Neutral Citation No: [2019] NICoroner 6 ***Judgment: approved by the Court for handing down (subject to editorial corrections)****	***Ref:*** **2019NICORONER6** ***Delivered: 28/05/2019***

IN THE CORONERS COURT FOR NORTHERN IRELAND

IN THE MATTER OF

AN INQUEST INTO THE DEATH OF ANGELA CROWLEY

Before: Coroner Patrick McGurgan

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[1] The deceased, Angela Crowley, born on 2 September 1965, of 12 Torr Road, Ballycastle, died on 3 May 2016.

[2] The deceased had a long standing history of depression and anxiety following the loss of her brother and father. She also had a history of bilateral breast cancer.

[3] In her evidence to the Inquest, Mary Teresa McCreanor, Senior Social Work Practitioner in Mental Health stated that at the time she was part of the Ballycastle/Ballymoney Community Mental Health Team ("CMHT"). She initially had contact with the deceased from 2 July 2013 until 25 March 2014. The deceased was being treated for anxiety and depression but discharged due to non-engagement with treatment offered.

[4] Ms McCreanor next encountered the deceased on 23 September 2015. Prior to this the deceased was having input from the Community Psychiatric Nurse ("CPN") Paul Reid from 5 August 2015.

[5] On 23 September 2015 the deceased arrived unannounced at Dalriada Mental Health Resource Centre in Ballycastle in a highly agitated state. She was seen by Ms McCreanor and then the following day seen jointly by Dr Ryan O'Neill, Consultant Psychiatrist, and Ms McCreanor. Anti-psychotic medication was prescribed and she was referred to the Home Treatment Team ("HTT"). The

deceased's engagement with the HTT between 25 September and 1 October was erratic and on 1 October she was admitted to Holywell Hospital under the Mental Health (NI) Order 1986.

[6] Following her discharge some 10 days later there was a joint 7 day follow-up visit to the deceased by Ms McCreanor and Paul Reid. There then followed numerous contacts and on 6 November 2015 Ms McCreanor learned that the deceased had gone to London. The deceased subsequently returned to Northern Ireland ("NI") and telephoned Ms McCreanor on 23 December 2015. She did not express any suicidality at that time but declined to see Ms McCreanor.

[7] On 4 January 2016 Ms McCreanor discovered that the deceased went to stay with a friend in London again on 2 January and that she was now registered with a GP in London and on 7 January Ms McCreanor forwarded relevant notes and reports to the new GP. There then followed telephone contacts between the deceased and Ms McCreanor and on 15 January the deceased's friend in London contacted Ms McCreanor worried that she could not locate the deceased. Ms McCreanor liaised with the PSNI and Metropolitan Police and crisis services in NI in case the deceased returned to NI.

[8] The deceased's partner contacted Ms McCreanor on 16th January to advise that the deceased had been located and was well.

[9] On 17 February 2016 Mr Reid informed Ms McCreanor that the deceased was now in Belfast in a Women's Aid Refuge. On 26 February Women's Aid informed Ms McCreanor that her new GP was Old Park Group Practice.

[10] On 29 February Ms McCreanor wrote to the new GP practice and to the One Point of Referral Team for Mental Health for the BHSCT.

In her evidence Ms McCreanor explained that she wrote to the different GPs in order to provide them with background information regarding the deceased as she believed that the sharing of information amongst professionals is/was vitally important.

[11] Ms McCreanor was very shocked to have learnt of the deceased's passing as she had never seen any evidence of self-harm. She also described the deceased as a socially avoidant and reclusive individual who loved her son.

[12] The deceased was registered with Ballycastle Medical Practice from 30 January 2007 until 11 February 2016. In his evidence to the Inquest, admitted under Rule 17, Dr Hegarty GP stated that the deceased's mental

health declined in September 2015. As a result the deceased was assessed by the mental health team and she was receiving care from the HTT from 24 September 2015. At this time the deceased was diagnosed with paranoid psychosis. The deceased did not engage with the HTT and Dr Hegarty assessed her at her home on 1 October 2015 whereupon she was detained under the Mental Health Order. There were two telephone encounters with the deceased on 15 October and 30 December 2015 but no further face to face contacts.

[13] On 1 February 2016 the deceased contacted the GP practice to inform them that she had returned from England and was in Belfast staying in a Women's Aid Shelter. She was seeking medication. As she was now living in Belfast she was advised to register with a GP there.

[14] In his statement to the Inquest, admitted under Rule 17, Dr McLaughlin of Oldpark Group Practice stated that the deceased initially registered with his practice on 8 February 2016. Dr McLaughlin met with the deceased on this date but thereafter there were no further face to face contacts. She was seeking medications and some prescriptions were issued on 22 February 2016.

[15] In her evidence to the Inquest, admitted under Rule 17, Dr Maire Harkin stated that the deceased was a patient of the Salisbury Medical Centre, Antrim Road Belfast from 23 February 2016 until her death on 3 May 2016. Dr Harkin met with the deceased on one occasion on 7 March 2016 when she was suffering from anxiety and difficulties with her accommodation. The deceased expressed having had recent suicidal ideation approximately 8-10 days previous but denied being suicidal at this consultation. Lifeline details were confirmed with the deceased and she was referred to the Mental Health Hub in Belfast for further support. A two week review was planned by Dr Harkin.

[16] Dr Harkin was made aware that the deceased contacted Lifeline 9 days later and had attended A&E in the Mater Hospital with suicidal ideation on 17 March. She was admitted onto the care of the HTT.

[17] On 24 March the deceased's Consultant Psychiatrist advised a change to medications and on 30 March the deceased was commenced on quetiapine again on the advice of the psychiatrist.

[18] On 7 April the deceased met with Dr Harkin's colleague, Dr Brown with ongoing anxiety symptoms with some improvement since commencing quetiapine. This was the last contact with Salisbury Medical Centre.

[19] Dr Ryan J O'Neill, Consultant Psychiatrist, gave evidence to the Inquest. Dr O'Neill had first assessed the deceased on 19 August 2013 following a request from her CMHT Keyworker. She was diagnosed with Generalised Anxiety Disorder, Recurrent Depressive Disorder-currently stable.

[20] Dr O'Neill next encountered the deceased on 24 September 2015 at a review appointment. Thought content revealed paranoid delusional system of morbid jealously. Dr O'Neill felt that there was deterioration in her presentation with an acute psychotic episode.

[21] On 27 October 2015 there was a further review. This was post release from Holywell Hospital and Dr O'Neill at this time felt that the deceased had improved and was no longer presenting with psychotic symptoms.

[22] There were further discussions regarding the deceased between Dr O'Neill and her Keyworker and ongoing fluctuations in her mental health were noted.

[23] Dr O'Neill explained the challenges to Mental Health professionals posed by individuals who "dip in and out" of treatment and the difficulties encountered in essentially trying to keep track of particularly high risk patients.

[24] In his evidence to the Inquest, admitted under Rule 17, Mr Paul Reid Community Mental Health Nurse, ("CPN"), outlined his involvement with the deceased from his initial assessment of the deceased on 5 August 2015 until his involvement ceased on 16 February 2016. There were a number of contacts in August 2015 and in October 2015. On 20 October Mr Reid paid an unscheduled visit to the deceased and noted that her mental health had improved, she was less paranoid and no longer felt that the house was being bugged by her partner.

[25] On 29 December 2015 the deceased's partner contacted Mr Reid with concerns about her mental health specifically that she was paranoid and non-complaint with her medication. A joint home visit between Mr Reid and a Senior Occupational Therapist was arranged for that same day. The deceased was not happy to see Mr Reid or the other staff member but they were invited into the property. The deceased still believed that her partner was having an affair but she denied any suicidal ideation. Mr Reid did not see the deceased following this visit although he remained up-dated about the deceased until his involvement in the case ended.

[26] In his evidence to the inquest, admitted under Rule 17, Dr Declan Love stated that on 18 March 2016 he was working as an SHO in the Emergency Department of the Mater Hospital Belfast in his role with the Unscheduled Care Team ("UCT"), when he encountered the deceased. He performed a co-assessment with a Mental Health Nurse. This was prompted by concerns raised by Women's Aid where the deceased was residing regarding deterioration in her mental health. The deceased denied suicidal ideation or thoughts of self-harming. Dr Love was of the opinion that the deceased had many risk factors which required urgent input from CMHT and her GP but did not warrant an inpatient admission. An immediate risk management plan was initiated which included a personal safety plan, lifeline details being provided and following a Multi- Disciplinary Team ("MDT") review on 18 March 2016 the supervising Consultant Psychiatrist, Dr John Caughey, arranged a medical review in his clinic the following week.

[27] In his evidence admitted under Rule 17, Dr John Caughey, stated that he reviewed the deceased on 22 March 2016. She reported low mood for many years, poor sleep for the past year, and poor appetite over the previous one to two months with zero energy levels. She further reported feeling anxious all the time and reported thoughts of life not worth living for a few weeks but denied any suicidal thoughts.

[28] Dr Caughey felt that the deceased had a moderate to severe depressive episode and the function of the HTT was explained to her. Dr Caughey believed that the deceased was acutely unwell and required intensive input which the HTT could offer. Dr Caughey spoke with the HTT whilst the deceased was with him and arrangements were put in place for contact to be made by the HTT that night with the deceased.

[29] In her evidence to the Inquest, Dr Caroline Donnelly stated that she was the Consultant Psychiatrist treating the deceased during her period of care with the HTT between 22 March 2016 and 8 April 2016.

[30] Dr Donnelly met with the deceased at the Women's Aid Hostel, where she was residing, on 22 March 2016. In preparation for the meeting Dr Donnelly read the notes provided by the UCT relating to the assessment on 18 March and the notes relating to the appointment the deceased had with Dr Caughey on 22 March. Dr Donnelly consulted at length with the deceased and overall she felt that the deceased was experiencing a depressive episode with an increase in severity of symptoms in the recent weeks prior.

[31] As a result of the decline in her mental health and the numerous factors contributing to her presentation, Dr Donnelly was of the opinion that the deceased required a period of care with HTT. This would initially involve daily contact with a mental health practitioner and contact was to be maintained with the deceased's Keyworker in Women's Aid and also a community support worker was recommended. Dr Donnelly believed that this approach was more suitable at that time for the deceased rather than a period of hospital admission. The HTT provides an intensive community based treatment initially on a daily basis. Dr Donnelly felt that it was important for the deceased to try and resolve her accommodation issue, financial issues and to become more independent which she believed would assist in the deceased's mental health recovery. These were issues which could not be addressed if the deceased had been admitted to hospital.

[32] Dr Donnelly gradually ceased the deceased's antidepressant Citalopram and replaced it with another, Duloxetine. Dr Donnelly, with the deceased's permission, spoke with the deceased's sister in England and obtained a collateral history. Dr Donnelly also at this time requested the deceased's notes and records from the Northern Health and Social Care Trust. These took some twenty one days to arrive. On receipt of the notes and records they were reviewed by Dr Donnelly and their content did not change her original diagnosis or treatment plan.

[33] Dr Donnelly continued to review progress of the deceased with the HTT and she was discussed at the MDT meeting on 5th April. At that meeting transfer to Primary Mental Health Care Team ("PMHCT") was recommended and this formally occurred on 21 April.

[34] In her evidence to the Inquest admitted under Rule 17, Dr Elaine Boyd, Consultant Psychiatrist stated that at the time she was a Senior Speciality Trainee to Dr Donnelly. Dr Boyd visited with the deceased on 31 March 2016 at the Women's Aid Hostel in order to assess her mental state. On assessment Dr Boyd felt that the deceased was suffering from a moderate to severe depressive episode with no evidence that day of psychotic symptoms. Dr Boyd added quetiapine for agitation and anxiety.

[35] Dr Boyd next reviewed the deceased on 12 April 2016. The deceased continued to report low mood although Dr Boyd felt that there had been some improvement since her last review.

[36] In her evidence to the Inquest, admitted under Rule 17, Ms Emma Sweeney stated that at the time she was a band 5 Mental Health Nurse with the HTT. Ms Sweeney was allocated to work with the deceased on 26 March 2016.

[37] Ms Sweeney visited with the deceased on 27 March 2016 and she noted that the deceased was appropriately dressed and appeared to be attending to her personal care. Following a discussion Ms Sweeney arranged to visit the deceased the following day. On the 28 March Ms Sweeney noted that the deceased had evidence of on-going low mood. Thoughts of life not worth living were expressed but the deceased indicated that her son was a protective factor.

[38] Ms Sweeney telephoned the deceased on 30 March to arrange a visit but this offer was declined by the deceased.

[39] Following the MDT meeting on 5 April Ms Sweeney visited the deceased at the Women's Aid Hostel. Psycho-therapeutic interventions were discussed as well as the planned transfer to the PMHCT.

[40] Ms Sweeney's final visit with the deceased was on 8 April. Whilst the deceased did disclose that she had suicidal thoughts the previous day and indeed had such thoughts for a long time they were related to not seeing her son. She denied any active thoughts of self- harm. On 11 April telephone contact was made with the deceased's sister to update her and also with Women's Aid to remind the staff there to remind the deceased about her appointment with Dr Boyd the following day.

[41] In her evidence to the Inquest, Caroline Fairley-Gribben stated that at the time she was a Mental Health Nurse with the PMHCT and that she carried out a comprehensive and detailed assessment of the deceased on 21 April 2016. The deceased reported anxiety symptoms, a history of depression and low mood. She denied any plan or intention to end her life. Sleep was disturbed and she found daily tasks a chore. Ms Fairley-Gribben found no evidence of psychosis or delusions and believed that the deceased was suffering from anxiety and a depressive episode. A safety plan was agreed and life line numbers provided as well as a suggestion of transfer to Ms Anne McShane Social Worker within the PMHCT. An appointment was then made with Ms Fairley-Gribben for 3 May.

[42] Ms Fairley-Gribben discussed the deceased with Ms McShane on 21 April and again on 22 April whenever the deceased was transferred to her care.

[43] In her evidence to the Inquest, admitted under Rule 17, Anne McShane stated that at the time she was a Band 6 Agency Social Worker with the Primary Mental Health Service. Between 12 and 29 April she was undergoing her induction into that team. During that time she followed up on issues as requested by Ms Fairley-Gribben.

[44] On 3 May 2016 Ms McShane received a telephone call from the deceased at 12 noon advising that she was unable to attend her appointment with Ms Fairley-Gribben due to childcare arrangements and as a result the appointment was rescheduled to 25 May at 11:00am.

[45] In his statement admitted under Rule 17, the deceased's son stated that on 3 May 2016 the deceased awoke him in order to get him up for school. He saw the deceased again at around 8am sitting on a sofa in the kitchen at the property drinking coffee. He then left for school at approximately 8.25am.

[46] In his statement to the Inquest, admitted under Rule 17, the deceased's partner stated that the deceased turned up unannounced at his property at the end of April and moved back into the property. He further stated that on 3 May 2016 he left the property in the early morning to go to work. He returned home at approximately 3.40pm and went to the back door as usual. He found this door to be blocked by a sofa and he thought the deceased had done this as she couldn't find a key and had gone off to bed. The deceased's partner gained access to the property and made a cup of tea. A short time later his son arrived home from school and he, the son, went upstairs to look for the deceased. The deceased's partner followed him and discovered the door to the spare bedroom locked. Unable to gain access to this room via the door, he retrieved a ladder and gained access through an open front window whereupon he discovered the deceased lying on the floor. He moved the deceased onto the bed and emergency services were contacted. On advice he placed the deceased onto the floor and commenced CPR.

[47] Unfortunately this proved futile and life was pronounced extinct by a Forensic Medical Officer at 12 Torr Road, Ballycastle on 3 May 2016 at 18.41pm.

[48] Ms Agnes Dee gave evidence to the Inquest. She explained that a Serious Adverse Incident Review had been conducted following this tragedy and highlighted poor communication between the Belfast and Northern Trusts in relation to the requesting of the notes and records. Improvements have been made in this regard which I commend.

[49] I find that all of the Practitioners who had dealings with the deceased acted timely and appropriately throughout. I find that there was a high level of input from those Practitioners into the care of the deceased. I further find that the decision by Dr Donnelly to offer HTT to the deceased as opposed to hospital admission was the correct one.

[50] I find that whilst there was a delay in the supply of the notes and records from the Northern Trust to the Belfast Trust and that they were not proactively chased by the Belfast Trust, this delay did not affect the outcome nor the approach to the treatment of the deceased.

[51] The evidence suggests that it is imperative that appropriate procedures are implemented regarding the sharing of information across all Trusts in a timely fashion.

[52] A toxicological analysis of a sample of the deceased's blood revealed a reading of approximately 895 milligrams of alcohol per 100 millilitres of blood. This is more than ten times the legal limit for driving. In addition, the sample was found to contain a number of drugs to included paracetamol, codeine, morphine (the breakdown product of the codeine), citalopram, duloxetine, diazepam, mirtazapine, promethazine, quetiapine and possibly zopiclone.

[53] I find on the balance of probabilities that the deceased died by her own act whilst the balance of her mind was disturbed.

[54] A post-mortem was performed and it records and I find that death was due to:

(a) Combined alcohol, codeine, citalopram, duloxetine, diazepam, mirtazapine, promethazine and quetiapine toxicity.