CORONERS ACT, 2003

SOUTH *AUSTRALIA*

FINDING OF INQUEST

An Inquest taken on behalf of our Sovereign Lady the Queen at Adelaide in the State of South Australia, on the 13th, 14th and 15th days of November 2012 and the 13th day of December 2012, by the Coroner's Court of the said State, constituted of Mark Frederick Johns, State Coroner, into the death of Jacqueline Mary Jenkinson.

The said Court finds that Jacqueline Mary Jenkinson aged 46 years, late of the Trevor Parry Community Rehabilitation Centre, 9 Greybox Avenue, Noarlunga Centre, South Australia died at Noarlunga Centre, South Australia on the 18th day of March 2010 as a result of mixed drug toxicity. The said Court finds that the circumstances of her death were as follows:

1. Introduction and cause of death

1.1. Jacqueline Mary Jenkinson died on 18 March 2010 at the Trevor Parry Centre at Noarlunga Centre. An autopsy was performed by Dr Winskog who gave the cause of death as mixed drug toxicity[1], and I so find. The drugs revealed by toxicological examination included clozapine, olanzapine, fluoxetine, norfluoxetine and oxycodone. The detected concentration of clozapine was potentially lethal in itself. The concentrations of olanzapine, fluoxetine, norfluoxetine and oxycodone were high and potentially toxic. The mixing of clozapine with these drugs can cause additive central nervous system and respiratory depression. There were also concentrations of diazepam and nordiazepam in her blood at therapeutic levels. These would have also contributed to a central nervous system depressant effect.

[1] Exhibit C1a

2. Background

2.1. The Trevor Parry Centre is a community rehabilitation centre. A community rehabilitation centre is a mental health facility providing residential rehabilitation facilities within the community. They contain a mixture of clinical and non-clinical staff. The clinical staff include mental health nurses, social workers, occupational therapists and there are visiting consultant psychiatrists and psychologists. The Trevor Parry Centre is one of three such centres in South Australia. The others are located at Elizabeth East and Mile End, providing a spread across the metropolitan area.

2.2. Ms Jenkinson was admitted to the Trevor Parry Centre in November 2009 from the Morier Ward of the Noarlunga Hospital where she had been admitted following an attempted suicide by drug overdose. While in the Trevor Parry Centre she shared a unit with another patient who I will refer to as R. R was a 21 year old woman with an intellectual disability who suffered from schizophrenia. As a result of the intellectual disability her mental age was that of a 14 year old.

2.3. For her part, Ms Jenkinson suffered from bipolar disorder. She also had a history of abusing alcohol and prescription drugs. She suffered also from chronic back pain and it was the latter for which the oxycodone had been prescribed[2].

2.4. Ms Jenkinson was not prescribed with clozapine. That medication was allocated to her roommate, R. The remainder of the medications found in Ms Jenkinson's blood at autopsy were amongst those which had been prescribed her. Clozapine is an antipsychotic agent for the treatment of schizophrenia in patients intolerant of or unresponsive to other antipsychotics. It is prescribed for what is referred to as treatment resistant schizophrenia. The circumstances in which Ms Jenkinson came to have access to the clozapine prescribed to R were closely considered in the course of this Inquest. It is sufficient for present purposes to note that there is no doubt that the source of the clozapine that was consumed, along with the other drugs, by Ms Jenkinson was the clozapine allocated and provided to R. The unit was configured with common kitchen and laundry areas and a common living area. There were separate bedrooms, each of which had an ensuite. Each of the bedrooms had a locked drawer in which medication could be stored. The drawer could only be accessed by a

[2] See interim separation summary, Exhibit C11

key provided to the occupant of the bedroom. The same key would also unlock the bedroom door and the main door to the unit. Each key would only unlock the bedroom door of the particular occupant to whom it was allocated and the drawer within that room. In addition to the locked drawer for storage of medication, there was another means of storage. That was referred to as the locked box method. As the name suggests, this was a box approximately the size of a fishing tackle box which was capable of being locked. Ms Jenkinson's medications were provided by this method. Under the locked box regime only a staff member could obtain access to the medication on behalf of the patient. Thus, Ms Jenkinson was only able to access her medication using her locked box.

2.5. The Trevor Parry Centre, as a community rehabilitation centre, was open for the use of patients with a mental illness but also who fulfilled certain other criteria which are set out in paragraph 12 of the affidavit of Matthew Ballestrin[3]. These broadly encompassed persons who were adults and not geriatric, who had not responded to an assertive community care service previously. The patient would also have a functional disability in the area of self care. The Centre was not available to patients with violent behavioural problems. The Trevor Parry Centre was opened in December 2007. It had 20 residential places available for consumers at any one time. There were 7 detached units and 1 staff administration building.

2.6. Community rehabilitation centres are a component of certain changes made to the mental health system in the last 5 years. They are part of what has been referred to as a 'stepped' system of care. Patients are admitted to a community rehabilitation centre in order to access assertive rehabilitation support to develop skills to manage their illness by themselves. The aim is to ultimately allow them to reside independently. The staff of the community rehabilitation centre work with the patients to encourage them to build skills in self care, shopping, budgeting and other social skills. Patients are also encouraged to manage their own illness and to take responsibility for the management of their own medication and other activities of daily living. Upon admission Ms Jenkinson was subjected to a formal risk assessment. Following that there would be monthly risk assessments or risk assessment on an as needed basis. Because of her history of suicide attempts by overdose and her chronic thoughts of self-harm, the initial assessment was that Ms Jenkinson would not be allowed to have

[3] Exhibit C14

access to her own medication, hence the locked box regime to which I have already made reference[4].

2.7. In the initial months, Ms Jenkinson settled in quite well. However, staff were concerned that she would take the opportunity to secrete her medications by diverting them[5]. Ms Jenkinson was also permitted to attend a local pharmacy shop to obtain her own Webster packs of medication. She was then to return them to the administration staff at the Trevor Parry Centre who would then deal with them by means of the locked box regime. Staff were concerned that in addition to diverting her oxycodone as described above, Ms Jenkinson was also thought to have removed some of the medication from the Webster packs while returning from the pharmacy. These issues were addressed in an appropriate manner by staff with Ms Jenkinson during the early months of 2010. A significant feature of her stay at the Trevor Parry Centre was that when she was absent from the Centre, she would resort to the use of alcohol. A noteworthy event occurred towards the end of January 2010 when Ms Jenkinson reported having been raped while away from the Centre by a man she had been socialising with. She may well have been affected by alcohol when that event occurred. In any event, it was a matter of significant distress to her and she expressed her concerns about it to several of the staff. The matter was appropriately dealt with by reference to the police and proper support from staff. It forms part of the background to the events that followed.

2.8. As will be plain from what I have said above, the Trevor Parry Centre and other community rehabilitation centres, are not locked medical facilities and the patients are free to come and go. Indeed, admission is on a voluntary basis. A community rehabilitation centre is not an approved treatment centre to which a person is detained under the Mental Health Act. The other aspect of Ms Jenkinson's presentation that requires comment is that she was at all times chronically suicidal and her suicidal thoughts ebbed and flowed, but there was always a chronic risk of self-harm.

[4] Exhibit C11
[5] Pretending to swallow them but instead secreting them for later use

3. The events leading to Ms Jenkinson's death

3.1. Anne Koerber was a psychologist who worked at the Trevor Parry Centre at the relevant time. She had contact with Ms Jenkinson from late in January 2010. At the time of her dealings with Ms Jenkinson, Ms Koerber was an intern. She was formally registered as a clinical psychologist later in the year. Her initial dealings with Ms Jenkinson were on an as needed basis. She was aware of Ms Jenkinson's history of a suicide attempt leading to her current admission to the Trevor Parry Centre. She was also aware of Ms Jenkinson's background history and her chronic level of suicidal ideation. Her first involvement with Ms Jenkinson was to discuss with Ms Jenkinson her possible enrolment in the program known as the 'Shaking the Blues' program. Ms Koerber explained that this was an 8 week program, not run within the Trevor Parry Centre but externally, which is designed to educate participants about anxiety and depression[6]. Ms Jenkinson was amenable to this suggestion and Ms Koerber made the appropriate arrangements for Ms Jenkinson's participation in the program. It was arranged that Ms Koerber would see Ms Jenkinson after each session at the Shaking the Blues program and discuss with her what she had gained from the most recent session. Ms Koerber explained that as her association with Ms Jenkinson progressed, Ms Jenkinson would approach her from time to time and Ms Koerber felt that Ms Jenkinson had developed a rapport with her[7].

3.2. On 9 March 2010 Ms Jenkinson informed Ms Koerber that she had something to reveal that might result in her being evicted from the Trevor Parry Centre. This episode involved the altering of a prescription for valium by Ms Jenkinson. In the course of this discussion Ms Jenkinson said that she had experienced suicidal thoughts the previous day and would have acted on them had she had the means to do so. She told Ms Koerber though that she was not feeling suicidal on that day. Ms Koerber counselled her over some time and encouraged her to consider ameliorating factors in her life. These were identified as her children and other examples of persons who had survived traumatic situations. Ms Koerber completed a risk assessment as a result of this interaction and assessed Ms Jenkinson as being at a moderate risk of harm to herself. Ms Koerber explained that she reached this conclusion because, while Ms Jenkinson was not feeling suicidal at the time of their discussion, she had felt suicidal

[6] Transcript, page 97
[7] Transcript, page 101

the previous day. Furthermore, she was chronically liable to such thoughts[8]. Ms Koerber discussed with Ms Jenkinson a strategy of talking to staff members if she were to feel suicidal again and also to focus on her participation in the Shaking the Blues program. It was at this point that Ms Koerber agreed with Ms Jenkinson that she would see her individually to talk about her anxiety which Ms Jenkinson felt was her real problem.

3.3. The next notable event, according to Ms Koerber, occurred on 15 March 2010 when she recorded in Ms Jenkinson's casenotes[9] that Ms Jenkinson had reported feeling suicidal and that her anxiety was unbearable. She felt the medication was not taking the edge off this condition. Ms Jenkinson informed Ms Koerber that she had the means available in her unit to commit suicide but no specific plan of when she would do this. Ms Jenkinson denied that she was going to use pills as the means of achieving her objective. Ms Jenkinson said that she would not be acting to take her life that day. She was sad because she had not been able to attend her daughter's birthday the previous weekend. Her daughter was rejecting her because of her alcohol use. Ms Koerber discussed this with Ms Jenkinson and explained to her that her daughter was not rejecting her, but was rejecting her alcohol abuse. She also pointed out that Ms Jenkinson's son did want to maintain contact with her. They went for a walk and Ms Koerber employed what she called a 'mindfulness exercise' in order to show Ms Jenkinson a method for avoiding ruminative thinking[10]. Following this Ms Jenkinson reported a decrease in her anxiety.

3.4. Following this meeting which occurred at approximately midday, Ms Koerber proceeded to the staff meeting room where the rest of the staff were engaged in a shift handover. She said that she informed those assembled at the handover what had transpired between she and Ms Jenkinson and, in particular, the information disclosed to her by Ms Jenkinson[11]. As it happened Dr Nance, who was the staff psychiatrist to whom Ms Jenkinson had been allocated, was present at the handover session. Dr Nance then undertook to see Ms Jenkinson armed with the information that had been imparted to him by Ms Koerber. Following Dr Nance's review of Ms Jenkinson he relayed to Ms Koerber that Ms Jenkinson was clearly distressed, but that suicidal ideation was a chronic state for her and it was his opinion that she would not be

[8] Transcript, page 106
[9] Exhibit C11, page 216
[10] Transcript, page 110
[11] Transcript, page 111

assisted by a hospital admission or a change in medication at that time. Following this conversation Ms Koerber prepared a risk assessment and management plan for Ms Jenkinson which can be found in her casenotes[12]. Ms Koerber's plan as recorded in the casenotes at that time was for staff to provide increased support to Ms Jenkinson and to regularly check on her wellbeing. They would prompt her to undertake self care tasks such as showering and preparing dinner as well as other activities and give her the opportunity to discuss her feelings. They would challenge unhelpful thinking. Dr Nance's opinion that Ms Jenkinson would not be assisted by an admission to hospital or a change in medication was also recorded here. In that risk assessment Ms Koerber assessed Ms Jenkinson as being at a significant risk of harm to herself but gave her overall assessment of risk as medium having regard to Ms Jenkinson's chronic underlying risk and the fact that Ms Jenkinson had assured her that she did not propose to act on her suicidal thoughts that day. Ms Koerber's risk assessment was informed by Dr Nance's remarks also.

3.5. Ms Koerber next saw Ms Jenkinson the following day, 16 March 2010, at approximately midday. Ms Jenkinson reported feeling much better and was not feeling suicidal. Ms Koerber expressed some curiosity to Ms Jenkinson at this change in her mood. Ms Jenkinson explained that the change was chiefly because she had not drunk any alcohol the previous night and this in itself was beneficial in that she was not experiencing any after effects from heavy alcohol consumption and also regarded her abstinence as a positive achievement. Thus encouraged, Ms Koerber pressed Ms Jenkinson for further details about the proposed means of suicide that she had refused to disclose the previous day. Ms Jenkinson then cooperated by explaining that her chosen method would be to take her housemate's clozapine. Furthermore, she knew how to gain access to the clozapine because she knew where to find the key to the drawer in which R stored the clozapine. I infer also that in saying this she also indicated that she knew how to gain access to the bedroom[13].

3.6. Ms Koerber, having left Ms Jenkinson, immediately attended the 1pm handover session and reported to the team what had been disclosed to her by Ms Jenkinson. Ms Koerber explained in her evidence that her thinking immediately after this revelation

[12] Exhibit C11, pages 11-12

[13] The evidence showed that R was in the habit of not closing her bedroom door. Furthermore, she was in the habit of not always locking the medication drawer. She was also not in the habit of securing the key as directed by staff. Her rehabilitation coordinator was in the process of working with her on these issues but they were a frequent feature of her presentation.

by Ms Jenkinson was that because the medication was that of another patient, namely R, she felt that she could not immediately act by removing the medication and thus immediately ameliorating the danger[14]. Instead, she raised the matter for discussion at the handover. In response to this initiative there were various discussions and different courses of action were mooted together with discussions of the implications of each course of action. The option of removing R's medication was one of these options, however it had to be balanced against R's need to be offered a level of independence in her own management of medication. Furthermore, discussion was had about what such a move would mean for the rest of the Centre, bearing in mind that the environment of the Centre was such that most other residents also had medication in their possession on site. Furthermore, it was possible for Ms Jenkinson to go to the local pharmacist and obtain medication if she so chose. The discussion then moved on to the notion of providing daily support to Ms Jenkinson in her activities of daily living and how that would be done. There was a discussion about the location of R's key and whether it could be kept in an alternative place.

3.7. Ms Koerber summarised the situation by saying that in the end she was not clear that there had been any actual decision or a clear course of action[15]. She did not have the sense that the option of removing the clozapine had been absolutely ruled out. She said that she did not consider the notion of contacting Dr Nance again at that point because he had seen Ms Jenkinson the previous day and because it was her view that Ms Jenkinson's mood had improved considerably and therefore the risk was reduced for that day[16]. Ms Koerber said that she felt that Ms Jenkinson was being cooperative in describing the means that she would employ.

3.8. Ms Koerber duly completed a risk assessment and management plan which is to be found in Ms Jenkinson's casenotes[17]. In this risk assessment Ms Koerber assigned a level of moderate to the risk of harm to self for Ms Jenkinson. She wrote in the management plan the fact that Ms Jenkinson had disclosed that she knew how to access her housemate's clozapine medication and that she had identified this as the way in which she would attempt suicide if she was to act. She wrote in the plan that this information had been conveyed to the Trevor Parry Centre team for further

[14] Transcript, page 121
[15] Transcript, page 121
[16] Transcript, page 122
[17] Exhibit C11, page 9

review. She explained that she wrote that because she did not feel that the issue had been finally addressed at that point.

3.9. She explained that in hindsight she wished that she had asked the meeting what everyone's view of the outcome was at that point[18]. She explained that now the risk assessment template has changed, and as a result there is greater emphasis in coming to a firm conclusion about the immediate course of action to deal with a crisis and the assignment of responsibility for further action[19].

3.10. The then Manager of Trevor Parry Centre, Mr Jamie Ryan, gave evidence at the Inquest. He could not recall if he had been present at the handover on 16 March 2010. In his statement[20] he had expressed the opinion that he was present, however, upon reflection, he thought that may have been a reference to the previous day's handover. In any event, in his evidence he had no recollection of the mention of clozapine[21] or Ms Jenkinson's access to R's medication. However, he did recall a discussion about R's lack of responsibility in securing her key and locking her bedroom door.

3.11. In the result, I am of the view that Ms Koerber's recollection about what occurred in this handover is accurate.

3.12. The following day, 17 March 2010, Ms Jenkinson had a relatively uneventful day. She attended at the hairdresser and had her hair done.

3.13. On 19 March 2010 a member of staff attended Ms Jenkinson's unit at approximately 12:30pm and found her unresponsive. The alarm was sounded and staff commenced the application of CPR. Ambulance staff were called but unfortunately Ms Jenkinson was unable to be resuscitated.

4. Conclusion

4.1. While Ms Jenkinson's death was clearly a tragedy, it has to be accepted that in a facility such at the Trevor Parry Centre, there must be some level of risk by the very nature of the need to encourage independent living in order to rehabilitate patients so that they can live in the mainstream community. Part of the inherent risk of living in

[18] Transcript, page 124
[19] Transcript, page 125
[20] Exhibit C19
[21] Transcript, page 155

a community is that people live in close proximity to one another. It is in the nature of things that not everyone lives in secure premises. It is common for people to share accommodation. It is common for people to have the means to obtain access to medication meant for another. These risks are more closely controlled and supervised in a facility such as the Trevor Parry Centre than they might be in the ordinary community. However, a certain amount of independence and freedom of action must be allowed, otherwise the object of rehabilitation for return to mainstream living could not be achieved. I repeat that the Trevor Parry Centre is not a public hospital, it is not a place at which mental health patients are confined. Their attendance at Trevor Parry Centre is voluntary and they have a certain amount of freedom of action.

4.2. It may be suggested that there was too much focus on the requirements of R and her need to continue to have responsibility for her own medication as part of her own treatment program. On the other hand, the fact of the matter is that there was a significant amount of effort put into counselling Ms Jenkinson. In the three days before her death she had two lengthy sessions with the psychologist, Dr Koehler, and she had a session with the psychiatrist, Dr Nance. She was provided with ongoing support by the staff of the Centre and it seems to me that part of her own therapy was her ability to manage living in a household with another person who may or may not, by her actions, expose Ms Jenkinson to an opportunity to gain access to medication. In my view this tragic death, while highly regrettable, is an event which could not have been prevented without substantially changing the nature of the Trevor Parry Centre and its intended purpose.

5. Changes made since Ms Jenkinson's death

5.1. Notwithstanding my view that no criticism ought be made of the management of the Trevor Parry Centre as a result of Ms Jenkinson's tragic death, it is encouraging to see that certain changes have been made to the operation of the Trevor Parry Centre following her death:

> 'Risk assessment
>
> Balance between risk management and rehabilitation has tipped more in favour of risk management. The process now involves a greater engagement of the community mental health team. Risk management is approached by considering dynamic and static factors. Clinical reviews occur on a weekly basis and each patient is reviewed at a minimum of 6 weekly or more frequently if there is a change in risk. The risk management plan is discussed and updated if appropriate. Furthermore, the risk management plan is updated

> on an 'as needs' basis as well. The new risk assessment template22 focuses attention on dynamic risk factors and changes to those. Changes in risk automatically ensure that changes flow through to the management plan. A formal mental state examination is now required as part of the risk assessment process. Staff of the Centre have had additional training in risk assessment and management, specifically addressing static and dynamic risk and management. Ongoing training is delivered to all staff online and is accessed annually as part of staff performance management. There are now clearer lines of responsibility.
>
> There have been changes to the handover process. These centre around a clinical handover tool known as IDSBAR which stands for Identification, Situation, Background, Assessment and Recommendation. This ensures that when an issue is identified there is a plan for resolution for each client. A board in the staff room called the 'Journey Board' is used to discuss each patient in turn at the handover.'

5.2. Finally, there have been changes in the Trevor Parry Centre in the management and storage of medication. The system of locked drawers in bedrooms, which I have referred to already, has changed. Now there are two locked drawers in each patient's bedroom. One drawer is accessible only by staff. The other drawer continues to be accessed by a unique key given to patients which also unlocks the patient's bedroom door. All medication within the Trevor Parry Centre is stored within these locked drawers. In the first phase of a patient's progression through the Centre, the medication is stored in the staff only locked drawer. The drawer is unlocked by a staff member who observes the patient taking the prescribed medication and then ensures that the medications are locked back in the drawer. As the consumer progresses towards more independent living, they are then required to prompt staff for the administration of their medication. The medication remains stored in the staff only locked drawer during this phase and if a patient fails to prompt staff, then staff will attend to remind the consumer within an hour of the designated time that they must take their medication. In the final phase a patient moves to self administration. In this situation only some of the consumer's medication is stored in a consumer accessible drawer. The remainder is stored in the staff only drawer. The amount accessible to the consumer depends on clinical risk and a patient will have access to no more than one week's supply of medication at any one time. The patient in this situation will be responsible independently for taking his or her own medication and then replacing it in the patient accessible drawer.

[22] Exhibit C14, MRB13

6. Recommendations

6.1. In summary, I am satisfied that the Trevor Parry Centre has made appropriate responses to Ms Jenkinson's tragic death and see no need to make any recommendations in this matter.

Key Words: Psychiatric/Mental Illness; Suicide; Drug Overdose

In witness whereof the said Coroner has hereunto set and subscribed his hand and Seal the 13th day of December, 2012.

State Coroner