FORM 38

Rule 60(2)

FINDING INTO DEATH WITHOUT INQUEST

Section 67 of the ***Coroners Act 2008***

Court reference: 5367/09

In the Coroners Court of Victoria at Melbourne

I, AUDREY JAMIESON, Coroner

having investigated the death of:

Details of deceased:

Surname: WEBSTER
First name: PATRICIA
Address: 269 Frankston Dandenong Road, Frankston North, Victoria 3200

without holding an inquest:

find that the identity of the deceased was PATRICIA CORAL WEBSTER
and death occurred on 13th November, 2009

at 269 Frankston Dandenong Road, Frankston North, Victoria 3200

from:

1(a) HANGING

Pursuant to Section 67(2) of the **Coroners Act 2008**, an inquest into the death was not held and the deceased was not immediately before the person died, a person placed in custody or care; but there is a public interest to be served in making findings regarding the following circumstances:

1. Mrs Patricia Webster was born on 16 January 1968. She was 41 years of age at the time of her death. She was married to Lindsay Webster and together they had two boys, both of them with a diagnosis of autism. Mrs Webster also had three children from a previous marriage with only her daughter, Melissa, living in the family home in Frankston North.

2. Mrs Webster had a history of a major depressive disorder in 1996 and again in 2005. She recovered with acute phase treatment of a combination of Electroconvulsive Therapy (ECT) and second generation antidepressants with local mental health service support. She had remained reasonably well with continued treatment and care by a general practitioner.

3. Approximately two to three months prior to her death, Mrs Webster stopped taking her prescription antidepressants. On 8 October 2009, Mrs Webster was assessed by the Peninsula Health Mental Health Service Northern Bayside Community Mental Health team. She was subsequently admitted to the Peninsula Health Adult Acute Inpatient Unit 2West for a period of 13 days. She reported increased family stresses in her life, and with the assistance of the Inpatient Unit Social Worker, Mrs Webster was given a referral to the Department of Human Services and the Respite and Carelink Centre to increase support in the home for Mrs Webster and her family. Nevertheless, she continued to voice ongoing concerns about her ability to support her sons and the family. On the day prior to her discharge she was still reporting feelings of self-harm/cutting.

4. On 21 October 2009, Mrs Webster was discharged and returned home to the care of her family, with case management provided by the Peninsula Health Mental Health Service Northern Bayside Community Mental Health team staff. Home visits occurred on 22 October, 24 October, 26 October, 27 October, 29 October, 2 November and 4 November 2009. Medical reviews with a Psychiatric Registrar occurred on 30 October and 5 November 2009, and an appointment with her general medical practitioner, Dr Yan Loh on 10 November 2009. On each occasion she continued to express suicidal ideation.

5. On 12 November 2009, at approximately 21:00 hours Mr Lindsay Webster contacted the Consultation, Liaison and Inpatient Psychiatric Service (CLIPS) at Peninsula Health. He reported that his wife had a rope earlier in the day and had expressed wanting to hang herself. Mr John Storey, Social Worker, spoke to both Mr and Mrs Webster by telephone, suggesting several times that they come to the Peninsula Health Emergency Department for an assessment and offered to arrange for Ambulance Victoria to transport her there. Mrs Webster refused to attend and she denied any current suicidal ideation or intent to Mr Storey. Mr Webster and Mr Storey developed a safety plan. Mr Webster stated that he would remain with Mrs Webster overnight and that Mrs Webster's daughter, Melissa, would remain with her the next day. Mrs Webster had an appointment with Dr Yan Loh at 14:00 hours and she had agreed to a review at Peninsula Health Mental Health Service Northern Bayside Community Mental Health team either before or after her appointment with Dr Loh. Mr Storey subsequently faxed a request for follow up and the assessment documentation to the Community Mental Health team.

6. On 13 November 2009 at 05:00 hours Mr Webster left the Frankston North home. Melissa subsequently left the home at 09:30 hours. Later, Ms Marie Germano from the Community Mental Health team attempted to telephone the Frankston North home without success. At 12:30 hours Ms Tara Illes telephoned the Frankston North home, again without success. She subsequently contacted Mr Webster at his place of employment to advise that she was unable to make contact with Mrs Webster. Mr Webster gave permission to Ms Illes for staff to enter the home. At approximately 14:20 hours Mr Illes attended the Frankston North home but

as she could not get a response at the front door, she returned to the team office. At approximately 14:30 hours Ms Illes and Ms Kim Makin-Clark returned to the Webster's family home and entered through the rear of the house. They located Mrs Webster hanging from the ceiling fan in the kitchen. They contacted Emergency Services and under the direction of the call taker they cut Mrs Webster down and commenced cardio pulmonary resuscitation (CPR) until the arrival of Ambulance Paramedics however, Mrs Webster was unable to be revived.

Investigation

7. Forensic Pathologist, Dr Matthew Lynch, performed an external examination of Mrs Webster at the Victorian Institute of Forensic Medicine. Dr Lynch reported to the Coroner that his external examination and findings were consistent with the Police Report of Death for the Coroner, Form 83. Dr Lynch found evidence of a ligature mark around about the neck and incised injuries to the regions of both wrists. He also reviewed a post mortem CT scan and found no evidence of occult trauma or natural disease. It was Dr Lynch's opinion that an internal examination was unlikely to contribute significantly to an understanding of the cause or circumstances of Mrs Webster's death. He attributed the cause of death to hanging. Toxicological analysis identified Temazepam in blood at 0.01mg/L.

8. The Police investigation did not identify any suspicious circumstances.

Findings

9. I find that Mrs Webster's admission on 8 October 2009, was appropriate and her length of stay as a voluntary patient on the Peninsula Health Adult Acute Inpatient Unit 2West was for a period above the statewide average. Further, the use of antidepressant medication treatment only[1] was not inappropriate.

10. Mrs Webster's post discharge follow up was reasonable and appropriate in the circumstances. The Peninsula Health Mental Health Service Northern Bayside Community Mental Health team provided almost daily contact to Mrs Webster or her husband following her discharge on 21 October 2009. The frequency of contact and engagement complied with the Office of the Chief Psychiatrist's Victoria, 2002 Guideline called "Discharge Planning for Adult Community Mental Health Services" requirements.

11. Mr Webster's out of hours contact with CLIPS led to the agreement of a safety plan after Mrs Webster refused to attend at the Emergency Department for a psychiatric assessment at the suggestion of Mr John Storey. As she denied any current suicidal ideation or intent to Mr Storey

[1] Both Mr and Mrs Webster had requested treatment with ECT, but the treating consulting psychiatrist, Dr Angela Lee, considered antidepressant use was more appropriate.

and Mr Webster did not dispute this at the time, it would have been inappropriate for Mr Storey to initiate attendance of Ambulance Victoria or Victoria Police to the Frankston North family home. Mr Storey did alert the Peninsula Health Mental Health Service Northern Bayside Community Mental Health team to the events and there was an agreement in place that Mrs Webster would require an urgent assessment at the Community Mental Health team office on the following day, 13 November 2009. Mr Storey also advised Mr Webster of the option of calling CLIPS again, or alternatively taking Mrs Webster to the Emergency Department at any stage should he be concerned.

12. There was however a breakdown in communication of all of the details of an arranged safety plan, including who would or would not be with Mrs Webster at home, what time her doctor's appointment was, what time the Peninsula Health Mental Health Service Northern Bayside Community Mental Health appointment was arranged for, who was responsible for transport and what were the overall expectations of the Webster family. The degree of risk of self-harm by Mrs Webster was clearly not appreciated by her family as she was left unsupervised in the home prior to the arrival of the community mental health worker. Mr Webster believed he had communicated that the workers should not wait for a response at the front door of the house, but by entering at the rear of the premises which they subsequently did, but this instruction does not appear to have been communicated to Ms Illes who attended the Webster's home in the first instances on her own on 13 November 2009. The unsupervised period of time enabled Mrs Webster sufficient time to access a ligature and plan and complete her suicide.

Comment

13. Communication by a Mental Health Service to a patient's family about a perceived risk of suicide is complex in the extreme, particularly in circumstances where the service is requesting some involvement in the family in keeping the patient safe. When a Mental Health Service is relying on carers and family members to provide observational activities aimed at keeping someone with suicidal ideation safe, communication of the expectations by the service and what to do in a crisis requires a higher level of education from the mental health staff to the family. The expectations of the service that families will appreciate risk to the same level of degree as their professional training enables them is not achievable in the absence of clear and unambiguous communication.

I **find** that Patricia Coral Webster intentionally took her own life by means of hanging.

Signature:

AUDREY JAMIESON
CORONER

9th August, 2011

Distribution list:

1. Mr Lindsay Webster
2. Peninsula Health Mental Health Service Northern Bayside Community Mental Health
3. Coroners Prevention Unit