LOCAL COURT
New South Wales
Wollongong

Jurisdiction:	Coronial
Matter	Inquest into the death of LYNDA VANESSA CLIFFORD
Hearing dates:	13 ---17 August 2012
Date of Findings:	5 September 2012
Findings of:	Ian Guy Deputy State Coroner, Wollongong
Representation:	Ms D Ward, Barrister, Counsel Assisting, instructed by Mr L Chee of Department of Attorney General and Justice. Mr J Harris, Solicitor, Legal Aid for the Family. Ms G Butler, Barrister for Dr Turnbull Ms J Sandford, Barrister instructed by NSW Crown Solicitors Office for the Illawarra Shoalhaven Local Health Network.

Reasons for Findings

1. Lynda Clifford had struggled at times in her life with mental illness and illicit drugs. It was in August 2009 then aged 29 that her mental state deteriorated significantly. With troubling auditory hallucinations and signs of a very high risk of self-harm she was admitted as a voluntary patient at Wollongong Hospital Mental Health Unit.

2. Lynda[1] remained an inpatient for over 2 weeks under the care of Dr Turnbull, Psychiatrist. There were concerns about Lynda's level of depression and suicide risk. Variations in existing antipsychotic drugs were made and 2 new drugs were introduced, being the antipsychotic drug Clozapine and the anti-depressant Fluoxetine.

3. Lynda was discharged on 24 August 2009 and returned to stay with her mother and her children. She was at the time of discharge taking a total of 6 medications, all of which have an effect upon the central nervous system and potentially produce a significant sedative result.

4. There were to be 4 discrete health professionals with whom Lynda would have contact after discharge from Hospital prior to her death, being –

    . The Community Mental Health Service.
    . Her G.P, Dr Floro
    . Her former private Psychiatrist, Dr Heiner.
    . The Methadone Clinic

5. The CMHS were involved because Lynda had commenced Clozapine that required weekly attendances at the Clozapine Clinic and it was understood Dr Heiner was away on leave for some 6 weeks. In the interim, CMHS would assume her care.

6. It was important at the time of discharge there was a treatment plan to rationalize the number of anti-psychotic medications Lynda was taking. This was not properly formulated nor communicated to others who were to assume her care.

7. The Discharge Summary prepared by the Mental Health Unit was not apparently received by Dr Heiner or Dr Floro. The Methadone Clinic was not listed as a medical provider on the Discharge Summary and was not sent to the Clinic.

8. The Hospital treating psychiatrist, Dr Turnbull did not communicate any intended treatment plan to those who would assume her care. The CMHS did not seek to adjust Lynda's medication and did not communicate in any substantive way with the private psychiatrist Dr Heiner or with the GP Dr Floro.

[1] With the family's consent I will refer to Ms Clifford by her Christian name.

9. Dr Heiner saw Lynda on 6 November 2009 and was greatly concerned about her level of sedation. No adjustments to the medication occurred, as he had not seen her for some 2 years. There was no subsequent communication from Dr Heiner to the prior Doctor and no apparent communication with the discharging Hospital.

10. Lynda's mother observed a significant deterioration in her daughter's health in the weeks after discharge from Hospital. She said she was heavily sedated for much of the day, often unable to do things with her young family, at times mumbling and needing help for basic things such as showering.

11. On 23 November 2009 Lynda was found at home by a family member and was unable to be revived. Dr McBride, Pathologist recorded the cause of death as drug interaction / overdose.

12. A number of issues arose concerning the quality of care provided by a number of health professionals and the Hospital, the level of communication between them and the cause of death. They can be conveniently summarised as—

. What was the cause of death?

. The actions of the Mental Health Unit

. The actions of the CMHS

. The actions of the Methadone Clinic

. The actions of Dr Heiner, Psychiatrist

. The actions of Dr Floro, GP

. What recommendations should be made?

The nature of an inquest

13. Before turning to the issues, it is important to briefly outline the nature of an inquest. It should be noted the role of the Coroner is limited by statute, in particular under section 81 of the Coroners Act 2009 to return a finding where there exists sufficient evidence, as to the identity of the deceased, the date, place, manner and cause of death. An inquest is not adversarial in nature. It is neither a criminal nor civil proceedings.

14. Section 82 allows for recommendations to be made by the Coroner as are considered necessary or desirable in relation to any matter connected with the death with which the inquest is concerned.

15. Apart from the statutory functions and power to make recommendations, an inquest may serve the important function of enabling family members to better understand the circumstances surrounding the death of a loved one.

16. The main focus of this inquest has been the manner and cause of Lynda's death. It should be noted is not the function of the Coroner to make formal findings of negligent behaviour on the part of any particular health professional involved in her care. Nor is the Coroner's role to sit as a type of medical misconduct tribunal. Where specific or systemic failings of an individual or organisation are identified, any commentary or findings are done so in the context of determining the manner and cause of death.

ISSUE 1-The cause of death

17. Dr McBride recorded the cause of death as overdose/drug interaction. His report summary said --

> "The deceased has a cocktail of prescription drugs with potential toxic and fatal levels for fluoxetine and methadone. The combination of drugs would have the potential for fatal drug interaction."

18. Dr McBride said it was a "negative" autopsy with no obvious organic feature causing the death. It was when the observations of heavy and congested lungs were viewed with the toxicology results that an opinion of respiratory depression was formed. The process of respiratory depression that ultimately leads to cardio-respiratory arrest can come on quickly, for example following an injection of drugs or can be slow and go on for 4 to 6 hours or more.

19. The toxicology results raised the question whether the respiratory depression can be attributed to an overdose (either intentional or accidental) of a particular drug (s) or whether it was from an interaction of a number of drugs. The results in summary were –
    . Clozapine 0.3 mg/l
    . Diazepam 0.10 mg/l
    . Fluoxetine 1.2 mg/l
    . Methadone 1.0 mg/l
    . Nordiazepam 0.14 mg/l
    . Quetiapine (Seroquel) 2.3 mg/l
    . Temazepam 0.05 mg/l

20. Some of the drug readings may at first instance be supportive of an overdose. For example, Fluoxetine was above the therapeutic range (.09--.4) and just short of the lethal range (1.3—6.8). Depending on the scale used, Methadone is arguably up at the upper limit of therapeutic or into the toxic range.

21. It was clear however drawing conclusions based on these levels alone to assess what may have been the dosage taken prior to death is fraught with difficulties. From the evidence of Professor Starmer, pharmacologist, Dr Kneebone, psychiatrist and Dr McBride, pathologist, the following emerged –

    . Fluoxetine is a known inhibitor of 2 isogenes involved in the metabolism and the elimination of a range of drugs including

Methadone, Clozapine and Seroquel that can cause plasma concentrations of these drugs to rise.

- There is after death the potential for chemicals and drugs to redistribute and affect the concentration of the samples taken.

- Clozapine can interfere with Methadone.

- Methadone levels that might otherwise be toxic to one person may be normal for a person stable on methadone over a number of years.

- When 3 or more drugs are involved, it is very difficult to work out the amount consumed.

22. Apart from the toxicology results, regard can be had to the evidence concerning the way the drugs were normally taken. Lynda's mother, Ms Lynette Rogers had control over the medication, holding them in her room in a locked cupboard. The exception was Methadone. When take- way doses were given, they were kept on a cupboard in the kitchen. Ms Rogers would make the tablets available to her each day, although there may have been some inconsistency when the medication was taken and the amount given, for example 2 tablets at once rather than one at night and one in the morning.

23. Although the possibility exists of access by Lynda to more of the medication than her mother made available, based on the evidence as to the way the drugs were normally available and the evidence from the experts as to the difficulties determining quantities taken prior to death, a finding cannot be made that the cause of death was an accidental overdose of a particular drug(s).

24. One aspect is clear. There is no evidence at all to suggest Lynda intended to take her life by an overdose.

25. There are however a number of factors supporting the conclusion the cause of death was respiratory depression from a drug interaction. They are in summary—

    - The evidence of the central nervous system depressant effects of the medications and their cumulative sedative potential on a patient.

    - The observations of Ms Rogers of Lynda's deterioration after discharge from hospital --- of increasing sedation, sleeping during the day, mumbling, bedwetting, needing help to shower and shortness of breath.

    - The observations of Dr Heiner on 6 November 2009 of her appearing heavily sedated.

. The evidence of Senior Constable Rowles who spoke with Ms Rogers, telling him she saw Lynda on 23 November 2009 about 3:30 p.m. lying down asleep on the lounge. She woke her to say she was going to do some shopping. Lynda made a nodding motion with her head.

. The opinion of Dr Kneebone, psychiatrist that while the concurrent use of Fluoxetine served to increase her serum concentration of Methadone through isoenzyme inhibition, such an increase only gave rise to fatal respiratory depression because of the synergistic central nervous system depressant effects of simultaneously being on 3 different antipsychotic medications and Diazepam in conjunction with her Methadone[2].

. Professor Starmer says the most likely cause of her death was an extremely high blood level of Fluoxetine in combination with a number of other drugs which all had central nervous system depressant activity.[3]

26. I am satisfied on the balance of probabilities the medical cause of death was respiratory depression as a result of the interaction of a number of prescribed medications that had a central nervous depressant effect.

ISSUE 2-The actions of the Mental Health Unit

27. There are no issues concerning Lynda's care and treatment from her admission on 6 August 2009 until immediately prior to her discharge on 24 August. Variations to the existing medications (Clopixol and Seroquel) were made. Methadone and benzodiazepines were continued during her admission. The two significant additions to the medication were the introduction of the anti-depressant Fluoxetine and the antipsychotic drug Clozapine, the latter directed at addressing her very high risk of suicide.

28. Nursing entries record occasions when medications were withheld due to observed signs of over sedation. When Lynda left Hospital she was on the following medications—
    . Clozapine - antipsychotic
    . Methadone
    . Fluoxetine- antidepressant
    . Seroquel (quetiapine)- antipsychotic
    . Temazepam
    . Diazepam
    . Clopixol- antipsychotic

29. Dr Kneebone, psychiatrist agreed the dosages, range of medications and at times the resultant sedative effects is not unusual in a hospital setting. What

[2] Brief p 63
[3] Brief p 679

was unusual was to be taking 3 anti-psychotics with the other medications when an outpatient.

30. Dr Kneebone had upon reviewing the hospital records and brief of evidence understood the treating psychiatrist Dr Turnbull had a management plan involving the immediate stopping of the anti-psychotic Clopixol and then the progressive lowering of the anti-psychotic Seroquel over a period of some 3 months as the new anti-psychotic Clozapine took effect. This "plan" was he considered clinically appropriate. He explained –

> "Managing potential central nervous system drug interactions becomes increasingly more difficult and unpredictable as the number of medications prescribed increases especially when they are 3 or more central nervous system active drugs being taken at any one time.
>
> In Ms Clifford's case, she has simultaneously taking 6 central nervous system active drugs.
>
> In light of the above a clear treatment priority would be to rationalise Ms Clifford's psychotropic medication regime and attempt a reduction in the number of central nervous system active drugs being taken by Ms Clifford at any one time. In Dr Turnbull's management plan (enunciated in his statement to the New South Wales police) he outlined his intent to cease Ms Clifford's Clopixol injections and embark on a progressive lowering of the dose of her Seroquel over the course of some 3 months as the Clozapine commenced on 20 August 2009 exerted a clinical effect.
>
> The author of this report felt Dr Turnbull's management plan was entirely reasonable and appropriate although it would have been highly desirable if he also included in his management plan a strategy for weaning Ms Clifford from the benzodiazepine medications Diazepam and Temazepam on an out patient basis".[4]

31. Dr Kneebone went on his report to observe the dosages of the medications were well within accepted prescribing guidelines. He said the combination of medications was acceptable but on the proviso they were prescribed only on a time limited basis (3 months or less), that her Clopixol injections were discontinued immediately following her discharge from Hospital and that Dr Turnbull's management plan was going to be instituted.

32. The evidence at the inquest however raised some important preliminary questions. What did Dr Turnbull in fact intend about the cessation of Clopixol and did he really intend to create a management plan at all for others.

The Clopixol

[4] Brief p 1018

33. Dr Turnbull's statement to police was "clopixol injections had been ceased, the last dose given on the day of discharge".[5] Dr Turnbull agreed in preparing his statement he had referred to the Discharge Summary that does not include Clopixol in the list of current medications. His evidence was far from clear, initially stating he assumed he had stopped it, as it is what he usually does. He said it was an old fashioned drug that has a high risk of Parkinsonism. He agreed however the medication chart for Clopixol had not been crossed out, normally a clear indication to stop the medication. Dr Turnbull's evidence was that he has no memory if he intended to stop or continue the Clopixol.

34. How then could the Clopixol continue to be given on 4 more occasions while Lynda was on the other 2 anti-psychotic drugs when the Discharge Summary does not record it as a current medication? Only part of the answer comes from the way the document was completed.

35. Dr Khanlarni was the psychiatric registrar who completed the Discharge Summary normally done by reference to the clinical notes and medication chart. If a medication is not crossed out it is fairly assumed it will continue. Although apparently having this assumption, Dr Khanlarni failed to record Clopixol as a current medication, identify the type of depot injection last given or record when the next injection was due.

36. As will be seen shortly, the CMHS team continued to give further Clopixol injections. There was not the rationalisation of the number of antipsychotic medications as suggested by Dr Kneebone. There was also the potential for the Clopixol to interfere with the other medications. As Dr Kneebone noted –

> "Another potential drug interaction to be aware of is the potential of the CNS effects of Clopixol being increased if used in conjunction with other CNS depressants such as Methadone, Clozapine, Diazepam or Quetiapine"[6].

37. It was said in submissions on behalf of Dr Turnbull the issue of Clopixol was in a practical sense of no involvement in the case and in a causal sense is not relevant. The post mortem toxicology report does not record the presence of Clopixol, although it is unclear whether the laboratory in fact tested for that drug. Dr Kneebone nevertheless said based upon the half-life of the drug it would still be producing a small effect upon Lynda. In any event the continuation of Clopixol starting back with her discharge under Dr Turnbull's care meant she was for a significant period of time on 3 anti-psychotic drugs and her other medication.

38. Referring to concepts of causal links to a death is in my view unhelpful .The statutory function under the Coroners Act requires consideration of the manner of death, namely the surrounding circumstances. A death may not be the result of a single identifiable event but rather a series of events each

[5] Brief p 34
[6] Brief p 63

compounding upon the other and a number of missed opportunities to address the problem. This is such a case.

39. These events highlight at the very least the importance of completing medical records to reflect the current medications and the formulation in writing of the proposed treatment plan. This leads to the next issue.

Was there a "treatment plan" for the reduction of Seroquel?

40. Dr Turnbull's statement to Police was—

> "Quetiapine (seroquel) also an antipsychotic would have a diminishing need as the clozapine exerted an effect and would have been reviewed by Dr Heiner over 3 to 4 months".

41. Dr Kneebone assumed there was a clinically appropriate treatment plan but was critical it was not communicated to other potential medical providers such as Dr Heiner and the CMHS who was to assume care until Dr Heiner returned from leave. The concern is on a fair analysis of Dr Turnbull's evidence at the inquest he did not consider it necessary or appropriate to communicate any proposed treatment plan, in particular an anticipated course of reduction of Seroquel as the Clozapine took effect.

42. Dr Turnbull agreed with the suggestion he didn't want to tell other private clinicians how to do their job. As to the fact Lynda was to be cared for by CMHS until she saw her private clinician, he said Registrars are "stand-alone clinicians" and if they feel assistance is required they can go to a senior doctor. Dr Turnbull said he wouldn't know how to "instruct" others to reduce the drugs because of variables that may occur, including rebound psychosis. He said CMHS had no doubts about what was happening and that after she was discharged he had no intentions concerning her future treatment; any psychiatrist who came across Lynda after discharge would be quite clear what the problems were and he wouldn't tell a consultant what his plan was. Dr Turnbull said there was no need for the CMHS to change anything.

43. There are in my opinion a number of concerns about Dr Turnbull's views--

- There is a marked difference between "instruction" and informing others what was the anticipated treatment plan for the anti-psychotics that may have a potentially grave impact upon a patient's health.

- It is a bold assumption to make that others involved in her care such as her GP and CMHS Registrars would share the same level of expertise and understand without any comment in the Discharge Summary what was the anticipated plan concerning the medication.

- It is clear the CMHS team were unaware of such a likely course of action of a reduction in 1 drug as the other takes effect. The simple fact is if the anticipated course was set out, CMHS could have been on notice to assess if Lynda was stable and began to reduce the Seroquel.

. To suggest that CMHS had no need to change anything does not sit with the fact she was under their care for some 2 months, there were signs of her being stable and as Dr Kneebone observed, efforts could be made to reduce the Seroquel.

. It runs counter to the requirement under the Hospital Directive[7] to develop a Care Plan at Discharge. The Directive requires identification of strategies/interventions, person responsible and target date.

. It runs counter to a most important aspect of patient care, namely communication, not just to the patient but also to other Doctors. It could produce the most unsatisfactory result of another doctor trying to work out why a patient is on such a variety of medications, how long they have been on them and what the prior Doctor was intending by the range of medications.

. Variables in future patient care should not mean as a matter of logic a proposed treatment plan could not be provided.

44. Dr Kneebone made the commonsense observation that he would not be telling another doctor "what to do", but would be telling the other doctor his plan. It is up to the other Doctor to decide if they want to follow it or not. He said he would have a risk management plan documented in the Hospital notes so that when there is a transfer you share with the Doctor your plan that can if desired be altered.

45. Dr Kneebone said he would have communicated both to Dr Ediriweera at CMHS and to Dr Heiner and the proposed treatment plan should have been in the Discharge Summary. It is in my view a sensible and plausible approach to have taken yet it did not occur in this case.

The issue of 5 repeats for Seroquel

46. At the time of discharge, Lynda was given a script signed by Dr Turnbull for the Seroquel, plus 5 repeats. Each script when filled provided 60 tablets to be taken at two tablets a day. Approximately 6 months of Seroquel tablets were then available yet it was anticipated she would see Dr Turnbull in about 6 weeks.

47. A review of the printout from the Pharmacy Lynda attended suggests the frequency of filling the Seroquel scripts was beyond the recommended dosage. However the fact remains she continued to present the Seroquel scripts up to and including the day of her death on 23 November 2009, despite what as Dr Kneebone indicates, should have been a lowering of the Seroquel as the Clozapine took effect.

[7] Policy Directive –Discharge Planning for Adult Mental Health Inpatient Services; Document number PD 2008-005

48. Dr Turnbull's explanation for the issue of 5 repeats was that it was "habit" and the Registrar who assumed care may not have a provider number. It is clear the issue for 6 months supply was not based upon a clinical assessment of the patient's needs. I agree with Dr Kneebone's observation that it was "less than ideal and reveals no thought out plan of management that should have been put into practice".

The distribution of the Discharge Summary

49. Dr Khanlarni intended the Discharge Summary to go to the CMHS, Dr Floro (GP) and Dr Heiner, Psychiatrist. All names appear at the foot of the form as service providers who will be undertaking follow up. The CMHS file shows the receipt of the Discharge Summary. Both Dr Heiner and Dr Floro assert they did not receive a copy.

50. Dr Khanlarni gave evidence it is usual practice after completion of the form to provide it to the ward clerk who would fax it to the relevant parties. The Hospital points to the stamp headed "faxed" appearing on the form held by the Mental Health Unit combined with evidence of the normal procedure to support the conclusion the forms were sent to all parties.

51. The stamp is evidence it was sent but is silent as to the recipient. There is no fax cover sheet on file, no endorsement on the stamp as to recipient and no endorsement against the relevant service provider.

52. Although there are undoubtedly concerns about the apparent failure by Dr Floro to receive several pieces of correspondence, I accept on balance neither he nor Dr Heiner received the form. The letter from Dr Heiner to Dr Floro dated 6 November 2009 makes no reference to a Discharge Summary and is inconsistent with his comment that "apparently" she had been admitted to the Mental Health Unit. The list of medications set out in Dr Heiner's letter is explainable by Ms Rogers' evidence she took the medications to the appointment. Dr Floro's account that when he saw Lynda and her mother they had not been given a copy is correct and says he asked for them to obtain a copy. The request for arrangements for an echocardiogram appear to have come not from the notation directed to Dr Floro on the form but from Ms Rogers telephoning Dr Floro's practice.

53. In my view the present Discharge Summary form is, when used in the environment of a busy ward prone to error as to recipient. An earlier version of the form[8] provided for a tick a box and date section that would provide for greater certainty it has been sent to all relevant parties.

The Methadone Clinic

54. It should not be overlooked that Lynda was seeing another important service provider, namely the Methadone Clinic. A discharge summary was not however sent to that organisation nor was it recorded as a service provider. The medications she was taking on discharge could have a potentially significant impact upon the methadone. As Dr Turnbull observed, "many

[8] Brief p 478

antidepressants can interact with Methadone. One mechanism is by increasing serum levels of Methadone. The risk is regarded as a moderate one"[9]. Despite this apparent moderate risk the very provider of the methadone was not recorded as a service provider and given a discharge summary.

55. Counsel for Dr Turnbull made the curious submission that as the Discharge Summary had not reached Dr Heiner it had no impact upon what he did. In a strict literal sense that is correct. But it can hardly be said by not informing and not communicating relevant information it acts in some mitigatory fashion.

Communication of a discharge care plan with the family

56. The issue of the extent of understanding of the treatment plan by Lynda's family arose during the inquest. Ms Rogers says they received no Discharge Summary or any paper work except a large number of scripts and was told she will be a "different person" with the new medication. She said there was no discussion about what the doctors intended or advice as to the potential symptoms to be aware of. She was not aware Lynda had to go to the Clozapine Clinic.

57. It is clear Ms Rogers was unaware of an intention to reduce the Seroquel as the Clozapine takes effect. In fact not even Dr Khanlarni who prepared the Discharge Summary was aware of this likely course.

58. The Hospital correctly identified the important role of the CMHS case manager and the appropriate contact with the family including an initial home visit. Their role and actions is not in any way the subject of criticism. What did emerge however, was a picture of a patient, affected by a large number of antipsychotic medications and a family member, no doubt in a distressed condition concerned about the welfare of her daughter, leaving the hospital with little information and so as Ms Rogers can recall, no written information.

59. Dr Kanlarni said a Discharge Summary is not given to the patient. Asked how a patient would know what medications to take, she said a Chemist who fills the scripts might produce a list. There was certainly no reference to any documentation by way of a care plan to assist the family. There is nothing in the Hospital records to suggest the creation of such a document.

60. Dr Kneebone said he would normally produce a treatment plan in writing for the family. It would not necessarily be a Discharge Summary. It sets out the list of medications, next appointment and after hours contact numbers. It would seem an eminently sensible course to follow.

61. The question then arises, what should Lynda and the family have received by way of documentation to assist in their understanding of her future treatment?

[9] Brief p 35

62. On the face of it, the Hospital should have complied with the New South Wales health Policy Directive -- Discharge Planning for Adult Mental Health Inpatient Services. This document was operational from January 2008 and certainly covered the period of Lynda's admission. So far as I can discern, this Directive required the development of a Discharge Care Plan. By way of example, at page 11, the discharge planning principles requires a comprehensive discharge care plan be developed before discharge. At page 13 it specifies a copy of the discharge care plan be provided to the consumer and with the consumers consent their family and primary carer. It further provides at page 15, a copy of the discharge care plan should be attached to the discharge summary wherever possible. An appendix 1 is found a checklist for the discharge care plan requiring identification of the list of medications, follow-up appointments and after hours contact information.

63. It is clear no such discharge care plan was provided to the family or indeed to CMHS. This mandatory directive appears clear enough yet the Local Health District has, in response to questions raised on my behalf after completion of the evidence, provided information that Care Plans are not provided to patients. The advice received is as follows---

> The care plans particularly as they relate to patients in acute inpatient units are documents used by inpatient staff to plan inpatient care. These are directed to plans to move a patient to the point where they can be discharged. They are not used by the inpatient units to prepare post-discharge care plans. These plans are essentially part of the record of that inpatient occasion of service.
>
> Once the patient is well enough to be discharged, information about that admission and the treatment they were receiving at the time of discharge including medications etc is communicated to those who will assume care e.g. GPs and the like in the discharge summary. For these reasons the Local Health District does not provide care plans to patients at the time of discharge.

64. The apparent contrast between the Policy Directive and the position of the Local Health District is stark. Where then does that leave the patient and the family? On the face of it, without a discharge care plan and according to Dr Khanlarni and Dr Turnbull, without a copy of the discharge summary. There is nothing so far as I can see that directs a copy of the discharge summary to be provided to the patient. I accept the CMHS case manager has an important role to play in liaising with the patient. Nevertheless, a review of the application of the Directive should in my opinion occur.

Issue 3 –The Actions of the Community Mental Health Service

65. Staff at the mental health unit understood Lynda had been under the recent care of Dr Heiner and he was on leave some 6 weeks. Dr Khanlarni properly sent out a letter to CMHS requesting a "short period of case management

and clozapine clinic"[10]. Lynda was appropriately assessed on a weekly basis as part of Clozapine program, there being significant potential health impacts to be considered against the benefits of Clozapine. The focus at the inquest was the reason for the continuation of Clopixol and what staff understood their actual role to be in her care.

The continuation of Clopixol

66. Whatever Dr Turnbull's actual intention concerning the Clopixol injections, they were continued by CMHS, albeit in largely unexplained circumstances.

67. The records indicate 4 occasions Clopixol was given. Three of the fortnightly injections were in fact 100 ml rather than the 200 ml given when an inpatient. There is no suggestion this change was based on a clinical assessment of the need for the drug. Moreover, there was no charting of the medication until the last injection on 20 October 2009. Dr Ediriweera appropriately made contact with Dr Khanlarni at the Mental Health Unit and it would appear he was advised Clopixol was to continue and at the dosage of 200 ml.

68. The gap between the last injection on 20 October 2009 and her death on 23 November 2009 was not the result of anyone turning their mind to whether it should cease but rather the time gap between CMHS completing their role and Lynda seeing Dr Heiner. In fact even on 23 November Dr Heiner was writing to the Dr Floro, GP requesting he give her the injection.

The role of CMHS

69. The notes of Dr Ediriweera, Psychiatric Registrar are detailed and helpful in recording his observations and treatment plan. The notes and evidence suggest when she was seen there was nothing about her appearance, in particular her level of sedation to cause concern. There is no suggestion that CMHS ignored obvious signs of sedation when they saw Lynda.

70. It appears Dr Ediriweera saw his role as primarily focusing on the Clozapine Clinic and as a caretaker between the discharge and planned assumption of responsibility by Dr Heiner. He said it was a "transitional period, I was seeing her for Clozapine". He did not consider he had any broader role to monitor her other medications as per the Discharge Summary, however as part of the team he had a role to monitor her general mental health.

71. This view of his role does not sit comfortably with Dr Ediriweera's decision to issue a script and 5 repeats for Seroquel on 29 September 2009. Lynda in fact filled the script on 1 occasion. It transpired it was for a lesser quantity namely 300 mg a day. Again this was not based on a clinical assessment but rather an error. The issue of repeats, as with Dr Turnbull, was not clinically based. It was standard or common to do so. It appears to be based at times on potential cost savings for a patient.

72. It is clear Dr Ediriweera did not intend to alter the medication as "she had just been released". It is also clear no consideration was given to the reduction of

[10] Brief p 98

Seroquel or rationalization of the number of medications she was taking. Equally he was given no information in the Discharge Summary or from any other source that this was the anticipated course as the Clozapine takes effect.

73. The CMHS notes make clear Lynda's mental state had significantly improved. By mid September 2009 and throughout October until the last appointment on 27 October, CMHS were being told the auditory hallucinations had gone and there were no suicidal thoughts. Dr Kneebone picks up on the significance of this stability and the need to review the amount of Seroquel. He said--

> "No attempts were made to reduce the dose of her Seroquel despite Ms Clifford denying thoughts of self harm, or auditory hallucinations or persecutory ideation when assessed at the Community Mental Health Unit in late October 2009.
>
> At those reviews, Ms Clifford described the mood as being good and insight and judgement were assessed to be reasonable, yet no adjustments to her psychotropic medication were made.
>
> To be fair to Dr Ediriweera, however is a trainee rather than fully qualified psychiatrist and if he is not aware of Dr Turnbull's plan of management he may have elected to continue with the status quo of medications if there was no evidence of excessive sedation and her psychotropic symptoms were well controlled on mental state examination".[11]

74. Dr Kneebone saw as appropriate allowing for variations between patients, a progressive lowering of the Seroquel over some 3 months after discharge, yet it did not occur. He made the telling observation Lynda was discharged on 24 August 2009 and ultimately her care was transferred to Dr Heiner in October being roughly 2 months. He considered it was an "absolution of responsibility of activating a plan of management" and that for "2 months Lynda was taking 3 antipsychotic medications simultaneously when she may not have needed to".

75. The difficulty of course as has been made apparent through this inquest is that no plan of management focusing on the immediate cessation of the Clopixol and reduction of the Seroquel as Lynda became stable was formulated, documented and communicated to CMHS staff and others.

The absence of communication to Dr Heiner

76. Although she was under the care of CMHS for some 2 months there was, save a telephone call outlining that Lynda was under their care, no significant communication with Dr Heiner of her progress and current medications. There was no communication with her GP Dr Floro. As Dr Kneebone

[11] Brief p 60

observed, it is “vital” there be lines of communication, either written or telephone when there are multiple doctors involved in a patient’s treatment.

77. The absence of communication is in my view symptomatic of the compartmentalized approach to medical care that occurred in this case.

ISSUE 3—The actions of the Methadone Clinic

78. Lynda had been attending the Methadone Clinic since 2008 and Methadone was continued during her hospital admission and after discharge. She was on the whole a regular daily attendee at the Clinic, often being driven there by her mother.

79. According to Dr Govender who saw her on a number of occasions, she appeared stable on Methadone and there was nothing about her appearance to raise concerns. On 23 November 2009, she had attended the Clinic, taken her daily dose and was allowed 2 take away doses. The reason provided however to the Clinic was clearly false, namely her son was in hospital. Despite the fact Lynda obtained take-always on more than one occasion by giving false reasons, she had been in the program long enough and stable enough for her to in fact be allowed a number of take-aways per week. Ms Rogers says the 2 take-aways were poured down the sink following her daughter's death given concerns the children may access them.

80. Dr Govender said he and other staff were aware of the fact the mix of drugs with Methadone is likely to have an effect on the central nervous system although he was unaware Fluoxetine (an antidepressant) could interact to increase Methadone plasma levels. From Dr Govender's evidence, the focus was one of observation of the client for signs of sedation rather than what he described as a “theoretical” impact. Nevertheless, Dr Kneebone made what I consider a logical and commonsense observation that with a dual diagnosis patient such as Lynda, it would be important those involved in the methadone treatment be aware of the potential effects of mental health drugs, in particular Fluoxetine.

81. The significance of the role of the Methadone Clinic in this inquest turns not so much on their actions but to a broader systemic issue of the lack of communication between the discharging Mental Health Unit and the Methadone Clinic.

82. Dr Turnbull assessed the risk of the interaction of the antidepressant drug and Methadone as a moderate one. He said Methadone has a very big impact upon the central nervous system. It would then be logical the very provider of the substance that can cause a moderate risk to the patient is given information about the current medications Lynda was taking. Yet it didn't happen.

ISSUE 4 –The actions of Dr Floro

83. Dr Floro had been Lynda's GP for several years. He was generally aware of a psychotic illness prior to her admission and had been arranging for her Clopixol injections. He had continued to provide before admission and after discharge benzodiazepams, namely Temazepam and Diazepam.

84. Dr Floro says Lynda and her mother came to see him shortly after discharge, something that happens regularly. But he said they came without a Discharge Summary. Exactly what he did when she attended on this and other occasions is less than clear due in part to the scarcity of detail in his medical notes.

85. The effect of Dr Floro's evidence was that his role was to deal with day-to-day GP matters leaving the mental health issues for the experts.

86. Ms Rogers says she told Dr Floro her daughter was constantly tired and Dr Floro said it was the "meds". Ms Rogers observations of Lynda are in contrast to Dr Floro's account that she presented well and in fact so well he had no reason to put it down in his notes, including the morning of 23 November 2009 when she came seeking to a Clopixol injection. Again the paucity of record keeping by Dr Floro makes it difficult to point to contemporaneous notes that support his account of events.

87. Moreover, Dr Floro's work systems concerning receipt and filing of correspondence appears to have been less than ideal. It is said 2 letters from Dr Heiner were not received. One is of particular note, being a letter dated 6 November 2009 from Dr Heiner that expresses his shock about Lynda's appearance. He said she was sedated, spending much of the day in bed or looking at the walls and that the current situation is "obviously of concern". Although there may be reasons to explain a variation in a person's appearance such as the time and amount of medications are taken or factors such as an infection, Dr Heiner's observations and the evidence of Ms Rogers do not readily sit with Dr Floro's evidence that when he saw her she appeared well.

88. Dr Floro maintains he requested the Discharge Summary from the family, a matter denied by Ms Rogers. Dr Floro's assertion the failure to personally seek a copy from the Hospital was because of some potential patient confidentiality issue is of little weight given he had been the treating doctor for a lengthy period.

89. Despite not receiving the Discharge Summary and being unaware of the various medications she was taking upon discharge including the fact she was on Methadone, Dr Floro nevertheless continued to issue scripts for benzodiazepams. He was unaware their strength had in fact been reduced upon discharge from Hospital. Dr Floro is correct when he says he wasn't adding any new medications however it is far from clear how he was able to assess whether the medications may in the circumstances of a recent admission to the mental health unit be contraindicated. Indeed Dr Kneebone noted that the antidepressant Fluoxetine can in fact increase the Diazepam levels.

90. Although there is a dispute between the recollections of Dr Floro and Ms Rogers and the records are unclear, one matter was clear. Ms Rogers had raised with Dr Floro concerns held by Dr Heiner about the number of medications Lynda was taking and there was no enquiry what was those concerns were.

ISSUE 5-The actions of Dr Heiner

91. Dr Heiner had not seen her for some 2 years. He received a call from the CMHS concerning Lynda and he suggested she make an appointment to see him. On 6 November 2009 Lynda and Ms Rogers saw Dr Heiner. He was so shocked at her appearance he felt she "would not have lasted a few months the way she was". She had no obvious psychotic symptoms but was slow, head down and slow to respond. He said he needed to catch up after not seeing her in 2 years, to clarify what might be causing the heavy level of sedation, make contact with the prior doctor and find out what happened at the Hospital.

92. Dr Heiner says he did not receive the Discharge Summary and believes the list of medications that he had set out in his letter to Dr Floro was from Ms Rogers. He said in the letter –

> …"As I have just caught up with her, I am not going to make any dramatic changes to her medication but the current situation in itself is obviously of concern."[12]

93. Dr Heiner said in evidence there were a number of possible explanations for the level of sedation and he needed to gather relevant information. It appears from the records there was then a further consultation on 11 November. It would be fair to say the notes of that consultation are indeed scant with the words appearing "been good". Dr Heiner believes this indicated there had been an improvement in her condition from the earlier week and the urgency may have dissipated.

94. It would appear there was a further intended appointment of one week later. In the interim some blood tests were ordered. Lynda was unable to attend that appointment due to car troubles and Dr Heiner did not see her again before she died on 23 November.

95. Dr Kneebone, psychiatrist expresses some sympathy for the position Dr Heiner was placed in without communication from Dr Turnbull, the absence of information in a Discharge Summary and no communication from CMHS. There are nevertheless issues as to what steps Dr Heiner in fact did take to gather relevant information and take appropriate action.

96. In answer to the question whether a Discharge Summary would have been of assistance at the consultation on 6 November, he said they tend "to leave a

[12] Brief p 460

lot to be desired" although acknowledged they are a "starting point". It would seem however as a matter of commonsense, a document setting out a diagnosis, current medications and hopefully a treatment plan would be a most important piece of information gathering. Dr Heiner says he assumed he would have tried to contact the Hospital but in fact there is no record of it. He agreed with the proposition that based upon his notes, we simply don't know what he did.

97. There is over the time from 6 November until her death on 23 November, no receipt of the Discharge Summary or any entries in Dr Heiner's records suggesting any discussion with the Hospital or Dr Turnbull (the last doctor considered by Dr Heiner to be the most useful source of information) or attempts at contact.

ISSUE 6 –The question of Recommendations

98. It is undoubtedly the case the inquest has been a distressing experience for Lynda's family. The personal statement from her mother revealed the family's love for her and the immense grief they all feel in her passing.

99. The inquest has however served an importance purpose. In considering the manner of death, it has highlighted a disturbing lack of communication between health professionals and missed opportunities to rationalize the number of medications Lynda was taking.

100. It should be remembered this was not case of a person inappropriately accessing medications intended for others. The Methadone, antipsychotic and antidepressant medications ultimately having a cumulative sedative effect leading to respiratory depression had been prescribed for her.

101. The family appropriately acknowledge the issue of communication is not limited to the health professionals. It is important where possible patients and family members be strong advocates in raising concerns with their Doctor.

102. The Hospital Directive entitled "Discharge Planning for Adult Mental Health Inpatient Services" rightly observes that "Effective Discharge Planning" is essential to the safe and successful transition of mental health consumers from Hospital to the Community. The Discharge Planning principles include--

> . Clear and timely communication between consumers, primary carers and all clinicians is essential".
>
> . A comprehensive Discharge Care Plan should be developed.
>
> . Provision of consumer and primary carer information and education is essential prior to discharge.[13]

[13] Policy Directive page 6

103. There can be no dispute about these guiding principles. There is however in my view comparatively little adherence to these principles in Lynda's case.

104. There was in short -

. No substantive communication between the Hospital's Mental Health Unit and the private psychiatrist and GP.

. No substantive communication between the Community Mental Health Service and the private psychiatrist and GP.

. No communication by the treating psychiatrist at the Mental Health Unit of an anticipated course of treatment in particular the reduction of one antipsychotic as the other takes effect.

. No substantive communication between the Mental Health Unit and the family.

. No communication from the GP with the Hospital or treating doctors.

. No apparent communication from the private psychiatrist after discharge with the Hospital or prior Doctors.

105. The question then arises as to the recommendations that should be made.

106. On the issue of receipt by other Health Professionals of Discharge Summaries, the Hospital referred to a Mental Health Clinical Business Rule document entitled "Dissemination of Adult Inpatient Discharge Summaries". It appears to have been introduced in October 2011. Among the reasons listed for the Rule is to ensure a record of transmission and receive receipt is available. It directs a ward clerk to fax the transfer /discharge to persons such as the GP, private psychiatrist and Clozapine co-ordinator. A "patient flow co-ordinator" is to undertake a weekly follow –up audit of sent /received summaries at the weekly community meetings.

107. I do not consider the Rule addresses the problem that arose in this case. It does not deal with the issue of a single faxed stamp on a form without endorsement as to whom it is sent. The audit in community meetings would not appear to enable confirmation the form was received by the outside provider, eg GP or psychiatrist. Consideration to a change of the form should occur.

108. On the issue of communication and co-ordination of care, I have been referred to 2 documents. The first is "Discharge Planning for Adult Mental Health Inpatient Services". I have previously referred to some of the guiding principles in effective discharge planning and their absence in this case. Reinforcement through further education and training of the importance of communication through the discharge process should be considered by the Hospital.

109. I have previously commented upon the apparent conflict between the Policy Directive and the approach taken by the Local Health District. A simple answer to the different approaches is not readily apparent. Although acknowledging the role of case managers, nevertheless so far as I can determine patients leaving the mental health unit received neither a discharge summary nor care plan. Regardless of the title of the document, the need to educate and involve the patient should be of particular importance. I consider a recommendation for a review of the discharge planning process and the documentation provided to be timely.

110. It must be said although there are an apparent myriad of Directives and Guidelines, it is unclear which existing form if any, provides for the patient and family the basics outlined by Dr Kneebone covering the diagnosis, list of current medication, next appointment and after hours contact telephone numbers. A review of the forms to ensure this sort of information is provided is recommended.

111. The second document is the "Care Co-ordination Guideline" published in December 2011. This lengthy document refers to the role of a "primary clinician" who is responsible for co-ordinating the care of a patient across different mental health service providers. The definition covers a nurse or allied health professional such as a social worker. It is unclear whether there is a significant difference to the pre-existing role a CMHS case manager. Nevertheless, the Guideline states the clinician is responsible to ensure "collaborative discussion" with the client and family regarding a discharge plan[14]. It refers to a discharge plan that will outline time frames, discharge strategies and local community supports following discharge.

112. It is hoped Lynda's family and wider community will take some comfort from the fact new Hospital guidelines and the proposed recommendations should assist in improving Discharge Planning and communication between Health Professionals.

113. The Court extends its sincere sympathies to the family for their loss.

Finding

114. Lynda Vanessa Clifford died on 23 November 2009 at 29 Lawarra Street Port Kembla, New South Wales from respiratory depression as a result of the interaction of prescribed medications.

115. **Recommendations**

To the Minister for NSW Health.

That consideration be given to:

[14] Page 18

1. A review of procedures in relation to the completion and dissemination of discharge summaries/care plans following mental health admissions to NSW Hospitals, in order to ensure:
    a. adequate details of current medications, current treatment plan and any recommendations for ongoing treatment are included;
    b. discharge summaries are disseminated to all necessary recipients, including Methadone Clinics involved in the patient's care, where clinically indicated; and
    c. the formatting of discharge summaries prompts administrative staff to confirm that summaries have been sent to all intended recipients.
2. A review of the Discharge Planning Process of Mental Health Patients by the Local Health District in light of the Discharge Planning Directive that suggests on a reading of the document the need for creation of and provision to the patient of a Care Plan.

3. In the event Guidelines and Directives do not already require it, consideration be given to developing a standardised document to be provided to a patient and/or family at discharge setting out:
    a. diagnosis made during admission (if available);
    b. medication regime at discharge;
    c. details of the next out patient or private appointment; and
    d. contact details should the patient or family have questions arising from discharge.
4. Consider amending the New South Wales Opioid Treatment Program Clinical Guidelines to highlight the need for prescribers to consider Fluoxetine interaction with Methadone and the capacity of Fluoxetine to inhibit metabolism of Methadone and thereby raise plasma Methadone levels.

To the Chief Executive Officer of the Illawarra Shoalhaven Local Health Network

That consideration be given to:

5. Taking appropriate steps to reinforce through further education and training at the Wollongong Hospital Mental Health Unit the importance of accurate record keeping in particular accurate recording of medications on discharge summaries and recording in the clinical notes decisions to cease medications.
6. Taking appropriate steps to reinforce through further education and training at the Wollongong Hospital Mental Health Unit the desirability when prescribing anti-psychotic medications to limit repeat authorisations to those cases where repeats are clinically indicated.
7. Taking appropriate steps to reinforce through further education and training at the Lake Illawarra Community Mental Health Team the importance of record keeping and the need to chart depot authorisations and administration.
8. Taking appropriate steps to reinforce through further education and training at the Lake Illawarra Community Mental Health Team the importance of communication of a patient's current and proposed treatment plan with those Health Professionals who are to assume care after discharge from CMHT.

Ian Guy
Deputy State Coroner
Wollongong

5 September 20102