr Yin, had also indicated in the referral (which was seen by the

[131] ts 20 – 21, 23 - 24 (Minett, C).
[132] ts 12, 26 - 27 (Minett, C).
[133] ts 27 (Minett, C).
[134] ts 14 (Minett, C).
[135] ts 26 (Minett, C).
[136] Exhibit 1, Tab 6 [22].
[137] ts 301 (Dr Wild).
[138] Exhibit 3, Tab 3.
[139] Exhibit 3, Tab 3.
[140] ts 302 (Dr Wild).
[141] Exhibit 1, Tab 10 [40].

deceased)[142] that the deceased's kidney functioning was very poor and she was very likely heading towards requiring dialysis at some point, which would have been extremely difficult for the deceased to manage.[143]

80. On 13 September 2009 the deceased was admitted to Fremantle Hospital with a diagnosis of subacute bowel obstruction. During her admission she developed worsening abdominal pain, vomiting and urinary retention, although this eventually resolved without surgery or catheterisation. Her friends and family were concerned about her condition and treatment during her admission.[144] Dr Wild also noted that pain relief was inadequate during the deceased's hospital stay.[145]

81. The deceased was discharged on 16 September 2009. That was the last time the deceased went to hospital. On discharge, the deceased reported that she was told to consider a pureed or liquid diet and that the bowel obstruction was unfixable.[146]

82. The deceased was also experiencing issues with her vision, and was concerned that she would no longer be able to legally drive.[147]

83. On a personal level, the deceased was experiencing emotional stress due to the ongoing stresses in relationships with members of her family and support group and coping with the news of the deaths of two family members in New Zealand.[148]

84. The deceased last saw Dr Wild in the clinic on 25 September 2009, three days before her death. On that occasion Dr Wild recorded that the deceased had two main current pains, one in her abdomen and one in her left lower back, radiating to her thigh.

[142] Exhibit 1, Tab 10 [41].
[143] ts 302 (Dr Wild).
[144] ts 33 (Minett, C), 86 – 87 (Minett, S),
[145] Exhibit 1, Tab 10 [42]; ts 303 (Dr Wild).
[146] Exhibit 1, Tab 10 [43].
[147] Exhibit 1, Tab 10 [46], ts 303 (Dr Wild).
[148] Exhibit 1, Tab 10 [51].

85. At that time she was being prescribed the following medications:[149]

- Pregabalin (Lyrica) – 150 mg/twice daily;
- Norspan 10 patch (Buprenorphine) – applied once weekly;
- Endep (Amitriptylene) - 20 mg at night and 10 mg in the morning;
- Panadeine Forte tablets – 8 x daily; and
- Ordine (morphine mixture) 10mg/ml solution – 5 ml twice daily (which was 2 ml in excess of her authorised total of 8 ml/day)- therefore equating to a total dose of 100mg per day rather than the authorised 80mg per day.

She was also taking 3 to 8 aspirin tablets per day for knee pain.[150]

86. The deceased reported that she was never pain free and graded her pain severity at 7 or 8 out of 10 before each morphine dose, reducing to 4 out of 10 after taking the morphine.[151]

87. On 26 September 2009 the deceased's carer, Margaret Bartlett, went interstate for 10 days for family reasons.[152] The deceased returned to her family home in Mrs Bartlett's absence, to be cared for by her husband. Mrs Bartlett understood that the deceased had a feeling of abandonment, but she also understood it was necessary for Mrs Bartlett to go.[153]

88. On the evening of 26 September 2009 Dr Wild had her regular evening telephone conversation with the deceased. The deceased reported having slept poorly the night before, so she was tired and had spent the day in bed. She said to Dr Wild that maybe she "just did not want to do life."[154]

[149] Exhibit 1, Tab 10 [48].
[150] Exhibit 1, Tab 10 [49].
[151] Exhibit 1, Tab 10 [49].
[152] Exhibit 1, Tab 10 [53]; ts 153 (Bartlett, M).
[153] Exhibit 1, Tab 10 [53]; ts 153 (Bartlett, M).
[154] Exhibit 1, Tab 10 [55].

89. The following day, the deceased spent the morning with Joyce Plumb's mother-in-law[155] and in the afternoon, she went for a drive with Mr Minett to the hills.[156] Mr Minett observed that the deceased was in pain and appeared weak that afternoon. He felt gravely concerned for her health, but her mood was fine.[157] Dr Wild spoke to the deceased by telephone that evening and she gave Dr Wild no cause for concern.[158]

## 28 SEPTEMBER 2009

90. As mentioned above, the deceased's usual carer, Mrs Bartlett, travelled interstate in late September 2009. Accordingly, the deceased was staying at her home with Mr Minett, although they were sleeping in separate bedrooms.[159] Unusually, Mr Minett had been left in charge of the deceased's medications for the period while Mrs Bartlett was absent.[160] This included the deceased's morphine mixture.[161]

91. Monday, 28 September 2009 was a public holiday. Despite the fact it was a public holiday, Mr Minett was required to attend an occupational health and safety course relating to his impending work on a mine site, commencing the following day.[162]

92. Prior to leaving the house for the course, Mr Minett left a small bottle of morphine mixture containing two doses next to the deceased's bed. Mr Minett hid the larger bottle of morphine mixture, containing the deceased's remaining doses of morphine mixture, in an unlocked chest of drawers in his bedroom.

93. Mr Minett left his home at about 8.00am. As far as he was aware the deceased was asleep in her bedroom when

[155] ts 123 – 124 (Plumb, J).
[156] ts 36 – 37 (Minett, C).
[157] ts 37 (Minett, C).
[158] Exhibit 1, Tab 10 [56]; ts 304 (Dr Wild).
[159] Exhibit 2, Tab 19 [36].
[160] Exhibit 2, Tab 19 [36], Tab 22 [50]; ts 153 (Bartlett, M).
[161] Exhibit 2, Tab 19 [36].
[162] ts 242 (Minett, C).

he left the house.[163] There was no carer available that day, so the deceased was left alone in the house.[164]

94. Sometime that morning the deceased telephoned Mrs Plumb. In her statement to police Mrs Plumb put the time as approximately 11.30am.[165] The telephone records show a telephone call of 843 seconds duration was made from the deceased's home telephone to Mrs Plumb's home telephone at 9.41am that morning, and a later call of 39 seconds duration was made at 11.06am.[166] In oral evidence Mrs Plumb was only able to recall one telephone conversation with the deceased and she appeared to accept that the call she had originally thought was made at 11.30am was most likely the call recorded at 9.41am.[167] That is consistent with the time of the later call to Dr Wild, as noted below.

95. When the deceased called Mrs Plumb that day she announced herself as Susie, which Mrs Plumb knew to be an alternative personality of the deceased that exhibited suicidal tendencies.[168] Susie told Mrs Plumb that she thought she had done something really bad and then told Mrs Plumb that she had taken a large dose of the deceased's medicine,[169] being ten times her normal dose of morphine.[170] Susie told Mrs Plumb that she had done so as the deceased hadn't slept for five days and she wanted her to sleep.[171] Mrs Plumb had also stated to police that Susie told her she had done so because she wanted to die,[172] but she did not recall this in oral evidence.[173]

96. Susie said to Mrs Plumb "can you help us", apparently referring to herself, being Susie, and the deceased.[174] Mrs Plumb asked Susie if she wanted her to ring Dr

[163] ts 243 (Minett, C).
[164] ts 244 - 245 (Minett, C).
[165] Exhibit 1, Tab 7 [20].
[166] Exhibits 5 and 6.
[167] ts 125, 128 (Plumb, J).
[168] Exhibit 2, Tab 21 [33].
[169] ts 126 – 127 (Plumb, J).
[170] Exhibit 1, Tab 7 [25]; ts 128 – 129 (Plumb, J).
[171] Exhibit 1, Tab 7 [31]; ts 126 - 127 (Plumb, J).
[172] Exhibit 1, Tab 7 [31].
[173] ts 127 (Plumb, J).
[174] ts 127 (Plumb, J).

Wild, and Susie agreed that she did.[175] Accordingly, Mrs Plumb hung up and rang Dr Wild at home, as she was not at work that day.[176] Dr Wild recalls receiving the telephone call at around 10.00am.[177]

97. Mrs Plumb told Dr Wild about the telephone call from the deceased.[178] Dr Wild recalled Mrs Plumb told her that the deceased had said that she had taken an overdose of 80ml (800mg) of morphine mixture.[179] Dr Wild immediately rang the deceased and spoke to her, in her alternative personality of Susie.[180]

98. Susie confirmed that she had taken her biggest ever overdose of morphine and said it was "a stupid thing to do."[181] She reported feeling nauseated and sleepy.[182] Dr Wild confirmed that the deceased was at home alone and advised her that she would come and see her.[183]

99. Dr Wild lived some distance from the deceased's home and did not have a key. Therefore, it took her some time to drive there and locate a key, eventually obtaining one from Mrs Plumb.[184] Dr Wild understood that the deceased had heard Dr Wild trying to enter unsuccessfully and had subsequently rung Mrs Plumb to advise her, which would account for the second recorded call from the deceased's home to Mrs Plumb at 11.06am[185] Dr Wild recalls entering the deceased's house at about 11.00am,[186] although based upon that call, it was likely to have been some time after 11.06am.

100. When Dr Wild arrived, the deceased was still awake but she was very sleepy and her speech was slurred. The deceased told Dr Wild that she had taken 1000 mg of morphine mixture and she expressed concern about Mr

[175] Exhibit 1, Tab 7 [32] – [33]; ts 127 - 128 (Plumb, J).
[176] Exhibit 1, Tab 7 [34]; Exhibit 2, Tab 21 [34]; ts 128 (Plumb, J).
[177] ts 305 (Dr Wild).
[178] ts 128 – 129 (Plumb, J).
[179] Exhibit 1, Tab 10 [57]; ts 306 (Dr Wild).
[180] Exhibit 1, Tab 10 [58]; ts 306 (Dr Wild).
[181] Exhibit 1, Tab 10 [58]; ts 306 (Dr Wild).
[182] Exhibit 1, Tab 10 [58].
[183] Exhibit 1, Tab 10 [58]; ts 306 (Dr Wild).
[184] Exhibit 1, Tab 10 [59]; ts 130 (Plumb, J), 306 (Dr Wild).
[185] Exhibits 5 & 6.
[186] Exhibit 1, Tab 10 [59]; ts 306 (Dr Wild).

Minett's reaction if he found out what she had done.[187] On the basis of the supply of morphine mixture that Mrs Bartlett had left for the deceased, Dr Wild considered it was unlikely the deceased had ingested any more than 800mg.[188]

101. Dr Wild acknowledged that an overdose of this amount was of serious concern[189] and in any other patient she would have sent them straight to hospital.[190] However, based upon her previous experience of the deceased when she had overdosed on amounts of morphine mixture up to 500mg, Dr Wild had formed the erroneous conclusion that the deceased was incapable of killing herself by an overdose of medication.[191] Dr Wild theorised that this was because the deceased did not absorb the medication as an otherwise healthy person would, because of her abdominal surgeries and reliance on a stoma bag, and she was also quite resistant to the sedating effects of any absorbed drug.[192] Dr Wild essentially believed that the deceased's ability to absorb drugs taken orally was impaired, and the bulk of the drugs passed through into the stoma bag.[193] Accordingly, Dr Wild mistakenly believed the deceased would simply sleep a bit longer than usual.[194]

102. Dr Wild was aware that the deceased was still wearing a Norspan 10 transdermal patch (buprenorphine). She did not remove the patch, despite the fact that it would add to the level of opiates in her system. Dr Wild considered that the patch would be making a trivial contribution to the problem and was not of great significance in the overall picture of the overdose. Further, she was unwilling to remove it as it was intended to last a week and it remained the only analgesia for the deceased if she awoke, given the deceased had drunk her remaining

[187] Exhibit 1, Tab 10 [60]; ts 306 (Dr Wild).
[188] Exhibit 1, Tab 10 [63] – [64]; ts 306 (Dr Wild).
[189] Exhibit 1, Tab 10 [65].
[190] ts 307 (Dr Wild).
[191] Exhibit 1, Tab 10 [65]; ts 307 (Dr Wild).
[192] Exhibit 1, Tab 10 [65]; ts 307 (Dr Wild).
[193] Exhibit 2, Tab 8 [4(e) (vii)], [15(e)-(g)]; ts 307 (Dr Wild).
[194] ts 307 (Dr Wild).

allocation of morphine mixture for the week.[195] Accordingly, Dr Wild chose not to remove the patch.

103. Dr Wild states that she saw no indication of any pills having been consumed by the deceased as part of her overdose,[196] although the later toxicology results indicate to the contrary. It is unclear whether evidence that the deceased had taken pills at the time might have altered the path that Dr Wild ultimately took that day, although it seems unlikely as Dr Wild had previously noted that the deceased struggled to absorb medication in tablet form.[197]

104. The deceased was still capable of walking when Dr Wild first arrived. Dr Wild observed the deceased walk to the toilet and empty her stoma bag. Whilst the deceased was sitting on the toilet, she dozed off a few times but was roused by Dr Wild each time. The deceased then walked herself back to bed, lay down on her side and went to sleep.[198]

105. Dr Wild did not attempt to rouse her and left her sleeping. In oral evidence, she told the court that at that time she had not realised that it was of any value to deliberately wake up the patient and keep them moving in those circumstances.[199] Instead, she thought at the time that it was of some benefit to the deceased that she was sleeping, given her usual problems with insomnia.[200]

106. Mr Minett came home from his course, as scheduled, at about 2.30pm.[201] The deceased was still asleep.

107. Dr Wild understood from her conversation with the deceased that the deceased did not want Dr Wild to inform Mr Minett that she had taken an overdose.[202] In an attempt to comply with that request, Dr Wild was, by

[195] ts 306 – 307 (Dr Wild).
[196] Exhibit 1, Tab 10 [65]; Exhibit 2, Tab 28 [15(h)].
[197] ts 294 (Dr Wild).
[198] ts 306 (Dr Wild).
[199] ts 308 (Dr Wild).
[200] ts 308 – 309 (Dr Wild).
[201] Exhibit1, Tab 6 [28]; ts 246 (Minett, C).
[202] ts 306 (Dr Wild).

her own admission, probably "fairly uninformative"[203] to Mr Minett. They had only a very brief conversation. Dr Wild did not see any need to tell Mr Minett about the overdose as she was confident that the deceased would sleep it off and then wake up. Although she could not recall the exact words used, Dr Wild thought she had said something like, "[The deceased] is asleep. She's taken a bit of extra morphine… just keep an eye on her."[204] Mr Minett's recollection of the conversation accords with Dr Wild's.[205]

108. Dr Wild could not recall whether she told Mr Minett to monitor the deceased's breathing,[206] but Mr Minett gave evidence that Dr Wild told him to keep an eye on the deceased and make sure she was breathing.[207]

109. Prior to leaving, Dr Wild had measured the deceased's breathing rate at "barely 5 per minute" but she noted they were good, big breaths and her colour was normal.[208] Although Dr Wild acknowledges that a respiratory rate of 5 breaths per minute is never a good sign, she did not consider it to be particularly unusual for the deceased and it did not give her cause for concern at the time.[209] Dr Wild has indicated that she has since come to understand that the kind of breathing the deceased was exhibiting at the time was actually agonal gasps, not good, big breaths, which indicated that it was an emergency situation requiring an ambulance as the deceased was close to death.[210]

110. Dr Wild did not give Mr Minett any instructions as to what to do if the deceased's breathing changed or stopped, or she did not wake up,[211] before she left. The deceased was lying on her side already, so there was no

[203] ts 309 (Dr Wild).
[204] ts 309 (Dr Wild).
[205] ts 248 (Minett, C).
[206] ts 309 (Dr Wild).
[207] ts 249 – 250 (Minett, C).
[208] Exhibit 1, Tab 10 [61].
[209] Exhibit 2, Tab 28 [16]; ts 307 – 308 (Dr Wild).
[210] Exhibit 2, Tab 28 [17] – [21]; ts 308 (Dr Wild).
[211] ts 253 (Minett, C),

discussion about putting the deceased in the coma or recovery position.[212]

111. Dr Wild left the deceased's house shortly after Mr Minett returned home. Mr Minett then proceeded to check on the deceased at least every 15 minutes whilst he prepared his belongings to go away the next day.[213] He did not observe the deceased change position and she did not wake,[214] despite Mr Minett trying to wake her by shaking her and yelling at her.[215]

112. By the evening, Mr Minett had become concerned that the deceased had not woken up.[216] Mr Minett recalls that he rang Dr Wild at that stage from the home telephone landline.[217] However, the telephone records show that the only call between Mr Minett and Dr Wild that evening was made by Dr Wild to the Minett house at 7.23pm.[218] This accords with Dr Wild's recollection of telephoning the deceased at about 7.30pm, expecting her to be awake by then.[219] I accept that Dr Wild telephoned Mr Minett, rather than the other way around.

113. During their telephone conversation, Mr Minett informed Dr Wild that the deceased was still asleep. This information surprised Dr Wild as she had thought the deceased would have passed the point of sedation and woken up by then.[220] She could not recall whether Mr Minett had told her he had unsuccessfully tried to rouse the deceased at that time, but acknowledged that she was set in a mindset that the deceased would be alright in any event.[221]

114. It was at this point that Dr Wild apparently informed Mr Minett that the deceased had taken an overdose of morphine.[222] Although Mr Minett's recollection of that

[212] ts 309 (Dr Wild).
[213] ts 250 (Minett, C).
[214] ts 257 (Minett, C).
[215] Exhibit 2, Tab 19 [61]; ts 250 (Minett, C).
[216] ts 253 (Minett. C).
[217] Exhibit 2, Tab 19 [62]; ts 253 – 255 (Minett, C).
[218] Exhibits 5 and 6.
[219] Exhibit 1, Tab 10 [68]; ts 310 – 311 (Dr Wild).
[220] ts 310 - 311 (Dr Wild).
[221] ts 311 (Dr Wild).
[222] Exhibit 1, Tab 10 [68]; ts 311 (Dr Wild).

conversation is vague, he accepts that it is likely that this is when he was told.[223] There was no discussion about calling an ambulance.[224] Dr Wild did not express any concern to Mr Minett that the deceased had not awoken and Mr Minett took his cue from her.[225]

115. After the phone call, Mr Minett continued to check the deceased approximately every 15 minutes until he went to bed, in a separate bedroom, at about 9.30pm.[226]

116. At approximately 12.30am the following morning, Mr Minett woke up and went in to the main bedroom to check on the deceased. The deceased was cool to the touch and not breathing. Mr Minett realised immediately that she had died.[227]

117. It appears from the telephone records that Mr Minett first telephoned Mrs Plumb,[228] although he does not recall that being the first telephone call he made.[229] After calling Mrs Plumb, he then called Dr Wild.[230] Dr Wild told Mr Minett to call an ambulance,[231] which he immediately did.[232] Dr Wild recalls being "absolutely appalled"[233] when Mr Minett rang her and told her that the deceased had stopped breathing. She hoped that the deceased might still be able to be resuscitated, which is why she told him to call an ambulance.

118. The ambulance arrived at the house just before 1.00am and was met outside by Mr Minett.[234] The paramedic and ambulance officer were taken inside to the deceased and observed that she was lying on her side with the duvet pulled up to her neck, as though she was sleeping.[235] The paramedic, Wayne Boisson, made an

[223] ts 271 – 272 (Minett, C).
[224] Exhibit 2, Tab 19 [63];
[225] ts 274 (Minett, C).
[226] Exhibit 2, Tab 19 [60], [65].
[227] Exhibit 2, Tab 19 [65] – [66], ts 264, 279 (Minett, C).
[228] Exhibits 5 and 6.
[229] ts 264 – 265, 267 – 268 (Minett, C).
[230] Exhibits 5 and 6.
[231] ts 264 (Minett, C).
[232] Exhibits 5 and 6.
[233] ts 311 (Dr Wild).
[234] Exhibit 1, Tab 8A [4] – [8], Tab 12.
[235] Exhibit 1, Tab 8A [11] – [12].

initial assessment that she was showing classic signs of a three hour death.[236] Based on St John Ambulance protocols they did not attempt to resuscitate the deceased but performed tests to confirm death.[237]

119. Mr Boisson and his partner then went to the kitchen and told Mr Minett that his wife had died.[238] Mr Boisson asked Mr Minett to ring the deceased's doctor. Mr Minett rang Dr Wild and spoke to her briefly, before passing the phone to Mr Boisson. As he did so, Mr Minett mentioned the deceased had taken a morphine overdose.[239]

120. Mr Boisson spoke to Dr Wild on the telephone. Mr Boisson asked Dr Wild if she could attend the house to complete a death certificate. Dr Wild initially indicated that she was unwilling to come. Mr Boisson explained that if she did not attend, he would need to call the police to attend. Dr Wild then indicated that she would come, and that it would take her approximately 40 minutes to get there.[240]

121. Mr Boisson also asked Dr Wild during that call about the morphine overdose and she advised that the deceased may have taken 80 mls of morphine that morning and she had done it before and slept it off.[241]

122. After speaking to Dr Wild, Mr Boisson handed the telephone back to Mr Minett and went outside the house with the other ambulance officer, Florian Breitenbach. They discussed the circumstances of the case, which had aroused their suspicions. The exact details of the conversations that prompted Mr Boisson's concerns are not available to the court, as he wrote the statements on a piece of paper that has apparently been lost during the course of the police investigation.[242] However, to the best of his recollection Mr Boisson was concerned that Mr Minett's account that he had been checking regularly on

[236] Exhibit 1, Tab 8 A [19]; ts 218 (Boisson, W).
[237] ts 218 (Boisson, W).
[238] Exhibit 1, Tab 8 A [23] – [24]; ts 219 (Boisson, W).
[239] Exhibit 1, Tab 8 A [28] – [29].
[240] Exhibit 1, Tab 8 A [31] – [35]; ts 221 – 222 (Boisson, W).
[241] Exhibit 1, Tab 8 A [36] – [39]; ts 219, 224 - 225 (Boisson, W)
[242] ts 221.

the deceased did not ring true,[243] and there was an unexplained delay in calling an ambulance, following the morphine overdose and after she was found unresponsive.[244] He was also concerned about comments Mr Minett had made about monitoring the deceased's breathing;[245] in particular a statement to the effect that the doctor had told him to watch the deceased "as her breathing starts to slow down".[246]

123. As a result of their discussion, the ambulance officers decided to telephone the police. Mr Boisson rang a police officer from the Coronial Unit and asked for police officers to attend the scene.[247]

124. One of the first police officers to attend the scene was First Class Constable Stephen Berens. Constable Berens spoke to the ambulance officers and then entered the house with his partner. They spoke briefly with Mr Minett, who exhibited a calm demeanour. This was noted by the police officers as unusual.[248] They did not see or speak to Dr Wild. As a result of the information provided by the ambulance officers and their observation of the scene, Constable Berens and his partner contacted their supervisor and cleared the house, declaring it a crime scene.[249]

125. Sergeant Robert Holtom next attended the scene and spoke to Constable Berens and his partner, as well as one of the ambulance officers.[250] Sergeant Holtom also spoke to Mr Minett and Dr Wild.[251] Following these conversations, Sergeant Holtom was sufficiently concerned that an unlawful act had occurred to contact Major Crime Squad.[252] Officers from Major Crime and forensic officers attended the scene. The Major Crime officers concluded, based on their own visual observation

[243] Exhibit 1, Tab 8B [13].
[244] ts 227 (Boisson, W).
[245] Exhibit 1, Tab 8A [49] – [50] – [53].
[246] Exhibit 1, Tab 8B [13] - [14].
[247] Exhibit 1, Tab 8A [42] – [43], Tab 12; ts 225 – 226 (Boisson, W).
[248] ts 100 – 102 (Berens, S).
[249] ts 101 (Berens, S).
[250] ts 106 – 107 (Holtom, R).
[251] ts 107 - 109 (Holtom, R).
[252] ts 109, 111 (Holtom, R).

of the scene, an initial examination of the scene by forensic officers, and all known facts at that time, there did not appear to be any criminality in relation to the death.[253] The matter was then left to be investigated by police from the Coronial Investigation Unit.

## POST MORTEM EXAMINATION

126. Dr McCreath conducted a post-mortem examination of the deceased on 2 October 2009.[254] In the examination Dr McCreath found narrowed coronary arteries (coronary atherosclerosis), extensive abdominal adhesions, a colostomy, froth in the airways and hypertensive changes in the kidneys. Initially the cause of death was undetermined, pending further investigations.[255]

127. Toxicological examination revealed the presence of multiple drugs in the deceased's system.[256] The majority were at therapeutic levels. However, the blood total codeine level was in the toxic fatal range and a very high blood morphine level was also found, consistent with that found in terminally ill cancer patients.[257] In her supplementary report, taking into account the toxicological results, the cause of death was determined by Dr McCreath to be multiple drug toxicity in a woman with coronary artery atherosclerosis.[258]

## DOCTOR JOYCE

128. Doctor Joyce is a specialist in general internal medicine and clinical pharmacology and toxicology. He is a Professor of Medicine and Pharmacology at the University of Western Australia and continues to practise in toxicology, predominantly for forensic purposes. Dr Joyce prepared a report dated 27 November 2013 in order to explore the relationships between the deceased's

[253] Exhibit 1, Tab 2.
[254] Exhibit 1, Tab 14; Exhibit 7B.
[255] Exhibit 1, Tab 14 – Confidential Report to the Coroner dated 2 October 2009.
[256] Exhibit 1, Tab 13.
[257] Exhibit 1, Tab 13.
[258] Exhibit 1, Tab 14 – Supplementary Confidential Report to the Coroner dated 15 June 2010.

medications, her illness and death.[259] He had been provided with a large number of materials relevant to the coronial investigation, as itemised in his report, although not a full copy of the post mortem examination report prepared by Dr McCreath.[260]

129. Dr Joyce later prepared an addendum to his first report, dated 22 February 2014, as his earlier report did not include the period before 2 October 2008.[261] At this time, Dr Joyce had been provided with a fully copy of the post mortem examination report and some information on the deceased's dispensed drugs from 29 July 1999 to 23 September 2009.[262]

130. Dr Joyce considered the concentrations of drugs detected in specimens collected from the deceased at the time of post-mortem examination, as recorded in the toxicology report.[263]

131. Dr Joyce concluded that the concentrations of the following drugs were of no toxicological significance:
    - salicylates and salicylic acid (from aspirin); and
    - doxylamine (from Mersyndol).[264]

132. Dr Joyce concluded that the concentrations of the following drugs were too low to have any toxicological significance, if they had been the only drugs present, and in any event their contribution would be very minor:[265]
    - desmethyldiazepam and diazepam; and
    - amitriptyline and nortriptyline.[266]

133. Dr Joyce noted the paracetamol concentration was not in the range generally taken as toxic, but was higher than expected in a person who was taking 8 tablets of Panadeine Forte each day (as the deceased had been

[259] Exhibit 2, Tab 1.
[260] Exhibit 2, Tab 1, pp 1 - 2.
[261] Exhibit 2, Tab 1A.
[262] Exhibit 2, Tab 1A, p 1.
[263] Exhibit 1, Tab 13.
[264] Exhibit 2, Tab 1, p 8.
[265] Exhibit 2, Tab 1, p 10.
[266] Exhibit 2, Tab 1, p 8.

prescribed).[267] He concluded it points to an overdose of a paracetamol-containing formulation, of which the deceased had two – Panadeine Forte and Mersyndol.[268]

134. Buprenorphine (Norspan patch) was not mentioned in the toxicology analysis, although a Norspan patch was found to be affixed to the deceased's left upper arm at the time of death.[269] Dr Joyce noted that buprenorphine is effective at very low concentrations and will commonly not be detected in patients who are exposed to low doses. Accordingly, failure to detect buprenorphine in the deceased's samples does not prove that it did not contribute to opioid toxicity.[270]

135. The deceased's Aorta Blood samples revealed the following levels of Morphine and Codeine:[271]
    - Codeine (Total) Approx 5.1mg/L
    - Codeine (Free) .45mg/L
    - Morphine (Total) Approx 8mg/L
    - Morphine (Free) 0.72mg/L

136. Some of the morphine found in the post mortem blood came from codeine, as codeine transforms to morphine in the body, to a level of about 10% of the drug.[272] However, the amounts of morphine in this case were much higher than 10% of the codeine, which is consistent with the history of morphine ingestion by the deceased.[273]

137. In relation to the morphine concentration, Dr Joyce noted that while morphine is liable to post-mortem redistribution to some degree, the possibility of post-mortem redistribution does not confuse the interpretation in this case because the concentrations are so high that the interpretation is unambiguous.[274] Dr Joyce observed the free morphine concentration was an amount expected to be lethal, and the total morphine

[267] Exhibit 2, Tab 1, p 8.
[268] Exhibit 2, Tab 1, p 8.
[269] Exhibit 1, Tab 14, Confidential Report to the Coroner, p 2.
[270] Exhibit 2, Tab 1, p 9.
[271] Exhibit 1, Tab 13.
[272] Exhibit 2, Tab 1, p 9.
[273] Exhibit 2, Tab 1, p 10; ts 174 (Dr Joyce).
[274] Exhibit 2, Tab 1, p 9.

concentration was also very high, "even among morphine poisoning fatalities."[275] Both the free and total morphine concentrations greatly exceeded the concentrations usually required for analgesia in cancer patients.[276] Dr Joyce concluded that the great majority of the morphine concentrations came from an acute overdose.[277] The morphine itself would have been sufficient to cause death.[278]

138. Dr Joyce also observed that the codeine concentrations, free and total, were much higher than expected from the deceased's prescribed doses of codeine, which indicated that this drug had also been taken in acute overdose.[279] The simultaneously high paracetamol concentration points to the Panadeine Forte as the source, with perhaps a smaller contribution from Mersyndol.[280] If taken on its own, in Dr Joyce's opinion the deceased would almost certainly have survived the codeine overdose without any medical treatment.[281]

139. Looked at in combination, the opiate drug concentrations will be lethal in practically everyone without intensive medical care.[282] Accordingly, in Dr Joyce's unchallenged opinion the circumstances of the deceased's death are consistent with opiate toxicity.[283] The deceased's clinical position on 28 September 2009 was consistent with such a conclusion, as she was showing the clinical signs of morphine toxicity, most notably her sedation and very low respiratory rate.[284]

140. Dr Joyce's conclusion was not affected by the information provided in relation to the deceased's history of opiate prescribing in the years preceding her death.[285] Dr Joyce accepted that the opiate prescribing during the year 2005 meant that the deceased had, at least at that

[275] Exhibit 2, Tab 1, p 10.
[276] Exhibit 2, Tab 1, p 10.
[277] Exhibit 2, Tab 1, p 10.
[278] ts 173 (Dr Joyce).
[279] Exhibit 2, Tab 1, p 10; ts 187 (Dr Joyce).
[280] Exhibit 2, Tab 1, p 10.
[281] ts 188 – 189 (Dr Joyce).
[282] Exhibit 2, Tab 1, p 10.
[283] Exhibit 2, Tab 1, p 10; ts 173 (Dr Joyce).
[284] ts 165 – 166, 174 -175, 179 (Dr Joyce).
[285] Exhibit 2, Tab 1A, p 14.

time, a very high degree of tolerance to opiate/opioid drugs, as well as benzodiazepine drugs.[286] However, as noted in his initial report, "[t]olerance is relative", and even people with a very high degree of acquired tolerance to opiate drugs will die if given a high enough dose.[287]

141. Dr Joyce indicated that opiates are drugs that bring toxicity at doses not much greater than tolerated doses; hence a physician should be getting very anxious about the patient if double the daily dose was taken. So in the case of the deceased, a dose of 160 mg would give anxiety about the patient's wellbeing, and anything above that "would cause a greater degree of anxiety."[288] An amount ten times the normal dose, as in the present case, "would inform a practitioner that the patient may be in peril of their lives."[289]

142. Dr Joyce accepted that a possible hypothesis for the deceased's tolerance to very high level of opiates was that the doses were not being entirely absorbed into the body, given the deceased's gastrointestinal surgery procedures may have had the consequence of impaired absorption of drugs.[290] However, even in those circumstances, in Dr Joyce's opinion "[i]t would not be reasonable to put that conjecture up against the fact of an 800 mg ingestion."[291] The fact that the deceased had taken an amount that would generally be expected to be lethal, and was ten times the dose that the deceased was known to tolerate, would outweigh any individual pieces of information that might suggest survivability in the circumstances.[292]

143. In his oral evidence, Dr Joyce explained that the reason why opiates can lead to death is their abilities to suppress breathing and to interfere with function of the cardiovascular system.[293] Therefore, on identifying a situation where a patient is in risk of their health or

[286] Exhibit 2, Tab 1A, pp 3 - 4.
[287] Exhibit 2, Tab 1, p 11.
[288] ts 173 (Dr Joyce).
[289] ts 173, 181 - 182 (Dr Joyce).
[290] ts 169 – 170, 175 – 176, 184 - 185 (Dr Joyce).
[291] ts 176 (Dr Joyce).
[292] ts 176 (Dr Joyce).
[293] ts 167 (Dr Joyce).

survival from an opiate overdose, the first management is to check their airways are clear and they are breathing, and to provide assistance if they are not. Keeping them awake, where possible, can also be helpful if the patient is not in hospital.[294] That should be followed as quickly as possible with the administration of the usual antidote to opiate toxicity, a narcotic antagonist drug called naloxone hydrochloride (naloxone) that is given intravenously.[295] Naloxone is generally carried by ambulance officers, so it would usually be most appropriate to summon an ambulance, who can administer naloxone and take the patient to hospital where the emergency treatment can be continued.[296] This would include repeat dosing of naloxone, as well as ventilation if necessary.[297]

144. Also, in relation to the Norspan patch, Dr Joyce indicated that the instruction to ambulance officers dealing with opioid overdoses is to look for patches and remove them.[298]

145. Dr Joyce was not supportive of managing such a patient at home and he did not know whether it could be done safely. In Dr Joyce's opinion, if home management in such circumstances were to be attempted, observations would need to be done by someone with nursing training, preferably a doctor or ambulance officer, and there would need to be oxygen resuscitation supplies readily available.[299]

146. Acccording to Dr Joyce, patients who have taken opiate overdoses, and who are treated appropriately before developing hypoxic brain and tissue damage, will survive without sequelae, as a rule.[300] In particular, if encountering an opiate overdose at a time when the patient is still conscious, the patient should survive the treatment. Therefore, in Dr Joyce's unchallenged expert

[294] ts 179 – 180 (Dr Joyce).
[295] ts 177 (Dr Joyce).
[296] ts 177 – 178, 183 (Dr Joyce).
[297] ts 177 (Dr Joyce).
[298] ts 181 (Dr Joyce).
[299] ts 183 (Dr Joyce).
[300] Exhibit 2, Tab 1, p 12.

opinion, the deceased's death was preventable, if the usual proper management course had been followed.[301]

## DOCTOR WINTERTON

147. Doctor Winterton is a doctor of medicine and a Clinical Associate Professor, specialising in paediatrics and community practice. Dr Winterton became involved in the investigation into the death of the deceased at the invitation of Dr Wild's legal representatives, as part of proceedings brought by the Medical Board of Australia against Dr Wild in the State Administrative Tribunal (the Tribunal).

148. Dr Winterton provided an expert opinion regarding complaints by the Board against Dr Wild in relation to her conduct while managing the medical care of the deceased.[302] By order of the Tribunal, Dr Winterton also participated in a conference with two other experts and prepared a joint statement identifying the issues and the matters of agreement and disagreement between them, for the benefit of the Tribunal.[303] Despite being engaged by Dr Wild, in providing expert evidence to the Tribunal Dr Winterton's overriding duty was to assist the Tribunal impartially, and the reports were prepared in that context.[304]

149. Dr Winterton acknowledged that, in caring for the deceased, Dr Wild was faced with an extraordinarily complicated patient with a multitude of medical problems and a multitude of psychological problems. In those circumstances, Dr Winterton accepted Dr Wild had taken on a difficult and challenging task and he concluded that Dr Wild had acted, in her opinion, in the best interest of the deceased. However, Dr Winterton also considered that Dr Wild had become enmeshed with the deceased and had lost sight of some of the boundary posts that should, and must, exist in the doctor-patient relationship, particularly when dealing with patients

[301] ts 183 (Dr Joyce).
[302] Exhibit 1, Tab 27.
[303] Exhibit 2, Tab 26.
[304] Exhibit 1, Tab 27.

such as the deceased.[305] This opinion was shared by the two experts with whom Dr Winterton conferred for the Tribunal proceedings.[306] The consequence of Dr Wild losing her ability to view the deceased's care with professional objectivity was the events of 28 September 2009, culminating in the death of the deceased.[307]

150. In regard to the events of 28 September 2009, Dr Winterton's opinion was that on that occasion Dr Wild did not act in the best interest of the deceased.[308] When faced with the circumstances of the deceased having reportedly taken an overdose of 1000 mg and the patient being sleepy, with slurred speech and a respiratory rate of five breaths per minute, best practice would have been to call an ambulance and stay by the patient's side until the ambulance arrived.[309] Dr Winterton concluded that Dr Wild's decision not to call an ambulance was based on a false premise (as to the deceased's level of tolerance of opiates) and thus, she made a wrong decision.[310]

151. Dr Winterton in conjunction with the experts associated with the Tribunal proceedings also described Dr Wild's failure to call an ambulance as a grave error in judgment. The three experts recognised that the deceased's death was most likely preventable. If Dr Wild had called an ambulance, the deceased's life could probably have been saved by either opiate antagonists (naloxone) administered by ambulance officers and/or urgent transfer for treatment to an emergency department.[311]

## STATE ADMINISTRATIVE TRIBUNAL

152. As mentioned above, the Medical Board of Australia brought proceedings against Dr Wild in the State Administrative Tribunal. The outcome of those

[305] Exhibit 2, Tab 27, pp 2 – 3.
[306] Exhibit 2, Tab 26, p 2 - 4.
[307] ts 195 (Dr Winterton).
[308] Exhibit 2, Tab 27, p 7.
[309] Exhibit 2, Tab 27, p 7 - 8.
[310] Exhibit 2, Tab 27, p 8.
[311] Exhibit 2, Tab 26, p 1; ts 191, 197 (Dr Winterton).

proceedings is set out in ***Medical Board of Australia and Wild*** [2012] WASAT 37.

153. In brief, the Tribunal made findings that Dr Wild acted carelessly and acted improperly in relation to her relationship with, and treatment of, the deceased, as defined in the relevant legislation. Those findings were based upon Dr Wild's own admission that her conduct in relation to the deceased amounted to acting improperly and acting carelessly in certain specified aspects, as set out in a Minute of Orders agreed between the parties.

154. The finding that Dr Wild acted carelessly related to her conduct on 28 September 2009, when she failed to provide any medical assistance to the deceased, failed to call an ambulance and left her in the care of Mr Minett without arranging any alternative medical or other assistance.

155. The Tribunal ordered that Dr Wild be suspended from practise for a period of three months and that her registration as a medical practitioner be subject to specified conditions, including limitations on her ability to provide counselling and therapy to patients and supervision requirements.

156. Dr Lachlan Dunjey, who gave evidence in these proceedings, has performed the role of Dr Wild's supervisor, and continues to do so. He has found Dr Wild to be compliant with the supervision requirements and considers she has reflected on the circumstances of the deceased's death and has insight about the matter.[312] Dr Wild also gave evidence that she had reflected on the events of that day many times and had gained insight as to what went wrong. She confirmed she would not adopt the same course of medical treatment if a similar situation presented itself today.[313]

[312] ts 74, 77 (Dr Dunjey).
[313] ts 315 (Dr Wild).

## ALLEGATION THAT MR MINETT WAS TOLD TO WATCH THE DECEASED AS HER BREATHING SLOWED

157. The attending paramedic, Mr Boisson, initially provided a statement to police at 4.00am in the morning on 29 September 2009, while still at the deceased's home.[314] When contacted in relation to this inquest, Mr Boisson volunteered additional information to his first statement, which was then included in a second statement, signed and dated 26 March 2014.[315]

158. In his second statement, Mr Boisson stated that he used a scrap piece of paper to write down quotes of conversations he had with Mr Minett, as well as conversations he overhead between Mr Minett and Dr Wild.[316] Mr Boisson handed the scrap piece of paper to the police officer who took his statement on 29 September 2009.[317] As mentioned above, that piece of scrap paper has apparently been lost.[318]

159. Without being able to refer to his contemporaneous notes from the night, Mr Boisson was reliant upon his memory, five years later, of the conversations that he had, and overheard, that night. However, Mr Boisson did have an independent memory of a particular comment Mr Minett made that night, described by Mr Boisson as follows:

> "He also made a comment along the lines of, the doctor had told him, 'to watch her as her breathing starts to slow down'.[319]

160. In oral evidence, Mr Boisson indicated that he believed this comment by Mr Minett was made prior to Mr Minett telephoning Dr Wild and advising her that the deceased had died.[320] Although he did not have access to his

[314] Exhibit 1 Tab 8A.
[315] Exhibit 1, Tab 8B.
[316] Exhibit 1, Tab 8B [23] – [24].
[317] Exhibit 1, Tab 8B [25].
[318] ts 221.
[319] Exhibit 1, Tab 8B [14].
[320] ts 220 (Boisson, W).

contemporaneous notes, he indicated that he recalled the statement quite clearly as being along the lines of what he included in his statement, although he did not know the exact words used.[321]

161. It was put to Mr Boisson by Dr Wild's counsel that it was possible Mr Minett had said that Dr Wild told him to watch the deceased, 'in case her breathing slows.'[322] While Mr Boisson appeared to accept it was possible, he was fairly confident that the words used were as he indicated in his second statement.[323]

162. The statement recalled by Mr Boisson was put to both Mr Minett[324] and Dr Wild when they gave oral evidence.

163. Mr Minett's recollection of the events of the evening was vague. He did not recall his conversation with the ambulance officers in any detail.[325] However, when asked about whether he had been told by Dr Wild to watch the deceased's breathing, he agreed that he was advised "just to watch her breathing"[326] and that he understood Dr Wild had wanted him to monitor the deceased's breathing, "to make sure she was breathing in a normal pattern."[327]

164. Dr Wild was also asked whether she ever told Mr Minett to watch the deceased's breathing as her breathing starts to slow down. Dr Wild was adamant that she did not say that to Mr Minett and she would never have said anything like that.[328] She suggested that either Mr Minett and/or the paramedic had misheard.[329]

165. At the time Dr Wild left the deceased in Mr Minett's care, the deceased's respiratory rate was apparently at barely five breaths per minute.[330] As noted by Dr Winterton in

[321] ts 233 – 234 (Boisson, W).
[322] ts 234 (Boisson, W).
[323] ts 235 (Boisson, W).
[324] ts 240 (Minett, C).
[325] ts 270 (Minett, C).
[326] ts 281 (Minett, C).
[327] ts 281 (Minett, C).
[328] ts 310 (Dr Wild).
[329] ts 310 (Dr Wild).
[330] Exhibit 1, Tab 10 [61].

oral evidence, there was really only one way to go if her respiration rate was to slow from that rate, namely to stop breathing altogether.[331] Therefore, if Dr Wild had told Mr Minett to watch the deceased's breathing as it slowed, it could be inferred that she was telling Mr Minett to watch as the deceased ceased breathing. This would be completely contrary to Dr Wild's evidence that she expected the deceased to recover fully from the overdose, with no ill effects.

166. Given that Mr Boisson's contemporaneous notes have, regrettably, been lost, I am left only with his best recollection. While I accept that the events of the night were unusual and, for that reason, Mr Boisson had a reasonably clear recollection even so many years on, his evidence taken at its highest was that the words said were to the effect of that statement. He also accepted it was possible something else was said by Mr Minett.

167. Mr Minett was vague as to what Dr Wild told him, but he did not recall her telling him anything matching exactly what Mr Boisson recalls him saying.

168. Dr Wild expressly denied making such a statement.

169. In those circumstances, I am unable to find that Dr Wild told Mr Minett to watch the deceased as her breathing slowed. The evidence is equally or more consistent with Dr Wild telling Mr Minett to monitor her breathing.

## AGREEMENT NOT TO CALL AN AMBULANCE

170. In her oral evidence, Joyce Plumb indicated that she was aware of a lasting request from the deceased not to be "put into the system."[332] She explained that by the system, she meant the public mental health system,[333] and that she understood the deceased's request to relate to any occasion where the deceased attempted suicide.[334]

[331] ts 206 (Dr Winterton).
[332] ts 142 (Plumb, J).
[333] ts 143 (Plumb, J).
[334] ts 142 – 144 (Plumb, J).

171. According to Mrs Plumb, the deceased had found previous experiences with mainstream mental health care, following previous suicide attempts, distressing and she did not believe she would find help for her mental health problems in that system.[335]

172. Mrs Plumb believed that this request was known to Sheree Minett, Margaret Bartlett and Dr Wild, being those people closest to the deceased and the people who would have the decision to make if she had taken an overdose. She did not, however, have a conversation expressly about this request with Dr Wild herself, and only believed the deceased had told Dr Wild but did not recall when.[336]

173. Mrs Minett gave evidence before Mrs Plumb, so she was not asked about her knowledge of such a request. However, Mrs Minett did give evidence that the deceased had not found her dealings with psychiatrists and psychologists satisfactory in the past.[337]

174. Mrs Bartlett agreed that she had a memory of the deceased making a lasting request not to be put into the mental health system again after going to Bentley Hospital.[338] However, Mrs Bartlett denied that she, or any of the deceased's other carers, had made a decision as to how to help the deceased in the future if she took an overdose[339] and did not recall ever discussing with the deceased whether an ambulance should be called, in the event she took a drug overdose.[340]

175. Dr Wild acknowledged that she was aware that the deceased thought seeking traditional psychiatric or psychological help was a waste of time and that she 'would rather die' than be admitted as a psychiatric in-patient.[341] Dr Wild did not recall having any discussion with Mrs Plumb, Mrs Bartlett or Mrs Minett about the

[335] ts 142 - 143 (Plumb, J).
[336] ts 144 (Plumb, J).
[337] ts 91 (Minett, S).
[338] ts 150, 154 (Bartlett, M).
[339] ts 151 (Bartlett, M).
[340] ts 159 (Bartlett, M).
[341] ts 300 – 301 (Dr Wild).

deceased's desire not to be hospitalised after an overdose, although she accepted it was possible she had.[342]

176. However, Dr Wild also gave oral evidence that she is personally opposed to suicide, assisted suicide and euthanasia, and is a signatory to a group of doctors called 'Medicine with Morality' who lobby politicians to support legislation valuing human life.[343] Accordingly, it was Dr Wild's evidence that, if she had understood that the deceased was in mortal danger on 28 September 2009, she would have called an ambulance even though she was aware of the deceased's desire not to be sent to a psychiatric unit.[344]

177. On the evidence above, I find that the deceased had a deep-seated fear of being admitted as a psychiatric in-patient in the public health system, and she had conveyed that fear to her carers and doctor. However, I also find that there is no evidence of an express agreement amongst the carers or with Dr Wild not to call an ambulance if the deceased attempted suicide by overdose. I accept that, on the basis of the evidence as a whole, the failure of Mrs Plumb, Mr Minett and Dr Wild to call an ambulance on 28 September 2009 was not related to any attempt to abide by the wishes of the deceased, but rather arose from their false belief that the deceased did not absorb drugs in the usual way, and hence could not die from a drug overdose.

## CONCLUSION ON CAUSE OF DEATH

178. I accept and adopt Dr McCreath's conclusion, as noted above, that the cause of death was multiple drug toxicity in a woman with coronary artery atherosclerosis.[345]

179. However, I also accept the evidence of Dr Joyce that the coronary artery disease was not the primary contributor

[342] ts 326 - 327 (Dr Wild).
[343] ts 313 – 314 (Dr Wild).
[344] ts 299, 300 - 301, 314 (Dr Wild).
[345] Exhibit 1, Tab 14 – Supplementary Confidential Report to the Coroner dated 15 June 2010.

to the death. Rather, the opiate toxicity, in particular the morphine toxicity, was the primary cause of death in the sense that, but for the acute overdose of morphine, the deceased would not have died at that time.[346]

## CONCLUSION ON MANNER OF DEATH

180. While it is not in dispute that the deceased took an acute overdose of morphine sometime in the morning of 28 September 2009, the state of mind of the deceased at the time she ingested the morphine mixture is unclear.

181. The circumstances in which the deceased took an overdose of codeine are even less clear, although Dr Joyce was able to determine that it was an acute overdose, rather than simply due to the deceased taking a bit too much medication over a few days.[347]

182. Around the time of her death in late September 2009, the deceased's husband and her carers had observed that the deceased's health was deteriorating significantly. Their views were borne out by the general evidence of Dr Wild as to the deceased's state of health in the month of September.[348] However, despite her deteriorating health, none of the witnesses believed the deceased was suicidal and was deliberately attempting to take her life on 28 September 2009.[349]

183. It is apparent that the deceased had taken drug overdoses on many previous occasions. While the deceased often expressed suicidal ideation and there was suicidal intention on many of the occasions when she had taken previous overdoses,[350] it was also understood by those close to the deceased that her intention was often equally to simply enable her to get some sleep, as she was chronically sleep deprived.[351]

[346] ts 173 (Dr Joyce).
[347] ts 187 (Dr Joyce).
[348] Exhibit 1, Tab 10 [37] – [50].
[349] Exhibit 2, Tab 19 [78]; ts 94 (Minett, S); ts 127 (Plumb, J); ts 160 (Bartlett, M);
[350] Exhibit 1, Tab 10, [17] – [18].
[351] Exhibit 1, Tab 7 [17]; Exhibit 2, Tab 21 [38]; ts 138 (Plumb, J); ts 298 (Dr Wild).

184. Further, as on each occasion the deceased had survived the overdose, it is possible that she may have been under the same misapprehension as Dr Wild and her other carers, namely that she could not take her own life by this mechanism.

185. An additional complicating feature is that the deceased's suicide attempts were often associated with an alter personality, as was the case on 28 September 2009.[352] It is difficult to assess the true state of mind of the deceased if she was, indeed, in an altered mental state at such a time.

186. Looking at the events of the day in question, Mrs Plumb's evidence was that when the deceased telephoned her in the morning, she identified herself as Suzie and told Mrs Plumb that she had taken a lot of medicine in order to help the deceased to sleep.[353] She then said to Mrs Plumb, "can you help us?" and agreed to Mrs Plumb's suggestion that Mrs Plumb call Dr Wild. That version of events does not point to an intention by the deceased to take her own life, even though the act of deliberately taking such an extraordinarily large amount of morphine would suggest otherwise.

187. Considering all the circumstances, I cannot determine whether the death arose from suicide or accident. Accordingly, I am obliged to make an open finding as to the manner of death.

## REFERRING DR WILD TO AHPRA

188. This case highlights the perils involved in doctors allowing the boundaries with their patients to become blurred.

189. By her own admission to the Tribunal, Dr Wild had failed to maintain proper professional boundaries with the deceased.[354] As a result, by September 2009, Dr Wild and the deceased were enmeshed in a relationship that

[352] Exhibit 1, Tab 7 [16]; Exhibit 2, Tab 22 [56].
[353] ts 126 – 127 (Plumb, J).
[354] Medical Board of Australia and Wild [2012] WASAT 37 [11].

crossed the usual boundaries and Dr Wild had lost her ability to be objective when it came to the care of the deceased.

190. Dr Wild's counsel submitted that there was no evidence led at inquest that would support the conclusion that Dr Wild's failure to call an ambulance on the day in question was due to the blurred relationship. However, Dr Winterton was expressly asked during the inquest about his reference to Dr Wild being enmeshed with the deceased's problems in his report.[355] He explained his use of the term, relating to Dr Wild's crossing of boundaries with the deceased, and noted that "it really does make it very difficult that when you're faced then with a critical decision you don't quite see it straight."[356]

191. Dr Winterton then went on further, in answer to a question about the consequences of Dr Wild's inability to view the deceased's case with appropriate professional objectivity, and he responded that the consequence was the events of that day in September 2009 and "the ultimate result", which I understood to be a reference to the deceased's death.[357]

192. Dr Winterton had a detailed understanding of the nature of the relationship between the deceased and Dr Wild, and of the events of 28 September 2009. I accept his evidence that the crossing of professional boundaries by Dr Wild affected her ability to view the deceased's clinical situation objectively and caused her to reach erroneous conclusions on that day from the information available to her and make the wrong decision.

193. On 28 September 2009, Dr Wild was called by Mrs Plumb and informed about the deceased's report of taking an extremely large morphine overdose. One might have expected Dr Wild to have called an ambulance to attend the deceased at that stage. However, she elected to attend the deceased at home, which was not in itself an improper approach to take given she may have had

[355] ts 193 – 194 (Dr Winterton).
[356] ts 194 (Dr Winterton).
[357] ts 195 (Dr Winterton).

some doubt as to the effect of the overdose on the deceased.

194. Once Dr Wild attended the deceased's home on the morning of 28 September 2009 and observed the deceased showing signs of sedation and morphine toxicity, proper medical management required her to ensure the deceased was breathing while summoning an ambulance to take the deceased to hospital, where her continuing safety could be assured and the overdose could be reversed.[358]

195. If she had done so, in the opinion of all the medical experts the deceased's death would almost certainly have been prevented.[359]

196. However, because of her inability to exercise clear clinical judgment in relation to the deceased, Dr Wild allowed herself to take false assurance from her knowledge that the deceased had apparently survived previous overdoses (although not of the same magnitude) and overlook the obvious signs that the deceased was experiencing morphine toxicity.[360]

197. By failing to recognise it was a medical emergency and to follow standard best medical practice in such circumstances, Dr Wild failed in her professional obligations and missed an opportunity to save the deceased's life.

198. She also left Mr Minett in the unenviable position of caring for his spouse in a medical emergency, without full knowledge of the circumstances and without the appropriate skills to deal with it. As a result, he was left in the distressing position of finding his wife deceased in her bed in the early hours of the morning and having to deal with the aftermath, including finding out that if he had thought to call an ambulance, he might have saved her.[361]

[358] ts 183 (Dr Joyce).
[359] ts 183 (Dr Joyce); Exhibit 2, Tab 26, p 1; ts 191, 197 (Dr Winterton).
[360] ts 327 (Dr Wild).
[361] ts 259 (Minett, C).

199. It was these failures that resulted in the Tribunal's finding that Dr Wild had acted carelessly in her care of the deceased and, taken in conjunction with other admitted conduct, led to the penalty of a period of suspension from practice.

200. As Dr Wild's counsel correctly points out in written submissions, the Board did not seek the more serious finding against Dr Wild in the Tribunal that she was incompetent.[362] I note that Dr Winterton referred in his initial report to Dr Wild admitting to acting incompetently on 28 September 2009[363] but I assume he was not using that term as it is defined in the *Medical Practitioners Act 2008* (WA).

201. Notwithstanding that Dr Wild had been the subject of the earlier proceedings, Counsel Assisting submitted that it was open for me to refer the evidence of the inquest to the Australian Health Practitioners Regulation Agency to allow it to assess whether there are any new matters arising during this inquest that it wishes to investigate.[364]

202. Although there was some potential, arising from the evidence of Mr Boisson and Mrs Plumb, to suggest that the original understanding of why Dr Wild failed to call an ambulance might be cast in some doubt, that evidence was of a limited nature and was not supported by the evidence of other witnesses.

203. On the whole of the evidence, I am satisfied that the evidence does not support an inference that Dr Wild failed to provide or request medical treatment for any reason other than her erroneous belief that the deceased could not die by way of drug overdose.

204. I accept Dr Wild's counsel's submission that the fact that she made admissions in the disciplinary proceedings in the Tribunal and gave candid evidence at the inquest, accepting the errors she made in the care of the

[362] Submissions to the Coroner on behalf of Dr Felicity Wild dated 5 May 2014, [7.20] – [7.22].
[363] Exhibit 2, Tab 27, p. 8
[364] Submissions filed on behalf of Counsel Assisting the Coroner dated 17 April 2014, p 31.

deceased on 28 September 2009, reflects insight.[365] Further, Dr Dunjey continues to supervise Dr Wild and considers her progress to be satisfactory and her insight to be good.

205. Accordingly, there would appear to be no practical purpose in referring the evidence obtained during the inquest to that agency, as it does not appear that any new evidence of significance has arisen. Dr Wild continues to be satisfactorily supervised in her practice of medicine and is unlikely to fall into similar error again.

## REFERRING TO THE DPP

206. Counsel Assisting submitted that it was open on the evidence for me to form a belief that an indictable offence has been committed in connection with the deceased's death.[366]

207. I have considered the evidence before me, and I do not consider that the evidence is sufficient for me to form a belief that an indictable offence has been committed in connection with the deceased's death by any person. Accordingly, I do not propose to refer the matter to the Director of Public Prosecutions.

S H LINTON
CORONER

15 May 2014

[365] Submissions to the Coroner on behalf of Dr Felicity Wild dated 5 May 2014, [8.1(e)] – [8.1(f)].
[366] Submissions filed on behalf of Counsel Assisting the Coroner dated 17 April 2014, p 32.