IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2009 1798

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)
Section 67 of the ***Coroners Act 2008***

I, PARESA ANTONIADIS SPANOS, Coroner,
having investigated the death of MELANIE ANNE REYNOLDS
without holding an inquest:

find that the identity of the deceased was MELANIE ANNE REYNOLDS
born on 30 June 1978, aged 30
and that the death occurred on or about 31 March 2009
at 105/546 Flinders Street, Melbourne, Victoria 3000
from:

1a. MIXED DRUG TOXICITY (PROPANOLOL, DULOXETINE AND CODEINE)

Pursuant to Section 67(2) of the **Coroners Act 2008**, I make findings with respect to **the following circumstances:**

BACKGROUND AND PERSONAL CIRCUMSTANCES

1. Melanie Reynolds was a 30-year-old single woman who resided alone and was employed as a Registered Nurse Division 1 with a speciality in paediatric nursing. Despite a history of mental illness from about 2002, Ms Reynolds worked for most of the ten year period immediately preceding her death. In 2002, Ms Reynolds was living in Queensland when she sought psychiatric treatment following a serious overdose. She appears not to have had any further contact with psychiatric services until 2007 when she was living in the United Kingdom and became unwell.

2. In 2008, Ms Reynolds returned to Tasmania where her parents lived and, following another overdose, the North West Mental Health Service in Tasmania provided her with psychiatric care. Ms Reynolds then sought private psychiatric care with private psychiatrist Dr Ross Kirkman and private psychologist Maureen Doherty.

3. Since 2007, Ms Reynolds' diagnoses included depression, adjustment disorder, melancholia and Borderline Personality Disorder (BPD). Treatment included the following medications in single or combination doses: quetiapine, venlafaxine, mirtazepine, citalopram, sodium valproate, duloxetine, diazepam, zolpidem, and propranolol and electro-convulsive therapy.

4. In November 2008, Ms Reynolds moved to Melbourne where she commenced employment at the Royal Children's Hospital via the casual staff bank. She worked regular, frequent shifts when available. In the months immediately preceding her death, she found there were limited shifts in paediatrics, her preferred area of nursing, and she took shifts in other adult units, which caused her some anxiety. Ms Reynolds enjoyed her work, finding that it gave her life structure. She reported to more than one healthcare professional, that when she was at work, she did not have the constancy of thoughts of self-harm which had been a predominant feature of her mental health since 2002. Such thought of self-harm were especially constant when she was alone and she clearly articulated the distress they caused her.

5. Ms Reynolds had a busy social life with friends, made through her workplaces, and a closer friendship with Mr Robert Carnovale.

JANUARY 2009 – REFERRAL TO PRIVATE PSYCHIATRIST

6. On 5 January 2009, Ms Reynolds consulted with private psychiatrist, Dr Ajit Selvendra following referral by her general practitioner Dr Mazair Fahandej. She described feelings of self-hatred, guilt and not being able to see a future for herself that included a relationship, friends, children or a career. She also described a chronic sense of emptiness, said that her life was empty and meaningless, that she had no fear of dying, and that she could not understand why she was like that.

7. On 9 February 2009, Ms Reynolds again consulted with Dr Selvendra with nightmares and increased suicidal ideation. Dr Selvendra increased the dose of her antidepressant duloxetine to 90mg daily and asked her to book two further appointments which Ms

Reynolds did not do. However, both Dr Selvendra and Dr Fahandej were very proactive in contacting her and arranging appointments.

8. On 16 February 2009, Ms Reynolds consulted another general practitioner, Dr David Sweeney, for the first time. She asked him for a prescription for Propranolol 40mgs which she told him she had been taking for an essential tremor and he gave her a script for the drug with three repeats.

23 MARCH 2009 - REFERRAL TO INNER WEST C.A.T.T.

9. On Monday 23 March 2009, Ms Reynolds again consulted with Dr Selvendra, reporting increased suicidal thoughts, associated distress with decreased sleep and erratic eating patterns. Dr Selvendra suggested increased clinical support but Ms Reynolds told him that hospital was unhelpful for her. She did however agree to a referral to the North Western Mental Health Inner West Area Mental Health Service, Crisis Assessment and Treatment Team (Inner West CATT), and Dr Selvendra accordingly made the referral.

10. The Inner West CATT made immediate telephone contact with Ms Reynolds and arranged an appointment to assess her on Tuesday 24 March 2009. At this appointment, consultant psychiatrist Dr Arthur Kokkinias and psychologist Ms Monica Bragg completed an assessment, diagnosing an exacerbation of Borderline Personality Disorder (BPD). Dr Kokkinias prescribed olanzapine 5mgs to improve her sleep pattern in addition to her current medication of duloxetine 120mgs daily, and made arrangements for Ms Reynolds to have regular contact from Inner West CATT.

11. The following day, Wednesday 25 March 2009, consultant psychiatrist, Dr Robert Karoly and registered nurse Ms Kerryn Devenish reviewed Ms Reynolds. Dr Karoly ceased the olanzapine because it was causing too much sedation and planned for Inner West CATT to telephone Melanie Reynolds next day.

12. On Thursday 26 Match 2009, Inner West CATT contacted Ms Reynolds late in the day, and she reported feeling better, with reduced suicidal thinking. She advised them that she was going to work a night shift and they arranged to contact her again on Saturday 28 March 2009.

13. On Thursday 26 March 2009, Dr Selvendra telephoned Ms Reynolds as he had not been contacted either by Ms Reynolds or by the Inner West Inner West CATT. Ms Reynolds

reported feeling better with Inner West CATT support and confirmed her appointment with Dr Selvendra for Monday 30 March 2009.

14. On Saturday 28 March 2009, Ms Reynolds telephoned Emergency Crisis, Assessment and Treatment Team (ECATT) who in turn contacted Inner West Inner West CATT. Ms Reynolds stated she was at home, was not coping and was ruminating about suicide. Social worker, Ms Jackie Pearce, contacted Ms Reynolds quickly at 1940hrs. Ms Reynolds reported spending the day at the Melbourne Botanical Gardens. She was now at home, feeling suicidal and finding it difficult to distract herself. Ms Pearce discussed distraction strategies and Ms Reynolds agreed to telephone her parents, who she said always made her feel better. Ms Reynolds said that she had plans to go to the zoo on Sunday 29 March 2009 and, on Monday 30 March 2009, to apply for permanent part-time employment to resolve the stress of her current unreliable work arrangements, and then to keep her appointment with Dr Selvendra. According to Ms Pearce's note of this telephone call, there was no documented plan for future Inner West CATT contacts, or clarification that Ms Reynolds was to initiate future contact. Ms Pearce does document that she directed Ms Reynolds to contact LifeLine and SuicideLine if she felt the need.

15. On Saturday 28 March 2009, Ms Reynolds telephoned her parents and apparently spent the day at the Melbourne Zoo. That evening she had dinner with Mr Carnovale and they watched a DVD together at her apartment until he left at 2100hrs. According to his statement, Ms Reynolds had been tired but otherwise appeared to be her usual self.

30 MARCH 2009 – CONCERNS FOR MS REYNOLDS' WELFARE

16. On Monday 30 March 2009, Inner West CATT attempted to telephone Dr Selvendra in order to discuss Ms Reynolds ongoing care. Their proposal was that Dr Selvendra discuss the cessation of Inner West CATT support with Ms Reynolds, and that she would be invited to contact them on an "as needs" basis. However, Ms Reynolds did not attend her appointment with Dr Selvendra, and Inner West CATT made no arrangements through him as he did not answer the telephone.

17. At 1400hrs on 30 March 2009, Dr Selvendra became concerned that Ms Reynolds may have taken an overdose, and telephoned Inner West CATT. Inner West CATT planned to make contact with Ms Reynolds by telephone, consider a home visit and review

further interventions if Ms Reynolds did not respond. They made attempts to contact her by telephone at 1500hrs, 1700hrs, and 1900hrs but to no avail.

18. At 2030hrs, Inner West CATT attended Ms Reynolds' flat but there was no response to their knocking or telephoning, and they decided to discuss what to do next at the team meeting on 31 March 2009. While it may have been reasonable for the attending clinicians to assume Ms Reynolds was at work, they made no attempts to verify this at the time.

19. On Tuesday 31 March 2009, Inner West CATT planned a home visit and, if this was unsuccessful, to arrange for Victoria Police to conduct a welfare check. An unsuccessful telephone call was made to Ms Reynolds' phone at 1010hrs and at 1015hrs, police were asked to conduct a welfare check.

31 MARCH 2009 – POLICE CONDUCT A WELFARE CHECK

20. Police attended Ms Reynolds' apartment at 1105hrs. They called her mobile number and could hear it ringing from inside the apartment but there was no response to their call or to their knocking. They gained entry with the assistance of the building manager who had an access key and found Ms Reynolds lying on the floor deceased. She was fully clothed and lying on a doona with two air conditioners positioned at her feet and at her head. Both were operating, blowing cool air towards her body.

21. Police searched the apartment and found no evidence of a disturbance or anything to indicate suspicious circumstances. They found a quantity of prescription medications dispensed in Ms Reynolds' name, including "Deralin" (propranolol), "Stilnox" (zolpidem), "Cymbalta" (duloxetine), "Zyprexa" (olanzapine), ibuprofen, paracetamol and codeine.

CAUSE OF DEATH

22. An autopsy was performed by Forensic Pathologist Dr Justin Du Plessis from the Victorian Institute of Forensic Medicine (VIFM) who found no evidence of significant natural disease or ante-mortem injuries which may have caused or contributed to death. Specifically, there were two small deep bruises on the head which were too minor to

have caused or contributed to death. Moreover, histological examination indicates that these bruises were probably sustained in the peri-mortem period.

23. Noting the results of toxicological analysis, Dr Du Plessis advised that the cause of Ms Reynolds' death was *mixed drug toxicity involving propanolol, duloxetine and codeine.* He commented that the propanolol, in particular, was at a toxic level in post-mortem blood and a large amount was still present in the stomach. He noted the presence of other drugs (diazepam and its metabolite nordiazepam, temazepam, paracetamol and ibuprofen), at concentrations which were too low to have caused or significantly contributed to death.

24. The toxicologist's report concluded that the results of routine toxicological analysis of post-mortem samples were *consistent with excessive and potentially fatal combination of codeine, propanolol and duloxetine in a person also using paracetamol, diazepam and ibuprofen.*

FINDING

25. I find that Ms Reynolds intentionally took her own life by ingesting an excessive quantity of a combination of drugs, namely propanolol, duloxetine and codeine. I further find that at the time that she did so, Ms Reynolds was suffering from acute symptoms of Borderline Personality Disorder and depression.

BORDERLINE PERSONALITY DISORDER

26. In light of Ms Reynolds diagnosis of BPD, I sought advice from the Coroners Prevention Unit,[1] specifically the Mental Health Investigator, who is a registered and very experienced psychiatric nurse, both as to the nature of BPD and the adequacy of the clinical management and care provided to Ms Reynolds in the period immediately preceding her death. That advice was to the following effect.

[1] The HMIT is part of the Coroners Prevention Unit (CPU) established in 2008 to strengthen the prevention role of the Coroner. CPU assists the Coroner to formulate prevention recommendations and comments, and monitors and evaluates their effectiveness once published. HMIT is staffed by practising Physicians and Nurses who are independent of the health professionals or institutions involved. They assist the Coroner's investigation of deaths occurring in a healthcare setting by evaluating the clinical management and care provided and identifying areas of improvement so similar deaths may be avoided in the future.

27. It is noteworthy that BPD is the only personality disorder to have recurrent suicidal or self-injurious behaviour as one of its diagnostic criteria, and to be associated with rates of completed suicide ranging from 4% to 10%[2] [3].

28. According to Spectrum, the Personality Disorder Service for Victoria –

> *"Suicidal threats and attempts peak when BPD patients are in their early twenties, but completed suicides are most common after their thirties. Suicide risk is increased by co-morbid depression, substance abuse disorders, escalation in emotion instability and multiple failed treatments.*
>
> *A mental health crisis is often subjective and does not always meet the idea of what is considered a crisis by mental health staff. Regardless, the following are factors often found with a crisis, including a trigger causing acute anxiety and emotional suffering, a sudden reduction in motivation and problem-solving ability, and an increase in help-seeking behaviour.*
>
> *The focus of treatment of BPD patients in public mental health systems should be directed towards providing support, containment, crisis management, minimal use of hospitalisation, prevention of iatrogenesis, sensible use of medications, a therapeutic approach based on mentalization, dialectical behaviour therapy (DBT) principles and supportive frameworks.* [4]

29. Ms Reynolds had participated in the recommended mentalisation therapies for BPD such as Dialectical Behaviour Therapy (DBT) and Cognitive Behaviour Therapy (CBT), but did not sustain the long term commitment required, reporting she did not gain anything from them.

30. Dr Selvendra referred Ms Reynolds to the Inner West CATT team because of her increased risk of self-harm and the need for greater support than he was able to provide. This is consistent with the Spectrum model of service whereby a patient would receive short-term and more assertive CATT community based care and follow-up during crisis, than could be provided by either a private practitioner or a public mental health

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[2] Beatson J, Rao S, Watson C. 2010 Borderline Personality Disorder. Towards Effective Treatment. Australian Postgraduate Medicine. Melbourne pp 57, 79.

[3] American Psychiatric Association (2001). Practice guideline for the treatment of patients with borderline personality disorder. Washington, DC: American Psychiatric Publishing.

[4] Sansone R. 2004 Chronic suicidality and borderline personality. Journal of Personality Disorders, 18, 215–225

community team. The Inner West CATT treatment plan appropriately concentrated on containment and support during this period of crisis.

31. Inner West CATT was not treating Ms Reynolds but they were keeping her safe with daily contact, and this type of contact does not have to be extensive to be effective. Ms Reynolds told Dr Selvendra and Inner West CATT workers that she was grateful and that their involvement made her feel safer. Ms Reynolds clearly felt comfortable telephoning Inner West CATT staff when she was distressed by her thoughts to self-harm and her reaction to them. This approach had been effective in keeping Ms Reynolds safe between 23 March 2009 and Saturday 29 March 2009.

32. There are difficulties in assessing the risk of patients with BPD. A constant, conundrum for staff is maintaining a balance between keeping a patient safe by assessing the acuity of what is usually a chronic and sustained suicide risk and wish to die, and heeding the evidence base which shows better patient outcomes if the service does not overly engage. According to Spectrum, it is during crisis that *"The behaviours being assessed are at their most extreme, the distress is very acute and the patient's ability to manage their feelings is a low point*[5].

33. Repeated suicidal behaviour is common in BPD patients, and is driven by the need to communicate emotional pain and distress to others, in particular, the need to communicate their intention to die. There is growing evidence that suicide attempts among BPD patients are no less dangerous than among those patients with other types of personality disorders. Spectrum recommends that acute-on-chronic suicidality be treated as an acute risk during the period of the crisis.[6]

34. One of the most difficult areas of assessing risk is the identification of the patient's suicide plan. It is rare that a patient's suicide plan is obvious to an assessing clinician, so clinicians rely heavily on the patient to communicate their plan. The existence of a plan, access to means and the lethality of the plan are all major indicators of the seriousness of a threat to die. Therefore, clinical assessment of suicide risk is tenuous where it is based on a patient being transparent and open about the details of their plan to die. Ms Reynolds had a plan that she had put in place (by procuring a supply of

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[5] Beatson J, Rao S, Watson C. 2010 Borderline Personality Disorder. Towards Effective Treatment. Australian Postgraduate Medicine. Melbourne pp 288

[6] Henriques G, Wenzel A, Brown G, et al. 2005. Suicide attempters' reaction to survival as a risk factor for eventual suicide. American Journal of Psychiatry, 162, pp 2180–2182

Propanolol) some weeks prior to her death, but she did not share this with any of the clinicians with whom she had engaged.

35. Ms Reynolds had a lengthy history of lethal overdose attempts. The positive intonations of future focussed plans confounded clinicians' assessment of her risk. If further details of previous attempts had been known to clinicians, it would have been apparent that she always had future focussed plans because she was an organised person. However, the timing of the overdoses was impulsive, within that broader context of an organised high functioning individual. Ms Reynolds did not deny having a plan, but would not disclose its detail, and it appears she made every effort to ensure access to means so she would be able to complete the plan if the need became overwhelming.

36. In Victoria, it is the staff of the CAT teams, part of the public mental health system, that provide most of the crisis intervention and short-term assertive community based care for those patients who are referred by their private practitioners, when they identify a crisis and/or increased risk, which they feel unable to manage adequately.

37. As noted above, Ms Reynolds was an organised and highly functional individual who was not always in crisis and, as at 28 March 2009, she appeared to have complied with the Inner West CATT plan. However, given her distress when contacted on Saturday 28 March 2009, it is arguable that optimal management and care indicated further planned follow-up contact by Inner West CATT, rather than a plan (albeit one that was never communicated) to effectively disengage, leaving Ms Reynolds to initiate contact on an "as needs" basis.

COMMENTS

Pursuant to section 67(3) of the **Coroners Act 2008**, I make the following comments connected with the death of Melanie Reynolds:

1. BPD is a complex psychiatric illness that poses challenges for treatment within the existing public mental health system.

2. In common with other situations where there is a shared care arrangement or transition from one health care practitioner or institution to another, the circumstances surrounding Ms Reynolds' death highlight the need for rigour and clarity at the point of transfer of a patient with BPD from the public mental health system back to the private

practitioner. [7] Ideally, decision-making around transfer should involve multi-disciplinary review, clear communication with the private practitioner, and a clearly articulated plan. At a minimum, that plan should stipulate how and when the transfer will occur, what the future roles of the private practitioner and the CATT team will be, and the extent to which the patient is involved in planning for disengagement and recommencement of treatment with the private practitioner.

3. Spectrum provided the Coroners Court of Victoria with a statement regarding the availability of BPD specific training for CATT staff. Spectrum does not provide specific training for CATT. The available training provides the necessary information clinicians need, although there is no evidence of evaluation that this meets the needs of this cohort of staff. Between 2009 and 2012, only 5-13% of attendees at the available Spectrum training were CATT staff. [8] In light of the fact that CATT staff provide most of the crisis and short-term assertive community based care for clients who are referred by private practitioners when a crisis is identified, this figure seems low. The current system relies on a CATT clinician recognising they require training specific to BPD.

RECOMMENDATIONS

Pursuant to section 72(2) of the Coroners Act 2008, I make the following recommendation(s) connected with the death of Melanie Reynolds:

1. That in order to improve the safety of people with a Borderline Personality Disorder (BPD) who are in crisis and referred to CATT/ECATT, Spectrum should assess whether the available BPD specific training meets the needs of CATT/ECATT clinicians, whose focus is on short-term assertive follow-up, and transfer of care back to private practitioners, rather than ongoing treatment and support of people with BPD.

2. If found wanting, that Spectrum work with the CATT/ECATT teams in public mental health services in Victoria, to develop BPD specific training suitable to the needs of CATT/ECATT clinicians, in order to improve the safety of people with BPD who are referred to them in crisis.

3. That all public Mental Health Services encourage CATT/ECATT team member to participate in BPD specific training

[7] Examination of a series of Coronial investigations of death of patients with psychiatric illness occurring at or around the point of transfer of care between private and public practitioners.
[8] Statement from Spectrum dated 3 January 2013.

Pursuant to rule 64(3) of the **Coroners Court Rules 2009**, I order that this finding be published on the internet.

I direct a copy of the finding to the following party for their information:

- The family of Ms Reynolds
- North Western Mental Health Inner West Area Mental Health Service, Crisis Assessment and Treatment Team (Inner West CATT)
- Senior Constable Joshua O'Neill c/o OIC Melbourne West Police Station
- SPECTRUM, Personality Disorder Service of Victoria
- Office of the Chief Psychiatrist
- Dr Ajit Selvendra, Psychiatrist
- Dr Mazair Fahandej, General Practitioner.

Signature:

PARESA ANTONIADIS SPANOS
CORONER
Date: 16 July 2013

Cc: Manager, Coroners Prevention Unit