IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2012 / 0070

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)
Section 67 of the ***Coroners Act 2008***

Inquest into the Death of: KIRSTAN MCRAE-JANSEN

Delivered On:	1 September 2014
Delivered At:	Coroners Court of Victoria 65 Kavanagh Street Southbank 3006
Hearing Dates:	12 March 2013
Findings of:	PETER WHITE, CORONER
Police Coronial Support Unit	S/C Tracey Ramsey

I, PETER WHITE, Coroner having investigated the death of KIRSTAN MCRAE-JANSEN

AND having held an inquest in relation to this death on 12 March 2013
at Melbourne
find that the identity of the deceased was KIRSTAN MCRAE-JANSEN
born on 1 August 1980
and the death occurred on or about 7 January 2012
at 12a Elmhurst Road, Blackburn 3130
from:

1 (a) CONSISTENT WITH PLASTIC BAG ASPHYXIA

in the following circumstances:

1. Kirstan McRae-Jansen (Kirstan) was a 32 year-old-woman with a history of schizophrenia, borderline personality disorder and substance abuse.[1]

2. She had made several suicide attempts with the first being at 22 years. These included overdosing on prescribed medication and self-harm by the cutting of her wrists.

3. At the time of her death, Kirstan was seeing Consultant Psychiatrist Dr Judith Hope, whom she had seen regularly at the Koonung Community Mental Health Clinic.

4. Kirstan's mother, Diane Harpour and sister, Erin McRae Jansen,[2] both testified detailing Kirstan's on going battle with depressive illness.[3]

5. From her mother's evidence, I note the following:

    a) From aged 15 Kirstan often stayed out with friends. She became pregnant and later decided to terminate the pregnancy, which she did. At aged 15-16 she '*made herself homeless and stayed with friends and eventually in a shelter for homeless teenagers.*'[4]

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[1] See exhibit 5 at page 1.

[2] Erin McCrae-Jansen was Kristan's half sister. Ms McRae-Jansen represented the family during Inquest.

[3] See exhibit 1 her mother's statement, at page 1. 'She was treated at Maroondah Hospital for several months and seemed to come good.'

Her father Stephen McCrae also made a statement setting out his criticisms of the management of his daughter's condition, which statement became exhibit 3.

[4] Ibid page 1.

b) Later upon her return to her mother's home she often got involved in protection of her mother against physical violence perpetrated by her mother's then partner.

c) Kirstan left school after year 10 in 1997. From that time her employment was irregular. Later she began a relationship with a male person and lived together with him at his parent's home over a 12 month period. According to her mother that person was a heroin addict and the relationship ended when he, *'tried to kill Kirstan.'*[5]

d) During 2004, Kirstan moved to a unit in Bon Beach and obtained employment as a carer for disabled persons. One day after a period of time without contact with her mother, her mother went to her unit and discovered Kirstan sitting in a corner while as she described it, *"she was in like a catatonic state."*[6]

   She was taken to Maroondah Hospital and admitted to the Adult Mental Health Unit.

e) Her mother further informed that during that time she had been treated for:

   > *"Paranoid Schizophrenia, Schizo-affective disorder, Bi Polar disorder, Drug induced psychosis, Dysthmia, Major Depressive Disorder, Anxiety Disorder, Substance Abuse Disorder and Borderline Personality Disorder."*

   Kirstan always felt that she didn't need medication and didn't have any of the disorders.[7]

f) During 2007, Kirstan disappeared from the home she shared with her mother while her mother was away in New Zealand. At this time she was engaged in a turbulent relationship and again according to her mother Kristan attempted suicide at least twice as a result of arguments with this person.

g) Further attempts were undertaken by overdose on prescribed medication and some of that medication specifically benzodiazepines, *'caused her to become more depressed and suicidal'*.

At transcript page 9, Ms Harpur testified that Kirstan from aged 13, spoke of her suicide ideation and thereafter saw a psychiatrist every week over a 12-month period.

[5] Ibid page 2.

[6] Ibid.

[7] Ibid.

These were often followed by admission to either Maroondah Mental Health Unit, or to Upton House at Box Hill.

h) In December 2010, Kirstan was admitted to Maroondah, as an involuntary patient after overdosing on olanzapine. She was given Valium PRN and later injured herself while trying to escape by climbing over a 20 foot wall, and falling to the concrete below.

i) Later, while celebrating Christmas Day with her family she excused herself and was later seen to run in front of a van, which collided with her. Her mother's belief was that this incident also occurred because of her earlier intake of Valium.[8]

j) In January 2011, Kirstan was placed on a Community Treatment order. In a further (later) incident in 2011 Kirstan took an overdose of Paracetamol and was admitted to the Austin Hospital ICU, where she stayed for two weeks, '*with failing kidneys and liver function*'. Following this incident and while still in the ward, Kirstan attempted to jump out of a hospital window, following which she was provided with one to one support nursing.

k) Kirstan completed a relaxation massage course in October 2011 about which, she became more positive in outlook, but soon after she reverted to her previous mindset, '*and seemed very depressed about everything. Kirstan wanted to be off the CTO and out of the Mental Health System. She was taking Paxam for anxiety. I believe this made her worse*'.[9]

6. From Dr Hope's evidence, I note the following:

   a) Dr Hope provided Kirstan with care at the Koonung Community Mental Health Clinic from August 2010.

   b) She summarized Kirstan's mental health history (as she believed it to be) from 1994.

   1994 Age 13

   First presentation to Child and Adolescent Mental Health Service (CAMHS)

   First suicide attempt

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[8] Ibid page 3 and 4.

[9] Ibid page 4.

1994	Onset self harming behaviour by cutting
1996	Significant increase in self harm behaviour
2004	First adult admission Diagnosis Schizophreniform Psychosis
2004	Second admission Diagnosis of Major Depressive Disorder
2005	3rd admission Schizoaffective Disorder, Polysubstance Use, Borderline Traits
2006	Fourth admission
2007	Fifth admission
2008	Treated in community Clear psychotic symptoms including persecutory delusions, believed that people were invading and bugging her home, believed in being followed, ideas of reference. Treated with risperidone, paroxetine, diazepam.
2009	(May), sixth admission.
2009	Assessed and accepted for Case Management and SPECTRUM involvement
2009	August, seventh submission

c) In relation to prior risk to self, Miss McRae had attempted suicide multiple times. She had attempted suicide by cutting her wrists, overdose, self hanging, cutting her throat, self drowning, and on one occasion lay in front of an oncoming train after taking alcohol and benzodiazapines.

d) Miss McRae also presented a risk to others including threats of violence to family, and physical aggression towards family members, which occurred in the setting of acute psychosis. She was reported to have previously held a knife to her mother's throat, and on a separate occasion attacked her mother with a glass. She had previously been charged with stabbing her mother's partner in the hand with a knife.

e) In November 2008, she assaulted an Emergency Department clinician.

f) Prior treatments had included:

- schema therapy, mindfulness and crisis management with a private psychologist
- group therapy with Spectrum
- antipsychotics: olanzapine, quetiapine, risperidone
- antidepressants: citalopram, sertaline, duloxetine

g) Miss McRae's substance history included the commencement of illicit drug use at age 15. Miss McRae described alcohol dependence by the age of 18. She commenced cannabis use around 17 to 18 years of age. She had used or experimented with most illicit substances except heroin.

h) Miss McRae's pattern was to use substances in order to manage her emotional distress. At the time of referral, Miss McRae was a regular user of cannabis, and an occasional user of alcohol.

i) Miss McRae's medical history included a termination of pregnancy at 15, and she was reported to have had several other terminations. She was otherwise medically well.'[10]

j) Dr Hope last saw Kirstan at Koonung on 15 December 2011, i.e. some three weeks before her death. At that time, Kirstan appeared to be in an improved and stable condition, and was said to be able to explain herself and converse in a rational manner.[11]

January 6 and 7, 2012

7. On 6 January 2012, Kirstan spoke to her sister Erin at 8.13 hours.[12]

8. On 7 January 2012, her sisters Erin and Ailie, attempted to contact her on the phone but were unable to do so. They subsequently attended her address and when unable to raise her, they broke into the house through a rear bedroom window.

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[10] See Dr Hope's statement at exhibit 5, pages 1 and 2.

[11] See transcript page 99.

[12] See exhibit 2.

9. Kirstan was lying on her left side on a single bed in the rear bedroom. She had a plastic shopping bag over her head and there was a 9 kg LPG bottle on the floor beside the bed, with the hose from the bottle extending up into the plastic bag.

10. At this point her sister Erin immediately tore the bag away from Kirstan's head and observed that there appeared to be blood coming from her nose. Erin then checked for a pulse with the intention of performing CPR and tried to turn her over, but realised Kirstan was very stiff and that in all likelihood, she had been deceased for a while.

11. She then checked the gas bottle, which she found to be empty.

12. Erin also observed that Kirstan had placed a towel at the bottom of the still closed bedroom door and had placed a second towel at the bottom of the closed sliding door in the hallway leading from the bedrooms to the dining/kitchen area.

13. Her sister Ailie immediately called for an ambulance, and later, ambulance officers and VicPol arrived. At this time, a search of the premises was established and that the premises was secure with no sign of forced entry.

14. Her medication seemed to be intact with no evidence tending to establish Kirstan had recently accessed medication blister packages or bottles.

15. Later an external examination performed by Forensic Pathologist Dr Melissa Baker, established early post mortem decomposition changes and lividity predominantly on the left side, consistent with the circumstances in which, she was located. No other external injuries were found.

16. Dr Baker's further finding was that Kirstan had died of plastic bag asphyxia.

Issues

17. At the time of Kirstan's death, she was the subject of a Community Treatment Order (CTO) and was being cared for and supervised by Eastern Health and its employees.

18. At Inquest, the family of Kirstan, represented by Ms McRae - Jansen a sister of Kirstan, made the following specific criticisms of the care provided by Eastern Health.

'That the intake of prescribed medication by Kirstan, was not appropriately monitored.'

19. In response, Dr Hope testified that Kirstan was previously on Depot medication and that she was monitored very closely. And that dispensed medication specifically clonazepam, was only dispensed two weeks at a time.

'That the medication, which was prescribed, didn't help her and was said, 'to make her worse'.

20. Dr Hope further testified that Kirstan initially received anti-depressant medication, which she had self-ceased; the olanzapine, which is a Depot anti-psychotic and the clonazepam, which is a benzodiazepine, which *'she had requested and remained on'*. The oral olanzapine was helpful when she took it regularly, giving her relief from both her psychotic and depressive symptoms. However, she did suffer some side effects from the Depot injections of olanzapine, which led to those injections being replaced by oral (wafer) intake.

21. The clonazepam was instituted at Kirstan's request and she reported no ill effects from its use.[13]

'That there was no or insufficient information being passed from her carer's, back to her family.'

22. In response, Dr Hope advised that the Koonung Community Health Clinic, welcomed family input, both the Mental Health Act and the Privacy Act limited the supply of information out, which matter had earlier been explained to family members.[14]

'That she was kept in hospital for too shorter periods following her earlier suicide attempts.'

23. Dr Hope testified that she was kept in hospital for different lengths of time depending upon her presentation, some involving acute psychosis, some not and that in the latter part of 2011, when she presented as *'overtly psychiatrically unwell'* that she had, *'reasonably lengthy admissions at those times.'*[15]

24. In conclusion, Dr Hope testified that she and Case Manager, RPN Imogen Zobel, were shocked at the outcome, but felt there was nothing to indicate that, *'we should have done things differently.'*[16]

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[13] See transcript page 102.

[14] Dr Hope testified as to one incident where a phone call to 'Imogen' from one of Kirstan's sisters had appropriately resulted in Kirstan being re-admitted to the unit. Dr Hope also testified that she tried to persuade Kirstan that it was important to continue to involve family members in her care planning, but that Kirstan was 'generally in opposition to discussions with her family and very keen to, 'maintain her privacy.' See transcript page 104. It was made difficult to work with the family because of the constraints imposed by Kirstan.

See also the similar testimony given by RPN Zobel.

[15] Transcript page 105.

[16] Transcript from page 65 and statement at exhibit 4.

'That she was seen by too many people and didn't want to be part of the mental health system.'

Finding

I find that Kirstan McCrae suffered from a persistent serious psychotic illness with intermittent mood swings and significant emotional distress.

As stated by her mother, Kirstan considered that each time she was remanded to a Mental Health Unit was for her, like going, back to square one.

While she understood that she was ill, she was deeply conflicted and typically denied to herself and others, the seriousness of her illness. It was against this underpinning theme then that she tried simply to get on with her life, this while continuing to resent the fact that she had become a part of the system.

I find however that her behaviours and level of illness during this time were indicative of persistent severe mental illness, which was demanding of the type of professional management then provided by her case manager, RPN Zobel, and Consultant Psychiatrist, Dr Hope.

I further find that at around the time of her death, Kirstan became increasingly sensitive to privacy of information issues primarily between her carers, which matter caused RPN Zobel, to seek a further review by Dr Hope.[17]

At this time, RPN Zobel reasonably believed that Kirstan's presentation indicated an increase in persecutory ideation. (I am satisfied that this state of mind was extremely challenging for Kirstan, who typically had poor coping mechanisms and tolerance to distress).

It was in these circumstances then that before her planned review could take place, Kirstan took her own life.

Having now further reviewed all of the evidence, I find myself satisfied that both Dr Hope and RPN Zobel were very caring of Kirstan and worked diligently in her support. I further find that the treatment and management provided to Kirstan was also reasonable and appropriate and did not contribute to her death.

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[17] She also instructed RPN Zobel not to discuss her circumstances with family members.

I direct that a copy of this finding be provided to the following:

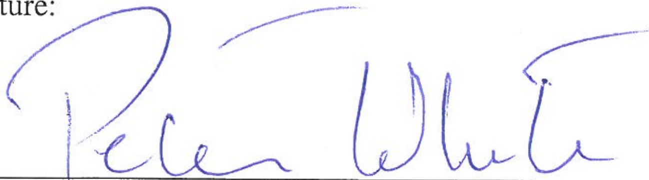
The Family of Kirstan McRae

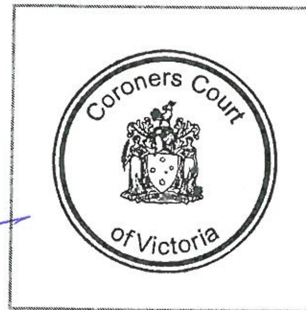
The Chief Executive of Eastern Health

Dr Judith Hope

RPN Imogen Zobel

Signature:





PETER WHITE
CORONER
Date: 1 September 2014