IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: 2013 / 2355

FINDING INTO DEATH WITH INQUEST

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

Inquest into the Death of: MERRILYN ELAINE IRELAND

Delivered On:	6 December 2013
Delivered At:	Coroners Court of Victoria Level 11, 222 Exhibition Street, Melbourne
Hearing Dates:	6 November 2013
Findings of:	PHILLIP BYRNE
Police Coronial Support Unit	Sergeant David Dimsey

I, PHILLIP BYRNE, Coroner, having investigated the death of MERRILYN ELAINE IRELAND

AND having held an inquest in relation to this death on 6 November 2013
at MELBOURNE
find that the identity of the deceased was MERRILYN ELAINE IRELAND
born on 31 May 1971
and the death occurred on 30 May 2013
at Room 7 Canterbury Community Care, 30-32 Canterbury Road, Canterbury 3126
from:

1 (a) UNDETERMINED IN A WOMAN WITH SCHIZOPHRENIA

in the following circumstances:

1. Ms Merrilyn Elaine Ireland, 41 years of age at the time of her death, resided at Room 7 Canterbury Community Care, 30-32 Canterbury Road, Canterbury.

2. Ms Ireland was an involuntary patient on a Community Treatment Order under the *Mental Health Act*. In the period leading up to her death, Ms Ireland's treating psychiatrist was Dr Jaideep Thoduguli of Eastern Health Adult Mental Health Program, Box Hill Mobile Support and Treatment Service. Dr Thoduguli had been Ms Ireland's treating psychiatrist since April 2011.

3. Ms Ireland had an extensive psychiatric history commencing in her late teens. She was initially diagnosed with Borderline Personality Disorder. She had several inpatient admissions to psychiatric units in the early to mid 1990s. It would appear Ms Ireland had extended periods of "wellness" until 2002 when she again became unwell, experiencing low mood and suicidal ideation. She had further inpatient admissions and, in 2007, Ms Ireland was diagnosed as suffering from a Schizoaffective disorder with persecutory delusions and auditory hallucinations. She again had various involuntary admissions. Ms Ireland was on various anti-psychotic medications. In October 2012, Ms Ireland's mental condition deteriorated. After consultation with Consultant Psychiatrist Dr Sathya Rao and having considered a second opinion, Ms Ireland underwent Electroconvulsive Therapy (ECT) to address persistent psychotic symptoms including suicidal ideation.

4. On 26 February 2013, Ms Ireland was discharged to Canterbury Community Care on a Community Treatment Order. In his comprehensive statement to the Court, Dr Thoduguli sets out the various placements and the course of treatment provided to Ms Ireland through

from February 2013 to May 2013. The material on the Brief of Evidence forms part of the formal record of these proceedings so that, except for some issues, I do not reproduce it in full in this finding.

5. Due to concerns for her wellbeing, the Community Treatment Order was for some time revoked, and Ms Ireland was admitted to Upton House as an involuntary patient. In respect of this admission, Ms Ireland had lodged an appeal with the Mental Health Review Board. On assessment, it was considered Ms Ireland's condition had improved, she denied continued suicidal/homicidal ideation and expressed a desire to "spend more time with her family". In the few days prior to her death, Ms Ireland's mental state was assessed as "stable with residual positive symptoms and negative symptoms." Her medication regime was reviewed on 28 May 2013 and remained unaltered. Plans were made for escorted leave to attend computer classes and to celebrate her birthday.

6. On the evening of 29 May 2013, Ms Ireland received a phone call from her mother, Mrs Carole Ireland, who has advised that her daughter was in good spirits and looking forward to her birthday on 31 May 2013. Ms Ireland also had a visit from her sister, Barbara, on the evening of 29 May 2013.

7. On the morning of 30 May 2013, staff attended Ms Ireland's room and found her in bed, unresponsive. Ambulance Paramedics attended, but Ms Ireland was unable to be resuscitated, and she was formally pronounced dead.

8. As an unexpected death, the matter was reported to the Coroner. In an endeavour to establish the precise cause of Ms Ireland's death, I directed an autopsy be performed. An autopsy was subsequently performed and the Victorian Institute of Forensic Medicine by forensic pathologist Dr Linda Iles. Unfortunately, in spite of extensive post mortem examination and comprehensive ancillary investigation, including toxicology, the precise cause of Ms Ireland's death remains "unascertained". However, Dr Iles provided, by way of comment, several interesting observations. She said:

> "*Those with a history of schizophrenia and schizoaffective disorder are at increased risk of sudden death for which there are no anatomical findings at post mortem examination. The mechanism of death in these patients is unclear, however may be the result of the inherent autonomic stability associated with schizophrenia, the effect of antipsychotic drugs on the cardiac conduction cycle, or a combination of the above. In addition, underlying cardiac channelopathies (molecular*

abnormalities of the cardiac iron channels) can precipitate sudden death, in which instance no anatomical findings will be seen at post mortem. Given that this cannot be excluded, it is recommended that the deceased's first degree relatives undergo medical review."

Dr Iles advises she saw no evidence of injury which could have caused or contributed to death.

9. There is no evidence to suggest Ms Ireland's untimely death was other than due to any natural cause.

10. As Ms Ireland's death occurred when she was an involuntary patient under the *Mental Health Act 1986,* in an approved mental health service, the coronial investigation culminated in a mandatory inquest which I conducted in the Court on 6 November 2013. The Brief of Evidence was tendered by a member of the Police Coronial Support Unit, with no other parties present.

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

Ms Stephanie Ireland

Mrs Carole Ireland

Dr Jenny Babb, Eastern Health

Dr Mark Oakley Browne

Signature:

PHILLIP BYRNE
CORONER
Date: 6 December 2013