CORONERS ACT, 2003

*SOUTH*  *AUSTRALIA*

# FINDING OF INQUEST

*An Inquest taken on behalf of our Sovereign Lady the Queen at Adelaide in the State of South Australia, on the 3rd, 4th, 5th and 6th days of September 2013, the 10th, 11th, 12th and 13th days of December 2013 and the 12th day of March 2014, by the Coroner's Court of the said State, constituted of Mark Frederick Johns, State Coroner, into the death of Michaela Jayne Mundy.*

*The said Court finds that Michaela Jayne Mundy aged 15 years, late of 28 High Street, Echunga, South Australia died at Echunga, South Australia on the 9th day of July 2012 as a result of neck compression due to hanging. The said Court finds that the circumstances of her death were as follows:*

## 1. Introduction and cause of death

1.1. Michaela Jayne Mundy died on 9 July 2012. She was aged 15 years. An autopsy was performed by Dr Karen Heath, forensic pathologist, who reported[1] that the cause of death was neck compression due to hanging, and I so find. Dr Heath reported that analysis of blood obtained at autopsy showed a therapeutic concentration of the antidepressant medication, fluoxetine.

## 2. Background

2.1. Michaela Mundy was born in August 1996. She was the first child of Michael and Ingrid. When she was 6 years of age her parents separated. Both parents subsequently remarried and had further children. Michaela initially lived with her mother. This continued until 2007 when her mother gave birth to a half sister following which her mother suffered from post-natal depression. As a result of that

[1] Exhibit C2a

Michaela went to live with her father and stayed a few nights per week with her mother. This arrangement was in place until 2011 when Michaela's father changed employment and was required to fly to Sydney regularly for contract work. From this time Michaela's living arrangements were less structured than previously. From sometime in 2010 Michaela's mother noted that Michaela was displaying symptoms of depression including lethargy and loss of appetite. She told her mother that she was feeling depressed. Her mother contacted the Child and Adolescent Mental Health Service (CAMHS) in June 2011.

2.2. Michaela was a student of Seymour College. The costs associated with her attendance at that school were met by her father. Her father was not made aware by either Michaela or her mother of her attendance at CAMHS.

## 3. Michaela attends Child and Adolescent Mental Health Service

3.1. Michaela's dealings with the Child and Adolescent Mental Health Service are best described through the evidence of the only person at that service with whom she had any contact, Ms Vina Hotich. Ms Hotich gave evidence at the Inquest. She described herself as one of the therapists at Mount Barker CAMHS and said that she was a social worker by qualification. She had commenced employment with CAMHS in September 2010 and said that her role was to provide therapeutic psychological services to children[2]. She said that Southern CAMHS (and I understand CAMHS generally) is a multi-disciplinary service. The bulk of the people who work at CAMHS as clinicians are psychologists and social workers. Mount Barker CAMHS also had the services on a part-time basis of a child psychiatrist[3].

3.2. Ms Hotich's first session with Michaela took place on 8 July 2011. Ms Hotich said that in that first session she spent most of her time talking to Michaela's mother before spending a relatively short amount of time with Michaela. Michaela's mother informed Ms Hotich that Michaela had cut her wrist and arms approximately two months prior to that first visit[4]. She also informed Ms Hotich that Michaela had been seen by a general practitioner and by a counsellor. She reported that the general practitioner had agreed that Michaela might be suffering from depression. Michaela's mother told Ms Hotich that she (the mother) had suffered from post-natal depression.

[2] Transcript, page 20
[3] Transcript, page 21
[4] Exhibit C9, page 41

She said that she herself would not be able to support Michaela's attendance at Seymour College. She said that Michaela's father was critical of Michaela in the way that she dressed, that he was only interested in Michaela's academic performance and that nothing else counted. She said that the father made threats that Michaela might be withdrawn from the school and that he also did not support her wishes to attend drama classes. Michaela's mother also informed Ms Hotich of her own family history of mental illness which included depression on the part of her mother which had required shock therapy.

3.3. In her session with Michaela, Ms Hotich said that Michaela described herself as feeling very depressed. When asked about suicidal ideation, Michaela said she had thoughts of death every day but that there was rarely any planning. Ms Hotich said Michaela described a vague thought about possibly 'OD'ing' on 'something', but she went on to add that she would not do that because she did not want to hurt people and it would probably be a bad decision[5].

3.4. Ms Hotich said that she completed an interim risk assessment[6]. This assessment was part of the initial consultation report and it was prepared on 8 July 2011. She assessed Michaela's risk of suicide and self-harm as low. She said that because there were no explicit plans and the only thing that had been mentioned[7] was rather vague, Ms Hotich regarded risk as low[8]. She added that overdose is a low lethality method of self-harm.

3.5. Notably, in the initial consultation report under the heading 'Description and history of the problem', Ms Hotich recorded the following:

> 'Mother describes a difficult relationship with Micky's father, both during and after their separation. Father can offer a nice house, a good private school for Micky but is also verbally abusive, controlling and not aware or not caring all too much about Micky's needs. Mother is more attuned to her daughter's needs but says she could not offer her daughter the lifestyle she gets with Dad. She also could not financially afford to have both her older biological children live with her, but has offered that to Micky.'

[5] Transcript, page 28
[6] Exhibit C9, page 50
[7] The reference to 'OD'ing'
[8] Transcript, page 31

Under the further heading ‘Clinical formulation’, Ms Hotich wrote:

> 'Depressive episode with anxiety, some self-harm and thoughts of death, likely because of ongoing unmet emotional needs plus verbal abuse and controlling/manipulative behaviours from father (mostly?).'

Under the further heading ‘Interim interventions’, she wrote:

> 'Explore family relationships with intent to find most supportive setup for Micky (physically and emotionally) and teach strategies to reduce depressive thoughts/feelings.'

It will be recalled that at this time Ms Hotich had spoken only to Michaela and her mother. She had not confirmed any of the allegations against the father. Although she did write the word ‘mostly?’ after recording in her clinical formulation that Michaela’s depressive episode was likely because of ongoing unmet emotional needs plus verbal abuse and controlling/manipulative behaviours from father, it is disturbing that she seems to have at a very early stage, made a judgment that the father probably had been guilty of these behaviours, thus causing Michaela’s depressive symptoms.

3.6. Ms Hotich saw Michaela for a second time on 22 July 2011. On this occasion she spent more time with Michaela and completed a risk assessment plan after the session. In this session she asked Michaela more about her self-harming. Michaela told her that she had cut herself because the pain from cutting was a different pain to take away the pain in her head. Following this second session Ms Hotich prepared a care plan[9]. The care plan recorded that the presenting concerns were a depressive episode with signs of anxiety, deliberate self-harm and ruminations about death. The risk of suicide was recorded by Ms Hotich as being low and the risk of self-harm was also described as low. The plan was to introduce strategies to reduce Michaela’s symptoms of depression and to manage her deliberate self-harm and suicidal thoughts. Ms Hotich recorded under her reasons for reaching the clinical judgment about risk assessment, the following:

> 'Deliberate self-harm and thoughts of death, but also a clear statement that she would “never do that”. She seems not prone to highly impulsive behaviours. She is well connected socially and is just starting a relationship with a young man she has been friends with for a long time, so overall risk is considered low. However, because of depressive symptoms and deliberate self-harm, risk should be checked regularly.'

[9] Exhibit C9, pages 13-14

3.7. In her session notes of this meeting, Ms Hotich recorded Michaela as having told her that her father was 'really, really strict' and that he yelled a lot. Her father expected her to be doing homework and chores all the time. She said that her father expected her to respect people but he did not do so himself. That he expected people to be caring but was not so himself and expected her to talk respectfully but he did not do that either. She said that she would appreciate more freedom to see her friends and not be pressured by her father about school performance and to do sport. She said she had tried to talk to her father about that and school counsellors had tried to speak to him also. She said that her father would not listen to her. She said that her father did not really know how depressed she was and was not aware of the cutting. She described her feelings while living with her mother as being much the same mentally and emotionally. She said that her mother's household was much more laid back and in fact was sometimes too much so. She said it was totally different from her father's and so it confused her, especially about pressure to study. She actually said that when it came to pressure and study she thought she was more like her father and added that it was good that he wanted her to do well, but that he went over the top.

3.8. Interestingly, Ms Hotich notes in this session that Michaela had talked to her mother about medication and had heard about antidepressants. Ms Hotich said that this revelation was probably a result of some questions that she asked Michaela about her knowledge of these things[10]. It was clear that Ms Hotich was not proposing medication for Michaela at that stage. Ms Hotich said that she gave no thought to the involvement of the CAMHS' psychiatrist at that stage[11] and that CAMHS' guidelines were that psychological treatment would be tried as first line treatment for 3 months or 4-6 sessions before consideration will be given to the involvement of a psychiatrist[12].

3.9. Ms Hotich said that the third attendance with Michaela was on 29 July 2011. She said that by this session she felt that she still had not established a therapeutic alliance to her satisfaction and that Michaela's engagement was tentative and tenuous[13]. Ms Hotich was desirous of improving Michaela's engagement with her. Michaela rated her depression over the period since the last session at 9.5 out of 10. She said that when she was with her boyfriend she felt better. Ms Hotich obtained Michaela's

[10] Transcript, page 35
[11] Transcript, page 36
[12] Transcript, page 36
[13] Transcript, page 37

agreement to meet for a number of sessions to see how she responded to counselling. Ms Hotich had two intentions, the first one was to explore the family relationships and the second was to teach Michaela strategies to reduce her depressive thoughts by cognitive behaviour therapy. Michaela was to measure her rates of depressive symptoms on a scale between 0 and 10 with 10 being the most severe and 0 being the least[14]. Ms Hotich said that during that third session she did not question Michaela about the topic of suicidal ideation[15].

3.10. The fourth session occurred on 2 September 2011. On this occasion Ms Hotich obtained from Michaela her ratings of her depressive symptoms. She recorded these as having been mostly 9 out of 10 or 9.5 out of 10 for ten days and only one day at 5 out of 10 when Michaela saw her boyfriend. On this occasion Ms Hotich recorded having interviewed both Michaela and her mother. She saw firstly Michaela's mother. She informed Ms Hotich that Michaela had reported that a car had been stalking her. She reported that Michaela's father had found out about Michaela's boyfriend and had been yelling at her and bullying her. She said that Michaela was spied on during the weekend while staying with her (ie Michaela's mother). Michaela's mother went on to say that Michaela's father had done the same thing to her (ie Michaela's mother) in the past. Michaela said that she had not gotten the registration number of the car and that these events only happened on the weekend or when Michaela was alone. Michaela reportedly felt invaded by the experience but noted that the car that was following her was not her father's car.

3.11. When Ms Hotich met with Michaela on this occasion, Michaela made reference to her father and the car[16] saying that this had happened on two occasions. Michaela went on to say that she was really stressed out and had had a particularly bad week in which she had been arguing with her father and stepmother most of the time. She said that she had felt more depressed but had not gone back to cutting. She said that her father had threatened that if she did not do as he said, he would make her life hell or take her out of drama and out of Seymour College. He also forbade her to see her boyfriend unless he was aware. Michaela was concerned that her school grades were dropping very badly at the moment and said that she had had a migraine for the previous three days as a result of her stress. She had done her ratings and I have already made reference to those. Ms Hotich's notes record that there was a discussion

[14] Transcript, page 39
[15] Transcript, page 38
[16] Ms Hotich understood Michaela to have connected the car with her father – in other words, that Michaela believed her father was 'stalking' her

about Michaela's living arrangement 'options'. They were noted as, firstly, living with friends, secondly, living at Dad's and, thirdly, living at Mum's. The first option of living with friends was what not really practicable as she did not have money, it would make both parents angry and would involve a change of school. The option of living at her father's was 'worse' and she noted that her father would not change and that she felt 'paranoia' and was really 'freaked out' and stressed. The possible arrangement of living with her mother would involve less stress but her mother did not really care about people or her environment and that living with her mother would involve a change of schools.

3.12. Finally, Ms Hotich noted that they discussed 'emotional impact of controlling abusive father' and noted 'I suggested her depression likely is related to her living circumstances'[17].

3.13. Ms Hotich said in her evidence that on this fourth occasion Michaela's engagement was still not addressed to her satisfaction[18].

3.14. During her session with Michaela's mother on 2 September 2011, Ms Hotich made a note that the school counsellor will try to speak to Michaela's father, but not mention the expression 'depression' because Michaela's father 'thinks that's 'b….sh..'[19]. This was followed by a note as follows:

> 'Rosie Lake (head of middle school) – Me talk to her
> Maybe too – Rebecca – school counsellor' [20]

Later in her evidence Ms Hotich agreed that this appeared to be a request by Michaela's mother that she (Ms Hotich) would speak to Rosie Lake who was the Head of the middle school at Seymour. Further, that she may also speak to Rebecca, the school counsellor there.

3.15. Ms Hotich's fifth session with Michaela took place on 14 October 2011. An interim session had been cancelled[21]. At this session Michaela reported that her school camp had not been good. Ms Hotich said even on this fifth session the therapeutic engagement was only 'tentative' and that Michaela was not positively engaging with her[22].

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[17] Exhibit C9
[18] Transcript, page 38
[19] This was explained in evidence as 'bullshit'
[20] Exhibit C9
[21] This was a session scheduled for 16 September 2011 – cancelled because Michaela had returned from a school camp tired
[22] Transcript, page 42

3.16. Ms Hotich said that Michaela did not attend the next scheduled appointment which was for 28 October 2011. She received a phone call from Michaela's mother on 15 November 2011 saying that Michaela did not want to continue with her engagement with CAMHS. Ms Hotich closed the file officially on 17 November 2011[23].

3.17. On 5 September 2011, following the conversation with Michaela's mother about making contact with Ms Lake from Seymour College, Ms Hotich did indeed telephone Ms Lake[24]. Ms Hotich's note of the conversation is significant and I set it out below. I do not set it out verbatim, rather where abbreviations appear I have adopted my understanding of their meaning. I believe the following is a fair and accurate description of that note:

> *'Phone call – Rosie – middle school coordinator*
> *Yes her and Rebecca support her (Micky) also homegroup teacher*
> *Father concerned re school performance and adolescent friendship choices*
> *She's a very torn young lady*
> *Impact: struggling to complete things, to focus*
> *Father very interested in her academic performance and her general wellbeing*
> *If he's not included in discussion re how Micky is, he might explode in the end*
> *School hasn't told him re marks yet*
> *Thinks home neither with father or mother is really good*
> *Vina make sure Micky is safe when father has been told marks*
> *Difficult to deal with Ingrid, too, because her anger is still in the forefront of her mind*
> *Explained my goals with her*
> *Rosie wants to be outright that school should tell father re Micky's mental health, but not call it 'depression'*
> *Already interactions with father*
> *School wants Micky to understand: teens end up worse off when keeping secrets from a parent. Rosie means that re the practical things. If she's dishonest with that it will be harder for dad to understand/accept her depression*
> *Vina: the victim possibly being blamed for not being very believable ….*
> *Rosie understood*
> *Had to stop. Client waiting. Might continue another time.*' [25]

Ms Hotich in her evidence agreed that there was a slightly different emphasis in her approach and that of Ms Lake. She agreed that Ms Lake was expressing the view that this is not a good situation, that Michaela's father does not have the whole picture. Michaela's father was concerned about Michaela's marks and her wellbeing, but Michaela and her mother will not let the school tell the father about the mental health issues. Ms Hotich's position was that she agreed that this was not a good situation,

[23] Transcript, page 45
[24] Transcript, page 49
[25] Exhibit C9

but that it is necessary to be very careful about what might happen when Michaela's father finds out about the mental health issues[26].

3.18. Again, Ms Hotich agreed that Ms Lake was saying that mother and daughter had expressly said that the school was not to tell the father, but that Ms Lake wanted Vina Hotich's assistance to get the mother and daughter to a position where they would permit the father to be told[27]. Ms Hotich agreed that the difference between she and Ms Lake was that Ms Hotich was expressing a reservation about the consequences for Michaela when her father found out about the situation[28]. Ms Hotich agreed that by the end of the conversation she and Ms Lake had reached a position where what Ms Lake was asking Ms Hotich to do was not exactly what Ms Hotich was prepared to do[29]. After the interruption Ms Hotich did not ring Ms Lake back.

3.19. On 16 December 2011 Ms Hotich had another telephone conversation with Rebecca Forrest from Seymour College. Ms Forrest informed Ms Hotich that the school had been mediating between the family and Michaela and that Michaela's father had seen a folder of Michaela's drawings which he thought were 'very dark'. Michaela's father was moving to Sydney and as a result Michaela was to move into the boarding house. Ms Forrest was conveying this information to Ms Hotich because Ms Forrest wanted Ms Hotich to make an appointment with a view to assisting Michaela to make the transition to the boarding house. Ms Hotich responded by informing Ms Forrest that the file had been closed and that there were certain requirements in order to reopen the file[30]. She said that the requirements were that someone, either the school or a parent, needed to refer Michaela back to CAMHS and then she would need to go again through the process of being assessed, assigned a priority rating and then would be seen, depending on the length of the waiting list[31]. Ms Hotich agreed following that conversation that she would speak with Michaela's mother or, hopefully Michaela herself, however this never occurred[32]. Ms Hotich agreed that it was apparent from Ms Forrest's comments in her conversation of 16 December 2011 that Ms Forrest had not previously been aware that CAMHS had ceased involvement with Michaela[33].

[26] Transcript, page 58
[27] Transcript, page 59
[28] Transcript, pages 59 and 60
[29] Transcript, page 60
[30] Transcript, page 67
[31] Transcript, page 68
[32] Transcript, page 68
[33] Transcript, page 69

3.20. In cross-examination Ms Hotich was asked whether Michaela's maternal history of depression might dispose her to that condition. Ms Hotich was reluctant to agree with that proposition and only allowed maternal history as a slight factor. Finally she agreed that it should influence her assessment of risk however[34].

3.21. Ms Hotich was asked about an aspect of the form she completed at the first session, namely the initial consultation report. That report contains a box 'interim interventions' under which the following appears:

> '**Interim Interventions**
> *(Feedback to Client/Carer/Others, notifications, investigations needed, referrals, information gaps)*'

Ms Hotich was asked whether the reference in the quoted words to 'referrals' might be a reference to a specialist or something of that nature. Ms Hotich replied quite defensively as follows:

> 'That might be, look just to clarify, we are all at CAMHS, we are all considered specialists in child and youth mental health problems.' [35]

This prompted me to ask Ms Hotich whether she considered that she was permitted by CAMHS to make a formal diagnosis of depression. She responded in the affirmative[36]. This occurred towards the end of the day's evidence. The following morning, after Ms Hotich had been giving evidence for a short time, I was prompted to ask her whether, given her evidence about her authority to diagnose depression, she believed that she was authorised to diagnose other mental pathologies such as schizophrenia. This caused her to respond that overnight she had thought about it and now did not believe that she had authority to officially diagnose a major depressive disorder as a social worker. Accordingly, she qualified her evidence of the previous day[37]. It is interesting that this qualification was not proffered at the beginning of the following day's evidence, but rather after questioning had gone on for some little time and a particular line of questioning had prompted me to make the enquiry about schizophrenia. It does not reflect well on Ms Hotich that she did not volunteer the qualification at the outset of the second day's evidence.

[34] Transcript, page 100
[35] Transcript, page 101
[36] Transcript, page 102
[37] Transcript, pages 118 and 119

3.22. In cross-examination Ms Hotich said that at CAMHS the staff have multi-disciplinary meetings monthly. Those meetings include all of the staff as well as the child psychiatrist. She was asked if she ever spoke to the CAMHS psychiatrist about Michaela's risk and acknowledged that she did not[38].

3.23. Ms Hotich was asked whether, as early as the first visit with Michaela when Michaela herself rated her depression as 9 out of 10, referred to self-harm and suicidal thoughts and was assessed by Ms Hotich as being a teenager with moderate to severe depression, she should have had a discussion with a psychiatrist. Ms Hotich responded in the negative. She responded that at CAMHS staff get a fair number of young people presenting with those issues and added 'it's still sort of our daily work'[39]. She added 'we have limited access to our psychiatrist' and 'I think it means we carry a bit more risk that we would otherwise on our own'[40]. She was ambivalent in her evidence about whether it was possible for her to pick up the telephone and speak to an on-call psychiatrist[41]. I had the impression that although it was a possibility, it was by no means a frequent occurrence.

3.24. Ms Hotich acknowledged that after the fourth visit when she was concerned about the lack of progress and was thinking that it might be necessary to escalate Michaela's care, she made no note to that effect in the casenotes[42]. She attributed this to carrying fairly high caseloads and added 'sometimes we just don't write everything down that may be, would be useful to write down'[43].

3.25. Ms Hotich was cross-examined on the subject of the disengagement from CAMHS following the phone call from Michaela's mother on 15 November 2011. She was asked if that was not an opportunity to attempt to take control of the situation by offering further treatment, for example from the child psychiatrist. She said that she did not adopt that course because Michaela's mother spoke of clear plans she had to take Michaela to another counsellor whom Ms Hotich thought was a private psychologist in Stirling. Ms Hotich said she was very confident that continued therapeutic support would happen[44]. She was asked whether it was appropriate to leave it to a parent to continue to engage and responded that CAMHS is not a

[38] Transcript, page s103 and 104
[39] Transcript, page 104
[40] Transcript, page 104
[41] Transcript, page 105
[42] Transcript, page 105
[43] Transcript, page 106
[44] Transcript, page 111

mandatory service and cannot command engagement[45]. Ms Hotich acknowledged that she did not explain to Michaela's mother in the telephone conversation of 15 November 2011 that there were other treatment options available at CAMHS, including a psychiatrist[46]. She acknowledged that she could and should have asked to speak to Michaela to ensure that she herself was comfortable with the decision[47]. She said that she was influenced in this approach because of her workload and agreed that it was a matter of resources. She said:

> 'I probably had 10 more matters that also really were concerning and I was probably okay to let it go because there were many other things calling for my attention.' [48]

3.26. Ms Hotich was cross-examined on the subject of Michaela's claims that her father was stalking her. Ms Hotich was asked whether that might have been an irrational thought process. She responded by saying that she did not think Michaela was out of touch with reality and did not have any sense of psychosis or early stages of psychosis. It was put to her that the idea of Michaela's father stalking Michaela was rather improbable bearing in mind that she spent most of her time staying with him, and that this was suggestive of the thought of stalking being somewhat irrational. She responded by saying that if it were irrational, it would be irrational behaviour on the part of Michaela's father[49]. This demonstrates to me a reluctance to acknowledge the possibility that Michaela's father was not stalking Michaela at all, and that in fact Michaela was attributing this behaviour to him incorrectly which was, in my opinion, a distinct possibility. Indeed, Ms Hotich said that she felt supported in her thinking on this subject by the fact that Michaela's mother had also referred to the supposed stalking. She acknowledged that Michaela's mother did not claim to have actually witnessed the stalking and finally conceded that therefore Michaela's mother's report of the event was no more than a repetition of whatever Michaela was saying about the matter and added nothing[50]. Ms Hotich did acknowledge that had she thought that Michaela had been displaying psychotic features, she would have immediately referred her to a psychiatrist[51].

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[45] Transcript, page 111
[46] Transcript, page 139
[47] Transcript, page 139
[48] Transcript, page 140
[49] Transcript, pages 115 and 116
[50] Transcript, page 117
[51] Transcript, page 118

3.27. It is notable that Ms Hotich's own records of this session where stalking was raised contains a reference attributable to Michaela that she was feeling 'paranoia'. It was again put to Ms Hotich that this may have been indicative of an incipient psychosis and she responded:

> 'You know, now that you're asking me these questions I'm starting to rethink but it happened, until the moment you asked me that thought had not occurred to me, from the way she was presenting.' [52]

3.28. Ms Hotich acknowledged that on the occasion of the fourth session, which it will be recalled was on 2 September 2011, she did not enquire about Michaela's suicidality. She responded by saying that she had asked her about that matter 'only six weeks before'[53]. Ms Hotich said that she had thought that if she and Michaela could talk through how Michaela's living situation was affecting her, and whether there were possible choices she could make where she would feel less depressed, that might be helpful to her[54].

3.29. I must say this seems to me to be a very impracticable approach with a young person of the age of 15 years who really has no control over her own living arrangements. Ms Hotich, when asked about Michaela's very depressed state on this occasion[55], responded 'you know we see a lot of young people who present with worse'[56]. I was left with the feeling that Ms Hotich either did not appreciate, or perhaps was not sufficiently careful about, the precariousness of Michaela's situation. Ms Hotich did not agree that by this stage Michaela needed to see a psychiatrist[57].

3.30. Ms Hotich, it is fair to say, did not think that antidepressant medication was desirable for people under the age of 18[58]. Ms Hotich agreed that it would have been appropriate at that stage to have commenced discussions with a psychiatrist about the appropriateness of antidepressants[59]. Ms Hotich was asked about the guidelines she had referred to under which four to six sessions of psychological treatment were to be undertaken before consideration would be given for a referral to a psychiatrist. In particular, she was asked whether there was any guideline about how intensive or

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[52] Transcript, page 130
[53] Transcript, page 120
[54] Transcript, page 121
[55] Ms Hotich herself recorded that Michaela's self rating of her depression was mostly 9 out of 10 to 9.5 out of 10 for ten days with an exclamation mark thereafter - Exhibit C9, page 32
[56] Transcript, page 121
[57] Transcript, page 122
[58] Transcript, pages 122-124 and Exhibit C17, page 7
[59] Transcript, page 126

frequent the therapy sessions should be. She was asked whether it made any difference whether the sessions took place over a very short period, for example, five or six appointments within a fortnight, or over a period of months. She said that intensity does not affect the policy[60].

3.31. Finally, Ms Hotich acknowledged that she did not support the notion of contacting Michaela's father and letting him know what was happening at CAMHS[61].

## 4. The involvement of Seymour College

4.1. I have already made a number of references to the staff of Seymour College and their discussions with Ms Hotich. Two staff members of Seymour College gave evidence at the Inquest. They were Ms Rosie Lake who was the Head of the middle school at Seymour College and Ms Rebecca Forrest who was a school counsellor. It was those two staff members who predominantly dealt with Michaela's mental health problems and who were discussing those problems with Michaela's father and mother. The evidence also demonstrates that other members of the staff of Seymour College were very much aware of the issue and had some involvement in it, but the principal participants in this aspect of Michaela's life at Seymour College were Ms Lake and Ms Forrest.

4.2. Exhibit C16 was a statement of Ms Forrest. It contains 33 annexures. For the most part, the annexures are email extracts evidencing email contact about Michaela. Many of the emails are between Ms Forrest and Michaela's father. Some of them are internal emails between staff of Seymour College. Some of them are between staff of Seymour College and Michaela's mother. There are also handwritten notes of meetings. Taken together with some other annexures to Exhibit C15, which was a statement of Ms Lake, they constitute an extensive documentary record of the school's involvement in Michaela's mental health problem. They clearly demonstrate an extensive and intensive effort on the part, particularly of Ms Forrest and also Ms Lake, but also of other staff members at Seymour College. They are an extensive and impressive record of the school's efforts to provide pastoral care for Michaela.

[60] Transcript, page 125
[61] Transcript, page 132

4.3. Michaela's father, Mr Mundy, appeared for himself at this Inquest. He also gave evidence. At one point in his evidence he was asked whether he had contacted Dr Garrood at the Stirling Medical Centre at any time after becoming aware of the fact that Michaela was seeing him. Mr Mundy responded by saying that he did not and he added:

> 'We were advised through Rebecca Forrest at Seymour just to keep it at arm's length. We were very concerned about any hostilities and the flow-on effect to Michaela, so discussion was open about that.' [62]

I do not think that Mr Mundy intended to be critical of Seymour College when he made that reference. Nevertheless, the issue was explored further. At one point, I observed, subject to anything that Mr Mundy might want to put to me, that it was my tentative view that I was most impressed with the way in which the school had handled its management of Michaela and I described its conduct as being exemplary and going 'above and beyond' what might normally be expected. At no point did Mr Mundy take issue with that characterisation of the school's performance. Indeed, at one point Mr Mundy, in framing a question to Ms Forrest, said:

> 'I have acknowledged in the Court that you have done a job way above what anyone would do and I commend you for that.' [63]

4.4. Unfortunately, Mr Mundy having been granted leave to appear, and having given evidence, did not further participate in the Inquest after an adjournment of several months, despite the Court and the Court staff having made him aware of the adjourned hearing dates. I make no criticism of him for that; clearly it is a most distressing matter for a parent to have to participate in any way in an Inquest into the death of his or her child. Nevertheless, had Mr Mundy wished to further pursue his suggestion that the school had encouraged him to remain at arm's length from any health practitioners involved in Michaela's care, he had an opportunity to do so and did not take it. In fact, the evidence in my opinion is very clear. No doubt the school staff members involved were encouraging Mr Mundy to give Michaela some latitude and 'breathing space' in his dealings with her. However, the school most certainly did not attempt to discourage him from involvement with the health professionals.

4.5. The evidence very clearly shows that from an early stage, the school encouraged Michaela and her mother to reveal to Mr Mundy Michaela's attendance at CAMHS

[62] Transcript, page 261
[63] Transcript, page 340

for treatment. It was Michaela and her mother who were reluctant to inform him of that. Indeed, it was the staff of Seymour College that gave the greatest impetus in the efforts to reach a situation in which that information would be shared with Mr Mundy.

4.6. In particular, Ms Lake met with Michaela's mother to talk to her about these concerns. The school was concerned about the approaching parent/teacher meetings and Ms Lake asked Michaela's mother to advise Ms Hotich of this in her next meeting with Ms Hotich. The telephone call between Ms Hotich and Ms Lake on 5 September 2011 was to enable the school to ask CAMHS to help Michaela and her mother get to a position where they were happy for Michaela's father to be informed. In that conversation there appeared to be a difference of opinion between Ms Lake and Ms Hotich as to whether it was advisable to make Michaela's father aware of the mental health issue[64]. It was Ms Lake's expectation that Ms Hotich would speak to Michaela's mother and Michaela about these matters. It is not entirely clear, but it is probable that Ms Hotich never did do this.

4.7. It is entirely clear that Mr Mundy never had any contact with CAMHS. It is also clear that he had no contact with any other of the health professionals with whom Michaela came into contact. In some of those instances he had the necessary information to enable him to make contact had he chosen to do so. He did not.

4.8. In any event, by 23 September 2011, after a good deal of prompting by Ms Lake and Ms Forrest, Michaela's mother had given permission to Seymour College to raise the issue of Michaela's mental health with Michaela's father. On 7 October 2011, at a meeting during the school holidays, between Ms Lake, Ms Forrest and Michaela's father and stepmother, it fell to the staff of Seymour College to advise Mr Mundy of the mental health problems being faced by Michaela. The school was placed in an extremely difficult position. In fact, the school became a conduit between Mr Mundy and Michaela's mother. I agree with counsel for Seymour College in his submission that this was an extremely onerous situation for the college staff and that it was handled with great professionalism and skill.

[64] Transcript, pages 58-60

## 5. 2011-2012 School holidays and early 2012 school year

5.1. The 2011 school year ended with a plan for Michaela to become a boarder the following year. This was a compromise between Michaela's father, mother and Michaela herself. Her father was working interstate during the week and it was therefore convenient from his point of view that Michaela would board. Michaela herself was probably less enthusiastic. In any event it appeared to be the general consensus that boarding was a good solution and might be beneficial for Michaela. A considerable amount of email correspondence passed between Mr Mundy and Ms Forrest on this topic[65]. Once again, it demonstrates a significant effort and level of commitment from Ms Forrest to assisting in arriving at a solution to the family's problems. It is apparent from an email from Ms Forrest to Mr Mundy dated 25 November 2011[66] that Michaela had a considerable amount of input into the decision to board. It demonstrates also that the issue was extensively traversed with Michaela by Ms Forrest. It demonstrates Ms Forrest's clear efforts to communicate openly with Mr Mundy and Michaela's mother in seeking to achieve an outcome that would be beneficial to both of Michaela's parents and of course, Michaela herself.

5.2. These discussions culminated in a document entitled 'parenting plan for year 2012' which can be found in annexure RF15 to exhibit C16. It states that as a result of a change in circumstances, an amended plan is necessary for the health, care, welfare, education and development of Michaela and that Michaela will reside at Seymour College in the boarding house from Monday to Friday.

5.3. In late November or early December 2011 Michaela's father found some writing by Michaela which he described as being 'dark'. Some of it is to be found at annexure RF16 to exhibit C16. This was provided by Mr Mundy to Ms Forrest. Ms Forrest posted some of the material to Michaela's mother on 5 December 2011.

5.4. The school holidays commenced on 9 December 2011. On 16 December 2011 Ms Forrest spoke with Ms Hotich of CAMHS. Ms Forrest informed Ms Hotich of the material that had been found by Michaela's father and informed Ms Hotich about the fact that Mr Mundy would be working interstate during the week and that Michaela would be moving into the boarding house at the commencement of the following school year. Ms Forrest also asked Ms Hotich if it would be possible for CAMHS to

[65] Exhibit C16a
[66] Exhibit C16a

arrange an appointment the following year to help Michaela with her transition into the boarding house. Ms Hotich replied that Michaela's file had been closed by CAMHS and that there was certain requirements in order to reopen the file, namely that someone would need to refer Michaela and that she would need to go again through the process of being assessed for a priority rating and would have to wait for a shorter or longer period according to the length of the waiting list[67]. Ms Hotich indicated that it was her intention to speak with Michaela's mother and hopefully Michaela herself as a result of that contact. That did not happen. It is clear from these events that Ms Forrest had not previously been aware that the CAMHS file had been closed.

5.5. On 30 January 2012 there was a boarding house barbeque and orientation[68] and the first term of the school year commenced on 31 January 2012[69]. Michaela attended the boarding house and stayed there for the school week commencing on 31 January 2012 and ending on 3 February 2012.

5.6. The following weekend Michaela was to spend the Saturday at her mother's and the Sunday at her father's. However, on the Sunday Mr Mundy received a phone message from Michaela's mother to say that Michaela had cut herself with a razor and was very depressed and would not be able to go to his house as planned[70]. On Sunday 5 February 2012 Michaela's mother contacted the Seymour College boarding house Director and informed her that Michaela had harmed herself and would not be coming back to the boarding house on Monday morning. On the Monday, 6 February 2012, Michaela did not attend school. Her mother took her to a doctor at Mount Barker (Dr Li of the Mount Barker Medical Centre). Her mother informed Rhonda Masters of Seymour College that apart from cutting herself, Michaela had taken six Panadol and one antihistamine tablet. Michaela's mother informed Ms Masters that boarding at Seymour College was making Michaela's depression worse.

5.7. In the result, Michaela never returned to the boarding house at Seymour College. In fact, Michaela continued to attend Seymour College as a day student, although there were many days of absence during the school terms up until her death[71].

[67] Transcript, page 68
[68] Transcript, page 177
[69] Transcript, page 177
[70] Annexure RF18 to Exhibit C16
[71] See generally Exhibit C16

## 6. Michaela sees Dr Li

6.1. Dr Yun Li is a general practitioner practising at the Mount Barker Medical Centre. Dr Li said that she saw Michaela on 6 February 2012 and Michaela was accompanied by her mother, Ingrid, and her half sister, Mia[72]. Dr Li was told that Michaela had just started at boarding school the previous week and did not like it and that she had had depression for about a year which was exacerbated by boarding. As a result of this Michaela had cut herself on the wrist. Dr Li obtained a history from Michaela who confirmed that she did not like boarding school at all and would prefer to be a day student. Dr Li confirmed that there had been a previous history of self cutting. She noted that Michaela was well groomed and admitted to suicidal thoughts, but that these were only fleeting. Dr Li was informed of Michaela's previous treatment at CAMHS and, accordingly, she decided to contact CAMHS while Michaela and her mother were still present. Dr Li was able to speak to a duty worker who also spoke separately with Michaela's mother on Dr Li's telephone. Dr Li said that the duty worker eventually suggested that it would be good to have a mental health plan done in order to arrange for Michaela to see a private psychologist and this would result in a quicker assessment for Michaela[73]. The duty worker informed Dr Li that CAMHS had closed their file but that it could be easily reopened if Michaela's mother called the caseworker, Ms Hotich. Dr Li asked the CAMHS duty worker to forward a list of local psychologists for her to refer Michaela.

6.2. Dr Li arranged for Michaela to return the following day with her mother in order that Dr Li could prepare the mental health plan. She said that on 7 February 2012 Michaela's mother told Dr Li that Michaela had been withdrawn from the boarding school and that Michaela was very happy about this. Dr Li noted that there was a difference between Michaela's presentation that day and the previous day in that Michaela was more talkative and said that she was happy to go back to school. She also said that she did not feel like harming herself anymore and promised that she would not do so again. She was happy to continue to live with her mother and travel to school every day. Dr Li did a mental health examination on that day. Michaela was well groomed, wearing makeup and had good eye contact, normal conversation and denied any hallucination. She denied any actual suicidal thoughts and denied any plan. She was cognitive, oriented to time, place and person and had good insight.

[72] Transcript, page 345
[73] Transcript, page 362

Michaela told Dr Li that she wanted to feel better which implied to Dr Li that Michaela had insight to her need for mental health treatment.

6.3. On that same day Dr Li wrote a letter to Seymour College about the boarding house issue. Dr Li wrote that Michaela had depression and that it would be advisable for her to be withdrawn from the boarding school until she was assessed by a psychologist.

6.4. Later that day, Michaela's mother informed Dr Li that she wished Michaela to be referred to psychologist, Natalie Worth. Accordingly, the following day, Dr Li wrote a referral letter to Natalie Worth and forwarded the completed mental health plan.

6.5. Dr Li said that several days later, namely 10 February 2012, she rang Michaela's mother to check on Michaela's welfare. She was unable to make contact with Michaela's mother and despite requesting that her call be returned, it was not. The following day Dr Li sent an email to Michaela's mother providing contact details for the Country Mental Health Service which is a 24 hour service in case she had been unable to make suitable arrangements for Michaela to be seen. She also provided information about the Women's and Children's Hospital and what could be done there for Michaela. Dr Li provided her personal mobile number as well.

6.6. On 14 February 2012 Dr Li still had heard nothing further from Michaela's mother. Accordingly, she contacted Ms Worth to whom she was unable to speak, but she left a message asking whether an appointment had been made with Ms Worth for Michaela to see her. She also attempted to make contact with Michaela's mother that day. That attempt was not successful either.

6.7. The following day, 15 February 2012, Dr Li attempted once more to contact Michaela's mother. On that day she was successful and was informed by Michaela's mother that Michaela was doing much better and her symptoms had improved significantly after withdrawal from boarding school. Michaela's mother informed Dr Li that Michaela was eating and sleeping well and that her father was aware of what was happening and that, furthermore, an appointment had been made for her to see Ms Worth on 24 February 2012.

6.8. Dr Li said that the next contact she had was on 20 March 2012 when she received a letter from Ms Worth reporting on her progress with Michaela. Dr Li had no concerns

as a result of the material in that letter. That was the last contact Dr Li had with Michaela or her family before Michaela's death[74].

6.9. In my opinion, Dr Li's treatment of Michaela was entirely appropriate given the limited role she played in the matter. She was diligent in following up with Michaela's mother on a number of occasions and providing useful information.

## 7. Michaela sees Natalie Worth, clinical psychologist

7.1. Ms Worth is a clinical psychologist in private practice. She consulted with Michaela on four occasions, commencing on 24 February 2012. Prior to seeing Michaela, Ms Worth had been contacted by Dr Li and confirmed that Dr Li had expressed her concern about Michaela's self-harm and that Dr Li was keen to make sure that Michaela obtained treatment and requested that Ms Worth inform her (Dr Li) if Michaela failed to attend[75]. Ms Worth also made contact with Ms Hotich of CAMHS to obtain some background information from her[76]. Ms Hotich said that she was keen for Michaela to see Ms Worth because she and Michaela had not formed an especially close therapeutic bond and that she was concerned that Michaela might cease attending counselling altogether if she did not find someone she could bond with[77]. Ms Worth asked specific and direct questions about Michaela's intention when cutting[78] and made specific inquiries on the topic of suicide[79]. In subsequent sessions she also made inquiries directed to the risk of suicide[80]. At the completion of the first session with Michaela, Ms Worth's preliminary view was that Michaela was suffering from depression and anxiety[81].

7.2. Ms Worth explained in her statement[82] the techniques she employs in cognitive behaviour therapy. She said that where a client wants to engage in those techniques but finds him or herself unable to, it is Ms Worth's practice to suggest that the person see a psychiatrist. She elaborated upon this in her oral evidence, explaining that it is a question of whether the client is lacking necessary motivation to complete the tasks that they have been set by her. She said that if this inability is attributable to

[74] Transcript, pages 355-356
[75] Transcript, page 406
[76] Transcript, page 407
[77] Transcript, page 407
[78] Transcript, page 412
[79] Transcript, pages 412, 443-444
[80] Transcript, page 444
[81] Transcript, page 415
[82] Exhibit C20

something more than lack of time or money, but that it is actually that they are unable to find the inner resources to carry out the techniques, it is at that point that she would discuss seeing a psychiatrist with a view to considering medication[83].

7.3. As a psychologist, Ms Worth was not able herself to prescribe medication, nor was she able to provide a referral to a psychiatrist[84]. Ms Worth explained all of this in her letter to Dr Li dated 20 March 2012[85] and she also had a number of discussions with Michaela's mother. Over the ensuing period, Michaela's mother made efforts to obtain an appointment with a psychiatrist for Michaela. There were a number of further discussions between Ms Worth and Michaela's mother about that topic[86]. In the meantime Ms Worth continued to see Michaela and engage in psychotherapy and supportive counsel. She saw Michaela on 16 March, 4 April and 27 April 2012.

7.4. Ms Worth's fourth session with Michaela was on 27 April 2012. She had made appointments for Michaela to see her on two further occasions, namely 18 May and 1 June 2012. However, prior to 18 May 2012 (probably around 14 May 2012) Michaela's mother informed Ms Worth that Michaela had obtained an appointment to see Dr Jason Garrood, a general practitioner with an interest in cognitive behavioural therapy. Michaela's mother cancelled the appointments scheduled for 18 May and 1 June 2012[87].

7.5. On 7 June 2012 Dr Garrood contacted Ms Worth and discussed Michaela with her. Dr Garrood said that he had prescribed medication for Michaela and that she was due to come back to him for a review soon. Dr Garrood said that he had diagnosed depression and anxiety and suggested that Ms Worth contact Michaela to see how she was responding to his treatment. Soon after this Ms Worth spoke with Michaela's mother who reported that Michaela was focussed on her medication but was suffering from some physical symptoms[88]. In response to this Ms Worth advised that Michaela should go back to see Dr Garrood and also suggested that Michaela might consider a one-off psychiatric assessment service provided by Dr Stephen Meredith out of Mount Barker Hospital[89]. Further, Ms Worth and Michaela's mother agreed that Ms Worth should make an appointment for Michaela on 11 July 2012 in order to allow

[83] Transcript, page 400
[84] Transcript, page 401
[85] Exhibit C11, page 4
[86] Transcript, page 422
[87] Transcript, pages 429-430
[88] Transcript, page 432
[89] Transcript, pages 432-433

Michaela to settle into her medication and any physical side effects to be allowed to settle. Furthermore, Michaela was very tired and found it difficult to have multiple appointments around the same time[90].

## 8. Michaela sees Dr Jason Garrood

8.1. Dr Garrood is a general practitioner with a particular interest in psychotherapy. He first saw Michaela on 18 May 2012 and there were three further consultations, namely on 7 June, 21 June and 5 July 2012.

8.2. On the first consultation with Michaela, Dr Garrood was informed by either Michaela or her mother that Michaela was seeing Ms Natalie Worth who Dr Garrood understood to be a clinical psychologist. Furthermore, Dr Garrood understood that Ms Worth was recommending that Michaela be provided with medication[91]. Dr Garrood was given to believe, probably by Michaela's mother, that Michaela had previously been seen by the Community Mental Health Service at Mount Barker where she saw a psychiatrist who had advised that she should go onto medication if counselling was not helping. By this he understood that Michaela had seen a psychiatrist at a fairly early stage in her treatment[92]. Dr Garrood obtained his information from Michaela and her mother and generally understood that Michaela's problems had begun when her parents were divorced and that she had been suffering from anxiety and depression for about three years. He understood it was especially bad in the previous year and she had made several attempts at suicide by overdosing on medication and had also cut her arms, but none of these attempts necessitated hospitalisation[93]. Dr Garrood did understand that Michaela was not living with her father at all[94] and that there was a strong family history on her mother's side of depression[95]. Dr Garrood established that Michaela had some insight into her condition[96] and he prescribed Michaela with the antidepressant medication, fluoxetine, as a capsule at the dose of 20mg, one per day[97]. He explained that as the medication came in capsule form in could not be broken in half as might be the case with a

[90] Transcript, page 433
[91] Transcript, page 566
[92] Transcript, pages 567, 621
[93] Transcript, page 568 – It is notable that this history is not, on the facts that are now known, correct. It is indicative of the difficult position that Dr Garrood found himself in. Later in his evidence he said that at that first appointment he realised that he was Michaela's 'last port of call'. He did not have the benefit of a letter of referral, nor of the details of Michaela's other treatment. His information was confined to the rather imprecise history given by Michaela and her mother.
[94] Transcript, page 569
[95] Transcript, page 570
[96] Transcript, page 572
[97] Transcript, page 572

tablet[98]. Dr Garrood provided appropriate advice to Michaela's mother about the need to carefully monitor Michaela against the risk of self-harm in the early stages after commencing antidepressant medication and provided appropriate warnings[99]. Dr Garrood said that he prescribed the antidepressant medication firstly because he had been specifically asked to do this, he was of the belief that it had been recommended by professionals and, thirdly, he had the impression that he was 'the last port of call for this child'[100].

8.3. Dr Garrood's plan following the appointment of 18 May 2012 was to monitor Michaela quite frequently and to try to get a psychiatric report from the psychiatrist who (he believed) had already assessed her. He intended to commence psychotherapy with Michaela in the future, but not initially because he understood that Michaela had been unhappy with some of her previous treatment. He did not want to put her off or to damage what he thought was a very fragile therapeutic relationship and therefore did not introduce the subject at the fist visit[101]. He made a follow-up appointment for four days after that appointment, namely 22 May 2012. That appointment did not occur because Michaela's mother rang up to cancel it, stating that she was not able to bring Michaela in due to her work commitments. She did say that Michaela appeared to be fine on her medication and that she (Michaela's mother) had no concerns about Michaela's condition. Dr Garrood was satisfied that she was monitoring Michaela and a further appointment was made for 7 June 2012.

8.4. Dr Garrood next saw Michaela on 7 June 2012. At that time he established that his earlier understanding that Michaela had been seen at the Adelaide Hills Community Mental Health Service was incorrect and in fact that she had been seen by CAMHS at Mount Barker[102]. He had made efforts to obtain information from the Adelaide Hills Community Mental Health Service in relation to Michaela but had been unable to do so[103].

8.5. Dr Garrood noted on 7 June 2012 that Michaela was feeling generally better, although she had an episode of disassociation which Dr Garrood thought sounded more like a

[98] Transcript, page 573
[99] Transcript, page 574
[100] Transcript, page 575
[101] Transcript, page 578
[102] Transcript, page 577
[103] Transcript, page 577

panic attack with buzzing ears, blurry vision and reduced recall[104]. Dr Garrood understood this to be an isolated incident[105]. Dr Garrood noted that there were no actual side effects from the medication and noted that a mental health plan had previously been provided in relation to Michaela by a Mount Barker doctor[106]. Dr Garrood was informed, as I have noted on this second visit, that Michaela had in fact been seen at CAMHS Mount Barker. He was told that she had been seen by a Dr 'Vera'[107]. It was Dr Garrood's belief that Dr 'Vera' was a psychiatrist. Thus his incorrect impression that Michaela had already been seen by a psychiatrist was continued on this second session[108]. Dr Garrood obtained Michaela and her mother's permission for him to contact the person referred to as Dr 'Vera' rather than Dr Garrood referring her to a psychiatrist for another assessment[109]. Dr Garrood had used the DASS tool on the program Medical Director to assess Michaela's depression and anxiety on a stress scale. His assessment was that she had extremely severe anxiety and depression[110]. Dr Garrood again indicated that he wanted to review Michaela weekly. An appointment was therefore made for 14 June 2012. However, Michaela did not attend that appointment. Instead, her mother attended in person. Her mother told Dr Garrood that Michaela was not feeling very well, that she had a temperature and that she had only been going to school for two to three days per week. Michaela was angry at home although there was some brief improvement and Michaela had said that she was feeling better in herself[111]. On this occasion Dr Garrood was told by Michaela's mother that Michaela had not seen a psychiatrist at CAMHS, contrary to his previous belief. This was when he first became aware that she had not actually seen a psychiatrist. Nevertheless, he still wished to obtain a report from whoever had seen Michaela at CAMHS[112]. At this stage his thinking was to obtain a report from the CAMHS therapist who had previously treated Michaela, or to obtain an appointment for her with a psychiatrist to get an assessment[113]. Dr Garrood made a further appointment to see Michaela within a week. The following day, 15 June 2012,

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[104] Transcript, page 580
[105] Transcript, page 581
[106] This is clearly a reference to Dr Li. Presumably Michaela or her mother informed Dr Garrood on this second visit that Dr Li had earlier provided a mental health plan in order that Michaela could be referred to Ms Worth.
[107] Exhibit C12 and Transcript, page 582
[108] The reference to Dr 'Vera' is clearly a reference to Ms Vena Hotich. It is apparent that neither Michaela nor her mother appreciated that Ms Hotich was a social worker and not a psychologist or a psychiatrist. I think it unlikely that they would have used the honorific 'Dr' for a person they knew to be a social worker, it is more likely that they would have used this expression for a psychologist or a psychiatrist or, indeed, a general practitioner.
[109] Transcript, page 584
[110] Transcript, pages 585-586
[111] Transcript, page 588
[112] Transcript, page 589
[113] Transcript, page 590

Dr Garrood made contact with CAMHS. He rang the Mount Barker office and spoke with a person called Robyn who he understood to be the coordinator[114]. Dr Garrood said that he informed Robyn that he was ringing to speak about Michaela Mundy and he used her name. Indeed he had permission from Michaela and her mother to make this contact. At that point Dr Garrood's aim was to ask that Michaela be provided with an assessment by a psychiatrist. Dr Garrood said that he was told by Robyn that it would not be possible for CAMHS to ask their psychiatrist to see Michaela 'as a one-off event'. In short, it was Dr Garrood's understanding that in order for Michaela to be psychiatrically assessed at CAMHS it would be necessary for her to go back into CAMHS' care. He said that if it had been suggested to him that it would not be necessary for Michaela to see a mental health worker but that she could be put straight in for a psychiatric assessment via CAMHS, he would certainly have presented that option to Michaela and her mother[115]. Dr Garrood said that he informed Robyn that he had prescribed antidepressants for Michaela. He said that Robyn did not offer him any options for Michaela to come back to CAMHS[116] and that the information he was provided by Robyn was that Michaela, if she was to have a psychiatric assessment at CAMHS, would have to come back to CAMHS, be assessed by the team and then it would be decided by the CAMHS team whether it was appropriate for her to have a psychiatric assessment[117].

8.6. Dr Garrood noted his conversation with the person 'Robyn' on his Medical Director program in a note dated 15 June 2012. A significant notation added by him was that Michaela had been seen five times and two DNAs[118]. Dr Garrood explained that it would not have been possible for him to subsequently, sometime after 15 June 2012, to have added that specific information about Michaela's attendance records at CAMHS[119]. That information was important because Dr Garrood could only have obtained that information from a person who had access to CAMHS' information relating to Michaela Mundy, and who therefore had been informed by Dr Garrood that he was calling about Michaela Mundy. This will be important for reasons that appear later.

[114] It is reasonably clear that this is a reference to Ms Robyn Duckworth who also gave evidence at the Inquest
[115] Transcript, page 594
[116] Transcript, page 594
[117] Transcript, page 595
[118] DNA means Did Not Attend
[119] Transcript, page 599

8.7. Michaela's third appointment with Dr Garrood was on 21 June 2012. On that occasion he recorded that Michaela was complaining of feeling nauseous with muscle pain and that she had felt faint at school and she believed she had passed out for ten minutes. Dr Garrood was sceptical about the report of passing out. He noted that she was emotionally feeling better but because she felt physically worse, her thoughts of self-harm were returning. She was still sleeping poorly. Dr Garrood assumed that the complaint of nausea was associated with the fluoxetine medication and he therefore decided to reduce the dose by half for about two weeks[120]. As a result it was necessary for him to issue a further prescription as the capsules could not be halved[121].

8.8. Dr Garrood organised a further review of Michaela for a week later. Her appointment was scheduled for 28 June 2012. However, Michaela did not attend on that day because her mother cancelled the appointment and rebooked for 5 July 2012. Bearing in mind that he had reduced Michaela's dosage of medication, he thought it appropriate to make contact with Michaela's mother. He had to leave a message on her telephone answering machine. He explained that the message had to be non-specific, for obvious reasons, and he said that he was hoping that all would be alright and if not that Michaela's mother should get in touch with him[122].

8.9. Dr Garrood's fourth and last consultation with Michaela was on 5 July 2012. On that occasion Michaela's mother reported that Michaela had been sleeping better and was less agitated. It was also reported that Michaela had gotten over the nausea and it was thought that the nausea had been caused by a virus that was going through the family. At that stage Dr Garrood revised his opinion that Michaela's earlier complaint of nausea was attributable to a side effect of the fluoxetine and he determined to increase the fluoxetine back to 20mg[123]. Michaela reported that she had been feeling more suicidal in the past week and was thinking of hanging herself all the time and how to do it. Furthermore, Michaela herself requested that the fluoxetine be increased back to 20mg[124]. Dr Garrood recorded that there was no obvious reason for this exacerbation of Michaela's depressive symptoms other than the fact that she had heard that her mother was going to 'file for maintenance' and that Michaela was 'worried about Dad's stalking'[125]. Nevertheless, Dr Garrood did not believe that

[120] Transcript, page 602
[121] Transcript, page 602
[122] Transcript, page 604
[123] Transcript, page 605
[124] Transcript, page 605
[125] Transcript, page 606

Michaela was an acute risk of suicide because he was reassured by the fact that Michaela wanted to increase her medication and that she had suggested this herself. He took that as a sign that she was feeling positive about the future[126]. He planned to increase the dose of medication and see Michaela in a week's time[127]. In retrospect, Dr Garrood agreed that he should have spoken to Michaela's mother about Michaela's expression of feeling suicidal and, in particular, he should have spoken to Michaela's mother about a safety plan. He also agreed that he should have advised Michaela's mother to take Michaela to the Women's and Children's Hospital on that occasion[128]. Dr Garrood frankly admitted that it would have been preferable had he referred Michaela to a private psychiatrist at least after 14 June 2012[129]. He also acknowledged that his note taking was not as good as it should have been[130]. He said that following his dealings with Michaela Mundy, and since her death, he has changed his practice. He no longer sees children or adolescents and is reluctant to see females under the age of 21[131].

## 9. The evidence of Robyn Duckworth

9.1. Robyn Duckworth is a social worker employed at CAMHS as a regional manager. She was Ms Hotich's supervisor and manager in Mount Barker CAMHS at the time Michaela was seen by Ms Hotich. Ms Duckworth explained that Ms Hotich reported directly to her and in fact that Ms Hotich, according to the practice adopted by CAMHS, had specifically chosen Ms Duckworth as her supervisor[132]. Ms Duckworth said that she had a recollection of three different occasions on which Ms Hotich spoke to her about Michaela. The first was what she described as a 'corridor conversation' in which Ms Hotich informed Ms Duckworth that she was concerned because she was not developing a rapport with Michaela. Ms Duckworth said that she would make a time for them to discuss it further. This occurred shortly thereafter. Ms Duckworth said that she had a clear recollection of that more detailed discussion because they ended up making a decision that she described as not being a normal decision for CAMHS[133]. That decision was to accede to Michaela's and her mother's request that Michaela's father not be informed of Michaela's involvement with CAMHS[134]. Ms

[126] Transcript, page 607
[127] Transcript, page 607
[128] Transcript, page 608
[129] Transcript, page 563
[130] Transcript, pages 563-564
[131] Transcript, page 564
[132] Transcript, page 245
[133] Transcript, page 460
[134] Transcript, page 460

Duckworth described the decision as being in her mind 'an interim decision'[135]. We now know that it was never revisited.

9.2. Ms Duckworth referred to a third occasion in which she discussed Michaela's case with Ms Hotich. She said that she followed up with Ms Hotich to ensure that the task of making contact with Seymour College 'to see whether we could get a message to the father through the school' had been performed[136]. Ms Duckworth acknowledged that none of these conversations were recorded in Michaela's case file[137].

9.3. Ms Duckworth also acknowledged that she had a conversation with Dr Garrood in 2012. She described this as being quite a lengthy conversation that lasted for up to 40 minutes[138].

9.4. Although she did not specifically recall, Ms Duckworth acknowledged that is quite possibly the case that Dr Garrood had stated that he had a patient he wished to refer to CAMHS for psychiatric review[139]. She said that this is something that is often requested by general practitioners, but which it is not CAMHS policy to accede to[140]. She said that CAMHS Mount Barker has from 220 to 250 cases open at any one time and the consultant is only available two days per week[141].

9.5. On the subject of the closure of Michaela's file, Ms Duckworth stated that CAMHS is a voluntary service and could not prevent a client from withdrawing from treatment[142].

9.6. Ms Duckworth was asked whether Ms Hotich informed her during their more detailed discussion that Michaela was quite depressed and had some suicidal ideation. Ms Duckworth agreed, saying:

> 'Yes, that's quite a common presentation in CAMHS.' [143]

That response was somewhat defensive and was similar to a response of Ms Hotich's about the frequency with which CAMHS' staff are confronted with cases similar to that of Michaela. It is unfortunate in my opinion that Ms Duckworth adopted a tactic

[135] Transcript, page 462
[136] Transcript, page 463
[137] Transcript, page 463
[138] Transcript, page 489
[139] Transcript, page 465
[140] Transcript, page 465
[141] Transcript, page 465
[142] Transcript, page 466
[143] Transcript, page 470

which could be regarded as attempting to minimise the seriousness of Michaela's situation by comparing it to the common experience of a CAMHS therapist.

9.7. Ms Duckworth made it quite plain that it was her recollection that Dr Garrood did not mention the name of the patient he was calling about. She acknowledged that towards the end of the conversation he used the name 'Micky' once and this caused her to wonder whether he was referring to Michaela Mundy[144]. She was insistent in her evidence that Dr Garrood did not mention Michaela's name[145]. It was put to Ms Duckworth that Dr Garrood had made a note in his records about Michaela's attendance record at CAMHS. She was asked to explain how that could be so if Michaela's name was not mentioned. She conceded that unless Michaela's name had been mentioned she would not have been unable to tell Dr Garrood about her attendance record[146]. She suggested that a possible explanation was that she had had a conversation with Dr Garrood after Michaela's death in which she may have mentioned the matter[147].

9.8. The evidence from Dr Garrood was perfectly clear that Medical Director, his case management system, cannot be altered retrospectively. On this difference in the evidence of Dr Garrood and that of Ms Duckworth, I accept Dr Garrood's version that he did indeed specifically refer to Michaela Mundy in his conversation with Ms Duckworth. I do not accept Ms Duckworth's evidence on that matter.

9.9. Ms Duckworth conceded that there was nothing to stop her reopening Michaela's file following her discussion with Dr Garrood, but maintained the position that she did not know it was Michaela he was ringing about[148]. Ms Duckworth said that in order for Michaela to be referred to a CAMHS psychiatrist at that point her care would need to be transferred to CAMHS and she would need to again become a patient of CAMHS and 'that was the sticking point'[149]. She re-emphasised this point later in her evidence saying that a patient in these circumstances would 'need to come to CAMHS for the whole package of care'[150].

9.10. Ms Duckworth conceded, without accepting that Dr Garrood specifically named Michaela, that in the conversation she had with Dr Garrood she could have reopened

[144] Transcript, page 475
[145] Transcript, pages 476-477, 479
[146] Transcript, page 479
[147] Transcript, page 477
[148] Transcript, page 481
[149] Transcript, page 482
[150] Transcript, page 486

Michaela's file and, in such a situation, had Dr Garrood said that he wanted to refer Michaela back to CAMHS, she would have been quite likely to look for a psychiatric assessment given the seriousness of what Dr Garrood was telling her[151].

9.11. Given my rejection of Ms Duckworth's evidence that Dr Garrood did not mention Michaela by name, and given that I have accepted his evidence on that point, I cannot accept Ms Duckworth's evidence that given the seriousness of the condition of the patient as described by Dr Garrood, she would have been likely to reopen the file and would likely have referred Michaela to a psychiatrist. In my opinion Ms Duckworth was certainly made aware of the seriousness of Michaela's condition and she was also made aware of Michaela's name and the fact that she had been a CAMHS patient previously. Despite all of this Ms Duckworth did not act in the manner she suggested she would have done had she known that it was Michaela. Given her refusal to acknowledge that she was informed of Michaela's name, it is not possible to determine why it was that she did not act in the manner that she asserted she would have done, armed with that information.

9.12. Perhaps she was not prepared to act without Dr Garrood passing Michaela's care entirely to CAMHS. If that is the case, she certainly did not concede that Dr Garrood had named Michaela, explained the seriousness of the situation, and that she refused to accommodate Dr Garrood's desire that CAMHS provide a psychiatric assessment for Michaela. It will be recalled that Dr Garrood's evidence was that had the proposition been offered of Michaela being readmitted to CAMHS as a patient, but with a different therapist, or with the option of seeing a psychiatrist, he would most certainly have gone back and put that proposition to Michaela and her mother. In my opinion the proposition simply was never offered to him.

9.13. In this respect I note that Exhibit C14, annexure CAD5, which is entitled 'Southern Mental Health, Child and Adolescent Mental Health Service, Regional Clinical Procedure, Referral, Intake and Assessment - Community Teams' states that:

> 'Referrals for children and young people who are actively engaged with another mental health clinician (ie private psychologist/psychiatrist) will not be accepted due to the potential ethical and clinical risk.'

[151] Transcript, page 493

9.14. Ms Duckworth's actions were consistent with that policy, but in my opinion amounted to too rigid an application of the policy. That policy, as with any other policy, is not to be universally applied in every single case. In my opinion CAMHS could, and should through the agency of Ms Duckworth, have offered to accommodate Dr Garrood's difficulty, without rigidly insisting on the application of the policy. After all, there had been what Ms Duckworth referred to as a '40 minute discussion' between she and Dr Garrood. It is difficult to imagine that he had not conveyed in great detail, precisely the dilemma he faced, bearing in mind as he described it, that he saw himself as Michaela's 'last port of call'. In those circumstances, I am unable to see how Ms Duckworth could not be persuaded to make an exception to the rigid application of that policy and at least attempt to obtain a psychiatric assessment for Michaela. In my opinion she should have done so.

## 10. Expert opinion of Dr Naso

10.1. Dr Naso is a senior consultant psychiatrist at Modbury Hospital. She is the consultation liaison psychiatrist covering the Emergency Department at that hospital. She was asked by counsel assisting me to provide an expert report reviewing Michaela's treatment. She became a Fellow of the Royal Australian and New Zealand College of Psychiatrists in 2002. While she was training in psychiatry she decided she would also work in a local general practice as a general practitioner. Her work in that practice was predominantly involving young families, young women and adolescent girls[152]. In her role at Modbury Hospital she performs clinical work, supervisory work and does some teaching. She provides consults and assessments and supervises registrars in the Emergency Department. She also provides a consultation liaison service to the Surgical, Medical, Paediatric and Palliative Care Wards. In the course of her work in the Emergency Department she sees children and adolescents[153]. She explained that in liaison with Eastern CAMHS at Modbury Hospital, and in liaison with the Paediatric Department of that hospital, a decision was made that Dr Naso would see any children or adolescents who required short term psychiatric admission and admit them to the Paediatric Ward at Modbury Hospital. Prior to this arrangement such children would simply be seen by the Emergency Department medical officer and sent directly to the Women's and Children's Hospital. Following the change, for short term admissions, Dr Naso would assess the child or

[152] Transcript, page 661
[153] Transcript, page 662

adolescent and if they required admission, they would be admitted under a paediatric bed card. Dr Naso and her registrars would provide a twice daily assessment of these teenagers. At the end of a period of three or four days Dr Naso would then assess them and make a decision about whether the adolescents could be discharged home with community follow-up or whether they would actually need a longer admission to Boylan Ward at the Women's and Children's Hospital. She said that that three or four day period would allow her, her registrar and the level 3 psychiatric nurses time to gain all of the collateral information that was needed as well as to undergo family meetings so that they could make a decision. She said that the majority of the patients that she saw who were admitted to the paediatric unit were female adolescents who had self-harmed in one way or another. She said however that if she saw a patient in the Emergency Department who was diagnosed as having a psychotic illness or high suicidal intent, her process was to contact the on-call psychiatrist at the Women's and Children's Hospital and to organise a direct admission into Boylan Ward[154]. Dr Naso said that she would see approximately ten adolescents per week during this period[155]. Dr Naso explained that the paediatric unit at Modbury Hospital has recently closed and unfortunately this arrangement has ceased[156]. That is certainly regrettable. Dr Naso said that in the course of her practice she had prescribed adolescents with antidepressant medication[157]. She has also prescribed adolescents with antipsychotic medication[158]. She said that the preferred medication for adolescent depression is fluoxetine, starting at a 10mg dose and increasing shortly thereafter. She said that the therapeutic dose is 20mg per day[159].

10.2. Mr Dixon, counsel for CAMHS, Ms Hotich and Ms Duckworth, suggested to Dr Naso in his cross-examination that as Dr Naso does not have any formal training in child and adolescent psychiatry, it would be more appropriate for a person with such qualifications to offer an expert opinion in this case[160]. Dr Naso disagreed with that proposition. She responded that if she felt that she was not able to provide an expert opinion in this case, she would have declined to do so. She said that it is because she sees teenagers and adolescents and because she keeps up with the literature that she

[154] Transcript, pages 664-665
[155] Transcript, page 667
[156] Transcript, pages 666-667
[157] Transcript, page 668
[158] Transcript, page 668
[159] Transcript, page 668
[160] Transcript, page 750

felt that it was appropriate for her to offer a report[161]. She also pointed out that the public health services in this State[162] are organised in a manner that contemplates that Emergency Departments at public hospitals will see and treat children and adolescents with mental health problems. Mr Dixon asked Dr Naso whether she agreed with the proposition that it is more appropriate for young adolescents to see a child psychiatrist than an adult psychiatrist. Dr Naso replied that many adult psychiatrists also see teenagers in their practice and that it is a good thing that they do because it would be virtually impossible for adolescents to get psychiatric help otherwise. She said that it is very difficult for a child to get in to see an adolescent psychiatrist. She said that in all the years she has worked as a psychiatrist she has never been able to get an adolescent directly in to see a child and adolescent psychiatrist privately[163]. Although Mr Dixon showed no hint of irony in asking that question, the fact of the matter is that Michaela Mundy never saw any psychiatrist during the period of her mental illness. Far less did she see a psychiatrist with specialist qualifications in child and adolescent psychiatry. Indeed, it was Mr Dixon's contention that it was never necessary for Michaela, during her treatment by CAMHS, to be seen by a psychiatrist at all, whether one with child and adolescent qualifications or not.

10.3. As will be seen in due course, I have concluded that Michaela Mundy most certainly ought to have been seen by a psychiatrist, but I will come to that in due course. For CAMHS, Ms Hotich and Ms Duckworth, through their counsel, to quibble about the expertise of Dr Naso in reviewing this case for the Coroner's Court is to show a misplaced sense of priority. Surely the greater priority would be to ensure expert treatment for a child such as Michaela at the outset, rather than to be concerned about the expertise of the psychiatrist who reviews her treatment in the Coroner's Court. In saying that, I certainly do not suggest that it is not important that the Court obtain appropriate expert evidence. In my opinion, Dr Naso was well placed for the reasons she gave, and which I accept, to provide the Court with an expert opinion and I have no hesitation in accepting her evidence as an expert.

10.4. An opportunity was afforded to CAMHS, Ms Hotich and Ms Duckworth on the application of their counsel to obtain their own expert opinion, and for that to be placed before the Court. For reasons which appear later in this finding, that did not

[161] Transcript, page 750
[162] Modbury Hospital is a public hospital and Dr Naso is employed in what might be described as the public health service
[163] Transcript, pages 750-751

occur. For the foregoing reasons, I have no hesitation in accepting Dr Naso's evidence and I now return to the detail of what she had to say. Indeed, Dr Naso had a very thorough understanding of Michaela's case. She had access to all of the casenotes, reports and witness statements that were available at the time she prepared her reported dated 13 February 2013[164]. After preparing that report she had the opportunity to read other documents as they came to hand, including the affidavit of Robyn Duckworth[165], the affidavit of Clive Skene[166], the affidavit of Rebecca Forrest[167] and the affidavit of Rosemary Lake[168]. Dr Naso had also read the transcript of all of the evidence up to and including the transcript of the penultimate day's evidence before she was called. The previous day's transcript was not available in time for her to read it before giving evidence[169]. In her evidence Dr Naso displayed an extremely good understanding of all of this material.

10.5. Dr Naso said that Michaela clearly found the arrangement of living with her mother and her father's families confusing. On the one hand her father's household imposed fairly strict boundaries, rules and regulations that she needed to follow. Her father was interested in academic pursuits. On the other hand, with her mother the environment was much more relaxed. There were not the rules and regulations imposed at her father's and she could pretty much come and go as she pleased. There were no limitations on her relationship with her boyfriend while she was in her mother's care, but on the other hand, her father was much more restrictive about when she could or could not see her boyfriend[170]. She explained the difficulty that this causes for a typical adolescent. She explained that it is quite normal in adolescence to push boundaries and to push limits in order to learn. She said that on the one hand an adolescent is saying that he or she wants to do whatever he or she wants, but then on the other hand in order for them to feel safe and secure they actually need those limits and those boundaries. If the limits and boundaries are very strict, an adolescent may never feel that he or she meets the parent's expectations. On the other hand if the adolescent is given too much freedom, the adolescent may wonder if that parent really cares about them[171].

[164] Exhibit C24
[165] Exhibit C13
[166] Exhibit C14
[167] Exhibit C16
[168] Exhibit C15
[169] Transcript, page 669
[170] Transcript, pages 670-671
[171] Transcript, pages 671-672

10.6. Dr Naso noted the genetic predispositions Michaela had for developing a mental illness. She commented on Michaela's mother's history of post-natal depression and the maternal grandmother's history of depression which actually required electroconvulsive treatment[172]. Dr Naso said that the studies clearly document that if one has a parent who has depression, one's chances of developing depression as a teenager are a lot higher than someone in the general population[173].

10.7. Dr Naso was taken through Ms Hotich's involvement with Michaela. She noted that at the first appointment Ms Hotich elucidated Michaela's living arrangements, the circumstances surrounding the divorce and that a major stress for Michaela was her relationship with her father[174]. Dr Naso noted that Ms Hotich recorded Michaela's daily sadness, her dark thoughts, some of which were suicidal, and that Ms Hotich planned to manage Michaela by exploring the family relationships and teaching Michaela some techniques to reduce the depressive thoughts that she had[175]. Dr Naso commented that in the circumstances some family therapy was ideal, however because Michaela and her mother were not prepared to permit her father to be involved, family therapy would not be an effective option[176].

10.8. Dr Naso agreed with Ms Hotich's conclusions that Michaela had a depressive episode with anxiety, some self-harm and thoughts of death. However, Ms Hotich's conclusion that these things were likely to have been caused by ongoing unmet emotional needs plus verbal abuse and controlling, manipulative behaviours from Michaela's father were judgments that could not be made from that first interview[177]. Dr Naso noted that Ms Hotich reached a conclusion at the end of that first interview that Michaela was not at high risk of suicide. However, Dr Naso believed that the risk assessment should have been marked as medium at the time[178]. She said that the 'dark thoughts' were never elaborated and that she, Dr Naso, still has no idea what the dark thoughts were referring to. She pointed out that these could be anything from suicide to psychotic thinking. She said that unless that was fully elucidated, then it is difficult to do an accurate risk assessment[179].

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[172] Transcript, page 673
[173] Transcript, page 674
[174] Transcript, page 675
[175] Transcript, page 676
[176] Transcript, page 677
[177] Transcript, page 678
[178] Transcript, pages 679-680
[179] Transcript, page 680

10.9. In dealing with Ms Hotich's second session with Michaela in which she was asked about her cutting, and Michaela's explanation that it was to cause a different pain to take away the pain in her head, Dr Naso commented that she did not know what exactly that meant. It could have meant that Michaela was trying to distract herself from anxiety or it could have been from thoughts she was having. Dr Naso placed some significance on Michaela's advice to Ms Hotich that during these times she thought she was in a trance like state. The significance of this to Dr Naso was that it may have meant that Michaela was dissociating. She explained that dissociation is a defence mechanism against distress. However, during a time of dissociation a person is extremely vulnerable because they lose a reasonable amount of control[180]. Dr Naso said that at this point in Ms Hotich's dealings with Michaela, Michaela had exhibited clear cut symptoms of a depressive illness on a background of a familial history of depression. Michaela had self-harmed because of the depression that she felt. Dr Naso said that it is known that deliberate self-harm on its own increases the risk of suicide. Added to the depression, and the possible dissociation, Dr Naso said that she would have started to be quite worried[181].

10.10. It was Dr Naso's opinion that Ms Hotich should at that point have consulted with a colleague. She said that given that CAMHS has a multi-disciplinary team approach, that would have been appropriate. She pointed out that dissociation is a complex subject and that a person with Ms Hotich's training could not be expected to make the necessary links to assess the situation[182].

10.11. It was Dr Naso's view that Michaela's risk level should have been increased at that second session. She said that in her opinion the risk level was moderate but that it could change to severe as nothing had actually changed for Michaela at that time[183].

10.12. Dr Naso remarked that from what she had noted in reading the materials available to her and the transcript, the CAMHS structure was a multi-disciplinary team which did not appear to necessarily work as a multi-disciplinary team. She thought that Ms Hotich's approach appeared to be that of an individual therapist[184]. She made the

[180] Transcript, page 682
[181] Transcript, page 683
[182] Transcript, page 685
[183] Transcript, page 686
[184] Transcript, page 687

obvious point that there is no point in being part of a multi-disciplinary team unless one utilises the resources that are available through that team[185].

10.13. In relation to the third session, Dr Naso noted that still nothing had changed regarding Michaela's treatment and that a therapeutic relationship had not developed and nothing had changed for Michaela, but potentially things had become worse[186]. She said that there ought to have been a concern that Michaela might disengage and, once again, consideration should have been given to seeing another colleague in the multi-disciplinary team[187]. She noted Ms Hotich's evidence that therapists in CAMHS are expected to try for a bit longer with young clients[188] and Dr Naso responded by saying that she did not think that a general guide such as that Ms Hotich was referring to should be inflexibly applied. She said this is where clinical judgment has to kick in[189].

10.14. In commenting on the occasion when Ms Hotich and Ms Duckworth discussed the matter of Michaela and her mother wishing to not involve Michaela's father in CAMHS treatment, Dr Naso said that it should be standard procedure for such a discussion with a supervisor to be documented[190]. She said that it is usually the primary clinicians responsibility to attend to that, in this case Ms Hotich's[191]. Dr Naso commented that the decision not to involve Michaela's father, or to insist on his involvement, was a 'vital issue'[192].

10.15. Dr Naso next discussed the fourth visit to Ms Hotich on 2 September 2011 at which Michaela revealed that she thought her father was stalking her. Dr Naso commented that this was a very unusual revelation. She said that it was a very unusual thing for a teenager to say about their father. She said she was not suggesting that there was no possibility at all that it was happening, but that a statement like that one requires extensive assessment around whether it is real or not. She said faced with such a situation a therapist would start to think there was a need to exclude the possibility of a psychotic illness. Bearing in mind that there was a maternal history and a reference to trance like states, the question was whether the depression was worsening. She said that it was necessary to ask directly what Michaela had seen; what made her

[185] Transcript, page 689
[186] Transcript, page 689
[187] Transcript, page 690
[188] Transcript, page 109
[189] Transcript, page 691
[190] Transcript, page 692
[191] Transcript, page 692
[192] Transcript, page 692

think that it was her father that was stalking her and what evidence she had. She said that it required a thorough assessment as to whether this was a delusional belief or not[193]. She said she saw no evidence of such a thorough assessment in the casenotes but that the assertion by Michaela of stalking seemed to have been taken as a real possibility by Ms Hotich[194].

10.16. In that same session Michaela had told Ms Hotich that when she was at her father's she was really stressed and felt paranoid and this was noted by Ms Hotich[195]. Dr Naso commented that this was another concerning indicator that the depressive disorder might be worsening and that Michaela might be developing a psychotic illness of some sort[196]. Dr Naso noted that Ms Hotich's evidence was that she did not explore the question of paranoia or psychosis because Michaela did not present to her as if she had lost touch with reality. Dr Naso commented that it is insufficient to reach a conclusion about possible early psychosis on the patient's presentation and demeanour without going further. She referred to early psychosis having a prodromal period and that the patient will not reveal the symptoms unless the therapist explores it as some length. Dr Naso said that to determine if someone is psychotic, the therapist must ask relevant questions. She remarked that it would not be reliable to see the person as apparently not psychotic during the therapeutic session and to conclude that is how the person is generally. She said that there is a phenomenon that occurs with dissociation such that when the person becomes really stressed they can experience micro psychotic episodes which are contained episodes and without a thorough assessment these can be missed by the therapist[197]. When asked whether Dr Naso would expect a social worker to be able to explore these issues, she responded that she would expect a social worker to at least be able to be on the alert and to think 'the story about stalking sounds a bit odd and, as a social worker I do not have the skills to really assess thoroughly whether there is a psychotic illness'. She would expect the social worker to be able to realise that it will be necessary to have a psychiatry registrar or a psychiatrist to assess the patient for that purpose[198]. Dr Naso said that if a social worker works in mental health as an individual clinician, they should be able to initially identify or be concerned that there might be something

[193] Transcript, page 694
[194] Transcript, page 694
[195] Transcript, page 695
[196] Transcript, page 695
[197] Transcript, page 696
[198] Transcript, page 696

deeper going on[199]. Dr Naso commented that it is the greatest benefit of the multi-disciplinary team that a social worker such Ms Hotich be able to refer a teenager such as Michaela internally to a psychiatrist[200].

10.17. Dr Naso noted that at this same fourth session on 2 September 2011, Michaela rated her depression as mostly 9 out of 10 or 9.5 out of 10 for the previous ten days. Dr Naso said that she would have asked Michaela what would it take to get to 10 out of 10; to ask how much worse can it get; so that she could work out how Michaela was scaling her feelings[201]. Dr Naso noted that Ms Hotich had said in her evidence that it was at this point that 'alarm bells were ringing' that Michaela's depression was significant and she did not seem to be improving[202]. Dr Naso summarised the situation as follows. In that session Michaela revealed herself as being severely depressed, and said things which raised the possibility of an underlying psychotic illness. She noted that Ms Hotich did not ask any questions about suicidal intent. Dr Naso said that at this point Ms Hotich should have obtained the opinion of a psychiatrist[203]. She said that Ms Hotich should have understood that she was out of her depth[204].

10.18. Dr Naso dealt with the next stage of the narrative, namely the occasion on which Ms Lake of Seymour College contacted Ms Hotich and raised the school's concerns about the fact that Michaela's father would be attending a parent interview shortly, and that he would be concerned about Michaela's grades and that the school felt that he needed to be informed of Michaela's mental illness. Dr Naso said that at this point the school was offering an alternative opinion on the matter of the father's involvement. Dr Naso pointed out that the school had been involved with the father and that if the school had had major concerns about involving the father, they would have brought that up and not promoted the idea[205]. Dr Naso said that this should have prompted Ms Hotich to have explored the need to involve her father with Michaela at the next appointment but that this did not happen[206].

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[199] Transcript, page 697
[200] Transcript, page 697
[201] Transcript, page 698
[202] Transcript, page 120
[203] Transcript, page 699
[204] Transcript, page 699
[205] Transcript, page 702
[206] Transcript, page 703

10.19. Dr Naso noted that at the next appointment on 14 October 2011 Ms Hotich did not return to the subject of Michaela's concern that her father was stalking her. She did not ask if that was still happening. For this and other reasons Dr Naso noted that the session was 'disconnected' from the previous session. Furthermore, Ms Hotich did not ask about suicidal ideation. It is fair to say that Dr Naso was not impressed with Ms Hotich's treatment[207].

10.20. The next stage in the narrative is when Michaela's mother contacted Ms Hotich to advise that Michaela did not wish to continue her treatment with CAMHS and the file was closed. Dr Naso said that at that point CAMHS should have contacted Seymour College to advise that Michaela had disengaged. She said that it is good practice when closing a file or discharging a patient to ensure that all relevant parties are informed of the status of the matter[208].

10.21. Dr Naso noted that the next significant occasion was on 16 December 2011 when Ms Hotich was contacted by Ms Forrest. It was on this occasion that Ms Hotich was informed by Ms Forrest that Michaela's father had seen the dark writings Michaela had written, that he was going to work in Sydney and as a result Michaela would be moving into the boarding house. This was the occasion on which Ms Forrest asked whether it would be possible for CAMHS to arrange an appointment early the following year to assist Michaela with her transition into the boarding school. Dr Naso remarked that on this occasion Ms Hotich should have contacted Michaela's mother and asked whether it would be possible for Michaela to return to CAMHS for further treatment and to offer the possibility that if Michaela did not wish to see Ms Hotich, then Ms Hotich could organise another therapist or a psychiatrist to see her[209].

10.22. Dr Naso noted the next contact on 7 February 2012 when Michaela's mother contacted Ms Hotich and informed her that Michaela had cut herself again and threatened to do it again if she was kept at the boarding school. Dr Naso noted that Ms Hotich did not offer to re-engage Michaela and remarked that Michaela's mother was ringing to ask for a psychiatric opinion and that Ms Hotich should have offered to arrange for that to occur[210]. Dr Naso said that it should not have been necessary for Michaela to go through the initial procedural requirements for a new patient at

[207] Transcript, pages 704-705
[208] Transcript, page 707
[209] Transcript, page 708
[210] Transcript, page 710

CAMHS in order for that to happen[211]. Dr Naso said that an episode of self-harm meant that there needed to be an immediate assessment. She said that an appointment should have been made or offered at which a psychiatric assessment could be done. For example, the next available appointment could be offered with a psychiatrist and in the meantime other interim plans could be put in place[212]. Dr Naso was critical of the fact that Ms Hotich did not at any time conduct a mental state examination on Michaela. She said that that should have occurred as part of the initial consultation. She said that it is one of the most valuable tools in that it allows a cross section or snapshot of a person's mental state at a particular time. It provides a baseline against which the person can be measured subsequently. She said that it involves a clinician going through a step by step process in which all questions about the mental state examination must be answered. These relate to the appearance of the patient, the patient's behaviour, conversation, whether they are guarded or closed, whether they have delusional beliefs, their mood, any perceptual abnormalities, any cognitive deficits, whether there is suicidal ideation or intent and the person's insight.

10.23. Dr Naso was asked about the fact that Michaela and her mother clearly did not understand the qualifications of Ms Hotich. It will be recalled that they were referring to her in their conversations with Dr Garrood as Dr 'Vera'[213]. Dr Naso said that it is vital that a patient be informed about the qualifications of the person with whom they are dealing. She said the patient has a right to know if they are talking to a social worker so that they might make the decision that it is necessary for them to see a different kind of therapist[214].

10.24. Dr Naso was asked about the NICE guidelines, which are the guidelines under which CAMHS was operating and which contemplated that there would be four to six sessions of psychotherapy before consideration would be given to referral to a psychiatrist or to the administration of antidepressants. Dr Naso noted that the cognitive behaviour therapy that was being contemplated by Ms Hotich involved a significant amount of 'homework' to be done by the patient between sessions. These would involve keeping a diary, recording daily moods and more than one entry per day so that every time the patient had a mood change it should be recorded together with the incident that happened beforehand with a view to the patient being able to

[211] Transcript, page 710
[212] Transcript, page 711
[213] Refer to Footnote 108
[214] Transcript, page 714

say how a particular event made them feel and what were the consequences. Dr Naso said that if a patient has moderate to severe depression, and depending on the neurovegetative symptoms the patient has, then it is in many cases unlikely that the patient will be able to do the cognitive behavioural therapy. In this instance the cognitive behavioural therapy falls down at the first hurdle. In such a circumstance it is wrong for the patient to have to wait for three months or four to six sessions before they can obtain an appointment with a psychiatrist[215]. As Dr Naso said:

> 'You can never replace good clinical judgment with guidelines.' [216]

10.25. Dr Naso said that a third of adolescents who present with depressive symptoms will recover by themselves, no matter what therapy they are given, within three months. She said that it is the ones who are on the more severe spectrum who require intervention. She said that the trick is to make a decision about the patients who are in the serious category who need referral for psychiatric treatment[217]. It was Dr Naso's opinion that when Michaela first presented to Ms Hotich she had a moderate depressive disorder which at times appeared to reach the intensity of a severe depressive disorder. So initially she was in the moderate to severe major depressive disorder category in which psychological therapy in the form of cognitive behavioural therapy or interpersonal therapy is recommended plus fluoxetine if necessary, without giving any sort of timeframe. She said that when a patient presents with severe major depression they need to go straight to a psychiatrist[218].

10.26. In short, Dr Naso considered that Ms Hotich, Ms Duckworth and CAMHS read the guidelines too rigidly[219].

10.27. Dr Naso was of the opinion that the formalised cognitive behavioural therapy was something Michaela was not able to partake in because her condition meant that she could not attain a level of motivation necessary.

10.28. Dr Naso was of the opinion that by the time Dr Garrood and Ms Worth saw Michaela, her mental state had deteriorated from where it had started when she first went to CAMHS in June 2011. By the time she saw Dr Garrood, in Dr Naso's opinion she fulfilled the criteria of a severe depressive disorder. Dr Naso said that if the depressive disorder had been treated earlier there would have been more chance that it

[215] Transcript, page 721
[216] Transcript, page 722
[217] Transcript, pages 722-723
[218] Transcript, page 723
[219] Transcript, page 724

would remit and that cognitive behavioural therapy could have then been commenced. Dr Naso said that it is more difficult to reverse a well established severe depressive disorder than to dislodge a moderate to severe depressive illness because in the meantime a lot of further damage is done, including academically, which feeds into the patient's self esteem. She said that if the illness is caught earlier there is more chance of a better outcome[220].

10.29. Dr Naso's opinion of Ms Worth's treatment of Michaela was that overall what Ms Worth did was excellent practice[221].

10.30. As to Dr Garrood's intervention, Dr Naso was of the opinion that he correctly prescribed fluoxetine. Dr Naso said that by the time Dr Garrood saw Michaela she had a severe depressive disorder and her depression had been continuing for more than nine months. This meant that Dr Garrood faced a difficult task. The other criticisms she made of Dr Garrood's treatment of Michaela have already been noted and I note that Dr Garrood accepted them.

10.31. On the subject of whether Michaela's death could have been prevented, Dr Naso frankly admitted that it is always difficult to say. However, she was able to express the opinion with confidence that if the depression had been treated sooner, there would have been more chance for the recovery process to occur. It was Dr Naso's opinion that Michaela should have been sent to see a psychiatrist after her visit with Ms Hotich on 2 September 2011 when it was obvious that she was significantly depressed and she was reporting stalking and making references to feeling paranoid when at her father's house. Dr Naso thought that at that point a psychiatrist was necessary[222].

10.32. Dr Naso was asked for her opinion about commencing teenagers and adolescents on antidepressant medication. In the present case, as we know, Michaela was not commenced on antidepressant medication until her depression had reached the stage of being severe major depression. Dr Naso said that on any view it was appropriate to commence her on antidepressants when Dr Garrood did. Dr Naso said that studies showed that teenagers on antidepressants had a 4% chance of emerging suicidal behaviours compared with 2% for the ones who were on a placebo. However, for ethical reasons, those studies excluded the very sick children with a severe depressive

[220] Transcript, page 726
[221] Transcript, page 730
[222] Transcript, page 734

disorder because they could not be excluded from antidepressant treatment. For that reason the study is subject to criticism because if the severely depressed children had been included in it, they would be the patients who would probably have benefited most from antidepressant usage. If it had been ethical and possible to carry out studies in which those children were included[223], the study would likely have reached a different outcome. Furthermore, Dr Naso referred to a study co-authored by Professor Goldney in 2010 in which he looked at nearly 600 teenagers who had committed suicide, of whom only 1.6% were actually on antidepressants[224]. In summary, Dr Naso's opinion was that if a patient is willing and motivated and supported by their family to do it, then psychotherapy should be pursued. However, if those elements do not fall into place, then psychotherapy is of limited use. It then becomes necessary to treat the condition because otherwise it will get worse the longer it is left, and antidepressants will be required[225].

10.33. Dr Naso disagreed with the proposition that it was more likely that there was a connection between Michaela's use of antidepressants and her death than any connection between the treatment, or lack thereof, that she had received while at CAMHS 'nine months before her death'. She responded as follows:

> 'No, I don't. I can't see how we can make a link between the antidepressant that she had been on as somehow being related to Michaela's death when she had been experiencing suicidal ruminations right from the very start of her assessment with CAMHS. The CAMHS treatment, my opinion, is that the depression should have been treated earlier. And then there would have been - I'm not saying that if it had been treated earlier that 100% it would have remitted or it would have gone into remission, but what I'm saying is that it would have given her a chance for it to go into remission rather than it continuing to deteriorate to the point of a severe depression, which is harder to treat.' [226]

10.34. Finally, Dr Naso was asked by counsel for Dr Garrood what should have happened after Dr Garrood rang Ms Duckworth and informed her of the fact that he was treating Michaela, that her symptoms were very severe, that she had suicidal ruminations and that he had commenced her on fluoxetine. I have now accepted in this finding that Dr Garrood's version of that conversation is the correct one. Dr Naso's opinion was that in those circumstances Ms Duckworth should have reviewed Michaela's notes and then should have recontacted Dr Garrood and told him that she would arrange an appointment for Michaela at the next possible opportunity to see the CAMHS

[223] For obvious reasons, namely giving a placebo to a severely depressed child, that could not happen.
[224] Transcript, pages 734-736
[225] Transcript, page 7237
[226] Transcript, pages 757-758

psychiatrist. If that was not possible, then Ms Duckworth should have assisted in facilitating some other sort of approach[227].

## 11. Application by counsel for CAMHS to call Professor Jureidini

11.1. On the third day of the Inquest, after Ms Hotich, Ms Lake, Ms Forrest and Mr Mundy had given evidence, counsel for CAMHS made an application. Counsel for CAMHS explained that he had instructions from that organisation to provide a further expert report from Professor Jureidini. Counsel explained that Professor Jureidini is an expert at paediatric adolescent psychiatry. Counsel referred to an expert report that had been obtained by counsel assisting the Court from Dr Maria Naso, Senior Staff Psychiatrist at Modbury Hospital[228]. That report was dated 13 February 2013. The report had been available to CAMHS and its legal advisors for more than three months prior to the commencement of this Inquest. Counsel from CAMHS framed his application in this way:

> 'In the report of Dr Maria Naso and from the way my friend opened to your Honour is (sic) that the issue is that had pharmacology been issued to Ms Mundy at the first instance, that may have avoided her ultimately committing suicide.
>
> Mr Jureidini has a different opinion, and I expect that what he will be telling your Honour is that that's not normal practice in paediatric and adolescent psychiatry to provide antidepressant medication in the first instance to young children and adolescents, and in particular to adolescents.' [229]

Counsel then made particular reference to the following passage from Dr Naso's report[230]:

> 'My opinion is that if Michaela had been seen by a CAMHS psychiatrist, a treatment plan of cognitive behaviour therapy, pharmacotherapy and family therapy would have been instituted.'

Counsel for CAMHS went on to say that Professor Jureidini would be likely to say that for depression in adolescents, for at least the first three months, there should be a series of psychology assessments before pharmacology is introduced. He went on to say, secondly, that Dr Naso appeared not to have undertaken what counsel referred to as 'further studies in relation to paediatric psychology' and for that reason Professor Jureidini would be a more appropriate expert.

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[227] Transcript, page 771
[228] Exhibit C24
[229] Transcript, page 280
[230] The report was subsequently admitted as Exhibit C24

11.2. As I say, at the time of this application, CAMHS and its legal advisors had been in possession of the material to be adduced at the Inquest, including Dr Naso's report, for at least three months. Counsel for CAMHS conceded that he had only turned his mind to the issue the week before the commencement of the Inquest[231] and had then spoken with Professor Jureidini. I specifically asked counsel for CAMHS whether it would be Professor Jureidini's evidence that Michaela ought not to have been seen by a psychiatrist and he responded that would not be Professor Jureidini's evidence[232].

11.3. As a result of this application other counsel, including counsel for Dr Garrood who treated Michaela and prescribed antidepressants for her, requested an opportunity to delay the evidence of Dr Garrood pending the receipt of any report from Professor Jureidini. Other adjustments had to be made to the witness list. It was clear that the evidence would not be completed in the time that had then been set aside for the Court to deal with this matter. It was then 5 September 2013. I asked counsel for CAMHS how soon a report could be obtained from Professor Jureidini and was informed that a report could be provided by 22 November 2013. I directed that if a report was to be provided from Professor Jureidini it should be provided by the end of September at the latest. The Inquest was adjourned on 6 September 2013 to 10 December 2013.

11.4. On the resumption of the Inquest on 10 December 2013 an application was made by counsel for CAMHS to tender a report that had been obtained from Professor Jureidini. The application was refused by me because Professor Jureidini was not available to give oral evidence. In fact, it had been apparent from correspondence that was tendered between counsel for CAMHS and counsel assisting me[233], that following receipt by counsel assisting me of the report obtained by counsel for CAMHS from Professor Jureidini, counsel assisting me had proceeded to obtain a further expert report from Professor Goldney. In late November 2013 it became apparent to counsel assisting me that Professor Jureidini was not going to be available to give evidence at the Inquest in the allotted hearing dates which were 10 December to 13 December 2013 inclusive. These dates had been set down since the adjournment on 6 September 2013. It became apparent in late November 2013 that Professor Jureidini would be in New Zealand during that period. Accordingly, counsel assisting wrote to counsel for CAMHS to advise that the Court would not be prepared to make arrangements to hear Professor Jureidini's evidence remotely from New Zealand. Counsel assisting also

[231] Transcript, page 281
[232] Transcript, page 281
[233] Exhibits C21 and C21a

informed counsel for CAMHS that Professor Jureidini's report would not be received by the Court without oral evidence being heard from Professor Jureidini. She informed counsel for CAMHS that a time for Professor Jureidini to give evidence had been allotted for Thursday, 12 December 2013 at 10am. She enclosed a copy of the report obtained by her from Professor Goldney. Her letter dated 27 November 2013 states:

> 'You will see in this report that Professor Goldney is largely in disagreement with the report of Professor Jureidini. In these circumstances you may wish to review whether you would want to call Professor Jureidini in any event.
>
> Considerable inconvenience and expense has been incurred in obtaining Professor Goldney's report in anticipation that Professor Jureidini would be giving evidence and if he is not to give evidence that expense and inconvenience could have been avoided.' [234]

The letter continued with a request that counsel for CAMHS advise by no later than close of business on 28 November 2013 as to whether Professor Jureidini would be giving oral evidence so that Professor Goldney could be informed whether he would be required to give evidence or not.

11.5. By email dated 29 November 2013, counsel for CAMHS wrote to counsel assisting me advising that Professor Jureidini would not be available to give evidence in the Coroner's Court in Adelaide at the allotted time. Counsel assisting responded by email dated 2 December 2013 advising that the Court would not be prepared to hear Professor Jureidini's evidence remotely and that, accordingly, Professor Goldney would be stood down[235].

11.6. It was against this background that I refused the application by counsel for CAMHS for Professor Jureidini's report to be tendered[236]. Counsel for CAMHS was asked by me how it was that he had obtained a report from Professor Jureidini when Professor Jureidini would not be available at the time that counsel was aware the Court would be sitting. He responded that it was always his understanding that Professor Jureidini would be available. In the result, I was not prepared to receive Professor Jureidini's report without him being present to be cross-examined and the application was refused[237].

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[234] Exhibit C21
[235] The emails are set out in Exhibit C21a and Exhibit C21b
[236] Transcript, page 392
[237] Transcript, pages 392-393

11.7. I record my concern that as a result of the application by counsel for CAMHS to seek a report from Professor Jureidini, the Coroner's Court of South Australia was put to the trouble and expense of rearranging witnesses and obtaining a further report from Professor Goldney that was not necessary. I add that I have not seen or read the reports of Professor Jureidini or Professor Goldney, and my only knowledge of the latter's report is counsel assisting's description of it in Exhibit C21 in which it is noted that he is largely in disagreement with the report of Professor Jureidini.

## 12. Conclusions

12.1. In my opinion CAMHS failed to provide an adequate service to Michaela Mundy. I make the following specific criticisms:

1) Although CAMHS is a multi-disciplinary structure, Ms Hotich was not operating that way. She was effectively an individual clinician operating alone. Ms Duckworth and Mr Skene gave evidence to the effect that Ms Hotich was actually doing what was expected of her in this respect. Thus, Ms Hotich's mode of operation was not unique to her and I assume that it is a regular occurrence. In my opinion the whole point of being part of a multi-disciplinary team was defeated by this mode of operation;

2) Ms Hotich should have referred Michaela to a psychiatrist on or after 2 September 2011;

3) Ms Hotich was wrong to accede to the request of Michaela and her mother not to involve Mr Mundy in Michaela's treatment. While she might initially have acceded to this request, she should have qualified that agreement by insisting that although he may not have needed to be involved immediately, the question should have been revisited quite early in the piece. The fact of the matter is that Mr Mundy had important information to impart which only became known during his evidence at Inquest;

4) Ms Duckworth should have insisted that Ms Hotich raise with Michaela and her mother the need to involve her father in the treatment following Ms Duckworth's discussions with Ms Hotich;

5) Ms Hotich should have raised the issue of involving Mr Mundy soon after she was first contacted by Ms Lake from Seymour College;

6) When Michaela's mother called Ms Hotich to say that Michaela did not wish to continue her treatment with CAMHS on 15 November 2011, Ms Hotich should have insisted on speaking with Michaela and attempting to persuade Michaela and her mother to maintain their engagement, if necessary with another therapist;

7) Ms Hotich should have advised Seymour College of Michaela disengaging from CAMHS' care on, or soon after, 17 November 2011;

8) Ms Hotich should have attempted to contact Michaela and/or her mother with a view to re-engaging her with CAMHS when Ms Forrest called Ms Hotich on 16 December 2011 to advise that Michaela was to commence boarding the following year and requesting that CAMHS make appointments with Michaela to assist her in making the transition to boarding early in the new year;

9) On 7 February 2012 when Michaela's mother called Ms Hotich to advise that Michaela had harmed herself following the first week at the boarding house, Ms Hotich should have attempted to re-engage with Michaela and her mother, again with another therapist if necessary, and/or a psychiatric referral;

10) On 15 June 2012 when Dr Garrood rang Ms Duckworth, Ms Duckworth should have organised to reopen Michaela's file and refer Michaela straight to a CAMHS psychiatrist;

11) Michaela's depressive symptoms deteriorated steadily from June 2011 until, certainly by the time she was seen by Ms Worth and Dr Garrood, she had severe major depression. Had her condition been properly treated earlier, Michaela would have had a better chance of not proceeding to severe major depression, and would have had a better chance of recovering;

12) When Dr Garrood spoke with Ms Duckworth he did indeed refer to Michaela by name. He explained that he had commenced her on fluoxetine and that she was severely depressed and that he was seeking a psychiatric assessment for her. Ms Duckworth did not accede to his request;

13) At no time in any of the appointments with Ms Hotich after the first visit, did Ms Hotich question Michaela about her suicidality. She should have done so on each separate occasion.

## 13. Recommendations

13.1. Pursuant to Section 25(2) of the Coroners Act 2003 I am empowered to make recommendations that in the opinion of the Court might prevent, or reduce the likelihood of, a recurrence of an event similar to the event that was the subject of the Inquest.

13.2. In my opinion the CAMHS 'extremely flat structure'[238] is fundamentally flawed. Social workers are no doubt very useful in dealing with the mildest of depression cases. However, the current approach where there is a very flat structure with many social workers, a number of psychologists, and less than half of a psychiatrist for 220 to 250 patients is inappropriate. Forty percent of a psychiatric position cannot possibly see more than a small percentage of those 200 to 250 patients. These apportionments need to be reapportioned. The service needs a greater number of psychiatrists. It is not for me to specify the correct proportion, but I believe that the number of psychiatrists engaged by CAMHS must be significantly increased so that the current disincentive to refer a patient such as Michaela to a psychiatrist is removed. Importantly, CAMHS must be restructured to reflect that it is a public health service. If the service were, for example, surgical, it would be provided in a hospital under the clinical supervision of a consultant. In the case of CAMHS, the service is not being provided in a building called a hospital, but the importance of the service is of the same order as a service such as a surgical service. The errors in this case and Michaela's tragic death amply demonstrate that. It follows that all services provided by CAMHS should be provided under the same level of consultant supervision as a surgical service in a public hospital. To be absolutely clear, I refer to supervision by a consultant psychiatrist. I make the following recommendations directed to the Minister for Mental Health and Substance Abuse:

1) That the current approach of CAMHS in which it fails to take proper advantage of the multi-disciplinary team approach be reformed so that therapists such as Ms Hotich are no longer operating as individual practitioners;

2) That the number of psychiatrists employed within CAMHS be increased so that the current disincentive to refer a patient such as Michaela is removed;

[238] Transcript, page 517

3) That all services provided by CAMHS should be provided under the same level of consultant supervision as a surgical service in a public hospital. To be absolutely clear, I refer to supervision by a consultant psychiatrist

*Key Words: Psychiatric/Mental Illness; Suicide*

*In witness whereof the said Coroner has hereunto set and subscribed his hand and Seal the 12th day of March, 2014.*

*State Coroner*

Inquest Number 25/2013 (1094/2012)