Coroners Act, 1996
[Section 26(1)]

Western *Australia*

RECORD OF INVESTIGATION INTO DEATH

Ref No: 07/13

I, Evelyn Felicia VICKER, Deputy State Coroner, having investigated the death of ***Ms D*** *with an inquest held at* ***Perth Coroner's Court, Court 51, CLC Building, 501 Hay Street, Perth*** *on* ***25 February – 1 March 2013 and 5-8 August 2013*** *find the identify of the deceased was* ***Ms D*** *and that death occurred on* ***10 May 2008*** *at* ***Hospital Angeles, Tijuana, Mexico, Central America****, as a result of* ***Septic Shock, Nosocomial Pneumonia in a woman with Acute Respiratory Distress Syndrome*** *in the following circumstances:*

Counsel Appearing :

Ms Melanie Smith assisting the Deputy State Coroner 25/2/2013 – 1/3/2013 and Mr Gary Cooper 5-8/8/2013
Dr Sharon Keeling (instructed by Phil Gleeson, Maurice Blackburn Lawyers) appeared on behalf of Ms D's husband and children and her sisters on 25/2/13-1/3/13
Mr Nicholas Egan (State Solicitors Office) appeared on behalf of Mother and Baby Unit, King Edward Memorial Hospital and Alma Street, Fremantle, Dr Brown, Dr Velayudhan, Ms Schipper, Ms Pierrie, Ms Bostwick & Ms Shepherd
Mr Dominic Bourke (instructed by MDA National) appeared on behalf of Dr Bassiri

SUPPRESSION ORDER

1.	**The name of the deceased not to be published**
2.	**The names of the deceased's husband, children nor any identifying feature or image to be published**

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INTRODUCTION

On 14 February 2008 Ms D (the deceased) was admitted as a voluntary patient to the Mother and Baby Unit (MBU) at King Edward Memorial Hospital (KEMH). She was given involuntary status on 18 February 2008. On 31 March 2008 the Mental Health Review Board (MHRB) removed the deceased from involuntary status and made her status voluntary under the Mental Health Act 1996.

On 1 April 2008 the deceased discharged herself from the MBU and was placed on a Community Treatment Order (CTO) by her treating psychiatrist. It was to be supervised by the Alma Street Centre, (ASC) Fremantle Hospital.

On 22 April 2008 the deceased flew to Mexico and on 28 April 2008 it appears she took a substance alleged to be butal (Pentobarbital). She was discovered in a comatose

state and taken to Hospital General de Tijuana before transfer to a private hospital on 7 May 2008.

She died at Hospital Angeles on 10 May 2008 with two of her sisters present.

The deceased was 39 years of age.

CAUSE OF DEATH

Dr Michele Martinez Franco of the Hospital Angeles issued a Mexican Death Certificate for the deceased on 10 May 2008 giving the cause of death as septic shock, nosocomial pneumonia and respiratory distress.

The ingestion of Nembutal would have led to respiratory depression which would predispose to the development of those conditions. Nembutal is a short acting barbiturate. In acute overdose it causes central nervous system and respiratory depression which can progress to coma, respiratory arrest and death. Maintenance of an adequate airway is required and pneumonia is a known complication.

There is no toxicology and the deceased was cremated in Mexico.

OFFICE OF THE CHIEF PSYCHIATRIST

The deceased died whilst still an involuntary patient under the *Mental Health Act 1996* due to the Community Treatment Order provisions. The office of the Chief Psychiatrist is required to investigate such deaths by way of an analysis of the clinical information. Dr Rowan Davidson completed an independent review of the deceased's care while an inpatient at MBU, and an outpatient on a CTO supervised by ASC. Dr Davidson also interviewed various participants in the deceased's care.

Family's Concerns

Following the death of the deceased in Mexico and the return of the sisters with her ashes, the family gradually managed to piece together the events preceding the deceased's death of which they had previously been unaware. While there were a number of issues of concern to the sisters it is probably fair to say the major issue as far as they were concerned was the constrictions the clinicians dealing with the deceased had felt themselves under with respect to the deceased's confidentiality.

The sisters undoubtedly felt had they not been so excluded, albeit at the request of the deceased, they would have been in a position to intervene successfully in the deceased's suicidal ideation for long enough to get her through the crisis around her death into a safer space. The

fact they knew nothing and were told nothing about the deceased that related to their efforts to keep the deceased safe in the first place has caused them ongoing grief and mistrust of public systems.

Review By The Chief Psychiatrist

The *Mental Health Act 1996* (the Act) requires a number of entities to be involved and apprised of events surrounding patients with involuntary status. While the deceased was on a CTO and not detained, she still had involuntary status under the Act due to the circumstances of the CTO. This was an extremely unusual CTO in that it did not relate to enforced depot medication, but rather was a tool by which it was hoped she could be monitored appropriately and integrated back into the community after a fairly substantial period of inpatient status.

Unfortunately it was not successful for all the reasons (mistrust of mainstream treatment, low self esteem, depression, sense of hopelessness) the deceased's sisters had been prepared to commit her to an appropriate facility in the first place. The sisters understood they would lose the deceased's trust in the short term. They desperately hoped that when she was well her trust would return and she would understand they had only ever acted to keep her safe because they loved and respected her as a sister, mother and person.

The Chief Psychiatrist undertook a review of the clinical issues culminating in the deceased's death in Tijuana. As a result of his review of the deceased's in-patient treatment by MBU/KEMH and her time as an outpatient of ASC the Chief Psychiatrist made eight recommendations with respect to improvements in the policies and procedures for the Mother and Baby Unit and nine recommendations to improve the Clinical Supervision of CTOs supervised by the Alma Street Centre.[1] I am satisfied both facilities have appropriately responded to the Chief Psychiatrist's recommendations and implemented them where possible.

Unfortunately it is my view, on all the papers I have reviewed, the issue of clinical judgment as to the appropriate ways to breach a person with involuntary status's confidentiality, and the decisions which are required to be made when the MHRB has changed the status of an involuntary patient still remain fundamentally unclear.

While this is not unexpected when one considers the competing interests which need to be balanced; for clinicians to have to make that valued judgement in fear of legal repercussions is inordinately difficult on top of the tensions already inherent in much of the clinical treatment

[1] Exhibit 1 Tab 41

which can be offered within the scope of s26 Mental Health Act 1996.

Confidentiality

One of the recommendations with respect to the MBU made by Dr Davidson related to a "consent form". Hospitals and associated facilities have procedures whereby they need to be informed of a patient's next of kin. When patients are of involuntary status it becomes somewhat complicated where the people most involved with a patient in the community may become those the patient is most mistrustful of whilst resistant to being in a facility.

In the case of the deceased the MBU initially had the deceased's sister, as her next of kin. There was also a notation her husband was to be a local contact in a different handwriting. It was the evidence of everybody, including her husband, the deceased's perception of her next of kin changed following her involuntary status on 18 February 2008. From that time on she gave quite repeated and specific instructions she did not wish the staff to provide her sisters with any information. While this had not been noted on a formal consent form, which the recommendation now suggests, it is clear had the consent form existed at the time of the deceased's involuntary status she would have quite specifically withdrawn consent for information to be provided to her sisters but allowed it

for her husband. She was clearly competent to make that decision. This makes the further recommendations with respect to the release of the information in circumstances of risk of harm (the public interest) as unclear as it was at the time of the deceased's inpatient stay.

The provisions of section 206 of the *Mental Health Act 1996* (doctor patient confidentiality) remain, and the provisions of the *Carers' Recognition Act 2004* do not really assist. While I accept Dr Davidson did consider the sisters to be carers within that Act due to their commitment to the deceased and her children, it is clear the deceased did not. To MBU it was her husband who was responsible for the children's care and the best compromise with respect to MBU was to breach the deceased's confidence by providing information to her husband in her presence.[2]

This raises the frustrating issue of whether a person acceptable to the patient as a recipient of information is prepared to accept that responsibility. The deceased's husband was clear he felt himself a carer for the children, but not the deceased. He consistently said he assumed the information provided to him would have been provided to the sisters or, at the very least, did not think about whether it would have been provided to the sisters. I do not believe the information in "carers guide to information sharing with

[2] t 8.8.13 p814

mental health clinicians" and "communicating with carers and families" solves this issue for clinicians. There needs to be more clarity and that clarity needs some legislative basis which both patients and clinicians understand.

Similarly, with respect to the MHRB provisions which require notification to MHRB of any person with involuntary status and the terms and conditions of CTOs for outpatient involuntary status.

There is no doubt the deceased's sisters acted in the deceased's best interests. If it is to be recognised parties such as the deceased's sisters are to be viewed by practitioners as people to whom information can be provided, then there should be a requirement, reflected on both consent forms and in the notification forms to the MHRB, people acting in a person's best interests to have them assessed for involuntary status which is then confirmed after assessment, should be persons notified of hearings where that patient's involuntary status is reviewed.

The nominated people would have to be prepared to accept that responsibility, and the patient would need to understand that nominated persons would be notified by statute or regulation of reviews by the MHRB as to their status.

Alternatively the notices of review from MHRB to a patient and the supervising facilities should carry a stipulation that those involved in the patient's ongoing involuntary status must be notified of the hearing.

Such a provision would have allowed Dr Brown to still only discuss the deceased's private information with her husband, and so not breach the deceased's confidentiality with respect to her sisters and so maintain a therapeutic relationship; but the deceased would have understood that at the MHRB hearing one of her sisters would have been notified as to the hearing, would be able to attend, and would then understand the material upon which the MHRB made its decision, as well as hearing the input from the treating clinicians.

The deceased would also understand clinicians had no option but to provide factual information for the review hearing which would also inform those who had cared for her in the community and present at the hearing as to her current situation.

The competing tensions around patient confidentiality as they stand currently make it extremely difficult for those involved in an involuntary patient's care to reconcile the conflict between sharing information with family members

and their duty of care and the restrictions placed upon them by law, privacy issues and health services policies.

I appreciate clinicians would be resistant to this type of legislative reform but it would provide clarity in what I accept are difficult competing clinical judgments and the interface with patient confidentiality.

Risk Management

Dr Davidson succinctly pointed out the deceased's medical files reveal an inordinate number of risk factors with respect to the deceased.[3] Those related to both the deceased's welfare, that of her children and to some extent, that of her husband and other family members.

In addition, her deep mistrust of conventional mental health facilities caused her to be evasive and mistrustful of regimes put in place by those facilities to care for her. One of the very reasons the deceased's sisters chose MBU for care of the deceased was the fact it was not as restrictive as other facilities and did allow a level of freedom which they felt would encourage the deceased to accept treatment. The sisters were attempting to provide the deceased with some dignity in her need for care, as they clearly understood too regimented a form of supervision would cause the deceased great distress. Ultimately it became apparent

[3] Exhibit 1 Tab 41 p9

the deceased only appeared to submit to supervision, rather than accept supervision.

The deceased was, for all those reasons, a very difficult person for whom to provide appropriate care. If the deceased was to be afforded any dignity there was always an increased risk, and for that reason there needed to be much more risk management awareness around her CTO. The case of the deceased has almost proved a CTO is not an appropriate form of supervision for a person exhibiting her particular characteristics. However, there are no alternatives where it is desirable to provide some form of monitoring in the event MHRB is correct in determining further restriction would be detrimental to a patient's progress.

The very fact of Dr Brown's concern and her extensive oral handover to Dr Ajay Velayudhan indicate this was an unusual case and therefore it was a case which required unusual supervision. In view of the fact there are few CTOs with such complicated antecedents I would suggest in future a CTO issued after a change of status by a MHRB hearing be treated as an emergency presentation for the purposes of the supervising Community Mental Health Service and warrant an urgent assessment to serve as a baseline for future assessments.

The CMHNs monitoring the deceased in the community commented on how unusual the whole circumstances of the deceased's supervision in the community was from their perception of the normal situation. I accept they felt they needed to build a therapeutic relationship but, the fact of the unusual circumstances should, in future, warrant an urgent review by the supervising psychiatrist after such a detailed and concerned handover. The provision of a written risk management plan would then follow for the benefit of the nurses.

In the deceased's case it would have been useful for there to be an ability to hold her passport while subject to a CTO. In view of the fact her perceived plan involved overseas travel, when the need arose to place her on a CTO it would have been preferable her supervising clinicians be in a position to intervene in her passport use. The information from the Australian Federal Police with respect to the ability to place an alert on travel facilities states it is only effective if the travel plan is imminent.[4] Once the dates of the deceased's itinerary had past, it would not have been possible to maintain an indefinite alert with respect to any prospective travel, nor desirable.

I accept it was not necessary for the deceased to travel to complete suicide but the indications were travel was what

[4] Exhibit 7

she planned, in the event she would put any plan into action. I note the current terms for CTOs do not allow any restriction on a person's movements provided they can be monitored and medicated.

On the facts of this case it seems the deceased's plans for travel were part of her attempts to reconcile with her husband. She knew he was aware of the implications of her plans with respect to travel. He was the one person she informed of the extent of her travel plans, and later her true location. The ability to travel was therefore a risk with respect to the deceased in conjunction with the other risk factors present.

I have not made recommendations to the effect of mandatory notification of persons involved in a patient receiving involuntary status to MHRB; or the holding of passports where such patients reveal plans inherently dependant on travel because they are very restrictive and likely to be resisted by clinicians and patients alike.

However I consider some discussion as to policies around these topics should occur due to increased use of CTOs for community supervision.[5]

[5] t 7.8.13 p772

CONCLUSION AS TO THE DEATH OF THE DECEASED

I am satisfied the deceased was a 39 year old mother of four, who well understood the mental health system due to her being both qualified for, and having worked in, facilities concerned with the treatment of mental illness. I accept Dr Brown's diagnosis of a depressive illness in conjunction with Cluster B personality traits and agree those issues were factors with which the deceased struggled for much of her adult life.

The deceased had become unwell in 1996 but had been nursed back to health by one of her sisters who provided her with support and a framework. When the deceased became a mother she dedicated her life to providing her children with a safe and nurturing environment but was unable to fully resolve her depressive tendencies.

The deceased was clearly a loving mother and very close to her sisters. Due to her illnesses she was very concerned she would not be able to care for her children in the holistic way she wished and became depressed and demoralised at her perceived lack of ability to live life as she wished in a complete happy family unit.

In 2008 the deceased experienced a number of stressors which exacerbated her illness and she deteriorated to the point of not being able to cope with the proper

maintenance of her family. This exacerbated her depression. Her sisters became extremely concerned and attempted to offer her support which they realised would require specialised and independent professional input.

The deceased's sisters researched available facilities and discovered MBU which attempted to respect the freedom of the patient while still providing support and assistance. While the deceased was initially resistant to conventional treatment she was persuaded MBU may be an alternative to the sorts of treatment she had experienced when employed.

The deceased agreed to become a voluntary patient but clearly found the experience intrusive. She attempted to discharge herself but was persuaded to take leave. It is doubtful she intended to return, however, she was still unable to care for her family appropriately in the community and, on an assessment at her home, the clinicians from MBU had no difficulty in accepting that the deceased needed involuntary status in an attempt to treat her illness and improve her functioning.

The deceased appeared to comply with treatment and supervision but it is likely she believed appropriate behaviours would enable her to leave that environment more rapidly than if she continued to reject attempts to

help her. It is not clear the deceased ever properly accepted she was in need of help, but rather hoped she could use the circumstances to involve her husband more in her own life, rather than just that of the children.

The deceased well knew how to mask her real presentation with a façade of seeming to comply with treatment. The fact the practitioners in MBU understood this was probably more of an impetus to the deceased to remove herself from their observation. Her opportunity came when the MHRB notified her of their routine review of her status. Due to her restrictions on the provision of information to her sisters the deceased would have understood it was very unlikely her treating clinicians would involve her sisters due to their perception it would affect her progress.

The deceased used the hearing at the MHRB to convince the members she was quite rational and able to make appropriate choices for her wellbeing. She effectively convinced the MHRB she would be better off without the restrictions imposed by her involuntary status.

Her involuntary status was removed.

Having removed herself from involuntary status the deceased understood as a voluntary patient she would be

free to discharge herself regardless of her undertakings to the MHRB.

Dr Brown, in an attempt to provide some control over the deceased's treatment and not understanding she could, or in her own words even should, return the deceased to involuntary inpatient status following location of traveller's cheques, put into action plans she hoped would protect the deceased. A CTO to be supervised by ASC was put in place.

Dr Brown's plans to involve her husband certainly protected the children. Dr Brown was not to know her husband would entirely disregard the request for the deceased not to have the baby. Dr Brown certainly did her best and one of the outcomes appears to have been to force the deceased to see the baby as a separate person. No harm came to the baby or the other children.

A CTO is generally used to enforce monitoring and medication by way of depot injections. The fact the deceased had said she would comply with oral medication was something of which the ASC Fremantle supervising nurses were aware and attempted to ensure compliance on their visits. The number of tablets was relatively consistent with the deceased's regime and therefore not

an obvious non-compliance the nurses could identify other than the deceased developing signs she could not mask.

I speculate the deceased found CMHS Shepherd more sympathetic than CMHN Bostwick and was insistent she wished for an appointment so she could be removed from the CTO and wished, pending that appointment, to only be visited once a week by Nurse Shepherd.

The nurses continued with biweekly meetings but the deceased was not urgently assessed by her supervising psychiatrist, and no written risk management plan was put in place with acknowledgement of her specific risk factors. When the deceased advised she wished to go "down south" she was not challenged openly about her plans because they appeared to be positive indications she was improving in the community. There is no evidence an urgent review or written risk management plan would have altered the impression she was reacting adequately.

The fact she rang to advise ASC of her plans to travel down south following a home visit would imply she knew their perception of her was that she was improving in the community with the rebuilding of social contacts.

In reality it seems the deceased was becoming more insistent with her requests to her husband for reconciliation.

There was no contact between her supervising community mental health team and the deceased's husband with respect to issues for the deceased and the children, and the deceased was free to continue with her attempts at persuading her husband to reconcile without restraint.

The fact there had been no contact with her sisters since her discharge probably indicated to the deceased her sisters were unaware of the fact she was in the community. It is likely the deceased was concerned her husband would need to involve them further in caring for the children should she remain on involuntary status albeit in the community.

It was probable she wanted reconciliation to occur to maintain an independent family unit without assistance from her sisters. The implication is there always was a plan on her behalf to travel to Mexico and use that as a reason for her husband to consider reconciliation. It is likely her intention originally was to obtain the Nembutal she understood was available there, and return to Australia with the option of being able to suicide if and when circumstances were such she believed it to be her only alternative.

Unfortunately, I believe the circumstances of her deteriorating function whilst in the community,

exacerbated by the travel, and her telephone conversations with her husband and the children caused the deceased to believe her long term circumstances would not improve and that her option was then suicide. I appreciate comments by Dr Brown it may be the deceased overdosed with the intention of being discovered and "saved" prior to being irretrievable, but note also her sisters' description of the deceased's anger at attempts to extend her life once she became conscious in hospital in Tijuana.

It is unclear whether having told her husband she was in Mexico the deceased expected him to either agree to reconcile, or go to Tijuana himself. The fact she was located whilst still alive, and on regaining consciousness observed her sisters to be there, may indicate she finally understood there would be no reconciliation in terms of a single family unit, and she believed she would not be capable of maintaining the family as she wished it to be with the co-care arrangements already in place.

There is no doubt from the description of the sisters that once the deceased understood she was still alive she made every attempt to ensure that the suicide she had attempted was successfully completed.

I find death arose by way of suicide.

SUPERVISION, TREATMENT AND CARE

The deceased was an intelligent and knowledgeable individual with direct experience of the Mental Health system in this state. Her time as an occupational therapist had made her deeply resistant to conventional medication and hospitalisation with the result she had to rely on accepted wellbeing measures without other clinical support. There is no doubt the deceased suffered from a variety of recognised mental health issues. The fact of her, at times, major depression is by itself a major risk factor for suicide. In addition, the deceased had Cluster B personality traits which are not wholly susceptible to medication.

Dr Brown, who I would suggest was the clinician with the best understanding of the deceased's illnesses was not of the view the deceased, under normal circumstances, had a level of depression that would lead to suicide on its own.[6] Nor is it necessary to be depressed to carry out a successful suicide. This court sees many examples of impulsive suicides based on a person's perception of their life at a particular time without any indication the person suffered depression. Certainly the fact of depression added to certain life stressors would exacerbate the risk of a successful suicide.

[6] t 28.2.13 p476

Dr Brown was of the view the deceased reached a decision, based on information about her life that she felt was no longer worth living, in the circumstances that she was faced with on her release from MBU. The deceased had abandoned her sisters which meant she became completely reliant upon her children and her husband to promote her wellbeing. It is clear the deceased was devoted to her children but wanted to provide them with a stable family unit by the return of the father figure, her husband, to that unit.

Consistently the deceased had allowed conversations between the clinicians and her husband which she had not permitted with her sisters. On occasions when her sisters visited she would not see them, or only see them in difficult circumstances, and on the occasion of the baby's birthday appeared distraught when arrangements were made for one of her sisters to take her to the venue rather than her husband.

On her change to voluntary status following MHRB review, and following release under a CTO, she had been present when Dr Brown advised her husband of the evidence they had of a potential suicide plan, although the deceased minimised its import. The deceased's husband was the one person who knew everything about her plans and was the person she maintained contact with once she returned to

the community due to the arrangements with the children keeping her involved with her husband on a daily basis. He was the one person who knew the extent of the information available about her and the clinicians concerns for a plan, and he was the one person she kept informed of her travel plans once she had left Australia. She knew he knew the background of that travel.

Dr Brown was of the view it wasn't the deceased's depression that was leading to her negative and suicidal thoughts, but rather she had reached a decision based on information about her life which she felt was no longer worth living. That decision wasn't all from the negative condition attributable to a depressive disorder.

Dr Bassiri also gave evidence to the effect the deceased continued to express concern about being identified as having a mental illness which further exacerbated any depression. Dr Bassiri considered depression to be more of a medical diagnosis which is treatable while stigmatisation and demoralisation is really a sense of hopelessness and negative judgment which may be outside the field of psychiatry and certainly is less amenable to treatment, certainly by way of medication.[7]

[7] t 27.2.2013 p277

Every single mental health practitioner involved with the deceased reported she was difficult to engage and evasive and did not always tell the truth. She gave excuses or reasons for her travel plans and traveller's cheques and, as stated by Dr Brown, a person cannot be forced to tell the truth, and lying is not a criterion under the Mental Health Act for involuntary status.[8] While all the mental health practitioners wished to establish trust and rapport with a view to building and then maintaining a therapeutic relationship none of them felt this had been successful despite their best efforts. The attempt to build and maintain a therapeutic relationship was a common thread between institutions as to why there was a desire not to breach the deceased's confidentiality with respect to her sisters in particular.

Despite Dr Davidson's review of the clinical care of the deceased and the recommendations which arose from that review there were no identifiable factors which stood alone in implying her care did not fall within acceptable levels.

Under the legislation by which the clinicians were bound, and the lack of clarity with respect to the involvement of the deceased's sisters I am of the view the deceased's

[8] t 28.2.13 p 459

supervision, treatment and care while at MBU was appropriate.

It was the very fact of the more open style of treatment which allowed the deceased to have some freedoms and feel less restricted which attracted the sisters to MBU. Unfortunately, I suspect even the minimal intrusion caused the deceased considerable angst and therefore the impetus to both mask and evade effective engagement towards any proper treatment. It is impossible for clinicians to overcome this. Factually those caring for her at MBU were alert to her evasiveness and did intrude on her privacy by searching her room and locating items which alerted them to her plans. She was confronted with that planning and denied the reality of her situation. While further evidence of a lack of engagement, it is also a lack of engagement about which the clinicians could do very little.

The transcript from the MHRB hearing is quite clear in evidencing Dr Bassiri's attempts to alert the Board to the MBU's concern with the deceased's ability to plan in secrecy. This was further clear from the deceased's file which was available, and was noted to have been available for review. It is unfortunate the report did not arrive at the Board prior to the hearing, however, I note Dr Bassiri offered to make it available to the members at the

hearing, and certainly conveyed the content to the report in her evidence.

The Board may not have placed any more weight on the written report than they did to the discussion they engaged in with Dr Bassiri. The deceased completely convinced the Board of her appropriate and understandable difficulties with involuntary status. She sounds entirely plausible. There was little to support involuntary status under s26 Mental Health Act 1996 on her presentation at the hearing.

The fact the deceased was able to present so "normally" does emphasise the difficulty for the MBU, and Dr Brown specifically, being so ambivalent over whether it was the restrictions imposed by inpatient involuntary status which was contributing to the lack of significant improvement whilst in that environment. I can well understand Dr Brown's concerns the deceased may be able to function appropriately in the community, if not constantly guarding herself from review by clinicians. That dichotomy made Dr Brown's decision to extend involuntary status but in an outpatient environment entirely understandable.

The selection of the CTO as an option is explicable.

The difficulty arises with the then perception of any supervising community mental health service as to the

need for a CTO where a patient is apparently agreeable to all the terms it imposes.

While early review would have been preferable it is still not clear the deceased's ability to mask her true presentation would have allowed Dr Velayudhan to understand the deceased's real circumstances. It was still the case the deceased was trying to reconcile with her husband and any plan she had for suicide appears to have been a contingency, rather than a certainty.

Consequently, while the deceased's supervision, treatment and care while in the community was not optimal; it would seem that was more due to the systems available for community supervision and resource issues, than a lack of care. There is nothing to suggest the care provided was below accepted practice at that time.[9]

Even with more clarity around patient confidentiality issues, personal dignity within the scope of the Mental Health Act 1996, and ongoing comprehensive risk assessment, the inability for practitioners to engage with the deceased in a meaningful way is unlikely to have given any good indication of precisely when a contingency plan became a positive course of action.

[9] t 7.8.13 p 820, p825

I accept the sisters' view the deceased could have been physically prevented from suiciding at any one point in time had she been under constant supervision while so unwell. However, the systems in place have to allow for the fact that being constantly under supervision for some patients may be the catalyst which prevents their ability to recover at all and so survive in the community.

The outcome for all concerned in this case is tragic, but one thing is clear. The deceased ultimately trusted her sisters and her husband with the most precious things in her life; her children. The fact she loved them and grieved for her loss of them is self evident in her suicide notes. She would have known her family would love and care for them in her absence.

E F VICKER
ACTING STATE CORONER

October 2013