

FORM 38

Rule 60(2)

FINDING INTO DEATH WITHOUT INQUEST

Section 67 of the Coroners Act 2008

Court reference: 3075/07

In the Coroners Court of Victoria at Melbourne

I PETER WHITE, Coroner

having investigated the death of:

Details of deceased:

Surname: ROSSE
First name: JANET
Address: 3/104 McCrae Street, Dandenong Victoria 3175

without holding an inquest:

find that the identity of the deceased was JANET CAROL ROSSE
and death occurred on 7th August, 2007

at Unit 3/104 McCrae Street, Dandenong, Victoria 3175

from

1a. MEXILETINE TOXICITY

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. Janet Rosse had a long-standing diagnosis of hyperkalaemic periodic paralysis. This caused occasional attacks of paralysis, which often led to hospitalisation and chronic and severe pain in her upper neck and body. She was under the care of Dr K Reardon, consultant neurologist, at the Neuromuscular Clinic and saw Dr Jeremy Couper, consultant psychiatrist, both at St Vincent's Hospital.
2. Janet Rosse had sought and obtained genetic counselling, together with her boyfriend, in relation to her condition and learnt that she had a 50% chance of passing her condition on to her fetus. In 1998, at aged 23, she took an overdose of medication in the context of a relationship breakdown and deterioration in her physical state.

3. In her first meeting with Dr Couper on December 16th 2004, she claimed that her father had told her mother when she was still a child that she should be put into a home because of her physical disability. At this time Dr Couper assessed her as suffering from a major depression of moderate severity. He formed the opinion that,

"Ms Rosse was a very proud young woman who, despite having intermittent paralytic attacks since childhood, continued to have difficulty coming to terms with her disability and its impact on her career ambitions and intimate relationships. I formed the view that she had a strong need to feel in control of her life and found the need to seek medical attention and submit to nursing care on regular occasions, humiliating and demeaning and therefore preferred to try to manage with the help of members of her family, as far as possible."

4. Dr Couper and Janet Rosse agreed to continue to meet so that Dr Couper could continue to provide psychiatric support and medication. According to Dr Couper this was to occur in parallel with ongoing support for her pain management provided by the Barbara Walker Centre team.

5. Monthly meetings with Dr Couper continued until May, 2005. Thereafter for various reasons these meetings were discontinued with Janet Rosse facing increasing difficulty at home as her ageing parents and other family members found it harder to assist her during bouts of paralysis. In these circumstances she made contact with Emily Buckland of the Royal District Nursing Service and told Dr Couper in September,

"that she was hopeful that more comprehensive home care was going to be arranged."

6. In October 2006, she attended Dr Couper's clinic in a wheelchair. During this meeting, she complained of the manner of her treatment by nursing when admitted to the St Vincent's Hospital neurology ward. Possible future respite admissions at the Bethlehem Hospital in Caulfield were discussed as a possible alternative to St Vincent's, but that matter was unresolved.

7. Dr Couper had further contact with Janet Rosse in January 2007 and saw her at the Barbara Walker Centre in February and, finally, on the 24th of April. At the second of these consultations, Janet Rosse informed that she had discharged herself against medical advice in March from the St Vincent's neurological unit and had gone to stay with a friend in Bulleen rather than return to her family.

"She spoke about some vague paranoid feelings she had...which she put down to stress. She told about new arrangements for her care, which involved a 17-year-old niece...As on all previous occasions, she did not mention any suicidal ideas or plans."

8. See Dr Couper's statement dated 23 of November 2007.

9. St Vincent's Neurology Department had contemporaneously also treated Janet Rosse for many years for her Hyperkalaemic Periodic Paralysis.

10. Most recently, I note that she was admitted to St Vincent's at the end of July 2007 and that she discharged herself after 4 days.

11. She was re-admitted shortly thereafter following a further bout of generalised weakness and inability to care for herself, this on the 2nd of August 2007.

12. According to Consultant Neurologist Professor Mark Cook, at the time of this second admission, Janet believed that the difficulties which caused the second of these admissions arose because of incomplete therapy she had received on the earlier occasion.

13. Further,

"Janet was admitted to hospital after having presented and was managed conservatively as potassium levels were normal. She was known to be seeing Dr Jeremy Couper with regard to her psychiatric situation and an appointment with him was scheduled to occur within the next few days. It was considered that she was likely to remain an inpatient for that time and that she would be taken to the appointment directly from the ward. Presumably for this reason it was not felt necessary to notify Dr Couper of any more urgent change, in that the psychiatric situation was not the trigger for the admission and... there had been no acute change in this regard."

14. In his statement, Professor Cook goes on to comment upon the depressed and anxious conduct displayed by Janet Rosse prior to her discharging herself on the 7th of August. He also acknowledges the connection between long-term neurological conditions and resulting,

"depression, anxiety and background social problems given the fundamentally untreatable nature of the underlying process."

15: Professor Cook further suggests that in this case the failure to consult her psychiatrist was not significant and that staff believed she would still keep her later appointment with Dr Couper, although she had specifically declined to see him before her discharge. I return to this matter below.

The 7th of August 2007:

16. When she arrived home on the 7th of August 2007 her sister, Natalie Rosse and partner, John, spent time with her between 1pm and 2.45pm, during which time she appeared to be upset. After they left, arrangements were made for her niece, Belinda, and a friend to visit with her later that afternoon. On arrival, between 5pm and 5.30pm, they let themselves in and found her lying in the hallway near the bathroom.

17. She was conscious and asked them to call an ambulance, which they did. Janet was breathing heavily and Belinda helped lift her up to a sitting position. Thereafter, she was directed over the phone to lay her head down again which she did. Belinda then gave her a drink.

18. Shortly afterwards Belinda found a note on the floor and some of Janet's medication lying around the lounge room floor which she considered to be unusual as her auntie usually kept her medication "*put away neatly*". Various family members arrived at the apartment together with ambulance officers.

19. Later family members were informed that Janet had died.

Finding:

20. On all the available evidence I am satisfied that on the 7th of August 2007, Janet released herself from the neurological ward at St Vincent's where she was being conservatively treated following an outbreak of generalized weakness and paralysis. These symptoms were a constant and depressing reminder of her neurological condition. She was well known to many of the nursing staff in the neurology unit having been admitted there on 21 previous occasions.

21. Normally on such occasions, she would present with varying degrees of weakness and gradually improve after rest and medical care, which would include physiotherapy.

22. I note here that the neurology ward regularly looked after such patients, i.e. patients with long-term neurological problems requiring care in such matters as toileting and showering, however, Janet Rosse felt degraded by her inability to care for herself and was noted to be anxious and tearful. It was in these circumstances then that she ignored advice to the contrary and discharged herself from hospital.

23. Overwhelmed by the constant and debilitating nature of her disability, she later deliberately ended her own life.

COMMENTS:

Pursuant to Section 67(3) of the **Coroners Act 2008**, I make the following comment(s) connected with the death:

1. It is also relevant that she had on the 30th July 2007 discharged herself without permission and, in these circumstances, I consider that her psychiatrist should have been notified of her most recent admission and consulted concerning her apparently depressed condition and later informed of her intention to again discharge.

RECOMMENDATIONS:

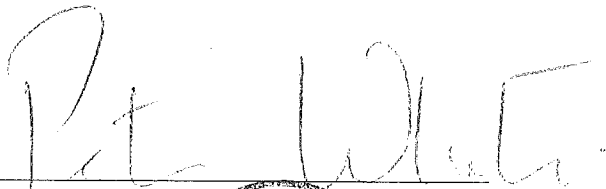
Pursuant to Section 72(2) of the **Coroners Act 2008**, I make the following recommendation(s) connected with the death:

1. I note with approval that, partly as a result of this death, a full review of administrative processes has been undertaken at St Vincent's and the integration of (Barbara Walker Centre) pain management patient histories with hospital patient histories has been achieved, through the introduction of the organisation-wide electronic Patient Administrative System.

2. I also note that because of this initiative, information regarding a patient's past and ongoing clinical activity is now readily available throughout the hospital.

3. As referred to above Professor Cook acknowledges the connection between mental illness and the untreatable nature of some neurological conditions. Over and above the Patient Administrative System, I recommend that a psychiatric consult is actively sought in all cases where neurological inpatients have a current psychiatric history managed by the Barbara Walker Centre.

Signature:



Peter White

Coroner

Date: 24 March 2010

