IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2011 0659

FINDING INTO DEATH WITH INQUEST

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

Inquest into the Death of: PALMA CASTRO

Delivered On:	14 May 2014
Delivered At:	Coroners Court of Victoria Level 11, 222 Exhibition Street Melbourne 3000
Hearing Dates:	11th and 12th November 2013
Findings of:	JOHN OLLE, CORONER
Representation:	Mr McCloskey on behalf of NorthWestern Mental Health
Police Coronial Support Unit	Senior Constable Tracey Ramsey

I, JOHN OLLE, Coroner having investigated the death of PALMA CASTRO

AND having held an inquest in relation to this death on 11th and 12th November 2013

at Coroners Court, MELBOURNE

find that the identity of the deceased was PALMA CASTRO

born on 16 May 1984

and the death occurred on 18 February 2011

at 1401 Sydney Road, Fawkner 3060

from:

1 (a) COMPRESSION OF THE NECK CONSEQUENT UPON HANGING

in the following circumstances:

1. Ms Palma Castro was aged 26 years at the time of her death. Palma had no established history of mental illness until 2007, at which time her mental illness emerged primarily following the breakdown of her relationship with her partner, who had been considered part of Palma's extended family. There were other stressors in her life which I do not consider necessary to detail. However, the culmination of these events led to Palma changing her job, experiencing increased conflict at home and Palma developing odd behaviours.

2. In 2008, Palma was diagnosed with cervical Adenocarcinoma[1], which was non-invasive and was appropriately treated with regular gynaecology reviews up until her death.[2] Palma was referred to and attended the usual counselling following diagnosis.

3. In 2009, she also sought counselling following an incident of bullying at work and sought help from a psychologist for depressive symptoms, but refused to commence the antidepressant prescribed by her General Practitioner, Dr Hassan Alkazali. In early 2009, Palma moved into a shared flat and was introduced to Alprazolam by her flatmate. Palma's use escalated, her reliance on Alprazolam increased.

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1 Adenocarcinoma: Cervical cancer is a malignant tumour found in the tissues of the cervix. The cancer cells break through the surface cells (epithelium) and the underlying tissue (stroma) of the cervix.

2 There is no evidence supporting Palma Castro's claim she underwent chemotherapy or major surgery.

Palma's first recorded overdose

4. In June 2009, Palma's first recorded overdose resulted in a three day admission at the John Cade Unit, Royal Melbourne Hospital. She was treated for an adjustment disorder.[3] Palma appears to have settled but continued her use of Alprazolam. Her family believe multiple car accidents and financial issues were from poor judgement whilst affected by Alprazolam.[4]

5. In January 2010, Palma met Adam, and commenced a serious relationship. Adam frequently worked away from home and Palma told her sister, Mel she was sad and flat when he was away. In February 2010, Dr Alkazali referred Palma to private psychiatrist Dr Mahendra Perera. Over a period of six months, Palma underwent an Alprazolam withdrawal program, supported by Dr Perera. It is unknown if Palma was using more than the prescribed reducing dose of Alprazolam, but it was not prescribed by her GPs. A review of Dr Perera and Dr Alkazali's medical records indicate that they believed she was compliant. Alprazolam does have a higher incidence of rebound anxiety. Intensified return of symptoms is common after withdrawal from Alprazolam.[5]

6. Between August 2010 and Christmas 2010, Palma had a difficult period, including a further overdose. From Christmas 2010 Palma increased the level of contact with Mel, who noticed a change in Palma's behaviour.

Focus at the inquest

7. The focus at the inquest related to two admissions to the Sunshine Hospital Emergency Department (ED) on the 17 and 18 February 2011.

8. In February 2011, Palma and Adam ended their relationship, with Palma essentially homeless, as she would not return to the family home. The medical records at Sunshine

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[3] World Health Organization, International Classification of Diseases Version 10: An adjustment disorder is a state of subjective distress and emotional disturbance, usually interfering with social functioning and performance, and arising in a period of adaption to a significant life change or to consequences of a stressful life event. The stressor may have affected the integrity of an individual's social network or the wider system of social supports and values. The stressor may involve only the individual or his or her group or community. Individual predisposition or vulnerability plays a greater role in the risk of occurrence and the shaping of the manifestations of adjustment disorders than in any other condition. The manifestations vary, and include depressed mood, anxiety, worry, a feeling of inability to cope, plan ahead, or continue in the present situation, and some degree of disability in the performance of daily routine. The individual may feel liable to dramatic behaviour or outbursts of violence. The onset is usually within a month of the occurrence of the stressful event or life change, and the duration of symptoms does not usually exceed six months, except in cases of prolonged depressive reaction.

[4] The long-term effects of benzodiazepines are: memory loss, confusion and difficulty thinking clearly, anxiety, irritability, paranoia and aggression, depression, lack of motivation, weakness fatigue, personality change and changes in emotional responses, drowsiness and sleepiness, headaches, and difficulty sleeping and disturbing dreams.

[5] Moylan, S; Giorlando, F; Nordfjærn, T; Berk, M, 2012. The role of alprazolam for the treatment of panic disorder in Australia. Australian & New Zealand Journal of Psychiatry. Mar2012, Vol. 46 Issue 3, p212-224. Page 13.

Hospital Emergency Department (ED) on 17 and 18 February 2011 list Palma as having no fixed abode.

9. Palma was taken to Sunshine Hospital Emergency Department ("ED") by Ambulance Victoria at 00:10hrs on 17 February 2011 after staff at Kmart called Victoria Police when Palma became distressed and was purchasing a belt, scissors, bleach and rope. In ED, she was assessed by ECATT clinician Robert Colella as extremely distressed and was offered a bed overnight. The following morning, on medical review by Dr Aruna Keerthiratne, psychiatric registrar, Palma declined the offer of a voluntary admission. Further, Palma refused permission for ECATT to notify her family or friends. Palma was discharged at 10:10hrs to her car. Palma was to notify ECATT staff when she had an address, to enable ECATT to make a referral to the CATT team.[6] Palma did not contact ECATT as planned.

10. About five hours after discharge, Palma was re-admitted to the ED following an overdose. Palma had booked a room at the Formula 1 Hotel in Fawkner, taken Alprazolam, Oxycodone, alcohol and had telephoned Adam to say goodbye. Palma told ECATT staff she had known the amount of tablets would not kill her, that she had not intended to kill herself and that her goodbye to Adam was an attempt to get him to come to the hotel to talk.

11. Palma was reviewed by ECATT clinician Deborah McBryde as not suicidal. She handed over care to nurse Colella. Both clinicians gave evidence at inquest, which I will address shortly. ED staff spoke to family members as early as 21:30hrs to arrange for Palma to be discharged to the care of a responsible person. A friend attended the ED and stayed with Palma but could not stay with her overnight, so Palma's family were required to come and pick her up. Palma left the ED with her brother Giuseppe, Mel, and Mel's husband Robert Dromi at 04:00hrs on 18 February 2011.

12. Palma subsequently became upset, called a taxi and went to the Formula 1 Hotel at 05:30hrs. There, she hanged herself sometime before 21:26hrs when Victoria Police completed a welfare check after Mel became concerned when Palma had not answered her telephone all day.

13. The tragic circumstances of Palma's death have been thoroughly reviewed internally by the NorthWestern Mental Health and of course through my investigation. A number of individual and systemic errors were identified. I am satisfied that lessons have been learnt

[6] Original Sunshine Hospital Medical Record Emergency Department Progress Note 1000hrs dated 17 February 2011.

and improvements implemented, designed to ensure the errors that were made in respect to the management of Palma will not be repeated.

14. The modern coronial system it is not about blame. Rather the coronial mandate is to ascertain where possible the cause of death, circumstances of death and to "contribute to the reduction of a number of preventable deaths…"[7]

15. At the outset I acknowledge the pain that was suffered by Palma's family notably Palma's sister Mel who described herself as Palma's best friend. Despite her obvious pain and grief Mel exhibited remarkable dignity throughout the investigation and inquest and with eloquence, expressed her desire to identify shortcomings in her dealings with NorthWestern Mental Health with a view to improvement not blame. Mel's demeanor and evidence has significantly shaped the tone of the inquest and greatly assisted the coronial process.

16. I further acknowledge the compassion and concerted efforts of members of the Victoria Police and Ambulance Service to assist Palma in her distress on 17 and 18 February 2011. In particular, I acknowledge Senior Constable Donna Coutts, stationed at Melton Police Station and Detective Senior Constable Caroline Johnson, stationed at Darebin Crime Investigation Unit. Deeply concerned for her welfare, they each displayed compassion and care for Palma at her time of distress and assisted her to receive treatment in her time of crisis.

17. Finally, although my investigation has identified individual and systemic shortcomings, I acknowledge the important and challenging work performed by clinical nursing and medical staff working in mental health. I have the deepest respect and admiration for these people. The Clinical nursing staff who have appeared before me have undergone genuine soul searching. I have no doubt they have improved their personal practice since this tragic case.

18. Dr David Fenn, Director of Clinical Services Midwest Area Mental Health Service provided a detailed report which reflected comprehensive and genuine analysis of the circumstances relating to Palma's two presentations at the ED. In evidence, Dr Fenn appropriately supported his staff but fearlessly identified shortcomings in practice, and detailed initiatives undertaken to address the systemic problems and ensure individual learning's were achieved. Dr Fenn has greatly assisted my investigation.

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[7] Preamble Coroners Act 2008

19. Evidence of Dr Fenn has enabled the issues before me to be crystallized. Having noted Dr Fenn's statement:

> Ms Castro's death is a tragic event which I and the staff at Midwest Area Mental Health Service deeply regret.

I endorse the following from his statement:

> At the initial presentation Ms Castro was clearly distressed. After completing his assessment Mr Colella recognised a moderate risk of suicide and documented his view on the risk assessment chart. The following morning it appeared Ms Castro's mental state had improved and at interview with Dr Keerthiratne she was able to calmly co-operative with a further detailed assessment of her situation. Dr Keerthiratne documented the overall risk as mild to moderate and offered an admission, which Ms Castro refused.
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> … Given the improvement in Ms Castro's mental state it appears community-based care may have been a reasonable course of action consistent with least restrictive practice. It is my view that it may have been helpful to obtain a further medical opinion after Ms Castro presented to the emergency department a second time within hours of being discharged.[8]

20. Dr Fenn frankly conceded that upon the second presentation within hours of being discharged in the first occasion, Palma should have been referred for medical review. Dr Fenn highlighted the potential problems to formulate a strict policy position regarding repeated medical reviews as ED staff are regularly called to assess patients who re attend on a frequent basis:

> Nevertheless, it is my view that a subsequent medical review may have helped in this particular case, but may not have altered the tragic course of events.[9]

21. He addressed gaps in the clinical documentation:

> Firstly, the formal risk assessment tool was not updated after Ms Castro returned to the Emergency Department… Secondly, there is a relative paucity of detailed information concerning the planned follow-up arrangements with a Crisis Assessment and Treatment Team post-discharge.

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[8] Page 43 Inquest Brief

[9] Page 44 Inquest Brief

Dr Fenn noted:

> Details of the discharge plan and its rationale were clearly documented prior to her first exit from the Emergency Department. In relation to the latter discharge, the notes do indicate that Ms Castro would only be discharged to the care of her family, but details of the plan for CATT home treatment may have and could have been better developed.

22. In the exercise of her clinical judgement, Dr Keerthiratne did not consider involuntary detention criteria had been met. Appropriately, she offered voluntary admission, which was declined. I do not criticize the clinical judgment exercised by Dr Keethiratne on the morning of the 18 February 2011.

23. The family were particularly concerned that Nurse Colella on the first admission had not made inquiries as to whether Palma had attempted suicide previously. In particular the event which led to her three day admission at the John Cade Clinic in 2009 was not investigated. Accordingly Dr Keerthiratne was not aware that Palma had a previous suicide attempt when she conducted a mental state review on the morning of the 18 February 2011. Dr Fenn highlighted the difficulty for one institution to ascertain the records and details in another.

The Re-Admission

24. However following the re-admission on the 18 February 2011 there should have been a medical review. In evidence nurse McBride acknowledged that in hindsight she should have called the doctor and requested further psychiatric review.

25. I accept the evidence of nurse McBryde that the management discharge plan she developed was premised on discharge to the care of Palma's family, with CATT follow up the following morning. Nurse McBryde was a conscientious, dedicated psychiatric nurse who erred in failing to request medical review following the second admission. I unreservedly accept she has learnt from this tragic case. It is a matter of speculation whether a medical review would have altered the plan which nurse McBryde had developed.

Nurse McBryde's discharge plan

26. Nurse McBryde's discharge plan was founded on the family "buying in" to the plan. Namely to agree to perform a continuous, supportive role to Palma overnight pending the planned assessment by CATT the following morning. Regrettably, nurse McBryde had

been unable, prior to the end of her shift, to personally confirm whether the family were able to fulfill the role required by her.

27. It is apparent the significance of the required role of family was not fully appreciated by nurse Colella at handover from nurse McBryde.

28. Importantly, nurse McBryde stated that the discharge plan in its entirety would have become unstuck without the overnight supportive role intended to be performed by the family.

Family were reluctant to perform a supporting role

29. Nurse Colella agreed with nurse McBryde's assessment that Palma did not meet the criteria for involuntary detention, pursuant to Section 8 of *The Mental Health Act*. It was Palma's wish to be discharged. He understood the need for Palma to be collected by family from the hospital. However, in conversation with Mel, it is apparent he mistakenly formed the view that Palma's overdose was merely a 'cry for help' and further, he did not appreciate the significant supportive role nurse McBryde intended the family to perform. In the conversation with nurse Colella, Mel strongly challenged the assessment that Palma was not suicidal, and detailed her concern that the family could not perform the supportive role required. She expressed reluctance to buy into the discharge plan, and explained the difficulties the plan would entail in terms of her parents and her own capacity to care for Palma. She continually expressed her concerns that Palma was suicidal and that the family would be unable to keep her safe.

30. In hindsight, nurse Colella acknowledged he did not fully appreciate Mel's expressed reservations. Further, he acknowledged that had he done so he would not have insisted Palma be discharged from hospital and would have requested a medical review at a further management plan developed. One option of course would be that Palma could not be safely discharged without support of her family.

31. Nurse Colella explained the practice he now develops since his involvement in Palma's care as follows:

> There is more weight on what the family's demands or anxieties are. So there's two parts. One are the client's needs, if you want to call it, and one of the family's capabilities to meet the needs. So there's two different assessments. And what they want, what the client wants.[10]

[10] T 144

32. Nurse Colella had earlier explained his practices now:

> I make sure I listen to their anxiety, of all the family for that matter. And the client's needs and wants. So I think that's changed. Instead of say, "No, it should be all right, we've got a good plan in place," you know, "if it changes you call us." I accept that that might be misleading.[11]

33. Nurse Colella addressed his use of the term "cry for help". In hindsight he acknowledged the phrase was misleading and tendered to give an impression to the family that the risk of suicide was not real. Of course, the fact that Palma was not considered to meet the criteria of Section 8 did not mean that she had made merely a cry for help. Palma was clearly a chronic risk for suicide and there was no information to suggest she had merely made a cry for help.

34. Nurse Colella apologized to the family and in particularly Mel for his failure to fully listen to her concerns and to react to them. To the credit of nurse Colella and Mel, there was a moving and positive exchange in court between them.

35. Mel explained to nurse Colella that she was not blaming anyone and acknowledged how difficult it was to read Palma. She believes that Palma had made a decision in order for her to be at peace. She was aware that Palma was "so different that last time. It was like she had made up her mind." Nurse Colella and Mel concluded their exchange by thanking each other for allowing them to talk.

36. In hindsight, Dr Fenn considered Palma required a brief period of hospitalization. In terms of discharge plan Dr Fenn explained what he would have preferred to have seen from a review of notes and that he could not see upon his review was:

> I want to know who the patient is, where they are going to stay. I want to see the address, I want to know when we're going to ring them to check that they are ok the next morning. Who I can ring. I want to – you, I want to see there is clear evidence that this is what we're going to do, when we're going to do it, how we're going to do it.[12]

37. Dr Fenn gave evidence about dialogue with the family:

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[11] T 143

[12] T 197

> I think one of the first things to do is to make sure the family understand the nature of the presentation and what our concerns are. Secondly, that we've actually heard what their concerns are and we've taken that on board in terms of our assessment to make sure that we're on the same page....is this a realistic plan we've got? Is this going to happen? Is this all right or are you just in fairyland here...You know, it has got to be grounded, it has got to be real.[13]

38. In respect to what the family should do if the plan comes unstuck Dr Fenn explained:

> So if the understand the risks and we all understand the risks, well, we all know what can go wrong and there should be some discussion about that and someone should - a shared understanding of that....that's the critical thing. And what disturbs me a little bit I guess is I'm not hearing that that really was – that there was a shared understanding.[14]

39. In respect to being able to provide a person such as Palma with a brief therapeutic admission Dr Fenn explained:

> Of course that's why doctors like myself prefer to admit patients to hospital so that we have the facilities available to do that kind of work.[15]

40. Dr Fenn explained his session with Palma was that she didn't want to remain in ED. He acknowledged the shortcomings with the facility and referred to an interstate model known as PECC (the Psychiatric Emergency Care Centre) which Dr Fenn noted:

> It is jointly staffed by both Emergency Department staff and psychiatric staff, to allow, say, a 24 hour assessment. And, you know, we've thought about that at Western Hospital but it's a funding issue obviously.[16]

41. Dr Fenn explained that there are two or three such units across the country which comprise of only two or three beds catered within or near an emergency department. Both ED health professionals and psychiatric staff PECC models. Dr Fenn considered a PECC model could have assisted the management of Palma Castro.[17] Dr Fenn was also critical of the failure in management plan to clearly identify what he considers looseness of the CATT review

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[13] T 198

[14] T 198

[15] T 200

[16] T 201

[17] T 202

proposed for the following day in the sense it did not identify with clarity: "who was going to call who, when, and what time and where."[18]

42. Dr Fenn explained that the management of Palma at his hospital:

> ...has weighed on my mind over the last two or three years. It's one of the more horrible situations which I've been confronted with in my role....We have taken it seriously. I think the family deserve to know that. It's hard to know if the things we've done really would make an enormous impact, but I've certainly talked to our staff and we're doing what we can. That's the truth of it.[19]

Conclusion

43. The ECATT assessment that Palma needed to address her Alprazolam addiction and seek counselling for alleged incidents was accurate and appropriate. Palma's maladaptive behaviours would most likely only change over the long term. However, the diagnosis on 17 and 18 February 2011 was an adjustment disorder and, in the initial instance, Palma's safety was the short-term problem that needed to be addressed.

44. It was not inappropriate to discharge Palma. However, ECATT and ED delegated the responsibility for keeping Palma safe to her family. The decision not to admit and the consequent discharge to her family was within usual practice. However, greater effort was required to ensure her family was equipped to look after Palma and that if this failed, they were informed of what action to take. The family had clearly highlighted their concerns about this to nurse Colella. In addition, a repeated formal mental state examination and risk assessment, combined with the family concerns, may have prompted a reassessment by the psychiatric registrar.

45. Regardless of Palma's intent, she remained vulnerable because of poor judgement, proven susceptibility to impulsive acts as shown by her history, the original distress at Kmart and the follow-up overdose. I am heartened that lessons learnt from this tragic case will result in improving the care of future patients of NorthWestern Mental Health.

Post Mortem Medical Examination

46. On the 21 February 2011 Dr Linda Iles, Forensic Pathologist at the Victorian Institute of Forensic Medicine performed an external examination on the body of Palma.

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[18] T 203

[19] T 204

47. Dr Iles formulated the cause of death to be hanging.

48. I am satisfied that Palma died in circumstances in which she intentionally took her own life.

Finding

I find the cause of death of Palma Castro to be compression of the neck consequent upon hanging. I offer my sincere condolences to Palma's family who clearly displayed her unrelenting love and support throughout her life.

RECOMMENDATIONS

Pursuant to section 72(2) of the **Coroners Act 2008**, I make the following recommendations connected with the death:

1. The following lessons learnt from my investigation are applicable across all Victorian mental health services:

    a. Risk assessment tools must be updated upon each admission;

    b. Planned follow-up arrangements with CATT must be clearly detailed post-discharge;

    c. When a patient is discharged to family, clear explanation is required to ensure family members fully understand what is required of them and accept the responsibility to ensure the safety of the patient. Follow up details must be clearly established. In particular, who they can contact in the event that something goes wrong. In the words of Dr Fenn, the plan must be realistic.

    d. Pressure must not be brought to bear on a family to accept responsibility of discharge of a patient if they express reluctance, discomfort and/or inability to perform a role in the discharge plan.

    e. If a medical review is not considered necessary upon re-admission of a patient the reasons for this decision must be clearly articulated on the hospital record.

Recommendation 1.

I recommend that The Office of the Chief Psychiatrist disseminate the above lessons at their own discretion.

2. Palma suffered an adjustment disorder. She rejected an offer of a bed in the Emergency Department. She may have benefited from a short admission, in the order of 2 – 3 days, in a

therapeutic setting. If available, a facility such as a Psychiatric Emergency Care Centre (PECC) would have been an option which clinicians could have offered Palma, until her crisis had passed.

Recommendation 2

I recommend that the Department of Health and The Office of Chief Psychiatrist consider the development of PECC units to service patients in crisis in need of short-term admissions.

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

The Family of Palma Castro

Senior Constable Amy Catterall, Investigating Member, Victoria Police

NorthWestern Mental Health

Department of Health

The Office of the Chief Psychiatrist

Signature:

JOHN OLLE
CORONER
Date: 14 May 2014