Coroners Act 1996
[Section 26(1)]

Western *Australia*

AMENDED RECORD OF INVESTIGATION INTO DEATH

Ref No: 4/17

I, Barry Paul King, Coroner, having investigated the death of ***Annette Silver*** *with an inquest held at* ***Perth Coroner's Court*** *on* ***19 January 2017****, find that the identity of the deceased person was* ***Annette Silver*** *and that death occurred on* ***2 January 2015*** *at* ***the train line between Queens Park Station and Welshpool Station in Bentley*** *from* ***multiple injuries*** *in the following circumstances:*

Counsel Appearing:

Mr J T Bishop assisted the Coroner
Ms C A Chapman (State Solicitor's Office) appeared on behalf of the Bentley Health Service

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INTRODUCTION

1. On 2 January 2015 Annette Silver (the deceased) was killed when she placed herself into the path of an oncoming Transperth railcar in Bentley.

2. The deceased's death was a 'reportable death' under section 3 of the *Coroners Act 1996* (the Act) because it 'appears to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from injury'.

3. Under section 19 of the Act, I had the jurisdiction to investigate the deceased's death because it appeared to me that the death was or may have been a reportable death.

4. As the deceased was an involuntary patient within the meaning of the *Mental Health Act 1996* at the time of her death, she was a 'person held in care' under section 3 of the Act.

5. Section 22(1)(a) of the Act provides that a coroner who has jurisdiction to investigate a death must hold an inquest if the death appears to be a Western Australian death and the deceased was immediately before death a person held in care.

6. An inquest to inquire into the death of the deceased was, therefore, mandatory.

7. On 19 January 2015, I held an inquest at the Perth Coroners Court into the deceased's death. The evidence adduced at the inquest comprised documentary evidence and oral testimony. The documentary evidence consisted of an investigation report and associated attachments prepared by Senior Constable Claire Lyons of Coronial Investigation Squad in the Western Australia Police.[1]

[1] Exhibit 1

8. Oral testimony was provided by:

   a) Dr Winston Choy, one of the deceased's treating psychiatrists;[2] and

   b) Dr Darryl Bassett, a consultant psychiatrist and clinical associate professor who had provided the Court with an independent report[3] of the deceased's management.[4]

9. Under section 25(3) of the Act, where a death investigated by a coroner is of a person who was held in care, the coroner must comment on the quality of the supervision, treatment and care of the person while in that care.

10. I have found that the supervision, treatment and care of the deceased was reasonable and generally appropriate in the circumstances.

THE DECEASED

11. The following background information about the deceased comes primarily from a record made by Senior Constable Lyons of a conversation she had with the deceased's sister Paula Redeckis (Paula) on 3 January 2015.[5]

12. The deceased was born to Fay and Albert Crane in Subiaco on 17 May 1967, making her 47 years old when she died. She was the youngest of her parents' seven children.

13. The deceased married Ian Silver in 1992. She and Mr Silver were both active members of Jehovah's Witnesses.

[2] ts 5 – 24 per Choy, W
[3] Exhibit 1, Tab 13
[4] ts 24 -39
[5] Exhibit 1, Tab 9

14. In 2003 the deceased displayed signs of anxiety and panic attacks, which increased leading up to a planned move to the United Kingdom with Mr Silver. She then suffered a significant episode in which she attempted suicide. She received treatment and resumed her usual activities.

15. 2011 the deceased and Mr Silver moved to Germany. In April 2012 Mr Silver told the deceased that he no longer wanted to be married to her or to be a Jehovah's Witness. Their relationship began to break down, and he moved out of their apartment in December 2012.

16. In October 2013 the deceased returned to Perth. She initiated divorce proceedings, which became final in December 2014. She blamed herself for the breakdown of her marriage.

17. The deceased lived alone and worked as a claims consultant with an insurance company.

18. The deceased saw a doctor at a medical clinic in Dianella on 27 October 2014 when she requested medication for anxiety. She was prescribed citalopram and temazepam. She attended three days later complaining of increased anxiety and her doctor noted that she had been taking the citalopram at night rather than in the morning.[6]

19. The deceased returned to her doctor on 4 November 2014. She was still not happy with the effects of the citalopram. The doctor referred her to a psychologist at the medical clinic.[7]

20. After returning to Perth, the deceased had met another man who became a close friend, but this friendship broke down in late October 2014 and the man stopped communicating with her.

21. On 30 November 2014 the deceased attempted suicide by overdosing prescribed temazepam. Her sisters found her

[6] Exhibit 1 Tab 12
[7] Exhibit 1 Tab 12

after being unable to contact her. She had left them a note in which she stated that she could not live with herself and that they were better off without her.[8] They called for an ambulance and she was taken to the emergency department at Royal Perth Hospital for treatment before being transferred to Bentley Hospital on the same day.

THE DECEASED'S ADMISSION TO BENTLEY HOSPITAL

22. Unless otherwise indicated by way of a footnote, the following information was obtained from the deceased's medical records at Bentley Hospital.[9]

23. On 30 November 2014 the deceased was admitted into an open ward at Bentley Hospital with a diagnosis of depression and anxiety. Bentley Hospital had two open wards and one secure, or locked, ward.

24. In an initial interview, a medical registrar formed the impression that the deceased had adjustment depression with secondary anxiety/depression and made a plan to re-start the deceased on a new antidepressant, given a query about the efficacy of citalopram, and to refer the deceased to a psychologist for psychotherapy.

25. On the next day, the deceased was reviewed by a treating team consisting of a registrar (the registrar), a psychiatric intern (the intern) and a mental health nurse. She told the team that she had been on citalopram in the past but had taken herself off it. She also said that she had been seeing a psychologist and that she found it helpful. The team re-commenced her on citalopram at her preference, and encouraged her to engage in occupational therapy. She was given quetiapine as required that night.

26. On 2 December 2014 Dr Choy reviewed the deceased and formed the impression that she had experienced a major

[8] Exhibit 1, Tab 19
[9] Exhibit 1, Tab 19

depressive episode with cluster C personality traits. After the review he met with her and her sisters. The plan at the time was to keep her as an inpatient for a short while, to change her medication to mirtazapine, and to plan her discharge to stay with a sister with follow up by a private psychiatrist.

27. Over the next three days the deceased's condition appeared to improve. She had ongoing anxiety, but it appeared to be manageable. She wanted to get back to work and to get on with life. On 5 December 2014 the registrar reviewed her and discharged her, but the deceased did not seem to be aware that it had occurred. She called her sister Susan Bellussi (Sue), who attended and expressed concerns about discharging the deceased given her high level of anxiety.

28. As a result of Sue's concerns, the deceased was offered weekend leave with her family, with the option to return early if she was not feeling comfortable. The deceased and her family agreed to that plan.

29. On 8 December 2014 the deceased returned to Bentley Hospital with her sisters Sue and Paula. They reported that she had experienced a melt-down after learning that her employer wanted her to come back to work and that she told them that she wanted to die and could not go on with life.

30. The treating team determined that the deceased would not be discharged, that she would be prescribed a further antidepressant, venlafaxine, in the mornings and that she would be reviewed by a consultant psychiatrist.

31. On the next morning, the deceased refused her medications and requested that she be discharged. Dr Choy reviewed her and informed her that she could be discharged later that week but that, if she wanted to stay, she would have to accept further medication. She was to talk with her sisters to work something out. The venlafaxine was ceased.

32. On the morning of 10 December 2014 the deceased's multi-disciplinary team met. The notes of the meeting record that the clinical psychologist said that the deceased had been more disclosive over a number of sessions, indicating that the deceased had been receiving psychotherapy during her admission. There are no records of that treatment.

33. On the afternoon of 10 December 2014 the deceased's sister Sue contacted Bentley Hospital and informed nursing staff that the deceased had called her family to say goodbye because she wanted to go back to her unit, not necessarily to kill herself but to 'leave it all behind'. The intern was concerned about the deceased saying goodbye, so placed her on a Form 1 under the *Mental Health Act 1996,* meaning that she was made an involuntary patient pending review by a psychiatrist. She was placed on 15 minute observations, so she would be visually observed every 15 minutes and, if she absconded and was not readily found, she would be declared absent without leave (AWOL) and police would be notified to apprehend her.

34. Dr Choy reviewed the deceased the next morning and placed her on a Form 6 under the *Mental Health Act 1996*, making her an involuntary patient until 7 January 2015. He noted that she had said that she was devoid of all emotion. He maintained the 15 minute observations.

35. That afternoon, 11 December 2014, Dr Choy and the treating team met with the deceased's three sisters and discussed the deceased's status under Form 6 and her recent increase in medication. The deceased's sisters were happy that the deceased was now 'unable' to leave the hospital, but the deceased was still in an open ward.

36. The next morning the deceased appeared pleasant and compliant, but then left the hospital sometime after 10.00 am and was not seen again that day. The hospital grounds were searched without success, she was declared AWOL and police were notified.

37. At 2.10 pm on 13 December 2014 the deceased presented by herself at the triage area of Bentley Hospital. She said that she had left the hospital in order to end her life, but realised that she could not. She had caught a bus to the city and had walked around. She had slept on the second storey of a house under construction. She was still ambivalent about the future.

38. The deceased was transferred to the secure ward and was placed on 15 minute observations.

39. On Monday 15 December 2014 the deceased was reviewed by a different psychiatrist, Dr Stevens, because Dr Choy had gone on leave. Dr Stevens noted that the deceased was anxious and had absconded with an intention to jump off of Shelley Bridge but realised that it was not high enough. She felt like she had no future and was not worthy of support. Dr Stevens considered that she had a depressive disorder with a possible background of Cluster C personality traits, and that she was at risk of further self-harm. He kept her in the secure ward.

40. From 15 December 2014 the clinical psychologist who had been providing the deceased with psychotherapy was on leave, and no cover was provided.

41. On the next day Dr Stevens reviewed the deceased on a ward round and noted that she remained depressed and anxious. He kept her on 15 minute observations and instructed that she could have escorted ground access.

42. On 17 December 2014 Dr Stevens, a psychiatric registrar and a mental health nurse reviewed the deceased. The deceased appeared almost delusional in relation to her derogatory view of herself. Dr Stevens' impression was of major depression. He kept her in the involuntary ward out of concern for her safety given her current mood.

43. Over the next few days the deceased's mental state appeared to improve, though her anxiety was still evident

and she was very negative about herself and was not future-oriented. She began to request that she be transferred to an open ward.

44. On 25 December 2014 she was allowed to leave the hospital for the day in the company of her sister Paula. The day went well, and the next morning she said that she felt that she was progressing and was making plans for the future.

45. On 26 December 2014 an acutely unwell patient required a bed in the secure ward. The deceased was seen by a duty registrar, who noted that she was guarded but bright and superficially reactive.[10] The registrar's impression was that the deceased was at moderate to high risk due to her guardedness about her mood, but that it was appropriate, in the context of the need to find a bed for the other patient, for her to be transferred to an open ward. The transfer occurred that evening.

46. Over the next three days, the deceased was kept on 15 minute observations for absconding from the open ward. She remained anxious but pleasant and reactive. She wrote a 'confession' in which she stated that she did not have depression; instead, she did not care about anyone or anything and had attempted suicide to escape life's responsibilities. She ended the confession by stating that she was despicable.

47. On 30 December 2014 the deceased was reviewed by the registrar and the intern. She indicated that she was feeling better and was a little less anxious. They asked her about her confession and she said that she was not convinced that she had depression. They, in turn, were not convinced that she no longer felt that way. They raised the idea of electro-convulsive therapy (ECT) with her. She said that she knew a bit about it and did not want it. She thought that time would improve her. She denied any suicidal thoughts.

[10] ts 11 and 20 per Choy, W

48. Later that afternoon the deceased was reviewed by a senior psychiatrist, Dr A Jaworska, and the registrar. The deceased said that her mood was good, and she was superficially pleasant and reactive. She displayed no psychotic symptoms and denied suicidal or self-harm thoughts. She felt that she was more like herself and more interactive. She described her mother as having had depressive symptoms and having been treated with ECT.

49. Dr Jaworska directed that the deceased could go on day leave with her sister the next day and that observations could be decreased to every 60 minutes. The deceased was not to have ECT at that stage.

50. On 1 January 2015 the deceased went out with Paula with plans to see a movie. She returned as planned and said that her mood was good. She appeared depressed and was considered to be an ongoing suicide risk, but showed no sign of psychosis.

51. On 2 January 2015 the registrar determined that the 60 minute visual observations of the deceased could cease, meaning that she would be under two-hourly observations. She spent much of the day at occupational therapy and interacted well with other patients, though her affect appeared to be restricted.

52. In the evening on 2 January 2015 the deceased told one of the nurses that she would like to go home in the foreseeable future, but not immediately. She denied suicidal or self-harm ideation, and said that she could not remember the last time she had any. That evening the deceased left the hospital for the last time.

EVENTS LEADING UP TO DEATH

53. At 7.00 pm on 2 January 2015 a security nurse saw the deceased walking in a garden area of the hospital grounds. At that time of the evening, observations were

carried out hourly. About half an hour later, another patient saw the deceased walking in the direction of the train station.

54. When she was not seen in the ward at 8.10 pm, the nurse in the ward spoke to the security nurse and they began to search for her. They spoke to the patient who had seen her and notified the duty medical officer that she was missing.

55. She was declared AWOL at 8.30 pm. Police were notified and the deceased's sister Paula was informed.

56. At about 7.55 pm on 2 January 2015 the deceased stood in the path of an on-coming Transperth railcar travelling from Queens Park Station to Welshpool Station. She had her back towards the railcar, her head bowed down and her arms folded across her chest. The railcar driver sounded the horn and applied full brakes but the railcar struck the deceased and travelled a further 150 metres.[11]

57. Police and ambulance officers attended the scene but the deceased was clearly dead as a result of the injuries she had sustained.

58. Bentley Hospital staff later discovered that the deceased had left a note in her room, in which she had written 'I'm Sorry. Things are not always as they seem. I wish they were.'[12]

CAUSE OF DEATH

59. On 6 January 2015 Chief Forensic Pathologist Dr C T Cooke conducted a post mortem examination of the deceased's body and found severe widespread injuries, with multiple fractures of bones and internal bleeding associated with extensive injuries to the body organs.

[11] Exhibit 1, Tabs 14 and 5
[12] Exhibit 1, Tabs 6 and 8

60. Dr Cooke formed the opinion, which I adopt as my finding, that the cause of death was multiple injuries.[13]

HOW DEATH OCCURRED

61. The circumstances in which the deceased was killed indicate that she caused her own death with an intention to do so. That she was capable of forming that intention despite her mental illness was confirmed by Dr Choy and by Dr Bassett.[14]

62. I find that death occurred by way of suicide.

COMMENTS ON THE TREATMENT, SUPERVISION AND CARE OF THE DECEASED

63. The Bentley Hospital notes for the deceased's admission reflect that she was managed on medications and that she received psychotherapy for the first half of her admission. She was regularly reviewed and assessed for risks of suicide and self-harm, but she was difficult to assess because she was reluctant to disclose her true symptoms.

64. Dr Choy identified three areas of her treatment in which Bentley Health Service considered that there were shortcomings. The first area was the lack of clinical psychology cover when the psychologist who was providing the deceased with psychotherapy went on leave. Since then, Bentley Hospital has more active cover arrangements but, because of resource issues, there is a system pressure due to a lack of sufficient psychologists.[15]

65. Dr Bassett agreed that cognitive behavioural therapy was very appropriate for the deceased; however, he considered

[13] Exhibit 1, Tab 4
[14] ts 14 and 15, per Choy, W; ts 37 per Bassett, D
[15] ts 15 – 16 per Choy, W

that the severity of the deceased's depression in the second half of her admission probably meant that applying intensive cognitive behavioural therapy would have been very difficult. This was so because severely depressed patients find it difficult to engage in talking therapies that require a cognitive approach, and by then she was too ill.[16]

66. The second area identified by Dr Choy was the transfer of the deceased from the secure ward on 26 December 2014. Dr Choy said that the decision was made by a junior medical registrar, who had the authority to make that decision, but who would normally be expected to involve a duty consultant since it was a weekend. He said that there was no evidence on the notes that a duty consultant had been involved, which raised concerns.

67. The third area identified by Dr Choy was the decision by Dr Jaworska to keep the deceased an involuntary patient under the *Mental Health Act 1996*. He said that Dr Jaworska had the power to make the deceased a voluntary patient, and in the circumstances it would have been reasonable to do so, but Dr Jaworska did not know the deceased and took the cautious approach to retain her as an involuntary patient.[17] Dr Choy did not elaborate on why this decision was an area of concern.

68. When asked for his views about the deceased's treatment at Bentley Hospital, Dr Bassett made a number of relevant observations.

69. Dr Bassett said that restriction does not stop people from committing suicide. He said that being in a secure ward is very traumatic and should be a last option for a person who is suicidal. It should be used where the person has such a severe illness that the containment will be therapeutic; otherwise, it will damage the therapeutic

[16] ts 35 – 36 per Bassett, D
[17] ts 20 Per Choy, W

relationship and will alter the person's view of himself or herself.[18]

70. Dr Bassett considered that the treating team was trying to use good judgment to balance restriction against freedom and were essentially getting it right. However, he said that he was 'old in the game' and perhaps would have been a little more conservative, but he could understand why they made the judgments they did.[19]

71. Dr Bassett raised the question of whether the deceased was moved from the secure ward because a bed had been required for another patient. He said that every secure ward in WA is always full because there are inadequate resources.[20]

72. Dr Bassett said that he did not think that discharging the deceased from the secure ward damaged her treatment. Rather it probably enhanced the treatment because she would have been relieved to get out of that ward. However, he would have wanted the decision to be made for clinical reasons and not administrative reasons. He noted, though, that sometimes doctors do not have a choice but to discharge the least ill person in the secure ward.[21]

73. Dr Bassett also opined that ECT would have been the treatment of choice for the deceased in the second half of her admission because she appeared to be psychotic. It was apparent from the notes that the treating team also thought so.[22] It is clear that the possibility of treating the deceased with ECT was being considered and she was asked about her attitude towards it.

74. Another potentially useful treatment described by Dr Bassett was transcranial magnetic stimulation (TMS), which has been difficult to provide in Perth until recently

[18] ts 32 – 33 per Bassett, D
[19] ts 32 – 34 per Bassett, D
[20] ts 32 per Bassett, D
[21] ts 34 per Bassett, D
[22] ts 28 per Bassett, D

because only one machine was available and the treatment is time-consuming. There are no side-effects and the treatment is virtually painless, but it does not always work.[23] There is one machine at Graylands Hospital where it is used a lot, but Dr Bassett was unaware whether other mental health services used it. He said that they are expensive and getting access to one is not easy.

75. Dr Bassett said that TMS has been slow to gain sufficient evidence to be used regularly clinically, but the evidence is good enough to say that it is worth offering to people with the deceased's sort of illness.[24] There was no evidence on the Bentley Hospital notes to indicate whether or not it had been considered for the deceased.

76. While Dr Bassett made the foregoing comments in oral evidence, he did so with the effective qualification that it is easy to be critical in hindsight. In his report, Dr Bassett stated that he found the approach to the deceased and her psychological health highly professional and caring. She received close supportive psychotherapy, with some assistance with coping strategies, occupational therapy interventions, and use of psychotropic medications of an appropriate regime. The *Mental Health Act 1996* was invoked appropriately and she was offered maximal freedom within the management plan.[25]

77. Dr Bassett stated that he got the clear impression from the notes that the deceased's treating health professionals were highly empathetic and motivated to help her throughout her care. The treatment modalities were very appropriate, though the application of psychological therapies was limited by the deceased's capacity to engage optimally with those therapies. She received quite extensive one-on-one time with nurses and was reviewed

[23] ts 29 per Bassett, D
[24] ts 30 - 31 per Bassett, D
[25] Exhibit 1, Tab 13

regularly by medical staff, including by way of quite lengthy discussions about her history.[26]

78. In his concluding remarks in his report, Dr Bassett said that he believed that the care received by the deceased at Royal Perth Hospital and Bentley Hospital was caring, thorough and appropriate. In his opinion, it was appropriate that she was offered structured psychotherapy of some form, but he doubted that it would have had a sufficient impact until the biological elements of her depressive disorder were restored.[27]

79. Dr Bassett stated in his report that, on the evidence available to him, the deceased suffered from an episode of major depressive disorder compounded by generalised anxiety disorder and significant related difficulties with intimate relationships, and she appeared to have suffered these disorders for at least 10 years prior to her death. He said that he suspected that the roots of her psychological ill-health stretched back to her childhood.[28]

80. In oral evidence, Dr Bassett said that suicide is extremely difficult to predict, completed suicide is almost unpredictable and on an individual basis is virtually impossible to predict.[29] He also said that the deceased was likely becoming psychologically depressed, and stopping suicide in someone with psychological depression is very difficult. When it reached that point for her, suicide was a relief.[30]

81. In my view, the evidence, including that of Dr Bassett, which I accept, indicates that the treatment, supervision and care of the deceased was reasonable and generally appropriate.

82. To the extent that it could have been improved, in particular by the provision of ongoing treatment by a

[26] Exhibit 1, Tab 13
[27] Exhibit 1, Tab 13
[28] Exhibit 1, Tab 13
[29] ts 31 per Bassett, D
[30] ts 37 per Bassett, D

psychologist, I am satisfied that any lack of particular care was unlikely to have had any contribution to her death. I am also satisfied that Bentley Health Service has taken steps to ensure that ongoing psychotherapy is available to patients from clinical psychologists.

CONCLUSION

83. It is clear that the deceased had severe and deeply rooted depression and anxiety, which led to her tragic suicide despite the support of a loving family as well as appropriate and empathetic clinical treatment.

B P King
Coroner
17 July 2017