CORONERS COURT

OF NEW SOUTH WALES

Inquest:	Inquest into the death of Michael Murray
Hearing dates:	30 October – 3 November 2023; 6, 7 and 9 November 2023
Date of findings:	17 April 2024
Place of findings:	Coroner's Court of New South Wales, Lidcombe, NSW
Findings of:	Deputy State Coroner, Magistrate Erin Kennedy
Catchwords:	CORONIAL LAW – Death in police operation – death as a result of a fall from height – borderline personality disorder – BPD – Dialectical Behaviour Therapy – DBT – Blue Mountains Hospital – benzodiazepines
File number:	2020/315984
Representation:	Mr W De Mars, Counsel Assisting, instructed by Ms B Lorenc (Crown Solicitor's Office) Mr S de Brennan for the Commissioner of the New South Wales Police Force, Negotiator Sue, Chief Inspector Anthony Mitchell, Former Sergeant Warwick Slarke, Constable Mark Walsh and Constable Emily Sims, instructed by Mr C Norman (Office of General Counsel) Mr P Rooney for the Nepean Blue Mountains Local Health District, South Western Sydney Local Health District, Dr R Yin, Dr P Byrne, Dr P Shinde, C Schnierer and J Fifita Ms R Rodger for Dr N Gunning Ms T Berberian for D Makarious Mr Elliot Rowe for Ms Boyle

Findings	***The identity of the deceased*** *The deceased person was Michael Murray* ***Date of death*** *Michael died on 2 November 2020* ***Place of death*** *Michael died at Landslide Lookout, Katoomba, NSW 2780* ***Cause of death*** *Michael died as a result of multiple blunt force injuries* ***Manner of death*** *Michael's death was the result of misadventure (fall from height)*
Recommendations	To NSW Health: 1. That NSW Health give consideration to investigating the feasibility of establishing Dialectical Behaviour Therapy (DBT) courses for mental health clients that are accessible outside of weekday business hours. 2. So far as NSW Health may be considering the utility of broadening the availability of access to Electronic Medical Records (EMR) across different Local Health Districts (LHD), that NSW Health examine the findings in this matter as part of the evidence base that would support such broader availability.
Non publication orders:	Non-publication orders made on 30 October 2023 prohibit the publication of certain evidence in this Inquest. A copy of these orders can be obtained on applications to the Coroners Court registry.

Contents

Background to Inquest

1. Mr Michael Murray died on the evening of 2 November 2020 after a fall from a cliff at Landslide Lookout in Katoomba at the age of 44. He was located at the lookout in the days prior to his death and taken by police to Blue Mountains Hospital. The hospital determined to discharge him, and he returned to the lookout Police again became concerned for his welfare following contact from Michael's partner. Michael agreed to voluntarily return to hospital, and he was scheduled and admitted. Michael remained in hospital until the morning of 2 November 2020.

2. Michael was then discharged from Blue Mountains Hospital after indicating that he intended to return to Sydney and his work. He did drive back to Sydney, but then returned to the lookout and police again located him, this time on a ledge. A police operation commenced in an attempt to coax him down from his position, however he fell from a significant height and sustained fatal injuries.

3. Michael was diagnosed with Borderline Personality Disorder, and the inquest looked in some detail at the diagnosis and treatment of what will be referred to as BPD.

Direct cause of death

4. The direct cause of Michael's death is not suspicious. A limited autopsy was performed by Dr Jennifer Pokorny on 6 November 2020. Dr Pokorny determined that Michael died as a result of multiple blunt force injuries, consistent with a fall from height. Toxicological analysis indicated that Michael's blood contained alcohol at a level that would be expected to cause noticeable intoxication (0.182g/ml). Diazepam, codeine and their metabolites were detected at levels similar to those seen with therapeutic use, and low levels of paracetamol and olanzapine were also detected.

Whether an inquest into Michael's death is mandatory on the basis that it was "as a result of police operations"

5. The inquest into Michael's death was mandatory pursuant to the definition "*as a result of police operations*" pursuant to s. 23(1)(c) of the *Coroners Act 2009* (NSW) ("the Act"). Pursuant to s. 27(1)(b) of the Act, an inquest into Michael's death is therefore mandatory. This is not to suggest that Michael's death was in any way caused by the intervention of police, who were attempting to safely remove Michael from the cliff's edge.

6. The requirement for Coroners to examine police operations which result in a person's death is a matter of important public policy. It ensures appropriate and independent scrutiny is given to the actions of police in the way that they exercise their considerable powers.

Function under the Coroners Act

7. The primary function is provided by s. 81 of the Act. It is to make findings as to:

    a. the identity of the deceased;

    b. the date and place of the person's death; and

    c. the manner and cause of the person's death.

8. Pursuant to s. 82 of the Act, the Coroner may make recommendations in relation to any matter connected with the death. Recommendations relating to public health and safety are specifically mentioned in the Act as an example of the category of recommendations that might be appropriate.

The issues

9. The scope of the inquest was to explore a number of factors.

10. In addition to the required findings under s. 81 of the Act, the major and overarching issues can be best summarised as follows:

    a. How was Michael treated in the community leading up to the admission to Blue Mountains Hospital?
    b. Was he properly diagnosed?
    c. How was Michael treated by Blue Mountains Hospital and was his treatment and release appropriate?
    d. Did the police operation initiated on 2 November 2020 in relation to Michael's welfare contribute in any way to his death?
    e. Are there any recommendations arising as a result of the circumstances of Michael's death?

Nature of the inquest

11. The proceedings are inquisitorial in nature, not adversarial. It was not the function of this inquest to find negligence nor apportion blame. The proceedings are not criminal. In effect the proceedings were to explore the manner and cause of Michael's death in light of the intervention of police in the matter pursuant to the Act.

Background to Michael

12. It is important to reflect on Michael and his life, he was far more than the illness from which he suffered. He was much loved and cherished by his family and partner. He was someone who worked hard to combat his illness and challenges. He showed insight and commitment to improve his life and had long battled with his mental health.

13. Michael was the youngest of four children, with three older sisters. He was born in Melbourne and moved to Mildura at a young age with his mother and one of his sisters, Sue. He had limited interactions with his father.

14. Michael gave reports to various clinicians later in life that his father had been violent and a heavy drinker. Growing up in Mildura, his sister described Michael as being adventurous and that he loved being active. Michael himself described having been bullied during high school. He commenced, although did not complete, year 12. At this stage he reported that his relationship with his mother became difficult and he moved out of home and lived with friends. His sister states that as he grew older, Michael began experimenting with drugs and having some minor incidents with police. His sister reported that his life seemed to become harder around this time.

15. From around the age of 20 in the mid-1990s Michael was in a relationship with a woman with whom he had a daughter who was born in 1996. His sister describes this relationship as always being rocky and they separated when Michael's daughter was very young. Michael wanted to be part of his daughter's life, but it appears that this was largely not possible. This affected Michael deeply, and his sister, Karen, said that Michael always thought of his daughter, no matter where he was.

16. There is limited detail concerning Michael's mental health up until 2011 available on the evidence. However, Michael's later accounts to clinicians suggested he'd struggled with his ability to regulate his emotions throughout his adult life.

17. Michael was sometimes described, in previous years, as having Bipolar Disorder in addition to Borderline Personality Disorder (BPD). Medication he was prescribed on an ongoing basis (Lithium and Olanzapine) related to a Bipolar diagnosis. That diagnosis and the prescribing of those medications, is first recorded in 2005, arising out of a single visit to a psychiatrist in Adelaide at that time.

18. He had been living in Adelaide in 2010 but ended up losing his employment and accommodation. In October 2010, Michael was admitted to Cooma Hospital, and then transferred to Bega Hospital, after consuming a quantity of diazepam and alcohol and indicating an intention to take his life. He was said to be experiencing ongoing suicidal ideation. In early 2011 he was living in his car in Jindabyne. Throughout 2011 Michael had a number of contacts with inpatient units in Cooma and Mildura, first arising out of an incident in early 2011 when he was found by police near Lake Jindabyne with cuts to his

wrists, indicating that he had slit his wrists with the intention of bleeding until he felt faint enough to fall into the water. It was not until 2011 that it appears it was identified that BPD may have been a more appropriate diagnosis.

19. It was during his subsequent stay at Cooma Hospital that he met his future partner, Ms Boyle.

20. Michael and his partner moved to Sydney together in late 2011 and at this time Michael commenced seeing a GP, Dr Neale Gunning, who upon Michael's return to Sydney from Mildura in 2016, became Michael's regular ongoing GP. The historical record of Michael's past diagnoses, which at times indicated a diagnosis of Bipolar, meant that up until late 2017, Dr Gunning was not aware at that time that Michael had BPD.

21. From around mid-2012 until around late 2015, Michael and his partner lived in Mildura. While living in Mildura, Michael undertook Dialectical Behaviour Therapy (DBT) as treatment for his BPD. DBT is one of a small number of therapies which are regarded as providing the best therapeutic benefit for people with BPD. His partner said that this therapy was incredibly effective for both Michael and her. In her words, the treatment transformed Michael back to his true nature, which was loving, respectful and caring.

22. Michael's mental health began deteriorating after they returned to Sydney. This put a great deal of strain on his relationship with his partner, although they remained living together in the years following. Even this became difficult, and he moved out. He remained homeless for a while until he took up residence at his workplace after his employer generously allowed him to stay on the premises. His relationship continued with his partner supporting him even during the periods when he could not remain at home.

23. Michael had reconnected with his mother around 2019, although by this stage she had the onset of dementia, and in August 2020, she passed away in a nursing home in Adelaide. Michael was unable to attend the funeral. The death of his mother caused Michael considerable upset.

24. Michael was seeking help and wanted to undertake another course of DBT. He was initially placed on a waitlist for one hospital, but it was belatedly identified that he was in the wrong catchment by virtual of his living address and was therefore not eligible for the program for which he was waitlisted through Bankstown. He was then transferred to another catchment, and it therefore took some time for assessment to be undertaken, for a program to commence and for him to commence the process. This was valuable time lost in relation to addressing his mental health.

25. The following is an analysis of the documentary and oral evidence in the proceedings. The Inquest looked at the treatment Michael was receiving prior to his admission to Blue Mountains Hospital.

PART A: Michael's Diagnosis, Care and Treatment

General background on the diagnosis of Michael and BPD

26. The inquest was assisted by expert medical evidence that was heard in conclave from three eminent psychiatrists; Associate Professor Sathya Rao, Professor Matthew Large and Dr Olav Nielssen, each having prepared a report. I will refer to their evidence throughout the analysis below and in these findings.

27. The expert evidence was, consistently, that there are no medications that are indicated for the treatment of BPD. Rather, best practice as recommended by the NHMRC Clinical Practice Guidelines for treatment of BPD states that "People with BPD should be provided with structured psychological therapies that are specifically designed for BPD, conducted by one or more adequately trained and supervised health professionals." Therapies that are specific to BPD include Dialectical Behaviour Therapy (DBT), Mentalization Based Treatment (MBT), Schema Focussed Therapy (SFT) and Transference Focussed Therapy (TFT).

28. In relation to Treatment Plans, it was observed by Associate Professor Rao that:

> *Best practice principles of treatment of a person with severe and complex BPD would include a well-documented and individualised crisis management plan and overall treatment plan that is developed collaboratively with the person suffering BPD and their family/carers.*

29. Such a plan should describe the roles and responsibilities of each of the services, clinicians and family/carers involved in the treatment and would be reviewed periodically and when clinical deterioration occurs.

30. All experts considered that BPD was an appropriate diagnosis for Michael and cast significant doubt on the appropriateness of Bipolar as a concurrent diagnosis. Professor Large observed variabilities involved in presentation of Bipolar and did not exclude the possibility that features may have been relevant to Michael. However, in relation to the diagnoses of BPD, I accept the views of the experts on this point.

31. Associate Professor Rao helpfully set out in his report the range of features that applied in Michael's case that suggest the appropriateness of the diagnosis of BPD. These included certain features of his childhood experiences, the fact that his illness had commenced at least from his early twenties, a long standing pattern of unstable emotions and frequent episodes of suicidal ideations, expressions, communications and attempts.

32. There was also agreement that BPD is a highly stigmatised disorder and Associate Professor Rao observed that the science around it is still relatively new. He described however that attempts are being made to better educate and destigmatise the condition,

noting that many GPs would not be aware of the diagnosis or appropriate treatment, and by this he made no criticism of GPs generally, merely noting it as a growing area of diagnosis.

33. The experts also discussed the need for specialists to treat BPD, given the nature of the diagnosis and the very targeted treatment required.

34. Ms Boyle's evidence suggested that Michael may have felt such stigma and that this may have been a reason why, at times, he may have preferred to view himself as having Bipolar. This was in keeping with the general observations of the experts in this case in relation to the stereotyping of the condition and the stigma attached.

The Impact of BPD

35. Dr Andrew Kaill gave evidence and was the Community Mental Health Emergency Team (CoMHET) psychiatrist who saw Michael a number of times in July and August 2020 and observed that it was a common feature of BPD that people often think about suicide every day. He observed that Michael had made a range of plans and attempts in the past of self harm and had evidently thought about suicide regularly over many years. More generally in relation to BPD, Dr Kaill observed that BPD was a common and high risk condition.

36. Dr Kaill expressed the view that Michael was someone who was "constantly high risk" in relation to suicidality. He was of the view that there was limited benefit from emergency inpatient admissions for individuals with BPD given the feature of chronic suicidality and the ineffectiveness of medications.

37. Dr Kaill performed a "screen" for BPD on 15 July 2020 and set out at length in his statement what this involved. He concluded that "*on the basis of Michael's presentation, history and screen performed, my diagnosis was BPD in crisis in the context of relationship stress, workplace stress and the stress associated with his mother's diagnosis of Alzheimer's dementia leading to her being placed in a nursing home.*"

38. It was also acknowledged that there are both challenging and beneficial roles played by carers of those with BPD. Dr Kaill observed that "*it would have been very difficult to live with Michael, and I think [his partner] did a really quite amazing job of supporting him, and living with him for such a long time*".

39. In relation to the potential value of a clinician receiving information from someone such as Ms Boyle, Dr Kaill observed that "*They say that the collaborative information from talking to a partner is the equivalent of sort of doing an MRI or something like that in another part of medicine, so it gives you all the really helpful information."*

40. Dr Kaill recognised and acknowledged the importance of input of family and friends of those suffering with BPD. He was not aware of any services specific to carers of people with BPD. He thought the main avenue would be through a private psychologist arranged

through a GP. He noted how difficult it would have been to sustain a relationship with Michael over 10 years, noting that "*many people with borderline personality really struggle to have long-term relationships, and they call it sort of walking on eggshells, ……., you're always worried that you're going to ……., cause offence or give insult or get an unpredictable angry action that's very difficult.*"

41. In the course of her frequent efforts to help advocate for Michael through community mental health services in Sydney, Ms Boyle said that she was not once directed to sources of support for carers.

42. Dr Kaill was an excellent witness, who had a very thorough understanding of Michael and the diagnosis of BPD. He did the best he could to treat Michael and importantly get him moving into appropriate treatment.

Dr Gunning's care and treatment of Michael

43. Dr Gunning was the long-term GP supporting and treating Michael. Michael had been prescribed the benzodiazepine diazepam (valium) over a long period of time and appeared on the evidence to have developed an unhealthy reliance on it. There was considerable evidence indicating that it was common for people with BPD to overuse benzodiazepines as a way of coping with their emotional dysregulation.

44. In keeping with this observation, Ms Boyle gave evidence that Michael would use the medication "as a substitute for actually dealing with things", and to "avoid dealing with his feelings". Ms Juliet Fifita, who provided care to Michael as part of a DBT program, gave evidence that this clinical care involved providing assistance in relation to the overuse of medication as a means of managing distress.

45. A further concern about the overuse of medication in people with BPD was identified by both Associate Professor Rao and Dr Nielssen as they related it to the high rate of suicide amongst people with BPD generally, along with the high preponderance of completed suicides involving the overuse of medication.

46. Dr Gunning gave evidence that Michael would regularly attend his practice late on a Friday afternoon. He expressed the view that this is the time that people who are "doctor shopping" would often come around "because they think we want to go home". He however believed at the time that Michael would attend at this time because it best suited him due to his work. I accept that he made this observation with the benefit of hindsight.

47. This was the time that he would also administer Michael's monthly depot olanzapine injection. He did not consider that Michael needed to be kept under observation after these injections as "he had been on it for a while".

48. Following an inpatient admission for Michael at Bankstown Hospital, discussed further below, Dr Gunning received a CoMHET discharge summary on 13 August 2019 that advised that Michael's "benzodiazepine dependence needed to be addressed at some

stage, with possible weaning and ceasing". In his evidence Dr Gunning could not recall taking any steps or making a plan with Michael as to how that might be achieved.

49. This discharge documentation that was received by Dr Gunning, had been authored by Dr Kaill, following contact from Ms Boyle expressing concerns about Michael's use of the medication. As a result, the discharge documentation he authored and that was sent to Dr Gunning contained the advice that Michael's valium prescription should be limited to 10mg per day, which translated to 2, as opposed to 4 tablets.

50. Notwithstanding that advice, on 24 July 2020, Dr Gunning increased the amount of valium being prescribed to Michael to up to 20 mg (4 tablets) per day. Dr Gunning gave frank evidence that in doing so, he made a mistake. When asked whether it was hard to say no to Michael, Dr Gunning replied, "I think I was a soft touch with him to be honest."

51. The suggested medication change arose because on 31 July 2020, Ms Boyle informed Dr Kaill about concerns she had regarding Michael's valium use, and that the more Michael took, the worse he would be. In his oral evidence Dr Kaill said that he would never prescribe valium in these circumstances, as Michael was using them as a way of coping with his feelings. However, he said that sudden withdrawal would not be helpful as this would probably make him feel worse.

52. Although on 11 August 2020, Dr Gunning limited the frequency with which Michael could collect his medication from the chemist to once every two days, he subsequently increased this to once every three days, and at no point did he take action to commence lowering his dose to comply with Dr Kaill's advice. Dr Gunning accepted in evidence that he should have done so.

53. Dr Kail agreed that it would have been ideal for Michael's valium use to have been weaned and ceased as had been recommended in 2019, however he stated that:

> *"… people with emotional dysregulation commonly abuse substances. Michael had a long history of using Olanzapine, antihistamines and Valium, and trying to - whereas it sounds really simple for you or me, I think it's really hard for someone like Michael to cut down and cease a medication like that."*

54. He agreed, however, that it was not appropriate for Dr Gunning, as Michael's GP, to increase the level at which valium was prescribed or the quantities or intervals at which it was dispensed.

55. Dr Nielssen gave evidence about the difficulties that ongoing benzodiazepine use can cause in the context of BPD. This included it being counterproductive to the aims of psychotherapy. Associate Professor Rao observed that the training of GPs generally in relation to BPD is very limited. Consequently, it would have been challenging for Dr Gunning to manage and make decisions concerning Michael's benzodiazepine use.

56. Professor Large agreed that benzodiazepines are not a helpful treatment in the circumstances and ideally would not be prescribed at all. However, he observed that once

someone has been prescribed benzodiazepines over a long period of time, significant caution needs to be applied in the rate at which their use is decreased. He was therefore somewhat sympathetic to the position that Dr Gunning was in while treating Michael.

57. By contrast Dr Nielssen made the observation that the large numbers of people entering jail each year provides an example of the large scale precipitous cessation of benzodiazepine use, thereby observing that "it's just not an emergency to stop these medications at all."

58. However, Dr Gunning had not been given such an "immediate" directive. The advice given to him in 2019 was to "wean and eventually cease" Michael's use. The advice given to him in July 2020 to limit the prescription to 10mg per day is something that could have been managed by Dr Gunning over time. There was, however, no reduction from the prescription level of 20mg per day over the ensuing three months. Dr Gunning's acknowledgment that he had made a mistake by failing to attempt to do so assisted the inquest, but it should be noted that Dr Gunning had a longstanding, supportive and caring professional relationship with Michael. He was doing his best to manage Michael with a complex mental health presentation. He provided consistency and support, and that should not go unnoticed.

59. In relation to use of olanzapine depot medication, Professor Large observed that it is well tolerated and "popular", while at the same time there were stringent guidelines around its use, requiring monitoring of the person concerned over three hours, due to there being a small risk of "post-injection syndrome". It could consequently be challenging for area health services to administer it, leading to its use in the community without monitoring. This appears to have happened in relation to its administration to Michael by Dr Gunning as set out above.

60. Despite being in general practice for 36 years, Dr Gunning gave evidence that to his knowledge he had only ever seen two patients who had a diagnosis of BPD. Given the prevalence of the condition, this would tend to support the expert opinion generally that this is a condition that is not yet well understood in the medical profession, particularly in relation to the area of general practice. Dr Gunning's attention was drawn to statistics that indicate that GPs are likely to see at least one person with BPD among every 16 consultations per day. He accepted that based on that statistic, it was likely that he was seeing many such patients, without being aware that they had the condition.

61. Associate Professor Rao gave evidence that the training given to GPs in relation to the detection and treatment of BPD is very limited. In the material appended to his report, Associate Professor Rao and colleagues have produced a book designed to further the practical knowledge of GPs in relation to BPD.

62. Finally, it is observed that, in view of that fact that other clinicians who had much less frequent contact with Michael, had expressed to them, frequent indications of suicidal intent by Michael, it is notable that this was not Dr Gunning's experience. Dr Gunning accepted the possibility that Michael may have compartmentalised him as a person from

whom he obtained prescription medications but didn't otherwise disclose his feelings or develop much of a therapeutic relationship. This was in keeping with the general principle of a common feature of BPD to result in "splitting", that is telling one health professional one thing and another quite a different account. This being consistent with Michael's diagnosis.

Co-ordination of Michael's care in the community during 2020

63. Michael's engagement with relevant services during the course of 2020 was extensive and complicated. In short, his engagement with services included:

    a. Attendance with a private psychologist (Danielle Makarios) under a Medicare mental health plan;

    b. Regular consultations with his GP (Dr Gunning) for his monthly depot olanzapine injection and receiving other medication prescriptions;

    c. Sporadic engagement with Bankstown Community Mental Health (CMH) Service, either on referral from his psychologist or upon discharge from Bankstown Hospital. This involved engaging with a number of different clinicians including:

        i. Psychiatrist Dr Andrew Kaill;

        ii. Occupational therapist Cohen Schnierer (his case manager at Bankstown CMH from late August 2020 until his death);

        iii. Individual counselling commencing in October (3 sessions), with Juliet Fifita (Occupational Therapist at Bankstown CMH);

        iv. Group DBT sessions commencing on 22 October (two sessions completed);

        v. Three separate short inpatient stays at Bankstown Hospital; Engagement with an NGO service provider (One Door); and

        vi. Engagement with a mental health nurse from the Credentialled Mental Health Nurse Service (on referral from his psychologist).

64. Associate Professor Rao considered the provision of services in the community to individuals with BPD. He expressed the view that given the complexities that exist within public mental health services across Australia, the overall co-ordination of Michael's care was adequate, and the fact that DBT was ultimately available to Michael, albeit after considerable delay, is commendable, given the state of availability of such therapy generally in mental health facilities in Australia.

65. Notwithstanding the opinion of Associate Professor Rao that the overall coordination of Michael's care was adequate, he identified a range of areas in relation to which Michael's treatment fell short of "best practice" and that might be improved upon, and they include:

a. Family/carer support for Ms Boyle;

b. Better care co-ordination and communication between all treatment providers;

c. Intensification of community contacts with Mr Murray when his psychosocial situation deteriorated (at least once a day contact);

d. Providing supportive psychotherapy/common factors approach that is therapeutic for BPD, while he was waiting for DBT;

e. The six month delay in commencing DBT for Mr Murray; and

f. A comprehensive BPD specific Treatment Plan and a Crisis Management Plan were not developed in active collaboration with Mr Murray and Ms Boyle.

Danielle Makarious

66. Evidence was given in the inquest by Ms Danielle Makarious, the psychologist in private practice to whom Michael was referred by Dr Gunning and who saw Michael over a period spanning 2018 to 2020, and at times sought to advocate on Michael's behalf for the greater involvement of community mental health services. Ms Makarious referred Michael to community mental health services on 21 March 2020 after he expressed suicidal thoughts to her.

67. On 2 April 2020, she was advised by Bankstown CMH that he had been discharged from their service as he denied any suicidal thoughts, was well and in good spirits. Upon being advised of this, Ms Makarious discussed her concerns with Dr Gunning who agreed with her that a plan moving forward would be to link Michael with a mental health nurse service who he could speak to on a regular basis free of charge.

68. The referral by Ms Makarious to community mental health on 21 March initially appears to have been to Liverpool CoMHET (based on the assumption that he was living in Casula). Clinicians from Liverpool CoMHET spoke with Michael and Ms Boyle on a number of occasions before referring him on to Bankstown CoMHET (including for assessment for a DBT program) once it was established that he was living in Bass Hill. Service notes indicate that this went no further than Bankstown CMH noting that "DBT at Bankstown is currently at capacity". Hence no referral to a DBT program was made, and Michael was discharged and referred back to his GP.

69. It was as a result of the efforts and advocacy of Ms Makarious in early April 2020 that Michael was able to gain some short term counselling assistance from the Credentialled Mental Health Nurse Service, and then from the "One Door" Mental Health, following his precipitous discharge from community mental health.

70. In July 2020, Ms Makarious again referred Michael to CoMHET for assistance, again following concerns about his suicidal ideation after he had been discharged from Bankstown Hospital. In doing so she expressed considerable frustration to Bankstown CoMHET about her perception that Michael had not received appropriate assistance from

the hospital. In evidence she stated that she did so because "*From my recollection of Mr Murray and our sessions, he was someone that was at that point willing to accept help, and needed support, and felt like the system was failing him, and was discharged before he was willing to be*".

The availability of DBT via community mental health and events just prior to Michael's hospitalisation

71. Ms Juliet Fifita, who became Michael's DBT counsellor once he commenced pre-treatment on 2 October 2020, gave evidence about DBT and the nature of the program offered by Bankstown CMH. Ms Fifita was trained in DBT by completion of a four day training program run earlier in 2020. She was an occupational therapist by training and had worked extensively as a mental health clinician prior to her DBT training. Ms Fifita described the utility of DBT in the following terms:

> *It's a very evidence-based therapy. There's been a lot of research that's been done into DBT and it's been found to be very effective. It's a stabilisation therapy, so it's a therapy that's effective for stabilising people that are in a pattern of crisis, and then once people move through DBT there are other modalities of therapy that can be very helpful, but that would be a very helpful therapy for someone who's in crisis and just needs to learn those core foundational skills to get out of that crisis mode.*

72. Ms Fifita observed that the capacity of the program was limited by the number of clinicians who were available to work on it, resulting in no more than ten participants being involved at any one time. Further, it was and remains, only available during business hours. In relation to this Ms Fifita said:

> *"… it was often problematic, because we did have quite a number of clients who were either employed or in tertiary study, and in many of them also in casual employment as well, which made it even more challenging for them to find that time to come to the program. So definitely was a barrier to access. That's for sure."*

73. Dr Kaill was also aware of limitations on the availability of DBT due to staffing considerations. He understood there to be only two psychologists/clinicians involved. He also observed that there were issues in relation to the recruitment and retention of clinicians due to the challenging nature of the work and the client group.

74. All three experts appeared to agree that there was little or no such therapies available after hours, with the possible exception of such services being available through privately paid psychological services. Professor Large observed that *"…it's very hard to work and get treatment for borderline personality disorder as a common clinical problem."*

75. In Michael's case, the availability of DBT and the hours during which it was conducted were a significant barrier. He was help seeking and desirous of commencing DBT in March 2020. Its unavailability at that time however, meant that he was not able to commence

the therapy until October 2020, seven months later. Even when a place did become available, the imposition on his work hours was a great source of stress to him. The time commitment required each week (a two hour group session and a one hour individual session) created a significant difficulty for him given the full time nature of his employment, particularly given that its location was a half hour drive from his workplace.

Dr Kaill's evidence concerning Michael's care and inpatient admissions in 2020

76. Michael was admitted to Bankstown Hospital on 6 July 2020 after he indicated that he had spent three hours at a cliff the previous night attempting to jump off. On 8 July 2020 he was discharged from hospital for follow up by Community Mental Health. He was referred again by Ms Makarious due to concerns that she held, and Community Mental Health conducted a home visit with him on 14 July 2020

77. Dr Kaill had first seen Michael on 15 July 2020, in his role as the psychiatrist for the Bankstown CoMHET. His role was to see people quickly, but not over a long period of time.

78. A client could see a psychiatrist on a longer term basis through one of the case management teams, and the DBT team also had a psychiatrist attached to it at the time, although that psychiatrist may have been drawn from either the adult team or the assertive outreach team.

79. At the consultation on 15 July 2020, Michael told Dr Kaill that on Sunday 12 July he had gone to the Blue Mountains with the intention of jumping to his death and said, "*that for some reason I could not do it as every time I tried to jump my legs turn to stone*." It appears that Michael had also travelled to the Blue Mountains on the preceding weekend on 4-5 July 2020, with the same intention.

80. The plan following this consultation was to refer Michael to DBT and Dr Kaill asked to see him again in a week. He said that he would not usually see a patient so soon but considered it appropriate due to the degree of concern he had regarding Michael's safety.

81. Michael next saw Dr Kaill on 24 July 2020. Michael reported having daily suicidal thoughts. He appeared to have returned to the Blue Mountains for a third successive weekend. Dr Kaill was of the view that his motivation in frequently going to the Blue Mountains was likely to have been mixed – both because of the beauty of the natural environment, but also because of his suicidal thoughts. Michael was stressed during this consultation, and accordingly, it was brief. Dr Kaill described his presentation as "help seeking … in a really maladaptive way" and that this was a hallmark of people with personality disorders. Michael was very desirous of undertaking DBT but saw his work situation as an insurmountable barrier to this. Michael asked for ongoing phone contact, twice a week and an arrangement was made for a further appointment in a week's time, again consistent with a raised level of concern about Michael's safety.

82. Accordingly, Michael again attended for a consultation on 31 July 2020. His further treatment appeared to reach an impasse. Michael expressed frustration at the perceived

incompatibility of his work hours with attending DBT. He was offered a further medical review which he declined, and a suggestion was made that he could undertake relationship counselling. He was told that he could self-refer back to CoMHET via the Mental Health Access Line. A discharge summary was prepared and forwarded to Dr Gunning.

83. Among other things the discharge summary contained the advice, as outlined above, that Michael should not be prescribed more than 10mg of valium per day.

84. Dr Kaill next saw Michael on 12 August 2020. This followed two admissions to Bankstown Hospital as a result of self harm incidents, on 3 and 6 August 2020. The second of the incidents occurred shortly after Michael had become aware that his mother, who was living in Adelaide, had died.

85. In Dr Kaill's opinion, in the circumstances, the grief associated with his mother's death would have had a particularly significant effect on Michael.

86. Dr Kaill did not see Michael after 12 August 2020 as he was admitted into the DBT program. There was an arrangement for Michael to having ongoing phone contact with Mr Cohen Schnierer, an occupational therapist who effectively acted as Michael's interim case manager, pending the commencement of DBT in October. Dr Kaill gave evidence that any further medical review was no longer with him, as Michael was from then on being assisted by a different team. He suggested that there may have been a role for a psychiatrist in relation to risk management if Michael's risks increased, but that regular contact with team psychologists, in addition to his private psychologist would be the most helpful evidence based treatment.

87. Dr Kaill did not consider there to be a need to stop Michael's ongoing Lithium and Olanzapine prescriptions on the basis that he understood that Michael thought they were helpful, notwithstanding that they were not medications he would have prescribed for BPD.

The extent of individualised case management provided to people with BPD

88. Cohen Schnierer, the case manager who had involvement with Michael in late August and during September 2020 gave evidence during the inquest. Mr Schnierer came to play that role as part of what he described as a "holding contact" for Michael after his acceptance into DBT, prior to its commencement some weeks later. The more usual position would be that a prospective client would be waiting for DBT to commence, without ongoing contact with the service. This deviation from the normal indicated the added level of concern and care that Michael was receiving.

89. Mr Schnierer's interim case management of Michael remained relatively limited in scope, consisting of eight separate phone conversations over a four week period. The only time he saw Michael in person was when he sat in on the first of Michael's pre-treatment sessions with Ms Fifita, on 2 October 2020. After that point, Mr Schnierer played no practical role in Michael's ongoing care.

90. Ms Fifita confirmed that it was not usual for someone in Michael's position to be receiving any case management. She said that this was very unusual and that "*usually they were standalone interventions. Either someone received community care coordination, or they received DBT*".

91. The Director of the SWSLHD Community Mental Health and Partnerships, Patrick Parker, was asked whether, in view of Michael's ongoing psychosocial crisis as of early October 2020, involving unresolved grief from his mother's death, his lack of housing, ongoing over-reliance on benzodiazepines and stress associated with his relationship breakdown, there was a place for ongoing care co-ordination for Michael through the CMH service. He was of the view that there was not a basis for Michael's inclusion in such ongoing care co-ordination.

92. DBT therapy had commenced, Michael was no longer receiving separate phone contact from Mr Schnierer where he could discuss on an ongoing basis practical day to day challenges he was facing with matters such as his accommodation and his emotional state.

93. Clients engaged in DBT are less likely to receive the same level as care co-ordination as other case managed clients. Although there was some evidence that arrangements could be made on an ad hoc basis, the ad hoc nature of any such arrangements, Michael's own experience, and the evidence of Mr Schnierer and Ms Fifita, suggests that such arrangements are unusual.

94. Professor Large agreed that, depending on the complexity of the client involved, in some instances it would be beneficial for there to be ongoing case management at the same time as engagement in a DBT program, although he didn't offer a view as to whether in Michael's instance, his case was considered by him to be of relevant complexity. He also observed that the provision of DBT services is relatively new and that they are under-resourced, with services often not having a GP or psychiatrist attached to them, and that they often don't have much of an identity within the health service., it would be beneficial for the services specific to BPD services to develop in the way that those directed to early psychosis have developed over time. He further observed that DBT programs are clearly cost saving given the high indirect costs, including those of hospital stays, that can be avoided.

95. Associate Professor Rao expressed the view that ongoing case management would have been beneficial for Michael during the period of deterioration of his mental health from August onwards, especially in the context of the death of his mother and his ongoing homelessness. In particular, he queried whether more could have been done to help Michael address his homelessness. He indicated that research supports the view that it is more cost effective to provide psychological treatments to people with BPD given the costs associated with ED admissions and gave evidence in relation to a Victorian initiative to provide core competency training to all mental health clinicians in relevant psychological therapies so that these can become more accessible and can be provided directly by case managers where appropriate.

Evidence of improvements to services available to BPD clients since Michael's death

96. In light of the evidence during the inquest highlighting the benefit of DBT for people such as Michael as well as the difficulties he faced in accessing this treatment during 2020, the Court received further evidence about improvements to services for BPD clients that have occurred within the South Western Sydney Local Health District since Michael's death.

97. One improvement in the availability of relevant services through Bankstown Community Mental Health that has occurred since Michael's death is the introduction of a "Gold Card Clinic" that has the potential to expedite the short term availability of DBT therapy to individuals such as Michael. Its referral criterion is stated to be "consumers who have presented with self-harm/suicidal crisis, with underlying cluster B personality traits". I accept Counsel Assisting's submission that the introduction of this service is commendable and agree that the expansion of the availability of such 'brief intervention' services it to be encouraged and is in keeping with one of Associate Professor Rao's recommendations.

98. The suggestions made by Associate Professor Rao in relation to Bankstown CMH and its provision of DBT services include that clinicians should have access to specialist BPD services (specifically Project Air Initiative for Personality Disorders) that could provide training, secondary consultations and assist in risk assessments for complex and severe BPD patients. He also observed that he did not find evidence for a comprehensive BPD management plan and crisis management plan, collaboratively developed with the patient and their family (if appropriate).

99. In relation to these matters, it is observed that material from the SWSLHD indicates that its development of Gold Card Clinics has occurred in collaboration with the Project Air Initiative and that to this extent at least there does appear to be collaboration with Project Air. This is also commendable, and I encourage SWSLHD to continue to identify opportunities for collaboration with the Project Air Initiative more generally, given its specialisation in the area of personality disorders.

Michael's DBT therapy session on 30 October 2020

100. Michael's presentation at his therapy session from 4 to 5pm on Friday 30 October 2020, just a few hours before his first admission to Blue Mountains Hospital, was of concern. Ms Fifita recorded matters including the following in her notes:

    a. Michael said he had "*no fight left in me*" and frequently just wants to die;

    b. His risks were "*high*", and he had chronic and constant suicidal ideation. He rated his suicide urge as 5 (out of 5) all week;

    c. His suicidal urge is strongest in the evenings and on weekends when he is by himself;

    d. One of his planned methods was throwing himself off a cliff;

e. His mother was a protective factor but now that she had passed away, he felt that the obstacles to suicide were eroding;

f. He was prescribed 4 valium tablets a day but had been taking 5-6. He was prescribed 2 panadeine forte per day but had been taking 4; and

g. He was arguing with Ms Boyle on the phone and was stressed at work, triggering him yelling at co-workers at times.

101. Ms Fifita gave evidence that she was very concerned about Michael's level of risk and that she was trying to formulate a safety plan for Michael. She indicated that this was made difficult because he was adamant that he would not call helpline numbers. She said that, although she didn't not document having done so, she offered Michael the option of a referral to CoMHET, but he declined this as well. She said that normally for someone in Michael's state of distress, a handover to that team would occur. She said that this was occurring right at 5pm, closing time and that she "did a handover to Cohen" (Mr Cohen Schnierer, the case manager who had had contact with Michael up until 2 October). She said that the handover involved her telling Mr Schnierer that she felt that Michael's level of risk had increased and that she was quite concerned.

102. Mr Schnierer had no recollection of receiving such a handover from Ms Fifita and had made no note of it.

103. Ms Fifita said that the possibility of an admission to hospital crossed her mind but that an involuntary admission would not be justified. When asked, Ms Fifita said that she "would have" raised the possibility of a voluntary admission with Michael, although she did not document this.

104. Ms Fifita was also of the view that it would not have been an option for her to call an on-call psychiatrist in order to assist in relation to risk management for Michael at this point.

105. Dr Kaill gave evidence that there is always an on-call psychiatrist available to give advice, including in such a circumstance.

Care and Treatment at Blue Mountains Hospital

106. On 30 October 2020, Michael travelled to the Blue Mountains. He sent a text message to Ms Boyle which read "I have nothing left for me in this life. I think it's time to go." Ms Boyle alerted local police, who began searching for Michael.

107. Around two hours later, police located Michael in his car in Katoomba. Attending officers called an Ambulance. Ambulance officers detained Michael under s.20 of the Mental Health Act (MHA) and conveyed him to Blue Mountains Hospital. Michael appears to have told police that he had come to Katoomba to look at the view from Landslide Lookout.

108. Michael indicated to ambulance officers that the relevant text message he sent to Ms Boyle was not intended as an indication that he was going to end his life but reflected the

end of his relationship and his mother's recent death. Michael was not happy about being transported to the hospital but was co-operative.

The first admission to Blue Mountains Hospital

109. Michael was taken to the Emergency Department at Blue Mountains Hospital in Katoomba around 9.57pm. The s.20 MHA request filled out by the relevant ambulance officer indicated that Michael had a history of being removed from the Blue Mountains with thoughts of jumping.

110. Dr Rodney Yin was a psychiatry Registrar at Nepean Hospital in Penrith. Part of his role involved providing telehealth consultations to other hospitals in the Nepean Blue Mountains Local Health District (NBMLHD) during after-hours periods (namely overnight and on weekends). Consequently, it fell to him to him to assess Michael by video link after he was brought to Blue Mountains Hospital in Katoomba on an involuntary basis by the Ambulance service. He conducted his psychiatric assessment at around 3.30am on Saturday 1 November 2020 after Michael was medically cleared by a doctor in the Emergency Department.

111. Dr Yin did not have a recollection of the assessment and relied on his notes in order to provide his statement and give oral evidence. The information he had available to him prior to seeing Michael by video consisted only of the limited entries made in the electronic record by clinicians in the Emergency Department at Blue Mountains Hospital. He did not have the capacity to seek any records from any other Local Health District given the manner in which the relevant information systems operate. He gave evidence that the only way he could have done so would have been to ask the ward clerk or nursing staff to contact the other LHD during working hours and ask for some information to be provided. He was unsure even whether this could have been done during the Saturday, as opposed to waiting for business hours on a weekday. He nevertheless said that it would be possible sometimes to ask administrative staff at the hospital to make contact with the after-hours service at another LHD.

112. Michael had been sleeping prior to Dr Yin's review. Consistent with the policy that applied in relation to telehealth psychiatric reviews conducted by Registrars, after he had assessed Michael, Dr Yin phoned the on call psychiatric consultant and "cleared" his plan with the consultant. The plan made by Dr Yin was as follows:

    a. *Can discharge home as per ED team plan*

    b. *Needs ACCESS follow up, pt will stay in BM (Blue Mountains) over this weekend, please refer to Penrith ACCESS team Mobile: xxxxxxxxx*

    c. *TAC TL was aware of this plan*

    d. *have this information "to make a formulation".*

113. The reference to Penrith ACCESS Team was the after-hours / weekend service based in Penrith. TAC TL was a reference to the Team Leader of the Mental Health "Triage and

Assessment Centre" at Nepean Hospital. Dr Yin's expectation was that by way of verbal handover, the Team Leader would be contacted by the Blue Mountains ED staff and be asked that Michael be provided with follow up by that service on the following day. If this had occurred, Dr Yin accepted that there would be an expectation that it would be referred to in the notes. There is no such reference in the notes.

114. Dr Yin accepted that he did not have any collateral information (from corroborative sources other than Michael) available to him and had not sought any prior to determining that it was not appropriate to continue to detain Michael, although he observed that Michael had indicated that he did not want Ms Boyle to be contacted. He said that the consultant with whom he discussed the matter was aware of this. Nor did Dr Yin have the documentation from the Ambulance Service that outlined the circumstances in which Michael had been detained and brought to the Hospital, as this was in hard copy only at Blue Mountains Hospital. That material referred to the fact that he'd had a session with his "mental health team today" and that he'd been "removed from the Blue Mountains after sitting at a cliff edge thinking about jumping". Dr Yin accepted that it may have been helpful to have this information "to make a formulation".

115. It is also the case that the records of this admission do not contain any record of his GP's details having been obtained or for there to be a referral after the weekend back to Michael's LHD or to his GP. It does not in fact appear that the Hospital obtained any details as to who his GP was on this occasion.

116. Dr Yin accepted that "ideally" he would have been kept in ED overnight to enable "more collateral" to be obtained from his doctor or from someone who knew him very well. He accepted that it would also have been helpful for him to have had the record of Michael's DBT counselling session with Ms Fifita that had occurred just hours earlier and during which he had expressed the strong suicidal urges he was experiencing, particularly on weekends.

117. There appeared to be little if any consideration given to the immediate circumstances of Michael's discharge on this occasion. Dr Yin's understanding appeared to be limited to the fact that Michael was "staying in the Blue Mountains over the weekend". Any discharge plan did not appear to pay regard to the fact his discharge, at 4am, involved the circumstances that he did not have accommodation, that his car was not at the hospital, and that no carer or potential support person had been contacted. This seems far from ideal.

118. During his oral evidence Dr Yin said that bed pressure from the Emergency Department was an issue at the time and that there was some pressure for the ED team in this respect. He accepted from Mr Rooney, counsel for NBMLHD, that bed pressure may have had a role to play in the decision to discharge.

119. Michael was brought back to Blue Mountains Hospital at around 11 am on 31 October, only 7 hours after his discharge from the ED. From a hindsight perspective, the fact that he was brought back so soon afterwards is consistent with the discharge on 31 October having been precipitous. Given his readmission so soon afterwards, the utility of any

discharge and follow up arrangements made at the time of Michael's discharge from the ED at 4am on 31 October, in practical terms, was rendered irrelevant. Nevertheless, those arrangements may raise concerns if are indicative of practices that occur more generally in these circumstances.

120. Had Michael not been brought back to the ED, it seems doubtful whether any arrangement had been made for Michael to have been actively followed up over the weekend. There is no record indicating that the Access Team had been made aware of the need for this to occur. Neither Dr Yin's record, nor the ED records contain anything to suggest that either the Bankstown mental health team, or Dr Gunning, would have been made aware of Michael's ED admission in Katoomba.

121. Further, the plan resulting from Dr Yin's review was for Michael's discharge home "per ED plan". What that plan was is not clear. There does not appear to be any record created by Blue Mountains Hospital following Dr Yin's review of Michael. Consistent with there being "bed pressure" at Blue Mountains Hospital, and this influencing what occurred, a record described as a "discharge referral" was made by a Doctor at 1.50am on 31 October, evidently anticipating that Michael's discharge from the Hospital would occur that day. This was notwithstanding that Michael had not yet been reviewed by Dr Yin. The document is also notable for its inaccuracies. It incorrectly describes Michael as having a history of psychotic illness, and that he was currently being prescribed Epilem (again, incorrectly). If this was the "ED Plan" referred to by Dr Yin, it is of particular concern that the potential discharge documentation contained such inaccuracies.

Events between 4am and 11am on Saturday 31 October 2020

122. Following the discharge at 4am, Michael returned to his car in central Katoomba.

123. Ms Boyle received a message from Michael at 4.27am stating that he was OK. She had a missed call from him at 7.28am then a text message at 7.33am stating "*last sunrise*". She received another phone call from Michael at 7.58am and they spoke for 28 minutes. This was followed immediately by a further phone call lasting 67 minutes. It appears therefore that they were on the phone until shortly after 9.30am. During the phone conversation Michael was talking about not wanting to live in general but maintained that his text the previous day was not meant to indicate an intention to take his life.

124. After the phone conversation ended Ms Boyle again contacted police, being particularly concerned about the "*last sunrise*" text message and another one stating "*why bother anymore*". Computer Aided Despatch (CAD) records indicate that she phoned police around 10.02am. The telephonist contacted the Hospital and was erroneously told that no one with Michael's name had been admitted there within the last 24 hours. The telephonist was then able to work out via COPS records that Michael had been taken to the Hospital the previous evening and that Landslide Lookout was a location he was known to frequent.

125. At 11.19am Rescue car crew 84 located Michael in his car at Landslide Lookout. Car crews BL14, BL20 and an ambulance also attended.

126. Police questioned Michael about the text, and he said that he had had a few beers before falling asleep. He agreed to attend the hospital voluntarily for an assessment of his mental health.

The second admission to Blue Mountains Hospital

127. Procedurally, the circumstances of Michael's return to Blue Mountains Hospital at around 11am on 31 October differed from his initial admission 13 or so hours earlier. On this occasion he agreed to attend the hospital voluntarily, in the company of ambulance officers. Consequently, his initial detention arose not from a certificate made by the ambulance service, but under the certificate of a doctor in the Emergency Department after Michael was taken there. Following that initial detention, it again fell to a Psychiatry Registrar, Dr Pradap Shinde, to conduct an assessment by video link from Nepean Hospital, in order to consider whether Michael should continue to be detained for treatment.

128. In his oral evidence Dr Shinde said that because this had been Michael's second presentation within 24 hours, "it was something … to be careful about before discharging".

129. Again, the only records available to him at the time were those from the earlier presentation at Katoomba, as he did not have access to electronic records from other LHDs. He indicated that he could have attempted to contact Michael's case manager, but that this might be hampered due to it being a Saturday. Dr Shinde did speak with Ms Boyle. She provided him with a contrasting picture to that given by Michael, who had told Dr Shinde that he was "fine". Dr Shinde also considered the fact that Michael had no accommodation to go to be a significant factor in the decision he reached for Michael to be kept for treatment on an involuntary basis as a mentally disordered person.

130. Dr Shinde was of the view that he did not have enough information available to him to determine whether it would be safe for Michael to be discharged. The plan he indicated in his notes was for the treating team at Blue Mountains Hospital Mental Health Unit to talk to and obtain a history and information from Michael's ex -partner, his Case Manager, and his General Practitioner. He agreed that the purpose of speaking with the case manager would be that that person could give a longer term history of Michael's mental health relevant to Michael's recent presentations.

131. As a result, Michael was admitted to the Mental Health Unit (MHU) at Blue Mountains Hospital (from ED). The MHU has 15 beds, all classified as acute mental health beds. There are two psychiatrists on staff, though they weren't on site on weekends. There was a rostered "on call psychiatrist" who could be contacted on weekends.

132. Dr Hilary Smith is a Career Medical Officer (CMO) with specific training in Psychiatry and works in the MHU. She has worked at Blue Mountains Hospital since 2014. She saw

Michael at the Unit on Sunday 1 November and was involved in the review of Michael conducted by psychiatrist Dr Pauline Byrne on Monday 2 November, which resulted in his discharge. In her notes of her review of Michael on 1 November (at 12 noon), she describes him as "loud and argumentative, irritable". She stated that he was "very demanding of high dose diazepam". He was expecting to be discharged. Dr Smith considered his continued detention to be the safest option. She expressed the opinion that Michael was "not a reliable historian" and noted her impression as "Cluster B personality disorder in crisis" and "polysubstance abuse".

133. The oral evidence of both Dr Smith and Dr Byrne was illuminating in light of their written statements. Dr Byrne indicated in her written statement that she had "reviewed the collateral history from (Michaels's) case manager prior to my assessment".

134. She was able to clarify in her oral evidence that this did not involve perusal of any written record of information obtained from the case manager (Mr Schnierer). Rather, on her account she had asked Dr Smith to contact Mr Schnierer. Dr Smith then phoned Mr Schnierer (evidently at about 10.15am). Her review of the collateral information obtained from the case manager consisted of a discussion that she had with Dr Smith after Dr Smith had spoken with Mr Schnierer, immediately prior to her review of Michael.

135. This evidence needs to be considered in tandem with the evidence of Dr Smith, and that of Mr Schnierer. In Dr Smith's written statement, she indicated that she had had two separate phone contacts with Mr Schnierer: one on the morning of 2 November prior to the review during which Mr Schnierer gave a corroborative history; and one after the review, the purpose of which was to inform Mr Schnierer of the discharge plan, during which Mr Schnierer "agreed to follow up with Mr Murray on discharge".

136. Dr Smith's notes made on 2 November at around 1pm, an hour or so after the discharge, make reference to the fact that Mr Schnierer had been contacted and the history corroborated. There is an additional brief reference to the case manager in the context of the "Plan", which she noted in the following terms:

    a. *D/c (discharge) back to car, home to Bass Hill*

    b. *Case manager aware*

    c. *Follow up already in place there at public DBT group.*

137. By contrast Mr Schnierer, who generally appeared to have made good notes of his phone contacts related to Michael, only notes and recalls one phone contact with a clinician at Blue Mountains Hospital on 2 November in connection with Michael. His note reads:

> *PC received from Blue Mountains MH*
>
> *Reports Michael has presented to their facility after 2x visits to Blue Mountains over weekend in context of suicidal ideation. Second visit was also in context of ETOH.*

Texted ex-partner suicidal intention facilitating intervention. Reports today presents as quite angry due to remaining in hospital. Expects that he will be discharged today.

Stated intention to fax over discharge summary.

Plan

Await outcome from Blue Mountains presentation.

DBT group 05/11

Attempted 7day F/U before DBT group.

138. In evidence Mr Schnierer referred to this being a brief phone call with a handover. He described what occurred as "notifying of the intention to discharge but it hadn't been finalised, I think at that point by the treating team." He didn't recall receiving any further advice informing him that the discharge had in fact taken place, and he did not receive any written discharge summary.

139. In view of Mr Schnierer's notes and his recollection, it was suggested to Dr Smith that she had inadvertently conflated the single contact she had had with Mr Schnierer, and that she had in fact only had that one contact. She accepted that this may have been the case. It is likely that there was only one such contact. It is also evident from Mr Schnierer's note that Dr Smith had in mind prior to the review being conducted, that its likely outcome would be Michael's discharge. The tenor of the note made by Mr Schnierer explains why there was no second phone call informing him of the discharge, as it had already been indicated to him that the discharge was very likely. It also explains Mr Schnierer's description of the call as a "handover of his clinical presentation".

The expert evidence in relation to the admissions to Blue Mountains Hospital

140. Dr Nielssen regarded the initial assessment at Blue Mountains Hospital by audiovisual link in the early hours of the morning as "sub-optimal" and the decision to discharge him at that hour of the day as not ideal, observing that "discharging psychiatric patients outside office hours, when many other services are not available, is often poor practice".

141. While not critical of the decision to discharge Michael on 2 November 2020, he observed that:

> *The main criticism I have of the treatment at BMH was in the comparatively high doses of benzodiazepine medication administered during Mr Murray's stay.*

142. While noting that there would be a risk of precipitous withdrawal syndrome if his valium was ceased, he considered that the quantity of benzodiazepine he was provided "had the potential to contribute [to] hazardous loss of inhibition".

143. Dr Nielssen observed that suicide by jumping involves considerable courage and that survivors are nearly always either psychotic or are intoxicated.

144. Dr Nielssen also referred to study he recently conducted in conjunction with other researchers indicating a high level of benzodiazepine present in suicides overall, and other studies indicating increased rates of suicide among people affected by benzodiazepines and alcohol. His study also found that a significant number of those who died by suicide (31.4%) had a recent bereavement. He also observed that in the Inquest matter of Camilla Margolis, a matter that also involved a death by jumping of someone with BPD, soon after discharge from Blue Mountains Hospital, Ms Margolis had also been administered benzodiazepines while at the hospital and had asked for her prn medication on the morning of discharge. On the basis of these observations, he suggests that one possible recommendation might be to exercise some caution discharging patients who have been administered benzodiazepine medications while in hospital, especially if they plan to drive and to exercise caution in recently bereaved patients with other risk factors.

145. In his report Associate Professor Rao expresses the following view:

> *The suicide risk assessments at the Blue Mountains Hospital during the two admissions from 30th October to 2nd November 2020 were less than optimal and the hospital did not appreciate the clinical deterioration and the escalation of Mr Murray's suicide risk. As such the duration of admissions were very brief and not appropriate to level of suicide risk that triggered Ms Boyle, Police and other health staff to organise admissions to the Hospital. There is no evidence to support that risk mitigation strategies were initiated by the hospital. The hospital discharged him back to his homeless state without organising appropriate accommodation. There is also no evidence to support that the hospital organised intensive community follow-ups given Mr Murray's precarious mental state.*

146. Associate Professor Rao also helpfully sets out suggestions for how service provision at Blue Mountains Hospital might be improved upon.

147. Similarly, he makes some suggestions for how the quality of governance processes for the Bankstown DBT program might be improved upon.

148. The observations made by Associate Professor Rao in relation to potential deficiencies relating to Michael's discharge on 2 November 2020 and the lack of escalation of risk management following Michael's DBT session on the afternoon of 30 October 2020 are noted and are potentially persuasive. However, in light of the overall weight of the expert evidence in these points (Dr Nielssen and Professor Large not adopting these criticisms), it is not submitted that Associate Professor Rao's suggestions arising from his conclusions should necessarily be adopted as formal recommendations arising out of the inquest.

149. In his report, Professor Large did not consider the care and treatment provided to Michael by Blue Mountains Hospital in connection with either admission to be inadequate.

Oral evidence of experts relating to the first admission

150. Dr Nielssen reiterated his concern about the first discharge having occurred at 4am in circumstances where it had not been possible to seek relevant corroborative information.

151. In his oral evidence Professor Large described there being a tension between the needs of the Emergency Department and "key performance indicators about discharge from EDs". He described a practice of not keeping people in hospital for assessment in the morning and that this was problematic because there were no mental health providers "on the ground" overnight, whereas they would be present between 8.30am and 5pm. He conceded that the circumstances involving Michael's assessment by telehealth and discharge overnight were "not ideal" but considered the circumstances to be complex and expressed doubt about whether it would have been appropriate to determine that Michael met the threshold for detention under the MHA, in order to keep him at the hospital until the morning when it would have been easier to obtain corroborative information.

152. Associate Professor Rao was not necessarily critical of the actions of Dr Yin himself, but expressed a concern more generally about the level of training that psychiatric registrars have in relation to people with BPD, and suggested that if Registrars were more highly trained in relation to BPD, a clinician in Dr Yin's position would be better equipped to make an appropriate decision about the appropriate of discharge in the circumstances and utility of further corroborative information. I accept his opinion on this issue, and the general position that some things could have been improved. However, I accept the submissions on behalf of Dr Yin, Dr Smith and Dr Byrne that in the circumstances, there was no direct criticism of those individuals in relation to the treatment of Michael, but rather Associate Professor Rao talked about a general need for improvement in training and education surrounding treatment of BPD.

Oral evidence of experts relating to the second admission

153. In contrast to the circumstances of the first discharge, Dr Nielssen was not critical of the discharge that occurred on 2 November 2020. In reaching this view he paid significant regard to what he viewed as the expert clinical experience of Dr Smith and Dr Byrne. He also noted the valid concern the doctors may have had that keeping Michael on the ward had the potential to exacerbate his mood instability.

154. Professor Large agreed. He did think, however, that it would have been helpful for the doctors to have had access to records from the LHD in relation to Michael's presentation at Bankstown Community Health on Friday 30 October, as this would have raised the degree of irrationality in the treating team's assessment of Michael's mental state. Notwithstanding such information, however, he was of the view that Michael's discharge was appropriate given that it was known that he was engaged in a DBT program and that Michael's suicidality would be ongoing regardless of when he was discharged.

155. Other issues raised in connection with his discharge on the second occasion included the question of the degree of communication with Ms Boyle. Professor Large considered that the issue as to whether his partner should have been contacted in connection with Michael's discharge was not straightforward, notwithstanding that Michael had signed a form nominating her as his designated carer, given that he had subsequently indicated that he did not want the hospital to contact her.

156. The hospital could have determined his partner be contacted and informed as to Michael's impending discharge. The clinicians had not taken any steps to see that Michael's written nomination of Ms Boyle as his designated carer was revoked in writing. Professor Large noted that the Act required a nominated carer, and in a situation where he wanted to revoke his partner as that person, best practice would have been to ensure the nomination of another person, which did not occur. This was an area for improvement and could have led to better communication to those supporting Michael.

157. In regard to the second admission, the submission that I accept, made on behalf of the NBMLHD, was that Michael's discharge on that occasion was appropriate, in that it was acknowledged by the experts that a continued in patient admission was unlikely to be helpful for Michael given the ongoing suicidality resulting from his BPD.

Failure to produce a discharge summary

158. A further matter that arose was the failure of those involved in Michael's discharge to create any discharge summary document. In view of Michael's death, as a practical matter this ultimately did not prove to be of significance. However, as a key compulsory document in relation to which stringent policies exist, for good reason, it is of concern that this simply did not happen.

159. It was not a case of it not having been done in a timely fashion within a day or so of discharge. It was not until 6 November 2020 that clinicians at the Hospital became aware of Michael's death and up until then, no discharge document was in evidence.

160. The Director of Mental Health for the Nepean and Blue Mountains LHD, Mr Matthew Russell, provided a statement and gave evidence which acknowledged this deficiency in the discharge process and provided the Court with copies of a revised transfer of care policy and a memorandum that had been issued in November 2021. It is hoped that those revised procedures assist to prevent future instances of failures in producing discharge documentation.

The operation of section 27 of the *Mental Health Act* 2007 (NSW)

161. During the inquest a question arose concerning the operation of s27 of the Mental Health Act. It is submitted that a plain reading of that section indicates that following the decision by Dr Byrne that Michael's continued detention was not justified, that MHA required the need for a third examination of Michael by a psychiatrist, prior to there

being a decision made about Michael's continued detention or discharge. That did not occur. Dr Smith appeared to accept that it should have.

162. Under s27, the examination by Dr Shinde (who was not a consultant psychiatrist) represented the required "Step 1" under s27(1)(a) of the Act. Dr Shinde's examination gave rise for the need for the examination by a psychiatrist (here, Dr Byrne - Step 2 per s27(b)) that took place on 2 November). Section 27 makes plain that in circumstances where the decision by Dr Byrne was that Michael did not remain a mentally ill or mentally disordered person, it was necessary for Michael to then be examined by another psychiatrist (the 'third examiner' - Step 3, s27(3)). This did not occur, and it was ultimately submitted by Counsel Assisting that Michael's discharge occurred in circumstances where it was contrary to the requirements of the MHA. The submissions on behalf of the Local Health District disagree with this, given he was admitted as a mentally disordered person, and not mentally ill.

163. Professor Large gave evidence that the practice of discharging a patient absent such further review by a second psychiatrist is the practice often adopted.

164. It was further submitted that this is a significant matter if examinations under "Step 3" of section 27 of the MHA routinely do not occur. Regardless of the perceived merits of such examinations, if such a significant requirement is routinely being overlooked, it was further submitted that urgent investigation by NSW health authorities should be undertaken in order to understand how such a practice has developed and to ensure that action is taken to ensure that the Act is being complied with. A recommendation relating to this matter was therefore suggested.

165. In Michael's case it meant that a further examination of him by a psychiatrist, in order to determine whether or not he was either mentally disordered or mentally ill and if so, whether his detention was necessary for his protection from harm, was technically required under the Act, but did not occur.

166. Submissions on behalf of the involved LHDs on this point were that Mr Murray was admitted as a mentally disordered person, and not a mentally ill patient, and therefore reference to patients that are deemed mentally ill are not relevant to Michael.

167. It was further submitted that s 31 results in the release of a person who is found to be no longer mentally disordered. And finally, factually it was said that it could be argued that Dr Shinde assessed Mr Murray on behalf of the consultant psychiatrist, satisfying the first step, with the second step being undertaken by Dr Smith upholding the detention the next day, a step permitted where the first step is undertaken by a psychiatrist.

168. The point of the submissions in reply was to highlight that once two medical practitioners have found that a person is not mentally ill or mentally disordered, he was required to be released, and Professor Large gave evidence the practice adopted across the whole State was that a person would be discharged absent a further review by a second psychiatrist, and that is consistent with s 31 of the Act.

169. Counsel Assisting highlights the plain English reading of the Act which appears to be consistent with requiring a third step being a review by a psychiatrist.

170. In this case however, I do not need to proceed further into this analysis, given ultimately there was no expert criticism of the release of Michael at that point, and the evidence before me would support that this is usual practice. I note ultimately there are recommendations being made to the Department of Health, and the practical application of the Act is a matter for its consideration, having been raised without the need for recommendation.

Accessibility of EMRs between Health Districts and BPD crisis plans

171. Professor Large and Dr Nielssen discussed the issue of the lack of accessibility of records as between LHDs. Professor Large noted that it is a difficult balancing act, with cross-accessibility increasing the potential it may allow for privacy breaches through improper accessing of confidential records. Presently there exists some degree of accessibility of discharge summaries as between LHDs, although it was understood that this is a work in progress. This is of concern, especially in terms of mental health treatment and the transient nature of patients.

172. The factual circumstances of this matter demonstrate the utility in enabling cross-accessibility of records generally. This is particularly the case for someone such as Michael, whose condition meant that he was predisposed to present frequently at ED Departments, and whose condition meant that he could not always be regarded as a reliable historian. The quality of the critical decision-making by clinicians in Katoomba concerning his safety in the context of a decision to discharge him would have been greatly enhanced and may well have led to different decisions being made had they had timely access to electronic records of his very recent presentation at Bankstown. There was some evidence that a move in this direction of such cross accessibility is being made in Victoria.

173. The Director of the SWSLHD Community Mental Health and Partnerships, Mr Parker, expressed the view that there would be benefits in being able to access EMRs across LHDs. He was not aware of any underlying policy rationale for there not being such accessibility.

174. Based on the evidence, it was also recommended by Counsel Assisting that consideration should be given to a recommendation that would lend weight to any move by NSW Health to enable such cross-accessibility.

175. Further, and for similar reasons in view of evidence that was heard during the inquest about the utility of BPD specific planning documents, it was also proposed that a recommendation should be considered, in relation to BPD crisis plans for community mental clients who have the condition and are known to frequently present at ED departments. It was submitted that such plans should be accessible in electronic across NSW LHDs. Examples of such plans appear at Annexure Associate Professor Rao's report.

176. In relation to such broader BPD specific plans, although Professor Large agreed that, in retrospect, having a care plan for Michael may have been of assistance, he pointed to time and resource considerations to query the feasibility of producing comprehensive BPD specific care plans for someone such as Michael, referring to the need to potentially involve as many as ten individuals in one meeting in order to do so. Associate Professor acknowledged that producing such plans can be labour intensive, however he emphasised that co-ordination and consistency are key aspects of the treatment of BPD and that it would be desirable for some version of the type of model plans that he appended to his report, even if somewhat less sophisticated, were attempted.

PART B – THE POLICE OPERATION

Events following discharge from Blue Mountains Hospital on 2 November 2020

177. At 11.18am Michael caught a taxi from the Hospital to where his car remained parked at Landslide Lookout.

178. From there he drove to Condell Park where he made a purchase at a tobacconist shop and then (at 1.20pm) went to his local chemist, the "Discount Drug Store". He collected 12 valium tablets (consistent with having been placed on a staged supply of this medication) and paid for his last script.

179. While in Sydney he purchased a "10 pack" of cans of an alcoholic beverage. Among the items located at the cliff edge after Michaels's death were the packaging for the "10 pack" of cans, including three unopened cans, along with a half empty bottle of "Jack Daniels" whiskey.

180. Michael then made his way back to Katoomba. At 1.38pm Ms Boyle received a text message from Michael in the form of an animated GIF. She assumed he had been discharged as he was not allowed his phone while on the ward. She responded with a message stating "*safe drive back xx*". At 3.54pm she received a message from Michael stating, "*I'm sorry*". At 3.58pm and 4.07 pm there were two phone conversations between Michael and Ms Boyle spanning 17 minutes.

181. At 4.17pm, Ms Boyle contacted Katoomba police station with her concerns about Michael's welfare.

182. She then contacted Bankstown Community Mental Health Centre. She spoke with Cohen Schnierer and told him that Michael was presently drinking at a clifftop in the Blue Mountains and explained that she had contacted the police. She said that she felt that he needed to be removed from the Blue Mountains and transferred back to Bankstown Hospital.

183. As a result, Julie Fifita called Michael and had a 9 minute phone conversation with Michael commencing at 4.38pm.

184. Michael told Ms Fifita that he was alone in his car, 300m from a cliff in the Blue Mountains. According to Ms Fifita, Michael sounded intoxicated and admitted he had been drinking. He was disorganised in his thoughts but was "very clear in his intent to take his own life".

185. Ms Fifita endeavoured to encourage Michael and dissuade him from his thoughts of suicide, but he ultimately terminated the call after 9 minutes, at around 4.47pm. It should be noted what a difficult role Ms Fifita had at that point in time.

186. Mr Schnierer called police around the same time to give them details of Michael's history, condition, and treatment. He also provided police with the CoMHET contact number if more information or assistance was required. The information provided was incorporated into a lengthy CAD entry at 5.09pm.

187. Although appearing in the CAD data entries, it does not appear that the information was broadcast on VKG radio.

Police involvement at the scene

188. Ms Boyle's phone call to Katoomba police station at 4.17pm resulted in a police CAD message being broadcast at 4.26pm, in the following terms:

> *inf has received a call from Michael Murray dob 28.11.1975 who has been released from mental health unit Katoomba hospital. Inf states he was drunk and threatening to jump of a cliff in blue mountains, inf states there was police interaction with Michael on Friday and Saturday for threatening self harm at Katoomba - Michaels dob is 28.11.1975 - his phone number is (*omitted*) - telstra. Driving silver toyota nfd*

189. The first car to respond was BL20, comprising two junior officers, Constable Emily Sims and Constable Matthew Walsh.

190. In his directed interview and oral evidence, Constable Walsh indicated that he was familiar with Michael's name through other officers who had attended the jobs relating to Michael on 30 October. Further, he had attended Landslide Lookout in the night of 31 October in connection with a concern for welfare matter involving a different person and had come across Michael's car parked at the Lookout on that occasion.

191. With this knowledge, when Constable Walsh heard the CAD job at 4.26pm on 2 November, he thought Landslide Lookout would be a likely location where Michael might be found. As the job was listed as "Priority 3", Constable Walsh and Constable Sims first completed the routine car accident job they were attending and then proceeded to the Lookout.

192. After observing that his car was locked and empty, they proceeded down the track to the Lookout. Shortly after arriving there, they spotted Michael. The Lookout comprises a fenced area on the edge of a cliff drop of around 120m. To the left hand side one can walk around the fence to an unfenced portion of the cliff edge. By 4.50pm, they had

noticed that Michael was sitting on a ledge near the cliff edge about 20 metres or so to the left of the fenced area. Both officers commenced recording on their body worn video cameras (BWV) and started to communicate with Michael. A message was broadcast on CAD at 4.54pm indicating that they had found Michael in this position.

193. In their directed interviews, both officers indicated that they sought advice by radio from their supervisor, Sergeant Warwick Slarke, as to whether they should engage with Michael. They were advised that they could if they felt able to, but to be cautious.

194. Thereafter both officers tried talking with him. Constable Sims told Michael her first name and asked if his name was Michael, which he confirmed.

195. She asked him what he was doing, and he replied, "*I've got to go*".

196. The primary negotiating ultimately fell to Constable Walsh, and he was then supported by Constable Sims. Constable Walsh received some advice about how he could develop rapport and continue dialogue with Michael. Other police attended the scene; however, it was Constable Walsh who continued to interact with Michael in the time leading up until his fall and he did his best to engage with him.

197. It should be noted that the reports and the body worn video shows that Michael was very affected by alcohol, he was unsteady on his feet and not able to be understood some of the time. The two officers did their best in the circumstances they found themselves. There was insufficient time for the official negotiation team to get there, although they were notified and were en route to the lookout at the time of Michael's fall.

Evidence in the proceedings regarding the police operation

198. Excellent evidence was given by negotiator Sue who provided evidence of the time it takes to assemble a team of negotiators to be deployed to a scene such as the one involving Michael, and the relevant considerations for negotiators in terms of involvement of others.

199. Sergeant Atkinson is a senior police rescue officer with lengthy experience in the Blue Mountains. He gave evidence of the prevalence of those attending the Blue Mountains with the intention of self-harming, sometimes at cliff locations. They respond to a large number of mental health related calls. Sergeant Atkinson also gave evidence about the practical difficulties of a rescue operation at Landslide Lookout.

200. Acting Superintendent Kirsty Hales also gave evidence. She was previously the head of the police negotiation unit and indicated that attending the Blue Mountains as a negotiator is not necessarily different from trying to attend various locations around the Sydney metropolitan area. Blue Mountains was classified as part of the Sydney metropolitan area when considering the deployment of negotiators.

Comments on submissions

201. Whilst I have referred to aspects of the evidence in these findings, I now consider the submissions made by the interested parties.

Submissions on behalf of Ms Boyle

202. Submissions were helpfully made on the part of Michael's partner, Ms Boyle. These helpfully reflected firsthand that Dr Gunning was a safe place for Michael, and that he was well intentioned when treating him.

203. They also recognised, and I agree, that the assistance provided by Ms Makarious was beneficial to Michael together with her attempts to co-ordinate his care with other treating providers. It is recognised that the limitations of the service provided was the access to funding for Michael but reflected his further commitment to his health.

204. The submissions drew attention to the delay in accessing DBT programs, and the anguish for friends and family and individuals themselves who, like Michael, seek help but cannot find it. Attention was also drawn to the fact that out of hours publicly available DBT would also be beneficial. It was also noted that health care generally suffers in out of hours contact, such as experienced by Michael when his suicidal urges were at their worst in the evenings and on weekends. It was raised that additional supports after hours may have been very beneficial to Michael and his care generally.

205. Importantly, the evidence disclosed the critical support of partners, family and friends in helping a person such as Michael manage the BPD diagnosis. His partner was credited with being an amazing support during his life. She also could attest to the positive effects DBT had on his diagnosis. She felt that there was not enough support for her, as she sought to support Michael, and I agree with the submission that further supports for partners and carers would ultimately result in better outcomes for those with mental health diagnosis.

206. It was also raised that the inability to access objective corroborative information through medical records was detrimental. It was noted that Dr Yin may have formed a different view if that material from Ms Fifita's file note was readily accessible, as noted by the expert panel.

207. The panel did note that better discharge practice could have been followed and was wary of discharge occurring in the early hours of 30 October 2020, in the early morning with no access to his car and no support person. Associate Professor Rao and Dr Nielssen noted that discharging patients outside officer hours where other services are limited is poor

practice. Dr Yin noted the competing priorities and factors that led to that outcome. However, as we know Michael returned following that date.

208. Although submissions were made that raised concern with the second discharge, the expert evidence was not critical on the second discharge. There was however the issue of cross accessibility of records being available across the LHD to give a full picture of a patient and treatment.

209. Concern was raised about the failure to have a discharge plan, and a failure to contact Ms Boyle. Professor Large talked about the considerations of notification in circumstances where the designated person has been withdrawn. Helpfully he indicated that if that occurs, the Act requires a nomination, and as such the hospital must work to have a designated person. There is also ability under the Act to notify of discharge to the principal carer, who in this case appeared to be his partner. This was a missed opportunity.

210. The submissions addressed support and training needs for officers on the scene and noted that NSWPF is currently in review as to mental health response.

211. The submission on behalf of Ms Boyle suggested the following recommendations to be considered:

To NSW Health

a. That NSW Health evaluate the wait-time for admission to comprehensive DBT programs and commit to further resourcing DBT programs to significantly reduce wait times.
b. That NSW Health take action to implement and promote accessible support services for family and carers of people with BPD.
c. That NSW Health evaluate capacity to expand case co-ordination and case management services.
d. That a greater number of subsidised psychology sessions under a Mental Health Care Plan (MHCP) be made accessible for individuals with BPD and other high-risk personality disorders.
e. That NSW Health consider recommending Building the Bonds of Attachment: Awakening Love in Deeply Troubled Children' by Daniel A Hughes as a resource for better understanding BPD.

To the National Disability Insurance Agency (NDIA)

f. That people with complex mental health conditions and personality disorders such as BPD be eligible for funding under the NDIS

g. That the NSWPF review of mental health training implement a meaningful and ongoing increase to mental health related training provided to officer.
h. That the NSWPF review procedures for passing information from lay informants to police officers attending critical incidents.
i. That NSWPF review the capacity of Blue Mountains Command to respond to clifftop suicide intervention matters, with a view to ensuring the most trained and equipped officers are deployed.

Submissions on behalf of Dr Gunning

212. Counsel for Dr Gunning submitted that the prescribing to diazepam and valium to Michael should be considered in the broader context of a number of factors, including that he had been prescribed it for the treatment of anxiety, not BPD, he had been on the medication for a long time, and he was in a period of crisis in 2020.

213. Counsel submits, that upon becoming aware of Michael's possible BPD diagnosis in December 2017, Dr Gunning referred him to a psychologist and noted the need for further psychiatric input. Counsel submits that there was no evidence in the inquest that suggesting that a complex patient with BPD, such as Michael, was within the scope of standard general practice without specialist input.

214. I accept that Mr Murray was a complex needs patient that needed a multidisciplinary team to ensure that his diagnoses and treatment was appropriate. Dr Gunning had a positive doctor patient relationship with Mr Murray and endeavoured to assist him during his crisis period, leading up to his engagement in the DBT program including by providing the pharmacy with the letter limiting dispensing of his regular medications.

215. It was noted that Dr Kaill indicated with the general insights into the diagnosis of BPD:

> *"One of the features of borderline personality is that people often think about suicide every day, and he had a range of plans and attempts in the past, from heroin overdoses to specifically buying a car without a catalytic converter and carrying a hose in the back to gas himself whenever he felt the – whenever he built up the courage, so he'd thought about suicide for a very long time and I presume sort of most days of the week."*

216. Dr Kaill also observed:

> *"there's been lots of studies done in borderline personality disorder because it's such a common and severe condition and the research shows that none of the medications really help in the randomised control trials."*

217. Importantly he noted that Michael was chronically high risk. The submission was made that the evidence of Dr Kaill provided a helpful context for the difficulties faced by practitioners generally in circumstances where any patients have BPD. The experts considered BPD was the appropriate diagnosis.

218. The experts had views about using benzodiazepine in treatment of BPD. Dr Kaill also indicated that weaning Michael would have been ideal. They however talked about this in terms of the complexity of BPD the need to be cautious as a treating doctor removing suddenly a benzodiazepine prescription.

219. Dr Gunning did his best at managing Michael, he was a caring GP and Michael clearly had a good relationship with him. Dr Gunning was insightful, noted where changes could have been made but this was in hindsight. He did the best he could at the time, with the information he had.

Submissions on behalf of NSWPF and involved officers

220. Counsel for the Commissioner of NSWPF outlined the context of the interactions of NSWPF officers with Michael from 30 October 2020 to 2 November 2020 and his relevant mental health background. I accept the submission of Counsel for the Commissioner that during their interactions with Michael on 2 November 2020, Constable Sims and Constable Walsh did their absolute best in what were very difficult circumstances. The Court is aware of the significant impact that Michael's death had on the officers who attended that day.

221. During the inquest, evidence was received regarding the extent of the mental health training for NSWPF officers.

222. Counsel for the NSWPF has highlighted the establishment of a the NSWPF Mental Health Leadership and Practitioners Group which was endorsed by the Commissioner's Executive Team on 24 April 2023 to further develop training packages for various NSWPF groups, including police attesting from the NSWPF Academy, as well as ongoing mandatory training for officers. The court was informed that the entire NSWPF mental health training regime is currently the subject of an extensive review.

223. I accept the submission of Counsel Assisting and Counsel for the Commissioner of Police that given this current review, and the evidence in this inquest, it is unnecessary to make recommendations in this matter in respect of the NSWPF.

Submissions on behalf of SWSLHD, NBLHD and related staff

224. Patrick Parker, the Director of Community Mental Health and Partnerships of SWSLHD, was able to give evidence of the Bankstown Community Mental Health Emergency Team (CoMHET). He indicated that this is a service that operates every day from 8.30 am to

10.30pm. Michael however was mostly managed by the Adult Community Mental Health Team.

225. Mr Parker outlined a number of programs and clinics that relate to the diagnosis of BPD being Project Air Strategy and Gold Card Clinics.

226. The Project Air Strategy for personality disorders aim to address the challenges of resourcing within the DBT program and aims to facilitate and improve capacity of mainstream health services to diagnose, manage and provide effective treatment for people with personality disorders as well as provide pathways to evidence-based care.

227. He indicated a key strategy of Project Air is the delivery of practical evidence based therapeutic techniques through crisis oriented psychological intervention deliver by Gold Card Clinics, these clinics aim to ensure the correct type of care is provided more quickly, reducing the need to access emergency and inpatient health service.

228. It is noted that Counsel Assisting raised that there could have been improvements if Bankstown Community Mental health became involved in a case management and care coordination capacity after a referral was made in March 2020.

229. In hindsight there was room for improvement, I accept that. However, there is no criticism of any individual partaking in this part of Michael's care. They were a committed group of health practitioners trying to assist Michael within the confines of various roles and employment. The regrettable thing was that Michael had to wait to join a DBT program, and that is a resourcing issue.

230. As previously referenced above, Ms Fifita described the power of DBT in the following way:

> *"…it's a very evidence-based therapy. Three's been a lot of research that's been done into DBT and it's been found to be very effective. It's a stabilisation therapy, so it's a therapy that's effective for stabilising people that are in a pattern of crisis and then, once people move through DBT, there are other modalities of therapy that can be very helpful, ….. that would've been a very helpful therapy for someone who is in crisis and just needs to learn those core foundation skills to get out of the crisis mode."*

231. Dr Kaill assisted by discussing the limitations of DBT due to staffing considerations. I agree with the submission that this was an ongoing theme of evidence at the inquest, and in particular the lack of resources available generally across the SWSLHD.

232. The experts notes that there were little or no therapies publicly available after hours. Professor Large noted that it is hard to work and get treatment for borderline personality disorder, as a common clinical problem.

233. The submissions for the SWSLHD point to many difficulties with DBT such as the lengthy time commitment, the lack of out of hours availability, the reluctance of patients to participate in DBT as set out by Dr Kaill. However, none of this sits with the fact that Michael was waitlisted, he wanted treatment, he made the time, and it was hard for him

to get into a course. There is a shortage of therapists, and there is obviously a need. This is a difficult diagnosis as we have heard, and many people are living with it. They live with suicidal ideation as part of their everyday lives, struggle in relationships and struggle with work. If, and when, they are in a position to put a hand up for therapy, ideally it would be there for them.

234. This may be a life changing or life saving opportunity for them. This program also may eliminate the presentations to emergency, the voluntary or involuntary hospitalisation at a time of crises, and a saving in resources when rescue attempts such as in this case are required.

235. The submission is made that no recommendations should be made in this matter. It is said that neither the SWSLHD or the NBHLHD or any parties are able to speak for, make submissions on behalf of, or represent the interests of either the NSW Ministry of Health or NSW Health.

236. It is further submitted that NSW Health is not interchangeable with the various LHDs, however it is submitted it would be procedurally unfair to make recommendations, particularly given there was no evidence of state wide issues. That is not a proper categorisation of the expert evidence.

237. This inquest delved into the complex and difficult diagnosis of BPD. It was privileged to receive the evidence of three eminent psychiatrists in this field, who spoke broadly about BPD, diagnosis and treatment. They spoke of the need to re-brand in effect, the condition, get information out to GPs and promote a move from medical treatments which can often be detrimental and result in loss of life, and move to a more thorough understanding and provision of DBT. I would anticipate that the Department of Health is best placed to receive these independent views, in a hope to save resources, families and lives, and to encourage those with BPD that the condition is recognised, understood and treatable to allow for happier and healthier lives.

Recommendations – consideration

238. I thank the representatives for Ms Boyle for framing and proposing carefully considered recommendations for consideration. The submissions on behalf of Ms Boyle present a human face and practical reality for those many people facing the care and treatment of loved ones in Michael's position with his diagnosis, and the hurdles and struggles in place when attempting to obtain treatment. Although very validly made, having considered the recommendations proposed on behalf of Ms Boyle, I consider some of those recommendations are outside the scope of this inquest.

239. After considering all of the submissions carefully and the focus of this particular inquest, I have determined that the two major recommendations made by Counsel Assisting address and absorb the spirit of the proposals of Ms Boyle in broader terms. The evidence supports the need for additional support for families and carers, more training,

programs and broader education on BPD.

240. The evidence supports that access to as much information about a patient with BPD is critical to understanding the complexity of the presentation and providing adequate and appropriate treatment. In that way access to EMR plays an obvious role, particularly given the emergency nature of the presentations.

241. In any event, the recommendations ask for the Department of Health to consider these proposals, consistent with the valuable expert evidence. In addition to these recommendations, I propose to send a copy of the findings with the reports of all three experts to the Department of Health. There is no prejudice identified in providing to the Department of Health the evidence in this matter and asking them to consider what was learned. In those circumstances, considering the evidence and the submissions made, I make the following recommendations to the Department of Health.

1. That NSW Health give consideration to investigating the feasibility of establishing Dialectical Behaviour Therapy (DBT) courses for mental health clients that are accessible outside of weekday business hours.

2. So far as NSW Health may be considering the utility of broadening the availability of access to EMRs across different LHDs, that NSW Health consider and examine the findings in this matter as part of the evidence base that would support such broader availability.

Issues

242. I have addressed each of the issues above in the findings, and do not intend to repeat each of them here. There have been findings that relate to identifiable areas of improvement, or some opportunities missed, but there has been no criticism of any individual, nor of any service provided to Michael. The concern identified is much broader and it is for the improved provision of accessibility of treatment for those with BPD who seek it out. The evidence from the experts was invaluable and identified a growing need for a shift in education and training of medical professionals to enable identification of BPD and greater knowledge of best treatment to achieve best patient outcomes. The tragedy of the loss of Michael has led to very considered and careful observations, and it would be hoped that this is of assistance to those in NSW Health who can start to facilitate the changes needed.

Manner of death

243. I note the submission of Counsel Assisting that the Court should closely consider whether the manner of Michael's death is more appropriately regarded as non-intentional or if his death was the result of a deliberate act.

244. The background to Michael's death on 2 November 2020 is outlined in detail in these findings. Michael was a person who, as a result of his BPD, experienced chronic suicidality for in excess of 20 years. Whilst I accept that Michael willingly attended the lookout, it is necessary to consider the surrounding circumstances and whether the evidence supports a finding that his final act of leaving the clifftop was a deliberate act with the intention of ending his life.

245. Whilst I note the preparatory steps taken by Michael in the lead up to his death, and the opinion expressed by expert Dr Olav Nielssen, that "...the sequence of events and the note found in [Michael's] possession suggests that [he] was fixed in his plan to commit suicide and became intoxicated in order to create the state of mind in which he could carry out that plan," the body worn video (BWV) of Michael at the lookout , shows that he was at the lookout for some time. During this time, he becomes increasingly intoxicated. The evidence discloses that Michael had access to both valium and alcohol. Around a minute prior to his fall, Michael stands up, and he is visibly unsteady on his feet, consistent with the post mortem toxicology which demonstrates an alcohol level that would be expected to cause noticeable intoxication. As described by Counsel Assisting, at the time just prior to his death, Michael is "teetering." From the available footage, it is not certain that when he left the cliff, he did so deliberately, and with the intention to end his life.

246. Noting the requisite standard for a finding of self inflicted death (*Briginshaw v Briginshaw (1938) 60 CLR 336)* and considering the available evidence, I am not persuaded that Michael's final act as he left the cliff face was deliberate. I find that Michael's death was due to misadventure (fall from height).

Conclusion

247. Michael was a person living with BPD and doing his best to engage in treatment that would assist him to manage his condition.

248. Counsel Assisting described BPD well. Borderline personality disorder is a mental illness that can make it difficult for people to feel safe in their relationships with other people, to have healthy thoughts and beliefs about themselves and to control their emotions and impulses. People with BPD may experience distress in their work, family and social life and may harm themselves. Having BPD is not due to the personal choices of the individual, it is a condition of the brain and mind. Research has not demonstrated how it is developed, but it is thought to be a combination of biological factors. Medicines do not usually assist in treatment.

249. There was limited criticism of the those treating Michael. He was a complex patient, his was a very difficult diagnosis to live with. He managed his own condition most of his life with the help of his partner.

250. The obvious observation to make is that he was ready for help. He knew what had worked in the past and he was prepared to commit to it. It is a tragedy that there was such delay in the provisions of DBT.

Findings required by section 81 (1)

251. Pursuant to s.81(1) of the Act, I make the following findings in relation to the death of Michael.

The identity of the deceased

252. The person who died was Michael Murray.

Date of death

253. Michael died at 6.13pm on 2 November 2020.

Place of death

254. The location of Michael's death was Landslide Lookout, Katoomba, NSW, 2780

Cause of death

255. Michael's death was due to multiple blunt force injuries.

Manner of death

256. Michael's death was the result of misadventure (fall from height).

Recommendations

257. Pursuant to s. 82 of the Act, Coroners may make recommendations connected with a death.

258. I make the following recommendations:

To NSW Health

1. That NSW Health give consideration to investigating the feasibility of establishing Dialectical Behaviour Therapy (DBT) courses for mental health clients that are accessible outside of weekday business hours.

2. So far as NSW Health may be considering the utility of broadening the availability of access to Electronic Medical Records (EMR) across different Local Health Districts (LHD), that NSW Health examine the findings in this matter as part of the evidence base that would support such broader availability.

Acknowledgements and concluding remarks

259. I acknowledge the profound loss and heartbreak that Michael's family and partner have grappled with as a result of his tragic death. I offer my sincere and respectful condolences for their difficult loss.

260. I would also like to acknowledge and thank Michael's partner, and his sister, for their engagement, contribution, and participation in this inquest.

261. It is also important to acknowledge the emotional toll of Michael's death on the police officers who attended Landslide Lookout and attempted, in difficult circumstances, to coax him back from the clifftop.

262. I thank the Officer in Charge, Detective Inspector Mark Conroy, for his conduct of the coronial investigation.

263. The counsel assisting team Mr de Mars and Ms Lorenc presented and organised the inquest and I thank them for their attention to detail and the care taken.

264. I close this inquest.

Magistrate Erin Kennedy

Deputy State Coroner, NSW State Coroner's Court, Lidcombe

17 April 2024