Coroners Act 1996
[Section 26(1)]

Western *Australia*

RECORD OF INVESTIGATION INTO DEATH

Ref: 11 /15

I, Sarah Helen Linton, Coroner, having investigated the death of ***Priscilla Fay STEPHENSON*** *with an inquest held at the* ***Perth Coroner's Court, Court 51, CLC Building, 501 Hay Street, Perth****, on* ***23 March 2015*** *find that the identity of the deceased person was* ***Priscilla Fay STEPHENSON*** *and that death occurred between* ***20 November 2012 and 21 November 2012*** *at* ***18 Samson Street, White Gum Valley*** *as a result of* ***combined drug toxicity*** *in the following circumstances:*

Counsel Appearing:

Mr T Bishop assisting the Coroner.
Ms R Hill (State Solicitor's Office) appearing on behalf of Fremantle Hospital and Health Services.

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INTRODUCTION

1. Priscilla Fay Stephenson (the deceased) was a troubled young woman with a long history of mental health and drug-related issues.

2. At the time she died, on or about 20 November 2012, the deceased was an involuntary patient within the meaning of the *Mental Health Act 1996* (WA) and was subject to a community treatment order under the provisions of that Act.

3. By virtue of her status as an involuntary patient, the deceased came within the definition of a 'person held in care' under section 3 of the *Coroners Act 1996* (WA). Pursuant to section 22(1) (a) of the *Coroners Act* an inquest was, therefore, mandatory. Accordingly, I held an inquest at the Perth Coroner's Court on 23 March 2015.

4. The primary focus of the inquest was on the circumstances of the deceased's death and the appropriateness of the decision to release the deceased on a community treatment order shortly prior to her death.

5. Two witnesses were called to give oral evidence at the inquest: Senior Constable Samantha Counsell from the Coronial Investigations Unit and Dr Ajay Velayudhan, the current Medical Co-Director Mental Health at the Alma Street Centre, who was involved in treating the deceased at Alma Street prior to her death. In addition, a significant quantity of documentary evidence was tendered, including the deceased's medical records from Fremantle Hospital.[1]

[1] Exhibit 1.

BACKGROUND OF THE DECEASED

6. The deceased was an Aboriginal female born in Queensland on 17 April 1984.[2] The deceased experienced a traumatic upbringing, involving serious physical and sexual abuse and the loss of more than one close family member in violent circumstances.[3]

7. Despite traumatic experiences and abuse as a young child the deceased was reportedly an active and popular student during her primary school years, with a special talent for singing. However, following the death of her younger brother in a car accident when she was 11 years old, her personal circumstances worsened and she exhibited increasingly disturbed behaviour at school.[4]

8. [5]The deceased was eventually placed into foster care. She was psychiatrically assessed at Princess Margaret Hospital in January 1997, which indicated traumatic developmental history on the background of a past history of abuse.[6] No definitive psychiatric diagnosis was made at that time. She was referred for appropriate counselling at Princess Margaret Hospital but did not attend.[7]

9. The deceased lived an itinerant lifestyle during her adolescent years. She developed polysubstance abuse issues and began to have intermittent contact with the justice system.[8] The deceased spent time at Rangeview Remand Centre in 1999 and underwent court-ordered psychological and psychiatric assessment during this

[2] Exhibit 1, Tab 15.
[3] Exhibit 1, Tab 5, 2 and Tab 17 [37].
[4] Exhibit 1, Tab 11, Discharge Summary 11.1.2002.
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[6] Exhibit 1, Tab 11, Discharge Summary 11.1.2002.
[7] Exhibit 1, Tab 11, Discharge Summary 11.1.2002.
[8] Exhibit 1, Tab 5, 2 and Tab 11, Discharge Summary 16.9.2008.

period. She was assessed as of normal intelligence and no psychotic phenomena were observed. However, it was felt that she may be suffering from dissociative phenomena secondary to her multiple traumas and abuse.

10. In January of the following year, she was again assessed while on remand at Rangeview for various offences and the psychiatrist was of the opinion that she was suffering from complex emotional behaviour problems referred to as 'borderline states'. It was recommended that she engage with welfare and mental health services in the future.

11. However, by the end of 2000, the deceased's mental health had deteriorated to the point that she was referred to Bentley Adolescent Unit with aggressive and disorganised behaviour, thought disorder and threats of self-harm. She was admitted as an involuntary patient for the first time on 9 September 2000.[9] The deceased had an organic screen, the results of which were normal. During her admission she showed clear signs of psychosis and was commenced on the antipsychotic medication risperidone. She slowly settled on medication and was eventually discharged in December 2000.

12. From that time, the deceased had repeated admissions to Graylands Hospital, Fremantle Hospital and Bentley Hospital and on many occasions an involuntary patient order was made.[10] Some of the admissions were prompted by court-ordered referrals following her arrest on criminal charges.[11] The deceased's psychotic episodes were most often characterised by erratic

[9] Exhibit 1, Tab 9.
[10] Exhibit 1, Tab 9.
[11] Exhibit 1, Tab 5, 2.

behaviour, disorganised thoughts, disinhibition and aggression.[12] Various diagnoses were made but generally involved drug-induced psychosis, schizophrenia and psychoaffective disorder. Her doctors found it difficult to conclusively state a diagnosis, due to the deceased's ongoing substance abuse.[13]

13. The deceased gave birth to a daughter in April 2004. The baby spent a significant period in the neonatal unit for opiate withdrawal treatment. The deceased was admitted to Graylands Hospital with a diagnosis of psychotic disorder a month after the birth.[14] She was assessed in the Mother & Baby Unit and her behaviour was considered to place her baby at risk. Due to her substance misuse and mental health issues, the child was removed from her care and placed into foster care not long after.[15] The deceased expressed an ongoing desire to see her daughter but she struggled to meet the requirements imposed by the Department for Child Protection before they would initiate contact.[16]

14. The deceased met her partner, Mario Merendino, in approximately 2006 and they became engaged about three years later.[17] At the time they met, the deceased was a heavy drug user and would use daily.[18] Her partner was aware that the deceased had spent time in mental health facilities due to her drug use.[19] She continued to abuse illicit drugs in spite of her involvement with drug counselling and methadone programs and close follow up in the community.

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[12] Exhibit 1, Tab 17 [36].
[13] Exhibit 1, Tab 17 [35].
[14] Exhibit 1, Tab 11, Discharge Summary 16.6.2004.
[15] Exhibit 1, Tab 5, 2 and Tab 11, Discharge Summary 16.6.2004 and Tab 17 [34] – [35].
[16] Exhibit 1, Tab 17 [38].
[17] Exhibit 1, Tab 7 [2].
[18] Exhibit 1, Tab 7 [6], [10].
[19] Exhibit 1, Tab 5, 2 and Tab 7 [11] – [12].

15. The frequency of the deceased's admissions to hospital increased over the years as her mental state deteriorated further. The recurrent admissions were mostly connected with non-compliance with medication and polysubstance abuse. On many occasions, she was made an involuntary patient under the *Mental Health Act* and, after a period of time being treated in hospital, was then discharged on a community treatment order supervised by the Alma Street Centre staff.

16. In 2011, the deceased presented to Fremantle Hospital on at least seven separate occasions, generally after being apprehended behaving in a bizarre manner while in a drug-induced psychosis. Discussions between hospital staff and the deceased's partner and family members suggested the deceased was only psychotic when she used drugs. The deceased was encouraged to attend drug and alcohol counselling but she did not appear motivated to engage with the services that were offered.

17. The deceased's engagement with psychiatric services was also sporadic. She was supposed to be on regular depot medication injections from about 2007, but they were not always able to be provided. Her oral medication compliance was also known to be highly variable. She often did not attend her appointments, requiring follow up phone calls and home visits.[20]

18. The deceased's medical records show that in 2012 she had no admission to the Alma Street Centre prior to November 2012, although she was admitted to Fremantle Hospital a number of times.[21] Her treatment by Alma Street Centre (including home visits and

[20] T 16.
[21] Exhibit 1, Tab 17 [47].

administering depots) continued intermittently throughout 2012.

19. While the deceased was out in the community, regular management plans were completed, the last one on 11 July 2012. The goals were clearly defined as minimising and ceasing her drug use, which would enable her to function at a higher level and possibly permit her to re-engage with her daughter and the community generally. She was receiving her depot medication every two weeks and her case manager indicated that action should be taken to provide ongoing education regarding her illicit substance use and to encourage her to attend Next Step. Her case manager asked her to consider residential rehabilitation or a more supportive home environment. She was also engaging with the Aboriginal Liaison Officer, who provided cultural support and understanding.[22]

20. On 13 August 2012, the deceased was reviewed. She was assessed as having a stable mental state and no current psychotic symptoms although her poor compliance with medication was noted.[23]

21. On 12 September 2012, she refused her depot medication but this was eventually given on 3 October 2012.[24]

22. During October 2012, the deceased's partner stated that the deceased had been using methamphetamine, which resulted in her displaying erratic behaviour and becoming abusive towards him.[25] Attempts were made by Alma Street staff to get the deceased to attend

[22] Fremantle Adult Client Management Plan 11.7.2012.
[23] Exhibit 1, Tab 10, 9.
[24] Exhibit 1, Tab 10, 9.
[25] Exhibit 1, Tab 5, 3 and Tab 7 [16].

Next Step for drug rehabilitation in October 2012, without success.[26]

FINAL ADMISSION TO FREMANTLE HOSPITAL

23. In the early hours of 1 November 2012, the deceased was arrested by police for breaching a violence restraining order and disorderly conduct, including attempting to bite a police officer.[27] She appeared to the police officers to be intoxicated and not making sense so she was conveyed to Fremantle Hospital for a mental health assessment.[28] She was kept at the Emergency Department but discharged herself against medical advice and her case worker was informed.[29]

24. A home visit was made on 1 November 2012, but the deceased was not at home.[30] At 2.30 pm on 2 November 2012, the deceased voluntarily presented to Alma Street Centre. She had apparently been running between cars on the road earlier. The deceased admitted she had been using intravenous methamphetamine in the preceding days and felt that she was a risk to herself.[31]

25. The deceased was assessed by Clinical Nurse Specialist Brett Heslop of the Fremantle Team. She presented with psychotic symptoms in the context of excessive drug abuse. Given the risk she posed to herself and to others due to her disorganisation, and her refusal to engage in treatment, Nurse Heslop completed a Form 1

[26] Exhibit 1, Tab 16, Outpatient Notes 4.10.12 – 10.10.12.
[27] Exhibit 1, Tab 5, 3 and Tab 16.2.
[28] Exhibit 1, Tab 5, 3.
[29] Exhibit 1, Tab 5, 3 and Tab 10, 10.
[30] Exhibit 1, Tab 16.1, Outpatient Notes, 2.11.212.
[31] Exhibit 1, Tab 5, 3 and Tab 10, 10.

referring the deceased for examination by a psychiatrist.[32]

26. As a bed was not immediately available in the appropriate ward, the deceased was transferred to Fremantle Hospital Emergency Department and kept in overnight waiting for a psychiatric bed to become available at the Alma Street Centre. She was sedated due to her agitated and aggressive behaviour. She attempted to leave at 2.55 am on 3 November 2012 and was given further sedation.[33]

27. The deceased eventually absconded at around 7.30 am that morning. She was returned to the Emergency Department by police at 9.55 am.[34] The deceased was admitted to Ward 4.1 at about 10.40 am under the care of her psychiatrist, Dr Velayudhan. On admission, she was assessed by the Duty Medical Officer and was observed to be dishevelled, agitated, and delusional and she lacked insight and judgment. She admitted to drinking alcohol but denied other substance abuse. The assessment was limited as she walked out of the interview before it could be completed.[35]

28. Blood tests performed showed that the deceased had abnormal liver function. She was admitted to a locked ward to await further assessment when less aroused.[36]

29. The deceased was uncooperative on the ward and frequently provocative, loud and restless. The deceased did not accept she was unwell and said she wanted to be discharged. She became agitated when informed she was being detained under the *Mental Health Act*. She

[32] Pursuant to s 29 of the *Mental Health Act*, Exhibit 1, Tab 16.4 and Tab 17 [52] - [53].
[33] Exhibit 1, Tab 10, 9.
[34] Exhibit 1, Tab 16.3, Adult Triage Assessment 3.11.2012.
[35] Exhibit 1, Tab 17 [56].
[36] Exhibit 1, Tab 10, 10 and Exhibit 16.4, Discharge Summary 20.11.2012.

was initially commenced on sodium valproate and 100 mg of quetiapine.[37]

30. The deceased was reviewed on 4 November 2012 by a Consultant Psychiatrist at Fremantle Hospital, Dr Matthew Samuel. She was diagnosed with a drug-induced psychosis. Dr Samuel considered the deceased met the criteria for detention as an involuntary patient so Dr Samuel completed a Form 6 involuntary patient order[38] due to her need for treatment to which she was unable to give consent.[39]

31. The deceased was reviewed again on 5 November 2012, this time by Dr Velayudhan, together with the Psychiatric Registrar, Dr Kalani. Dr Velayudhan formed the impression of drug-induced psychosis and possible schizophrenia but the diagnosis was difficult given her admitted amphetamine use and non-compliance with her depot medication.[40] She did not want to stay in hospital and became agitated when advised she was on a Form 6. Due to the deceased's high levels of agitation and disinhibition and minimal response to medication the deceased was started on Accuphase and her quetiapine dose was increased to thrice daily.[41]

32. On 7 November 2012, the deceased's partner, who had been visiting the deceased daily,[42] commented that he felt that the deceased would continue to use drugs when released. She persistently requested to be discharged home and became agitated when her request was denied.

[37] Exhibit 1, Tab 16.3, Integrated Progress Notes, 3.11.2012 at 14:15.
[38] Exhibit 1, Tab 16.4.
[39] T 7 - 8.
[40] T 13.
[41] Exhibit 1, Tab 10, 10 and Tab 16.3, Integrated Progress Notes 5.11.2012 at 10:00 and Tab 17 [59] – [66].
[42] Exhibit 1, Tab 7 [18].

33. On 9 November 2012, Dr Velayudhan reviewed the deceased and did not consider her suitable for discharge at that time. He altered her medications later that day as she had become increasingly disorganised and agitated throughout the day.[43]

34. In the morning of 12 November 2012, the deceased's mood was noted to be elevated and she was observed running around the ward responding to unseen stimuli. Her quetiapine dose was increased further to 400 mg by Dr Velayudhan and some of her other medications were changed.[44]

35. Later that day, Dr Velayudhan reviewed the deceased again in company with Dr Kalani. He noted the deceased's partner had reported concerns that the deceased was voicing suicidal thoughts. When questioned by the doctors she also threatened suicide in anger. Although there was no previous history of self-harm, she was regarded as a high risk to herself because of her impulsivity and disorganisation. She was managed on the locked ward with 15 minute visual observations.[45] Dr Velayudhan telephoned the deceased's partner that afternoon and they discussed the need to keep the deceased in hospital for the next few days, but not for any longer than was required. The deceased's partner was happy with the plan.[46]

36. A second opinion was sought on 13 November 2012 at the request of the deceased. The reviewing Consultant Psychiatrist, Dr Lazar, agreed with the current treatment plan to continue with hospitalisation under the *Mental Health Act*.[47] The deceased denied any

[43] Exhibit 1, Tab 17 [68] – [71].
[44] Exhibit 1, Tab 17 [73].
[45] Exhibit 1, Tab 16.3, Integrated Progress Notes 12.11.2012 at 15:30 and Tab 17 [74] – [78].
[46] Exhibit 1, Tab 16.3, Integrated Progress Notes 12.11.2012 at 4.10 pm and Tab 17 [79] – [81].
[47] Exhibit 1, Tab 5, 3, Tab 10, 10 and Tab 16.2.

further suicidal thoughts that day, attributing her earlier threats to anger, and appeared more settled, although she still wanted to go home.[48] She was moved out of the high observation room later that day.[49] She had not made any attempts at suicide during the time she was under observation.[50]

37. Her psychotic symptoms gradually improved and on 16 November 2012 it was agreed that if the deceased was not agitated or 'disorganised' in her behaviour[51] over the weekend and limited her PRN (as required) medications,[52] she might be considered for discharge on 19 November 2012.[53]

38. On 19 November 2012, the deceased was reported to be feeling settled and was thinking before she acted. She still expressed a desire to go home to spend time with her partner, his mother and siblings. She said she would be happy to keep taking her medication. She claimed she didn't have any cravings for drugs. She denied any psychotic symptoms but described feeling sad about her past. She had goals for her future and denied any suicidal thoughts. It was felt that her psychosis had resolved and she agreed to start on the antidepressant escitalopram to assist with grief issues relating to the death of family members.[54]

39. The deceased was compliant with all of her oral medication and her depot was given on 20 November 2012. She was reviewed again by the Psychiatric Registrar, Dr Kalani, that day. The deceased showed no signs of psychosis, appeared

[48] Exhibit 1, Tab 16.3, Integrated Progress Notes 13.11.2012 at 13:00 and 15:00.
[49] Exhibit 1, Tab 17 [82].
[50] T 9.
[51] T 10.
[52] T 8, 10.
[53] Exhibit 1, Tab 17 [83] – [85].
[54] Exhibit 1, Tab 10, 11 and Tab 17 [86] – [91].

pleasant and calm and appeared to have gained some insight. She reported remaining well, her mood was good and she stated she wanted to stay off drugs. She also stated her long-term goal was to get access to her daughter. It was felt that she was a low risk to herself and others, although it was acknowledged that her risk would fluctuate in the context of her substance use and poor compliance.[55] It was explained to the deceased that to remain well she must comply with her medications, attend her scheduled appointments and avoid using drugs.[56] Dr Kalani also discussed referral to a counselling service for her grief issues.[57]

40. The deceased was further reviewed by Dr Velayudhan at 2.10 pm. He also noted the deceased had improved significantly and had no psychotic symptoms. The possibility of discharge was discussed by Dr Kalani with the deceased's partner, who was happy with the discharge plan.[58]

RELEASE ON COMMUNITY TREATMENT ORDER

41. Community treatment orders are used to provide involuntary treatment under the *Mental Health Act* to individuals who suffer from a mental illness. They are a community-based alternative to detention in an authorised hospital. The person remains an involuntary patient while on the order, so they must still meet each of the criteria for involuntary treatment under Part 3 of the *Mental Health Act.*[59]

42. Dr Velayudhan believed that the deceased met the criteria under the Act for involuntary treatment as:

[55] Exhibit 1, Tab 16.3, Integrated Progress Notes 13.11.2012 at 12:30.
[56] T 18 – 19; Exhibit 1, Tab 17 [97].
[57] Exhibit 1, Tab 16.2 and 16.3, Integrated Progress Notes, 21.11.2012 at 16:00 (Late Entry).
[58] T 14; Exhibit 1, Tab 16.2 and 16.3, Integrated Progress Notes, 21.11.2012 at 16:00 (Late Entry).
[59] Exhibit 1, Tab 17 [104].

- she had a mental illness that required treatment;
- when unwell, there was a risk to others and herself, as she often placed herself in situations where she was at risk;
- her engagement with services would fluctuate;
- she had limited insight into her illness; and
- she needed continuing antipsychotic treatment.[60]

43. However, in keeping with the need to provide treatment in the least restrictive manner[61] and taking into account the effect of continued detention on the deceased, Dr Velayudhan formed the opinion that appropriate treatment could be provided by way of a community treatment order.[62]

44. Therefore, the deceased was discharged on 20 November 2012 on a community treatment order pursuant to the provisions of Part 3, Division 3 of the *Mental Health Act*. The responsible practitioner was Community Mental Health Nurse Erica Lewis at Alma Street Centre and the Supervising Psychiatrist was Dr Velayudhan. The conditions of the order were:

    - Injection of Zuclopenthixol Decanoate 200 mg every two weeks (a long acting injectable antipsychotic);
    - Quetiapine tablets 400 mg (an antipsychotic with mood-stabilising properties);
    - Valproate tablets 500 mg in the morning and 1000 mg at night (used for mood stabilisation);
    - Escitalopram tablets 10 mg daily (an antidepressant); and
    - Attend appointments with doctors and case manager as advised.[63]

[60] Exhibit 1, Tab 17 [106].
[61] Exhibit 1, Tab 17.12, 5.
[62] Exhibit 1, Tab 17 [106].
[63] T 11 – 12, 15 - 16; Exhibit 1, Tab 16.4.

45. Inpatient rehabilitation for management of drug dependence was strongly recommended and Serenity Lodge was suggested as an option, but the deceased declined. She said she would talk about it further with her case manager.[64]

46. The deceased was given two days of tablets while a Webster pack of medication was being prepared and a follow-up appointment was arranged with the Psychiatric Registrar on 28 November 2012.[65] Her next depot was due on 4 December 2012.[66]

EVENTS AFTER DISCHARGE

47. Dr Velayudhan was aware that the deceased would be returning to live with her partner. Although placement back with the deceased's partner, who was a known drug user, was not ideal given her substance abuse issues, there does not appear to have been any better alternative accommodation for her.[67] In addition, it is apparent that the deceased's partner cared for her and did his best to support and help her. The staff at Alma Street Centre had found in the past that Mr Merendino had assisted them in engaging with the deceased and would contact them when her condition deteriorated.[68] I accept that in those circumstances, while not optimal, it was an appropriate arrangement, given what was available.

48. The deceased was collected by her partner and his sister from Fremantle Hospital at about 2.30 pm and they returned home to Samson Street, White Gum

[64] Exhibit 1, Tab 16.2.
[65] Exhibit 1, Tab 10, 11.
[66] Exhibit 1, Tab 16.2.
[67] T 14; Exhibit 1, Tab 17 [111] – [113].
[68] T 14 – 15, 20; Exhibit 1, Tab 17 [109] – [110].

Valley.[69] The deceased's partner lived there with his mother and his sister lived next door. According to the deceased's partner, the deceased appeared to be "the best [he] had ever seen her"[70] that day and Dr Velayudhan agreed with this assessment of the deceased.[71]

49. They watched television and the deceased consumed one beer before having dinner. The deceased's partner fell asleep at about 7.30 pm and he did not wake until the following afternoon.[72]

50. The deceased's partner believed that there were no illicit drugs in the house when he went to sleep. While the deceased's partner was sleeping it appears that the deceased left the house and purchased heroin from an unknown supplier.[73] Once back at the house, the evidence suggests she used a brown leather belt as a tourniquet around her left upper arm before injecting an unknown quantity of heroin into her left wrist.[74]

51. According to the deceased's partner, the deceased often injected more than one syringe at a time, and in this case it appears that she refilled the syringe following the first injection. However, the deceased appears to have lapsed into unconsciousness in the couple's bed before she had the opportunity to inject the second syringe.[75] Later toxicological analysis suggests the deceased died rapidly, within twenty minutes of injecting the heroin.[76]

52. The deceased's partner was woken by his aunt just after midday on 21 November 2012. At that time he touched

[69] Exhibit 1, Tab 7 [19].
[70] Exhibit 1, Tab 7 [21].
[71] T 15.
[72] Exhibit 1, Tab 7 [23] – [27].
[73] Exhibit 1, Tab 7 [30].
[74] Exhibit 1, Tab 5, 3.
[75] Exhibit 1, Tab 5, 4.
[76] Exhibit 1, Tab 4, 2.

the deceased and found her to be cold to the touch. He also noticed an odour in the room and realised that she had died.[77] An ambulance was requested.

53. While waiting for the ambulance, the deceased's partner located the syringe filled with heroin on the bedside table. Rather surprisingly, given what had happened to the deceased, the deceased's partner injected himself with the contents of the syringe before flushing the used syringe down the toilet.[78]

54. When the paramedics arrived they confirmed that the deceased had died. Police officers conducted a search of the residence and located a brown leather belt on a chair in the bedroom, which was consistent in appearance with having been used as a tourniquet by the deceased prior to her death. The deceased's partner denied removing the tourniquet prior to police and paramedic arrival but the investigating officer concluded it was likely he had done so to facilitate injecting himself.[79] Nevertheless, there was no evidence to suggest the deceased's partner had any involvement in her death.[80]

55. No suicide note was located in the residence by police.[81] The deceased had written notes while she was in hospital, which were seized by police.[82] Nothing in the notes suggests the deceased was experiencing suicidal thoughts.

[77] Exhibit 1, Tab 7 [31] – [33].
[78] Exhibit 1, Tab 5, 4 and Tab 6, 2 and Tab 7 [35].
[79] T 5; Exhibit 1, Tab 5, 4 and Tab 6, 2 and Tab 7 [37]
[80] T 5 – 6.
[81] Exhibit 1, Tab 5, 4.
[82] Exhibit 1, Tab 13.

CAUSE AND MANNER OF DEATH

Post Mortem Report

56. On 26 November 2012, a forensic pathologist, Dr C. T. Cooke, conducted a post-mortem examination on the deceased. The examination showed a puncture mark and small bruise to the skin of the left wrist and there were scars to the elbow crease regions and also to the right wrist.[83]

57. Microscopic examination of some of the major body tissues showed terminal aspiration of some regurgitated vomit into the small airways to the lungs.[84]

58. Toxicological analysis showed the presence of opiates, consistent with the recent use of heroin, together with therapeutic levels of some prescribed-type medications consistent with the deceased's medication regime.[85] These agents have a combined sedating effect, which can result in impairment of consciousness, coma and death.[86]

59. At the conclusion of all investigations, Dr Cooke formed the opinion that the cause of death was combined drug toxicity.[87] I accept and adopt the opinion of Dr Cooke as to the cause of death.

Manner of Death

60. Other than experiencing some fleeting suicidal thoughts while in hospital during her last admission, the deceased did not have a known history of suicidal ideation.

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[83] Exhibit 1, Tab 3.
[84] Exhibit 1, Tab 3.
[85] Exhibit 1, Tab 4.
[86] Exhibit 1, Tab 3.
[87] Exhibit 1, Tab 3.

61. There is no evidence that at the time she took the heroin the deceased intended to take her life. The evidence points to the deceased being unaware of the possible fatal effect of taking the heroin in conjunction with her prescribed medication.

62. Accordingly, I find that the death arose by way of accident.

QUALITY OF SUPERVISION, TREATMENT AND CARE

63. As mentioned above, Dr Velayudhan was called to give evidence at the inquest. He was the Consultant Psychiatrist at Alma Street Centre from 2007 and, by virtue of this position, he had overarching responsibility for the deceased's care at the Alma Street Centre.

64. Dr Velayudhan first became involved in treating the deceased in September 2008 when she was discharged from the Frankland Centre and released on a community treatment order. He continued to have intermittent involvement in her treatment over the years until her death. It was apparent from his evidence that he knew her well and had a good understanding of her mental health issues as well as her personal issues. He expressed his shock and sadness at her sudden death and he personally conveyed his condolences to the deceased's partner and relatives in the days following her death.[88] This was not a case where the psychiatric care was not diligent or well considered.

65. At the time of her death, the deceased was the subject of a community treatment order. She had successfully completed such orders in the past, although she would

[88] Exhibit 1, Tab 17 [102].

tend to later relapse after abusing drugs. Given the length of time the deceased had already been detained, the noted improvement in her condition and the need to offer treatment in the least restrictive setting, I am satisfied it was appropriate to release the deceased on the order.

66. Although steps were taken to counsel the deceased against abusing illicit substances on her release and to engage her in drug rehabilitation, she was not motivated to do so.[89] As Dr Velayudhan explained, a community treatment order cannot address illicit substance abuse if the level of motivation is not there.[90]

67. Regardless of where the deceased was residing, she would have been able to easily access drugs in the community. Therefore, living elsewhere would not necessarily have changed the outcome. It was ultimately her choice to use illicit drugs, in spite of repeated advice and encouragement to abstain.

68. From the information available, I am satisfied the supervision, treatment and care of the deceased was reasonable and appropriate.

CONCLUSION

69. The deceased experienced a very difficult childhood, exposed to violence and abuse and deprived of love and stability. It is not surprising that she developed serious substance abuse and mental health issues that limited her ability to live and function in the community as an adult. Sadly, her health issues limited her ability to

[89] T 18 – 19.
[90] T 19.

have contact with her daughter, which was her primary goal in life.

70. The deceased was fortunate to have found a partner in her later years who, despite his own drug issues, was supportive and caring. Together with his extended family, they attempted to keep the deceased safe and well.

71. Nevertheless, despite their support the deceased frequently succumbed to drug abuse, which precipitated or compounded a deterioration in her mental health. This led to numerous hospital admissions and ongoing outpatient care in the community.

72. On the last occasion the deceased was admitted to hospital, she was initially very unwell and was housed in a locked ward. However, as the effects of the illicit drugs on her system diminished and the prescription medications took effect, her condition gradually improved.

73. By the time she was released from hospital on to the community order on 20 November 2012, the universal opinion of those who knew her was that she was in the best state she had ever been. This no doubt gave her doctors and family encouragement that she was doing well and was not at risk of hurting herself.

74. Unfortunately, after a quiet night at home, when the opportunity presented itself that she was unsupervised, the deceased was unable to resist reverting to her old habits and purchasing heroin to use that night.

75. The fatal effect of the heroin on her system, in combination with the prescription drugs she was

taking, was rapid and unexpected. There is no suggestion that any action by Mr Merendino contributed in any way to her death and by the time he became aware of what had happened, it was too late for any medical help.

S H Linton
Coroner
2 September 2015