Coroners Act, 1996

[Section 26(1)]

Western Australia

RECORDOFINVESTIGATIONOFDEATH

Ref No: 20/13

I, Evelyn Felicia VICKER, Deputy State Coroner, having investigated the death of Leah Christine Blinkhorn with an inquest held at the Perth Coroner's Court, Court 58, CLC Building, 501 Hay Street, Perth, on 14 May 2013 find the identity of the deceased was Leah Christine Blinkhorn and that death occurred on 11 June 2009 at 3 Daglish Street, Wembley, as the result of Multiple Drug Toxicity (Lamotrigine, Doxylamine, Venlafaxine, Valproic Acid, Codeine, Morphine) in the following circumstances:

Counsel Appearing :

Ms Emily Winborne assisted the Deputy State Coroner
Mr T French appeared on behalf of Perth Clinic
Mr A Musikanth appeared on behalf of Registered Nurse Barbara Biggins
Mr T Hammond appeared on behalf of Registered Nurse Kenneth Reed

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INTRODUCTION

Leah Christine Blinkhorn (the deceased) was residing at the address of friends who were living away from Perth. She had a history of depression and alcohol abuse for which she was receiving treatment.

On 10 June 2009 at 11:11pm[1] the deceased rang Perth Clinic and advised she had over medicated and wanted to know whether she should go to hospital. Other than naming a mix of over the counter and prescription mediction she declined to provide any further information. She was advised to go to hospital immediately.

The following day a friend of the deceased attended at the residence and discovered her body. It was evident resuscitation would not be of benefit.

The deceased was 29 years of age.

CALL TO PERTH CLINIC

It became evident during the course of the inquest both Ms Young and Dr Golic had provided the deceased with Perth Clinic contact numbers in the event of her seeking assistance. Perth Clinic, Nursing Director, Rachael Whiteley[5] also indicated Perth Clinic provides patients with cards on discharge. While it is accepted Perth Clinic is not an emergency facility, and the only appropriate admission for

[4] Exhibit 1, Tab 9
[5] Exhibit 2

emergency situations are those to the ED of hospitals, it is inevitable ex-patients will call Perth Clinic from time-to-time for input to do with their mental health difficulties. It is understood these will not always be crisis calls and will frequently be calls seeking information from an institution with which a patient feels confident.

In crisis situations patient know, and are advised, they need to contact an ED and where a patient has some difficulty with this I am satisfied Perth Clinic has procedures in place to facilitate appropriate responses to crisis calls. I accept the difficulty from time-to-time for staff is determining the difference between a crisis call, and a call which is couched in different terms.

The evidence was Perth Clinic may receive calls both through the switchboard and directly in some instances. During business hours there is a switchboard in operation, however, at night the switchboard is referred to River Ward and River Ward becomes the reception point for incoming calls to Perth Clinic business number. On the evening of 10 June 2009 the nurse on duty in River Ward was Registered Nurse, Barbara Biggins. While RN Biggins was not a Registered Mental Health Nurse she certainly has qualifications in the area of mental health.

The night nursing coordinator on 10 June 2009 was Mr Kenneth Reed, a very experienced Registered Mental Health Nurse with experience in both the public and private

sector. RMHN Reed had contact with the deceased when she was an inpatient in March 2009, while RN Biggins did not.

According to the Perth Clinic telephone records the deceased called Perth Clinic at 11:11pm on 10 June 2009 when RN Biggins was on River Ward and RMHN Reed was performing the night security round of the hospital. The call lasted five minutes and nine seconds.

RN Biggins stated that when she answered the telephone ringing at the nursing station she was confronted with a female voice who stated she had taken some tablets. When she was asked what she had taken, she responded with "two boxes of Restavit, a box of Panadeine, Efexor and Sodium Valproate".[6] Despite questioning from RN Biggins the deceased, who had not identified herself, insisted she only wished to know whether she should go to hospital at that point or wait until the morning.

RN Biggins informed the court[7] the deceased initially refused to supply her name but at a later point did supply her name as Leah Blinkhorn. RN Biggins did not recognize the name. She questioned the deceased including asking her whether she was alone. The deceased responded she was, and RN Biggins re-emphasized the deceased must go to hospital. The deceased indicated she would call a friend to take her to hospital. The deceased was becoming angry with RN Biggins' questioning and eventually the telephone call terminated, with

[6] Exhibit 1, Tab 20
[7] Transcript 14.05.2013, Pg 14

RN Biggins unable to obtain more than her name and an indication of the substances she alleged she had taken.

While RN Biggins was on the 'phone with the deceased, RMHN Reed returned to the nursing station. When the deceased provided her name RN Biggins wrote the name on a piece of paper and passed it to RMHN Reed, who then looked up the deceased's details on the computer. He recognized the name and realised he had been at Perth Clinic during her recent admission.

The information on the computer RMHN Reed accessed provided an address and telephone number. The information available to the inquest indicated this was the address at which the deceased was staying, being the address of her friends where she was house sitting.

RN Biggins and RMHN Reed discussed the situation and RMHN Reed attempted to telephone the deceased on the telephone numbers with which he was provided. There was no response and he and RN Biggins discussed the telephone call and believed the deceased had called a friend and gone to hospital as she had affirmed she would do when questioned by RN Biggins. In evidence, RMHN Reed indicated he remembered the deceased and believed her to be a positive and competent person for whom he had no concerns in view of the fact she had telephoned for advice.[8]

[8] Transcript 14.05.2013, Pg 33

I accept Perth Clinic staff may not have access to the same information as the deceased's psychiatrist and psychologist with respect to the reason for her admission to SCGH ED in February 2009. Co-incidentally her overdose on that occasion had been of the same substances as alleged on this occasion.

In evidence RMHN Reed said he was aware of the procedures for police performing a welfare check. Neither RMHN Reed nor RN Biggins believed the call warranted police intervention. It appeared the deceased had been compliant with their advice as they were unable to reach her on the telephone. RN Biggins did, however, fill out a crisis call management form which is intended to be faxed to a patient's treating psychiatrist for their information.

In evidence, Dr Golic indicated he was of the view it was a crisis call, with knowledge of the deceased, however stated he had never experienced a difficulty with the staff at Perth Clinic not appropriately responding to their understanding of the quality of a call.[9]

LOCATION OF THE DECEASED

The ex-partner of the deceased, with whom she was in frequent contact, had spoken with the deceased late on the evening of 10 June 2009.

The ex-partner of the deceased attempted to contact the deceased during the day of 11 June 2009 and when she could

[9] Transcript 14.05.2013, Pg 41

not successfully raise the deceased she became concerned and attended at 3 Daglish Street, Wembley. She discovered the body of the deceased and called emergency services. There was nothing which could be done for the deceased.

In close proximity to the deceased was a journal which she had commenced to write in the days preceding her death. There is no doubt from the content of the journal the deceased had a strong death wish on the evening of 10 June 2009 and believed she had no reason to live. She expresses this in surprisingly positive terms for the people in her life.

It is difficult to place the timing of her call to Perth Clinic in the context of her entry for the night of 10 June 2009. RN Biggins stated the deceased sounded quite alert and orientated at the time of the call and is entirely possible she had either not yet consumed the medication she referred to, or had consumed it recently enough for it not to have affected her at the time of the telephone call.

POST MORTEM REPORT

The post mortem examination of the deceased was carried out by Dr Judith McCreath on 16 June 2009.

The post mortem examination revealed pill fragments still within her stomach contents, with aspiration of stomach contents and excess fluid in her lungs. Microscopic examination showed inflammation in her thyroid but the post

mortem examination was otherwise unremarkable.[10]

Of more relevance to the death of the deceased were the results of the post mortem toxicology by the Chemistry Centre.

There was no alcohol detectable in the deceased's system at the time of her death, however, analysis of her blood revealed a therapeutic level of Codeine, but toxic level of Valproic Acid. The paracetamol was therapeutic, but Lamotrigine, Doxylamine and Venlafaxine were all in the toxic-fatal range. Similarly her liver revealed fatal levels of Doxylamine and toxic-fatal levels of Venlafaxine. Her stomach contents revealed Lamotrigine, Paracetamol, Doxylamine and Venlafaxine.

Dr Golic[11] commented the Venlafaxine was her current medication, and while she had been prescribed both Sodium Valproate and Lamotrigine, she had been non-compliant with those medications and it was very likely she had a reserved amount. Of significance is the information she gave Dr Golic that on her last admission to SCGH ED she had stockpiled some of her medication for that overdose.[12] It would seem that experience was a pre-run for her overdose on this occasion which I have no doubt was intentional. There may be some argument for the compulsory return of medication to pharmacists where no longer prescribed but enforcement would be almost impossible.

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[10] Exhibit 1, Tab 21
[11] Transcript 14.05.2013, Pg 47
[12] Exhibit 1, Tab 8, Pg 6

In hindsight, the death of the deceased by way of medication overdose without the impulsivity fostered by her alcohol consumption would indicate on this occasion the deceased's overdose was entirely deliberate. It was also a feature of her particular un-wellness she suffered from impulsivity and un-predictability. Those are often features of personality disorders which make predictions of suicide extremely difficult.

CONCLUSION AS TO THE DEATH OF THE DECEASED

I am satisfied the deceased was a 29 year old female who suffered from a combination of personality disorders which seriously affected her ability to realize the full potential of her life.

The deceased had very clear views about the treatment she found acceptable. While she engaged with treatment it was always with the underlying decision making remaining within her control.

In the days preceding 10 June 2009 it is clear from the deceased's journal she was moving closer to a decision about suicide.

On the evening of 10 June 2009 she made a decision and took medication she had to hand. She placed the empty mediction packets beside the rubbish bin in the kitchen and went to bed.

I am unable to determine at precisely what stage with respect to the deceased's deliberate overdose the telephone call to Perth Clinic occurred. Nevertheless, I am satisfied she rang Perth Clinic as a way of communicating her decision. I am unclear as to her motive. It is almost as if she was throwing a coin, depending on which way it landed would determine whether she lived or died. Quite at odds with her decision making as to her treatment options.

I can understand RN Biggins' perception the telephone call from the deceased was for the purposes of seeking advice and accept there was not enough known about the deceased personally to indicate this was a very real notification of an intention to die. However there may have been some clues which justified referral to the police for their assistance. The fact she made a statement she had taken too much medication but was evasive with any detail appears significant in hindsight.

I am satisfied she positioned her journal and other possessions in close proximity to herself including a envelope "my last will and testament" with instructions as to how the journal was to be read.[13]

It is not clear when she actually died but I am satisfied it was after midnight in the early hour of 11 June 2009 due to the clarity of her telephone call with RN Biggins at 11:11pm on 10 June 2009.

[13] Exhibit 1, Tab 2

I find death arose by way of Suicide.

RECOMMENDATIONS

Evidence was heard from Inspector Davies of the Police Operations Communications Centre as to the ability of police to trace unidentified callers and institute welfare checks where a real concern was expressed.[14] Without going into the intricacies of that facility I am of the view a call from an organization such as Perth Clinic, despite the fact they are not an emergency assistance line, does warrant, in appropriate circumstances the involvement of the police.

RN Biggins gave evidence of a number of calls received by Perth Clinic in her experience which are obviously not of concern with respect to the welfare of a patient, however, in this case I believe had a call been made, it may have been possible to locate the deceased prior to her death by way of overdose.

The fact the deceased had aspirated does mean death was not solely due to respiratory depression and may have been more rapid than would often be the case. However, from the context of the telephone call she did not appear to be adversely affected by drugs at the time of the call. It is therefore possible the deceased could have been located prior to death, depending upon when that occurred.

[14] Exhibit 5

Accordingly I make the following recommendations with respect to Perth Clinic.

Recommendation 1

Staff likely to respond to telephone inquiries at Perth Clinic, particularly at night, are trained to make clinical assessments on the telephone as well as normal risk assessments in their day to day work experience. There are a number of emergency telephone operators who train call receivers in appropriate assessment.

Recommendation 2

River Ward, as the ward receiving telephone calls from the switchboard after hours always be staffed by nurses trained in telephone assessment.

Recommendation 3

Perth Clinic investigate the feasibility of a tracer call facility with the Police or more simply provide their service provider information next to telephones capable of receiving outside calls with instructions about timing the commencement and duration of calls where a concern may arise as to the safety of the caller.

EF VICKER
Deputy State Coroner

30 May 2013