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 12th, 13th and 15th days of September 2017 and the 5th day of March 2018, by the Coroner's Court of the said State, constituted of Jayne Samia Basheer, Deputy State Coroner, into the deaths of Miranda Robyn Howard and Aurora Holly Violet McPherson-Smith.

The said Court finds that Miranda Robyn Howard aged 22 years, late of 13 Dean Grove, Heathpool died at the Royal Adelaide Hospital, North Terrace, Adelaide, South Australia on the 27th day of November 2013 as a result of aspiration pneumonia complicating overdose of prescription medications on a background of borderline personality disorder.

The said Court finds that Aurora Holly Violet McPherson-Smith aged 18 years, late of 20 Driffield Road, Bridgewater died at the Royal Adelaide Hospital, North Terrace, Adelaide, South Australia on the 1st day of July 2015 as a result of multi-organ failure due to ingestion of concentrated hydrochloric acid.

The said Court finds that the circumstances of their deaths were as follows:

1. Introduction

1.1. This Inquest concerns the deaths of Miranda Robyn Howard and Aurora Holly Violet McPherson-Smith, separated by around 18 months, but in circumstances which give rise to similar issues about the treatment of Borderline Personality Disorder in South Australia. Ms Howard died on 27 November 2013 aged 22 years. Ms McPherson-Smith died on 1 July 2015 aged 18 years.

1.2. The Court received 50 documentary exhibits including sworn statements of medical practitioners and health professionals, forensic pathologists, police investigators, civilian witnesses, expert reports, hospital records and case notes relating to each of the deceased. Mr Ahura Kalali appeared as Counsel Assisting the Inquest. Ms Sarah Sloan of the Crown Solicitor's Office was granted leave to appear as counsel for the Central Adelaide Local Health Network, the Women's and Children's Health Network and Southern Adelaide Local Health Network.

1.3. Two psychiatrists were called to give oral evidence. Dr Maria Naso prepared overview reports and provided expert opinion regarding the medical management of each of the deceased. The reports also addressed the current delivery of Borderline Personality Disorder services in South Australia.[1]

1.4. Dr Martha Kent OAM gave oral evidence. Dr Kent had read and considered Dr Naso's reports and her evidence addressed a wide range of relevant matters including the work of the South Australian Borderline Personality Disorder Work Group (SA BPD Work Group) 2010-2013 and the recommendations made to the State Government in June 2013. Dr Kent also provided opinion evidence regarding the medical management of the deceased.

1.5. The expert evidence was remarkably consistent in its content and, in many respects, it can be described as a united body of evidence.

1.6. Whilst there are differences in the circumstances which led to the deaths of Miranda Howard and Aurora McPherson-Smith, there is no dispute that neither of them received a timely diagnosis of Borderline Personality Disorder. Nor was there any dispute that, at the time of their deaths, they were each suffering from BPD in its most severe form.

1.7. In the years leading to their deaths the deceased had ongoing interaction with state mental health services (private and public). Both suffered from chronic suicide ideation and self-harming behaviour. This led to multiple presentations and admissions to hospital Emergency Departments (EDs) and, at times, lengthy periods of hospitalisation. Due to her young age, Ms McPherson-Smith's engagement with mental health services included the Child and Adolescent Mental Health Service (CAMHS) and also adult services.

---

[1] Exhibit C43 and C43a

2. Terminology[2]

ACT	Acceptance and Commitment Therapy
BPD	Borderline Personality Disorder
CBT	Cognitive Behaviour Therapy
DASSA	Drug and Alcohol Services South Australia
DBT	Dialectical Behaviour Therapy
DSM V	The Diagnostic and Statistical Manual of Mental Disorder (American Psychiatric Association) - 5th edition
ECMHS	Eastern Community Mental Health Service
ED	Emergency Department
GP	General Practitioner
FPH	Fullarton Private Hospital
HYPE	Helping Young People Early Program (Orygen), Victoria
ICC	Intermediate Care Centre
ITO	Involuntary Treatment Order
ICU	Intensive Care Unit
Kahlyn	Kahlyn Day Centre
MBT	Mentalisation Based Therapy
Ms Howard, Miranda or the deceased	Miranda Robyn Howard
Ms McPherson-Smith, Aurora or the deceased	Aurora Holly Violet McPherson-Smith
National Guidelines	National Health and Medical Research Council Guidelines for Health Professionals Caring for People with Borderline Personality Disorder (2013)
NGO	Non-Government Organisation
Orygen	Orygen Youth Health, Victoria
RAH	Royal Adelaide Hospital
SA BPD Work Group	South Australian Borderline Personality Work Group
SAMHC	South Australian Mental Health Commission
SA Mental Health Clinical Network	South Australian Mental Health Clinical Network
SAPOL	South Australia Police
Spectrum	Spectrum Personality Disorder Service, Victoria
SSYS	Second Story Youth Service
TAC	The Adelaide Clinic
The Act	The Coroner's Act, 2003 (SA)
WCH	Women's and Children's Hospital

[2] Italics are used in these findings for the purpose of emphasis

3. Background of Miranda Robyn Howard

3.1. Miranda Howard died on 27 November 2013. She was 22 years old.

3.2. Ms Howard was raised by a loving family. She lived at Goodwood with her parents and her sister prior to moving into rental accommodation at Heathpool in January 2013.

3.3. Throughout her schooling years Ms Howard was described by her mother (Robyn Pettigrew) as having a bubbly, witty and funny personality and an active lifestyle. After completing Year 12 in 2009, Ms Howard studied Genetics at the University of Adelaide and gained distinctions in her first year of study.[3] Her ambition was to be a paediatrician, to be involved in sport and to travel.[4] For all intents and purposes it appeared that this intelligent and capable young woman had a bright and happy future.

3.4. Ms Howard's parents first became aware of mental health issues when their daughter was in Year 11 at Urrbrae High School. The school provided information that she had been self-harming by scratching her arm.

3.5. The next few years were characterised by a serious decline her mental health. Ms Howard suffered from chronic suicidal ideation and she frequently self-harmed. This led to multiple ED presentations and admissions. Despite being under ongoing medical care and supervision for many years, her mental health steadily deteriorated.

3.6. At about 9:28pm on 21 November 2013 South Australia Police received a phone call via '131444' from a friend of Ms Howard's. Ms Emilia Yap told the police that her friend was posting suicidal messages on Facebook.[5]

3.7. Police officers attended at her home at around 9:50pm. They located Ms Howard in a semi-conscious state. She told the police that she had taken 70 Seroquel tablets.[6] Police and ambulance officers located empty drug packets and prescriptions for Quetiapine.[7] Ms Howard was taken by ambulance to the ED of the Royal Adelaide Hospital (RAH) and admitted into the Intensive Care Unit (ICU) with a suspected prescription drug overdose. Her clinical picture was consistent with a Quetiapine overdose.[8]

---

[3] Exhibit C1c
[4] Exhibit C1c, page 9
[5] Exhibit C9; Exhibit C10a, Exhibit C11; Exhibit C12
[6] Seroquel is the generic brand name for a long acting release of Quetiapine. Quetiapine is a mood altering drug commonly prescribed for patients with a psychiatric illness: Exhibit C5, page 3; Exhibit C4a
[7] Exhibit C12, pages 4-6; Exhibit C12b, C12d
[8] Exhibit C5, page 3

3.8. Initially a full recovery was anticipated, but over the coming days her condition deteriorated. On 27 November 2013 Ms Howard suffered from an unexpected arrhythmia of the heart and later a fatal cardiac arrest.[9] Her life was declared to be extinct at 11:05pm by Dr Michael Edmonds.

4. Background of Aurora Holly Violet McPherson-Smith

4.1. Aurora Holly Violet McPherson-Smith died on Wednesday 1 July 2015.[10] She was 18 years old.

4.2. Ms McPherson-Smith lived with her parents and sister at Bridgewater in the Adelaide Hills. She too was raised by a close-knit and loving family. Her mother said that Aurora was a beautiful little girl growing up. She was a child who was very much loved and adored by her entire family. She loved ballet and netball and set high standards for herself. Throughout her schooling Aurora achieved high grades and received several awards. By year 10 she had already started pre-International Baccalaureate (IB) subjects.[11]

4.3. It appeared that Ms McPherson-Smith was a normal, healthy, happy, thriving girl. Indeed, her maternal grandmother once said that it looked like their family was 'one of the lucky ones' and likely to escape the potentially problematic teenage years.[12] The future for this young woman certainly appeared to be very bright.

4.4. However, in September 2012, her parents were told by a school counsellor that their daughter had disclosed that she did not want to live, that she had been experiencing bulimia and that on the previous day she had tried to stab herself.

4.5. Her mother arranged for a referral to CAMHS at Mount Barker. Thus began a lengthy period of engagement with mental health services.

4.6. The next few years were characterised by a serious decline in mental health. As in the case of Ms Howard, Ms McPherson-Smith suffered from chronic suicidal ideation and she became preoccupied with thoughts of death. She frequently self-harmed which led

[9] Exhibit C5
[10] Exhibit C27
[11] Exhibit C21
[12] Exhibit C21

to multiple ED admissions and periods of hospitalisation. Despite being under ongoing medical care and supervision for many years (in adolescent and adult mental health services) her mental health steadily deteriorated.

4.7. In February, March and April 2015 Ms McPherson-Smith spent short periods of time in temporary accommodation at Catherine House.[13] Her struggle with mental health continued.

4.8. On 30 June 2015 Ms McPherson-Smith had lunch with her father (Jonathan Smith) in the food court area of the Central Market on Gouger Street, Adelaide.[14]

4.9. Subsequently he became concerned about Aurora's welfare and at around 7:28pm SAPOL was contacted.[15] At around 9:12pm police officers located her collapsed in a public toilet block at Rymill Park.[16] A number of items were located nearby including a block of packaged dry ice, several empty drink bottles, a 500ml black plastic container with a red lid labelled 'Hydrochloric Acid' and a half empty 700ml bottle of Petrovska Vodka.[17]

4.10. Police suspected that Ms McPherson-Smith had consumed alcohol and concentrated hydrochloric acid.[18] She was taken by ambulance to the RAH ED and admitted into the Intensive Care Unit. CT scans and the clinical findings were found to be in keeping with ingestion of a corrosive substance. The scans showed multiple abnormalities and the injuries were deemed non-survivable.

4.11. On 1 July 2015, and after consultations with medical staff, the decision was made to shift Ms McPherson-Smith's care towards palliative care. At 12 noon on 1 July 2015 life was certified to be extinct.[19]

4.12. It is the purpose of this Inquest to examine the cause and circumstances of these deaths.

---

[13] Exhibit C27, page 13
[14] Exhibit C13b
[15] Exhibit C13b, pages 2 - 5
[16] Exhibit C27; Exhibit C23; Exhibit C24
[17] Exhibit C27, page 4
[18] Exhibit C27, page 11 and Exhibit C27f
[19] Exhibit C27, page 35

5. Cause of death - Miranda Howard

5.1. A review of Ms Howard's medical case notes was undertaken by Dr Iain McIntyre and forensic pathologist Dr John Gilbert (Forensic Science South Australia). Since the cause of death could be determined from the case notes with some certainty an autopsy was not recommended or undertaken.[20]

5.2. Toxicology testing was conducted on a specimen of blood obtained on admission to the RAH and confirmed a Quetiapine concentration of approximately 7.2mg/L. This is a greater than therapeutic concentration, approximately seven times the upper limit of the reported therapeutic range and at the lower limit of the range of concentrations reported in fatal overdoses. Therapeutic concentrations of Fluvoxamine and Norquetiapine (metabolites of Quetiapine) were also detected. No other common drugs including Diazepam were detected.[21]

5.3. The suggested cause of death was aspiration pneumonia complicating overdose of prescription medications in a woman with a borderline personality disorder.[22] I accept the expert opinion as to the cause of death and so find.

6. Cause of death - Aurora McPherson-Smith

6.1. On 3 July 2015 an autopsy was conducted on Ms McPherson-Smith by Dr Gilbert.[23]

6.2. On external examination Dr Gilbert noted large areas of old skin-grafted burns and associated skin-donor sites. There were also numerous old parallel scars over both arms and both legs in keeping with previous self-inflicted injury. The internal abnormalities noted on the clinical CT scans and the clinical findings were in keeping with ingestion of a corrosive.

6.3. Toxicological examination of a specimen of blood obtained at the RAH at 12:50am on 1 July 2015 detected a blood alcohol concentration of 0.109 in 100ml of blood.[24] Therapeutic levels of Morphine and Midazolam (administered in hospital), a sub-

---

[20] Exhibit 2a
[21] Exhibit C3a
[22] Exhibit C2a, page 1
[23] Exhibit C14a
[24] Exhibit C15a

therapeutic level of Quetiapine and a therapeutic level of Fluoxetine were also present in the blood sample.[25]

6.4. Death was attributed to multi-organ failure due to ingestion of concentrated hydrochloric acid. I accept the expert opinion of Dr Gilbert and find this to be the cause of death.

7. Reason for Inquest

7.1. Section 21 of the *Coroner's Act 2003 (SA)* (the Act) provides that:

> '(1) The Coroner's Court must hold an inquest to ascertain the cause or circumstances of the following events:
>
> (a) a death in custody;
>
> (b) if the State Coroner considers it necessary or desirable to do so, or the Attorney-General so directs—
>
> (i) **any other reportable death** or a death that would, but for section 3(2), have been a reportable death; or
>
> (ii) the disappearance from any place of a person ordinarily resident in the State; or
>
> (iii) the disappearance from, or within, the State of any person; or
>
> (iv) a fire or accident that causes injury to person or property;
>
> (c) any other event if so required under some other Act.' (Emphasis added).

7.2. A 'reportable death' is defined by section 3 of the Act to include a death by 'unexpected, unnatural, unusual, violent or unknown cause'. The jurisdiction of the Coroner's Court is 'to hold inquests in order to ascertain the cause or circumstances of the events prescribed by or under this Act or any other Act'.[26]

7.3. The deaths of Ms Howard and Ms McPherson-Smith are properly characterised as unexpected, unnatural and unusual. Accordingly, the State Coroner directed that an Inquest must be held to ascertain the cause and circumstances surrounding their respective deaths. It was determined that a joint inquest was appropriate noting that:

i) Both young women had been diagnosed with Borderline Personality Disorder in its most severe form;

[25] Exhibit C14a, page 3;

[26] Section 13 of the *Coroner's Act* (2003) (SA)

ii) Both had a history of suicidal ideation and self-harming behaviour, a common feature of severe BPD; and

iii) Both had significant interaction with mental health services and various health professionals over a number of years including multiple presentations and admissions to hospital EDs.

The standard of proof in coronial inquiries is the civil standard of proof on the balance of probabilities.

8. Borderline Personality Disorder - an overview

8.1. As previously stated, there is no dispute that at the time of their deaths Ms Howard and Ms McPherson-Smith were suffering from BPD in its most severe form. I consider it useful at the outset to say something about the general nature of BPD and the diagnostic criteria.[27]

8.2. BPD is a complex and severe disorder and one which appears to be widely misunderstood, not only in the community, but also amongst psychiatrists, medical practitioners and other health professionals. The core symptoms of BPD are severe mood swings that are difficult to control. It is well-known that people who suffer from this condition are very high users of health services generally and psychiatry services in particular.[28]

8.3. Patients with BPD have chronic suicidal ideation and an intense and frantic need to avoid rejection or perceived abandonment. They are very impulsive and interpersonally sensitive, particularly to feelings of rejection and abandonment.[29] Their behaviours may be difficult to manage. Dr Kent OAM explained that the sufferer does not behave badly or necessarily 'act out' because they choose to do so. Rather, the behaviour extends from an internal state of distress and agitation, intense emotions or a sense of emptiness or nothingness, which is very difficult to live with. Put another way, the behaviour stems from the BPD sufferer attempting to modify or manage their internal worlds. The exact cause is unknown.

[27] Transcript, pages 44-47, 142
[28] Transcript, page 139; Exhibit C43, pages 29 - 30
[29] Transcript, page 142, 144

8.4. BPD generally commences in adolescence. The current theory is that it probably involves a combination of biological factors (ie genetics) and invalidating experiences that happen to a person while growing up (ie some form of trauma early in life). One of the complexities in diagnosing BPD is that the sufferer may develop comorbidity with other disorders (eg depression, anxiety, eating disorders, post-traumatic stress disorder, bipolar disorder and substance abuse disorders).[30] Patients with severe BPD also have episodes of dissociation and can have what appear to be psychotic symptoms. They can be misdiagnosed with depression, mania, psychosis, schizoaffective disorder and obsessive compulsive disorder. Misdiagnosis is common.

8.5. Seventy percent of people diagnosed with BPD will attempt suicide at least once. Ten percent of diagnosed patients who present for help will ultimately end their lives. There is some research that this figure can reach forty five percent if it is a severe and complex presentation. It is unclear what percentage is due to actual suicidal intent or to misadventure from poor impulse control.

8.6. Diagnostic Criteria

Dr Naso and Dr Kent OAM referred to the 5th edition of the taxonomic and diagnostic tool published by the American Psychiatric Association, namely, the Diagnostic and Statistical Manual of Mental Disorders, 2013 (DSM V). The DSM V criteria for Borderline Personality Disorder are described as follows:

> 'A pervasive pattern of instability of interpersonal relationships, self-image and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:
>
> 1. Frantic efforts to avoid real or imagined abandonment. (Note: do not include suicidal or self-mutilating behaviour covered in Criterion 5).
> 2. A pattern of unstable and intense interpersonal relationships characterised by alternating between extremes of idealisation and devaluation.
> 3. Identity disturbance: markedly and persistently unstable self-image or sense of self.
> 4. Impulsivity in at least two areas that are potentially self-damaging (eg spending, sex, substance abuse, reckless driving, binge eating: (Note: do not include suicidal or self-mutilating behaviour covered in Criterion 5).
> 5. Recurrent suicidal behaviour, gestures or threats, or self-mutilating behaviour.

[30] Transcript, page 151 (N.B. Comorbidity is the presence of one or more additional diseases or disorders co-occurring with, that is, concomitant or concurrent with, a primary disease or disorder; in the countable sense of the term, a comorbidity (plural comorbidities) is each additional disorder or disease.

6. Affective instability due to a marked reactivity of mood (eg intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days).
7. Chronic feelings of emptiness.
8. Inappropriate, intense anger or difficulty controlling anger (eg frequent displays of temper, constant anger, recurrent physical fights).
9. Transient, stress-related paranoid ideation or severe dissociative symptoms'[31]

In order to be diagnosed with BPD a person must have at least five of the nine criteria and it must be demonstrated that the criteria impacts on their functioning in areas such as school, work or within relationships.

8.7. Dr Naso and Dr Kent concluded that Miranda Howard and Aurora McPherson-Smith each fulfilled all of the nine criteria for BPD.[32]

9. <u>The issues</u>

9.1. The central issues which I have identified as relevant to this Inquest include:

1) An assessment of current delivery of services for the treatment of BPD in South Australia in the context of the deaths of Miranda Howard and Aurora McPherson-Smith.

2) The adequacy of the medical management and treatment of Ms Howard and Ms McPherson-Smith by individual medical practitioners and health professionals:

   a) Whether either of the deceased was misdiagnosed;

   b) Whether there was any significant delay in diagnosis;

   c) The skills and experience of the medical practitioners and health professionals who were involved in their care;

   d) Whether evidence-based treatments were readily available as treatment options in the public and private sector and, if not, why not? and

   e) Whether any deficiencies in their medical management and treatment caused or contributed to their deaths;

[31] Exhibit C44 at page 8-Table 1; DSM V criteria for Borderline Personality Disorder (American Psychiatric Association, 2013
[32] Transcript, page 56 (N.B Dr Naso mentioned that she has seen patients who met only 3-4 of the criteria but at such an intense and severe level that they would fulfil the criteria for a BPD diagnosis. Some flexibility is therefore required in applying the diagnostic criteria

f) The circumstances leading to the multiple ED presentations and hospital admissions of the deceased;

g) The interface between public and private mental health services in South Australia.

3) An assessment of the recommendations made to the State Government in June 2013 by the SA Borderline Personality Work Group in its final report entitled '*Borderline Personality Disorder: An Overview of Current Delivery of Borderline Personality Disorder Services in the Public Sector across South Australia and a Proposed Way Forward*' (June 2014);[33]

4) The State Government's response, if any, to the National Guidelines and the June 2014 recommendations of the SA Borderline Personality Work Group;

5) A consideration of interstate models for service delivery and treatment for BPD and, in particular, the Spectrum Personality Disorder Service for Victoria, Orygen Youth Health and the Helping Young People Early (HYPE) program; and

6) Whether the deaths of Ms Howard and Ms McPherson-Smith could have reasonably been prevented.

10. <u>Summary of key events, medical management and treatment</u>

10.1. Ms Howard and Ms McPherson-Smith had ongoing engagement with a range of mental health services (private and public) in the years leading to their deaths. It is beyond the scope of this inquiry to determine whether every aspect of their physical and mental health needs were adequately addressed.

10.2. The focus of the Inquest must necessarily relate to key aspects of their care and, in particular, the system of care currently available in South Australia for the treatment of BPD. Neither is it within the scope of this inquiry to answer each and every question posed by the respective families.[34] That said, it is entirely understandable why such questions have been raised. The fact that I have not referred to all of the events and information provided by the deceased's parents and/or friends should not be taken to mean that I have not read and considered their statements.[35]

---

[33] Exhibit C44
[34] See for example Exhibit C1e
[35] Exhibit C1c; Exhibit C13b

10.3. I trust that these findings will provide at least some of the answers that are so desperately sought by the families of Miranda and Aurora.

10.4. I propose now to set out, in chronological order, a summary of key events relating to the deceased, their medical management and their respective paths through the maze of mental health services in South Australia.

10.5. When considering the issue of medical management I have found it useful to reflect on the diagnostic criteria for BPD.

11. Summary for Miranda Howard

11.1. Dr Madeleine Turnbull

Dr Turnbull was Ms Howard's treating GP. A statement was provided to the Inquest.[36] From August 2010 Ms Howard presented with a range of symptoms which were attributed to stress and anxiety. Trials of antidepressant medications resulted in little improvement in her symptoms. On 23 December 2010 Dr Turnbull referred Ms Howard to a private psychiatrist, Dr Gabriella Berce.[37]

11.2. Dr Turnbull maintained contact with Ms Howard between August 2010 and their last consultation on 25 October 2013. She followed her patient's progress while she was under the care of Dr Berce and other health professionals.

11.3. Dr Gabriella Berce

Dr Berce provided a statement to the Inquest.[38] Dr Berce has since died.

11.4. Dr Berce was a Fellow of the Royal Australian and New Zealand College of Psychiatrists. She was employed as a psychiatrist in the public sector for a few years before entering private practice in 2010. The first consultation with Ms Howard took place on 8 February 2011. Dr Berce continued as primary clinician until mid-June 2013. *After the initial consultation the differential diagnosis was first episode psychosis or complex partial seizures with possible pervasive development disorder*.[39]

11.5. Dr Berce trialled several antidepressant and antipsychotic medications including Sertraline, Olanzapine, Aripiprazole, Risperidone, Amisulpride, Lithium, Quetiapine,

---

[36] Exhibit C8
[37] Exhibit C8; Exhibit C12, pages 12-14
[38] Exhibit C6
[39] Exhibit C12, page 15

Asenapine and Fluvoxamine.[40] Ms Howard's mother described the medication as having 'a severe numbing effect on every aspect of her life'.[41] Throughout the period of treatment Dr Berce arranged for periodic admissions to the Fullarton Private Hospital (FPH) and The Adelaide Clinic (TAC). There were four admissions to the FPH and three admissions to TAC. In addition, while under the care of Dr Berce, Ms Howard had multiple presentations and admissions to public hospitals (primarily the RAH ED) on account of self-harming.[42] She also had one admission to the Margaret Tobin Centre (Flinders Medical Centre).

11.6. *By June 2011 the diagnosis of Dr Berce was schizoaffective disorder/manic episode* (on account of suicidal ideation and hallucinations). In early January 2012 Dr Berce readmitted Ms Howard to the FPH where she remained until 3 February 2012. The trigger for this admission was an increase in hallucinations and suicidal thoughts. The diagnosis was schizoaffective disorder/depressive episode. It is noteworthy that *on this occasion 'possible' borderline personality features were documented for the first time*.[43]

11.7. *The pattern of hospital admissions continued throughout 2012*. For example on 22 March 2012, during a further admission to the FPH, Ms Howard drank 250mls of body wash.

11.8. Between 26 March 2012 and 11 April 2012 again she was hospitalised. On discharge *the diagnosis was schizoaffective disorder with depressive episode*.[44] Various medications were continued.[45]

11.9. On review by Dr Berce on 19 April 2012, Ms Howard's mental state was unchanged with ongoing hallucinations and suicidal ideation. A referral was made to the Kahlyn Day Centre (Kahlyn) for group work, initially Cognitive Behaviour Therapy (CBT).[46]

---

[40] Exhibit C6, page 4; Exhibit C12, page 15, 19-20 (for summary of medication and uses)
[41] Exhibit C1c, page 9
[42] Exhibit C6, page 3; Exhibit C12, page 15
[43] Exhibit C43, page 3
[44] Exhibit C43, page 6
[45] Exhibit C43, page 6
[46] Exhibit C43, page 6; Kahlyn offers various therapies including CBT, Dialectical Behaviour Therapy (DBT), Art Therapy and the Young Person's Group. Attendance at the Kahlyn groups require a referral from a credentialed private psychiatrist (ie a psychiatrist who has admitting rights to the Adelaide Clinic/Fullarton Private Hospital). Patients may have private health insurance but unless they have a credentialed private psychiatrist they cannot have access to private inpatient or outpatient services
[46] Exhibit C1c, pages 9-10

11.10. On 30 April 2012 Dr Turnbull (GP) arranged for an admission to the RAH ED arising from threats by Ms Howard to jump off a building, overdose, or run in front of a train.

11.11. At this stage Dr Berce arranged for a second opinion at the Flinders Medical Centre (Margaret Tobin Centre) under the care of a psychiatrist, Dr Allan Nelson. On the date of discharge (21 May 2012) *the diagnosis was Borderline Personality Disorder, possible psychosis.*

11.12. This pattern of ongoing crises and ED presentations continued for the remainder of 2012.[47] Ms Howard continued to describe hallucinations and to engage in suicidal behaviours.

11.13. In about June 2012 a referral was made to the Southern Assessment and Crisis Intervention Service (SACIS) but attempts by the service to engage Ms Howard and to facilitate a further psychiatric opinion from Dr Kalucy, were unsuccessful.[48]

11.14. On 28 May 2012 Ms Howard's mother discovered (from Miranda's blog) that her daughter was planning to kill herself on 24 or 25 June 2012.[49] Not surprisingly the family held grave fears for her safety.[50]

11.15. On 15 June 2012 (during the Adelaide Cabaret festival) a box containing Panadol tablets, razor blades and a suicide letter was found in Ms Howard's bedroom. Her parents sought urgent assistance from the Assessment and Crisis Intervention Service (ACIS). This led to an admission to Ward C3 of the RAH (the psychiatric ward) where Ms Howard remained until 25 July 2012.[51] The situation was complicated by her refusal to have contact and/or stay with her parents at this time.

11.16. On 19 August 2012 there was a re-admission to the RAH and then to TAC. Ms Howard had decided that her parents were 'the enemy' and, although her mother said that she was welcome to come home, she told her friends that she had been kicked out of home.[52] Thus commenced a period of living at hostel accommodation including Chisolm House

[47] For details refer Exhibit C43, pages 7 - 15
[48] The Assessment and Crisis Intervention Service (ACIS) is a 24 hour Mental Health triage service which is the main point of access to public adult mental health services in South Australia. Its main role is triage, emergency psychiatric assessment/management and crisis intervention.
[49] Exhibit C1c, page 10
[50] Exhibit C1c, page 10
[51] Exhibit C1c, page 13
[52] Exhibit C1c, page 13

and Youth 110. The staff at these facilities experienced difficulty in managing Ms Howard's behaviour.

11.17. To complicate matters SACIS declined to accept a referral (on account of the high level of risk). A further referral was made to an Intermediate Care Centre (ICC).

11.18. The ICC is a system whereby a person whose mental health has deteriorated, but they are not yet ready for detention or admission to a psychiatric facility, can be admitted for a short time to assist in managing their issues and reducing, or possibly arresting, the deterioration. It is also used as a step-down facility from psychiatric wards such as Ward C3 at the RAH.[53]

11.19. Ms Howard turned 21 years old on 28 August 2012.

11.20. On 17 September 2012 she threatened to jump off a footbridge which caused staff at Youth 110 to call an ambulance. *Notwithstanding a psychiatric determination at the RAH ED that she was at chronic risk,* Ms Howard was discharged back to Youth 110.

11.21. Between October 2012 and December 2012 there were no less than 11 hospital presentations/admissions for self-harming behaviour including an overdose of prescription medication.

11.22. On 17 December 2012 an admission to the RAH ED was arranged by Dr Berce but Ms Howard absconded. On the following day she was re-admitted to the RAH ED (after slashing her throat) and later transferred to the FPH with a diagnosis of *Borderline Personality Disorder in Crisis.*

11.23. Ms Howard spent Christmas Day 2012 with her family. In early 2013 her mother found rental accommodation for her daughter at 13 Dean Grove, Heathpool. She moved in on 1 January 2013 with a newly adopted cat.[54] At this point in time Ms Howard was seeing her family approximately twice per week. She was not well enough to continue her university studies.[55]

11.24. I make two observations about the events and circumstances of 2012. Firstly, around 15 months had elapsed from the date of Ms Howard's first consultation with Dr Berce

[53] Exhibit C7, pages 10 - 11
[54] Exhibit C1c, pages 13-14
[55] Exhibit C1c, page 14

to the date of Dr Nelson's BPD diagnosis. Secondly, notwithstanding the diagnosis, *no clear management plan was put in place.* Essentially, Ms Howard and her family bounced between a range of mental health services and short-term crisis hospital admissions in a desperate bid to manage her condition.

11.25. The downward spiral continued throughout 2013.[56] For example, in February 2013 there were three self-harming episodes (18 February, 25 February and 28 February). On 28 February 2013 Ms Howard was admitted to the RAH Burns Unit for a self-inflicted burn that was sufficiently serious to warrant a stay of several days (until 5 March 2013).

11.26. During March 2013 staff at the outpatient Burns Unit formed the view that Ms Howard had tampered with her dressings and wounds.

11.27. On 2 April 2013 Ms Howard presented to the RAH Burns Unit with fresh cuts to her arm. On 28 April 2013, and after self-harming by cutting her thigh, she was assessed at the RAH ED to be at *chronic risk and at risk of misadventure.*

11.28. On 6 May 2013 Ms Howard presented to the RAH ED and *reported a history of daily self-harming*. An overnight admission to an emergency psychiatric bed was arranged.

11.29. Dr Berce arranged a two week stay for Ms Howard at the FPH commencing on 31 May 2013. Towards the end of the stay she self-harmed which led to her being sent to the RAH alone and unaccompanied in a taxi with her prescription medications. Ms Howard absconded from the taxi without attending at the RAH and she subsequently overdosed on the medications. For obvious reasons, any practice or policy of the FPH which permits high risk patients to travel alone to other hospitals in taxis and/or other chauffer driven services must immediately cease.

11.30. Family members searched the streets and located Ms Howard. She was readmitted to the RAH on 11 June 2013 and subsequently transferred to Ward C3 where she remained until 27 June 2013.[57]

11.31. When Dr Berce learned about this incident she immediately discharged Ms Howard from her care. *Dr Berce did not see her long-term patient again.*[58] Not surprisingly this abrupt and sudden termination of services caused a high level of distress to

---

[56] For details refer Exhibit C43, pages 15 - 22
[57] Exhibit C43, pages 17 - 18; Exhibit C1c, pages 15 - 16
[58] Exhibit C6, pages 4 - 5; Exhibit C1c, page 16

Ms Howard and her family. Ms Howard's mother described Dr Berce's conduct as negligent.[59]

11.32. In her statement Dr Berce provided two reasons for the decision: firstly, she said that assertive case management was required; secondly, Dr Berce believed that she had done everything she could for Ms Howard with no apparent benefit.[60]

11.33. The hunt then began for a new psychiatrist. Despite considerable efforts Ms Howard's mother was unable to find a psychiatrist in the private sector who was willing to take on a new patient or a person with BPD.[61]

11.34. Mr Jason Gill

I turn now to the care provided by Mr Gill. He provided interim care between 18 July 2013 and 9 September 2013 (and subsequently assumed primary care between 21 October 2013 to the date of Ms Howard's death).

11.35. Mr Gill is a psychologist employed by the Eastern Community Mental Health Service (ECMHS). He provided a statement to the Inquest.[62] Mr Gill saw Ms Howard on seven occasions between 18 July 2013 and 14 November 2013.

11.36. Initially, Ms Howard presented as quite engaging and cooperative. She described self-harming as a way as coping with the strong emotions she was experiencing. At the first appointment (18 July 2013), Ms Howard informed Mr Gill that she had chosen 31 July 2013 to commit suicide. Her belief was that if she killed herself all traces of her would be erased from everybody's memory and she would 'go home.' *She also described auditory hallucinations of three voices that occasionally spoke to her and told her that she was worthless*.[63]

11.37. Mr Gill commenced Dialectical Behaviour Therapy (DBT) as the primary treatment, a therapy which he described as 'the gold standard' of treatment for BPD.[64] Notwithstanding his efforts, the self-harming behaviour and hospital admissions continued. *Ms Howard often attended her sessions with self-inflicted injuries* including

[59] Exhibit C1c, page 16
[60] Exhibit C6, pages 4 - 5
[61] Exhibit C1c, pages 16 - 17; Exhibit C1c, pages 16 - 17
[62] Exhibit C7
[63] Exhibit C7, pages 4 - 5; Exhibit C12, page 16
[64] Exhibit C7, page 10

bruising and black eyes (apparently from conduct such as repeatedly hitting her head against a wall).

11.38. There was ACIS involvement during this period and, on one occasion, an emergency assessment was conducted at the RAH ED.[65] Between 14 and 20 August 2013 there was a planned admission to the Eastern Intermediate Care Centre but this admission did not appear to assist Ms Howard.

11.39. On 1 September 2013 the family celebrated Miranda's 22nd birthday with family and friends.[66] No doubt from the family's perspective this was a positive milestone since Miranda had told them many times that she saw no point in living past the age of 21.

11.40. Between 9 September 2013 and 7 November 2013 no consultations occurred because Ms Howard's mother believed (albeit erroneously) that she had found a private psychiatrist, Professor Galletly, to take over her daughter's care. An appointment with Professor Galletly was scheduled for 24 September 2013.

11.41. During this period between psychiatrists Ms Howard's mother described Miranda as 'hugely distressed' *by what she perceived as abandonment by the mental health system.*'[67] Two days before her appointment with Professor Galletly she attended at the RAH ED with self-inflicted wounds. To compound matters, without a private psychiatrist, Ms Howard was unable to attend at Kahlyn, a place which had provided essential therapy along with some routine and stability.

11.42. On 24 September 2013 Professor Galletly conducted an assessment which turned out to be a single assessment only. The ECMHS declined to resume care of Ms Howard until a report was received from Professor Galletly.

11.43. On 4 October 2013 Mr Gill received the report in which Dr Galletly recommended that Ms Howard be accepted into the public system. The reason cited was that 'the level of availability to respond to a crisis is not possible for a single private psychiatrist'.[68]

11.44. During October 2013 Ms Howard had approximately five admissions to the RAH ED. Her mother viewed these admissions as an indication of the overwhelming distress her

---

[65] Exhibit C1c, page 17
[66] Exhibit C1c, page 18
[67] Exhibit C1c, page 20
[68] Transcript, page 91; Exhibit C1c, page 18; Exhibit C7, page 15

daughter felt about the lack of medical support at this time and her fear of receiving no further support.[69] On one occasion she was found by police lying in the middle of a road.[70]

11.45. On 21 October 2013 Mr Gill assumed primary care. The care plan included a referral to the ECMHS 20 week intensive DBT program and weekly individual therapy sessions with Mr Gill. The DBT program was due to commence at the end of January 2014. Ms Howard had agreed to be a participant.[71]

11.46. In early November 2013 Ms Howard travelled to Perth. On 5 November 2013 she was admitted to Fremantle Hospital as she appeared to be suicidal.[72]

11.47. On return to Adelaide Ms Howard commenced the last two sessions with Mr Gill. These sessions were directed at the pre-commitment phase for the intensive DBT program.[73]

11.48. On 7 November 2013 Ms Howard arrived with three bandages on her arm which she reported as a friction burn, a boiling water burn and a heated metal burn. *All of the injuries were self-inflicted.* Mr Gill discussed the nature of intensive DBT therapy including the therapeutic boundaries and rules. Ms Howard struggled with the process stating that *she was not feeling any emotions and had not done so for a couple of weeks*.[74]

11.49. At the last session on 14 November 2013, there was discussion about the need to commit and engage in long-term therapy in order to change her suicidal and self-harming behaviours. *Ms Howard found this idea really difficult as she could not imagine coping without self-harming. She described the idea of not self-harming as seemingly* '*impossible*'.[75]

11.50. On the afternoon of 18 November 2013 Mr Gill learned that Ms Howard had been cutting herself, burning herself, hitting herself and biting herself on the lip. She had also threatened to end her life by jumping off a bridge. After discussion with a senior psychologist, Mr Gill concluded that her presentation did not represent a deterioration

---

[69] Exhibit C1c, page 20
[70] Exhibit C1c, page 20
[71] Exhibit C43, page 21; Exhibit C7, page 15
[72] Exhibit C1c, page 21
[73] Exhibit C43a, page 12
[74] Exhibit C43, page 22; Exhibit C7, pages 16 - 17
[75] Exhibit C7, pages 18 - 19

in her mental state or an escalation in the level of risk and he advised her mother of this risk assessment on the same day. Mr Gill also explained that any further contact about an acute situation, escalation or deterioration in Miranda's condition should be directed to the Mental Health Triage (and that he could access information via the case notes). At the time Mr Gill was concerned that his relationship with Ms Howard might be undermined if she learned that her mother was in frequent contact with him.[76]

11.51. The severance of contact with Mr Gill caused a great deal of distress to Ms Howard's mother. She cried during the call.[77] When she rang the number that had been provided she was informed that messages could not be left for Mr Gill or ECMHS. With the benefit of hindsight it may not have been the most opportune time for Mr Gill to sever this line of communication.

11.52. At around 6:30pm on Thursday 21 November 2013 Ms Howard's mother went to her daughter's house to help her select clothes for a Frisbee party. Miranda spoke about plans to see a friend on 26 November 2013, her travel plans to Melbourne for a Frisbee tournament on 7 and 8 December 2013 and plans to relocate to Perth in January 2014. Her mother left the house at around 8pm and returned home. In her statement she said 'When I saw Miranda on 21 November 2013, she was in no way the worst mental state I have seen her in'.[78]

11.53. At about 9:04pm on 21 November 2013, as previously stated, Ms Emilia Yap noticed suicidal messages from Ms Howard on Facebook so she contacted SAPOL. It was later discovered that Ms Howard had also sent a text message to a friend from Perth asking for help as she had taken an overdose of medication but the friend's phone was not working and the message was not received until much later.[79]

11.54. On 28 November 2013 Mr Gill learned that Ms Howard had passed away.[80] He does not believe that she intended to die and opined that the drug overdose was Ms Howard's way of looking for support and gaining access to a hospital. Her mother also does not believe that her daughter intended to end her life. On the contrary, she views the overdose as a desperate attempt by Miranda to get herself admitted to the RAH and to stay alive.[81]

---

[76] Exhibit C7, pages 19 - 20
[77] Exhibit C1c, page 21; Exhibit C7, page 20
[78] C71c, page 22
[79] Exhibit C1c, page 23
[80] Exhibit C7, pages 21-22
[81] Exhibit C1c, page 25

12. Summary for Aurora McPherson-Smith

12.1. On 25 September 2012 Ms McPherson-Smith's mother (Julie McPherson) arranged for her daughter to be referred to CAMHS. Aurora was then aged 15 years. The referral was triggered when the school advised that *Aurora had disclosed that she did not want to live*.[82]

12.2. The initial mental health assessment was done by a Mount Barker CAMHS case worker, Ms Hotich. Ms Hotich noted obsessive compulsive disorder (OCD) type rituals, deliberate self-harming and strong suicidal ideation with depressive moods. Cognitive Behaviour Therapy (CBT) sessions were commenced which included Aurora's parents. *In the first session she disclosed daily cutting behaviour and thoughts of suicide*. Aurora believed there was no cure for what she was experiencing.[83]

12.3. On 6 November 2012 a CAMHS psychiatrist, Dr Sue Shannon, conducted a review. *The diagnosis was depression with compulsive behaviours*. Sertraline (an antidepressant) was trialled and continued psychological therapy with Ms Hotich was recommended.[84]

12.4. On 8 September 2012 Ms McPherson-Smith presented to hospital with thoughts of stabbing herself. On 2 October 2012 there was a further presentation following an argument with her father and, in November 2012, she presented on consecutive days (10 and 11 November). *The diagnosis was 'situational crisis'*.

12.5. Between 6 and 10 December 2012 there was an admission to the Boylan Ward of the Women's and Children's Hospital (WCH). This ward is reserved specifically for adolescent mental health patients. Whilst at the Boylan Ward arrangements were made on discharge for Ms McPherson-Smith to have regular outpatient appointments with Dr Phil Brock, the outpatient psychiatry registrar.

12.6. Dr Shannon conducted a further psychiatric review on 29 January 2013. *By this stage Ms McPherson-Smith was reporting daily thoughts of suicide and said that she would eventually hang herself*. Dr Shannon concluded that the risk of suicide was not

[82] Exhibit C21, page 4
[83] Exhibit C43a, page 3
[84] Exhibit C43a, page3

imminent noting that the reports were incongruous with the reality that she was attending ballet most afternoons and continuing to enjoy this activity.[85]

12.7. On 4 February 2013 however, Ms McPherson-Smith took a large overdose of Paracetamol (225 tablets) which led to a lengthy admission of around six weeks in the Boylan Ward. *During this admission the self-harming behaviour increased.*[86] *On discharge the diagnosis was Major Depression*. It is noteworthy that by this time 15 sessions of CBT had delivered little benefit.

12.8. Thereafter Ms McPherson-Smith refused to continue the CBT sessions with Ms Hotich. She also refused further engagement with Dr Shannon. It was decided that a new CAMHS therapist would be allocated.

12.9. I turn now to consider the lengthy period of care under Ms Donna Broadhurst.

12.10. Ms Donna Broadhurst
A statement was provided to the Inquest.[87] Ms Broadhurst holds a Bachelor of Early Childhood (Hons), Bachelor of Arts (majoring in psychology) and a Masters in Social Work.

12.11. Ms Broadhurst was employed at the Mt Barker office of CAMHS between November 2010 and December 2014. Her primary role was to provide 'therapeutic services' to families and individual children.[88] She provided services to Ms McPherson-Smith and her parents from February 2013 to September/October 2014.

12.12. Ms Broadhurst met Aurora for the first time at the Boylan Ward on 7 February 2013. At this time she was under the care of Dr Phil Brock. During the early sessions on the ward, Ms Broadhurst's new client continued to threaten suicide. A notation made by Ms Broadhurst dated 8 April 2013 stated that *her self-harming has increased since the admission to Boylan Ward.*[89]

12.13. Ms McPherson-Smith resisted further CAMHS contact. In fact, she did not agree to meet with Ms Broadhurst at the CAMHS offices until 21 August 2013. In the interim

[85] Exhibit C43a, page 3
[86] Exhibit C43a, pages 20 - 21
[87] Exhibit C18
[88] Exhibit C18, page 2
[89] Exhibit C43a, page 4

period Ms Broadhurst provided support to Ms McPherson-Smith's parents and Dr Brock provided regular outpatient services.

12.14. From 21 August 2013 onwards Ms Broadhurst conducted weekly sessions with Ms McPherson-Smith at CAMHS and provided additional support visits at school, at home or at hospital. She continued to provide support to her client's parents, a decision which later proved problematic.

12.15. Various therapeutic techniques were trialled by Ms Broadhurst including psychoeducation, mindfulness, relaxation techniques, interactive drawing therapy, narrative therapy, CBT, motivational interviewing, interpersonal therapy and safety planning. On the available evidence it is unclear whether Ms Broadhurst had the qualifications and experience to effectively deliver these therapies. It is noted that she was not a qualified psychologist.

12.16. The pattern of ED presentations and admissions continued. I find that it was strikingly similar to the pattern of hospitalisation that occurred in Ms Howard's case.

12.17. Between 16 March 2013 and 15 May 2013 she presented to the WCH ED on seven occasions (16 March, 5 April, 9 April, 17 April, 19 April, 21 April and 15 May). *Five of the presentations followed self-inflicted lacerations*. Two presentations related to anxiety at school.[90]

12.18. Between 14 and 19 June 2013 there was an admission to the Boylan Ward. *Dr Brock noted the diagnosis of Major Depression with Anxiety* and Ms McPherson-Smith was discharged on Fluoxetine (40mg) and Quetiapine (25 mg).[91]

12.19. It is noteworthy that in a care plan dated 8 August 2013, Ms Broadhurst documented '*behaviours consistent with emerging Borderline Personality Disorder.*'[92] However, there is nothing in the evidence to indicate that these observations were communicated to Dr Brock or any other medical practitioner.

12.20. On 1 October 2013 Ms McPherson-Smith was admitted overnight to WCH ED *following a polypharmacy overdose*. A booklet explaining depression was provided to

---

[90] Exhibit C43a, pages 21 - 22
[91] Exhibit C43a, page 21
[92] Exhibit C43a, page 4

her parents. The evidence indicates that *no reference was made to the possibility of a BPD diagnosis.*[93] By November 2013 a regression in behaviour was noted.[94]

12.21. On 14 October 2013 Ms McPherson-Smith had a scheduled appointment with Dr Brock. He commenced her on another antidepressant, Venlafaxine, as the Fluoxetine had not been beneficial.[95]

12.22. On 21 October 2013 Ms McPherson-Smith's mother advised Ms Broadhurst that she and her husband were not happy with Dr Brock.[96]

12.23. It is plain that Ms McPherson-Smith's parents did not have a positive experience in Boylan Ward. Communication was described as very poor and the use of medications without explanation was distressing to them. As parents, the lack of feedback about Aurora's care and plans on her discharge was also distressing.[97]

12.24. Ms McPherson-Smith saw Dr Brock as an outpatient until November 2013. The appointments were mostly weekly (for approximately nine months). *However no clear diagnosis was made during this period*. Ms McPherson said that she lost confidence in Dr Brock and found him to be disrespectful to her and her husband.[98] He was also described as unreliable and some appointments were missed with no prior notification.[99]

12.25. On 18 November 2013 Ms McPherson-Smith was taken by ambulance and SAPOL to the WCH ED following aggression at home.

12.26. On 19 November 2013 the family was advised that Dr Brock was no longer available to see Aurora as an outpatient. *No meeting or reasonable explanation was offered for the sudden termination of Dr Brock's services*.[100]

12.27. By this stage Ms McPherson-Smith had developed a deep attachment to Ms Broadhurst. On one occasion (12 November) she refused to leave the office after her appointment and said 'What will you do if I kill myself tonight?' A few days later (15 November)

[93] Exhibit C43a, page 5
[94] Exhibit C43a, page 5
[95] Exhibit C43a, page 5
[96] Exhibit C43a, page 5
[97] Exhibit C21, page 7
[98] Exhibit C21, page 8
[99] Exhibit C21, page 8
[100] Exhibit C21, page 9

she asked Ms Broadhurst to attend her ballet concert and on a further occasion she asked Ms Broadhurst not to go to Melbourne for three days, claiming that she would die.[101]

12.28. The evidence indicates that after seeking advice within CAMHS, by 2014 Ms Broadhurst recognised that the therapeutic relationship was not working. The conflict of interest in seeking to support both Ms McPherson-Smith and her parents was apparent and she attempted (albeit belatedly) to put clear therapeutic boundaries in place.

12.29. On 12 February 2014 Ms Broadhurst advised Julie McPherson to seek a separate therapist.[102] This caused significant tension as she too had developed a level of reliance on Ms Broadhurst.[103] This tension was exacerbated by Julie McPherson's belief that in February 2013 Ms Broadhurst had provided her daughter with a USB stick to record the family at home without permission.[104]

12.30. On 1 April 2014 there was a phone call which Ms Broadhurst found particularly distressing. Ms McPherson-Smith had cut herself badly and they had a lengthy telephone conversation while she was self-harming and awaiting an ambulance. On admission to the WCH ED Ms McPherson-Smith was uncooperative and biting staff. *A psychiatrist confirmed a diagnosis of Borderline Personality Disorder.*[105]

12.31. On 3 April 2014 Ms Broadhurst sought to reinforce the new therapeutic boundaries by advising her client that if she received a similar phone call an ambulance and the police would immediately be called and the call would be terminated.

12.32. In light of the evidence it appears that this conversation led to three ED admissions at the WCH on three consecutive days (for suicidal ideation on 7 April, a polypharmacy overdose on 8 April and a suspected psychotic episode on 9 April 2014).

12.33. The instability and suicide threats continued. For example, on 12 June 2014 Ms McPherson-Smith told Ms Broadhurst that it was the last time that she would see her (seemingly a response to Ms Broadhurst taking one weeks' leave).[106]

---

[101] Exhibit C43a, pages 5 - 6
[102] Exhibit C43a, pages 6 - 7; N.B By late March 2014 Aurora's mother was attending the Sanctuary Support Group (a BPD carer's group).
[103] Exhibit C43a, pages 8 - 9
[104] ExhibitC43a, page 7; Ms Broadhurst stated that the USB stick was provided for the purpose of downloading some family conflict that Ms McPherson-Smith had already filmed.
[105] Exhibit C43a, page 8
[106] Exhibit C43a, page 8

12.34. *By July 2014 Ms Broadhurst was including DBT principles in therapy, but with little positive response*.

12.35. Significantly, *on 7 August 2014 Ms McPherson-Smith told Ms Broadhurst that she had been reading about the different degrees of skin burns*. *By this time her client had started to burn herself as a self-harming strategy*.[107] Her efforts at self-harm were becoming increasingly serious. The next day Ms Broadhurst advised her client that all sessions would be based in the CAMHS offices and not elsewhere. This upset Aurora who was no doubt confused by the changes.

12.36. The hospital admissions continued (on 11 August 2014 following alcohol intoxication and self-harm and on 12 August 2014 for alcohol intoxication and suicidal ideation).

12.37. On 21 August 2014 there was an admission to the WCH ED for self-inflicted burns. *The documented diagnosis continued to be Borderline Personality Disorder. Notwithstanding the diagnosis, no coordinated treatment plan was put in place*.

12.38. On 25 August 2014 Ms Broadhurst sought advice from Professor Jureidini. He suggested that she develop 'a more adult' relationship with her client. The case was subsequently discussed with Dr Cathy Ludbrook in anticipation of Aurora's transfer to adult services when she turned 18 years old. Dr Ludbrook agreed to take over care.[108]

12.39. Between 28 August 2014 and 18 September 2014 there was a lengthy admission to the Newland Ward (WCH) following a self-inflicted burn to a thigh with oil and boiling water. During this admission *Ms McPherson-Smith reported that she wanted to continue self-harming*.

12.40. In early September 2014 Professor Jureidini requested Dr Ludbrook to become involved sooner.[109]

12.41. <u>Dr Cathy Ludbrook</u>

On 18 September 2014 Ms McPherson-Smith was admitted to the RAH ED for *self-inflicted acid burns* and she remained in the WCH Burns Unit until 10 October 2014.[110] Dr Ludbrook first saw her new patient as a consultant.

---

[107] Exhibit C43a, page 8
[108] Exhibit C43a, pages 8 - 9
[109] Exhibit C19, page 4
[110] Exhibit C43a, pages 21-22

12.42. A threat to harm herself with scissors made on 8 October 2014 resulted in a fast tracked admission to The Adelaide Clinic (TAC) directly from the WCH Burns Unit. Dr Ludbrook assumed primary care.[111]

12.43. Dr Ludbrook is a senior consultant psychiatrist. She became a Fellow of the Royal Australian and New Zealand College of Psychiatrists in March 1996. A Certificate of Child and Adolescent Psychiatry from the College and a Graduate Diploma in Psychotherapy were conferred in 1998. Dr Ludbrook has wide experience and expertise in the field of psychiatry including four to five years as Psychiatric Registrar at the RAH, WCH, Hillcrest Hospital, Glenside Hospital and Carramar Mental Health Clinic (1991-1995), a period as a consultant psychiatrist at the WCH (1998-2000), involvement with youth services (2008-2011) and teaching positions. Currently Dr Ludbrook is self-employed in private psychiatry with consulting rooms at TAC. She teaches part-time at the WCH.[112]

12.44. I find that Dr Ludbrook is an expert in the field of psychiatry and has clinical expertise in the treatment of BPD.

12.45. On 30 September 2014 a conference was held with the deceased's parents and the medical team which included Ms Broadhurst and Dr Ludbrook.[113]

12.46. On reviewing the relevant discharge summaries, the past psychiatric history and current presentation*, Dr Ludbrook's opinion was that Ms McPherson-Smith was suffering from Borderline Personality Disorder. Even though a BPD diagnosis had been made in April 2013 it appears that this was the first time that an assertive management plan was put in place*.

12.47. Dr Ludbrook concluded that *her patient remained at significant risk of self-harm and that the risk would not be reduced by continued hospitalisation*.

12.48. From late October 2014 to early December 2014 outpatient therapy was provided. Ms McPherson-Smith attended all but one appointment. *Dr Ludbrook immediately applied recognised evidence based therapies for BPD*.

[111] Exhibit C43a, page 22
[112] Exhibit C19, pages 1 - 4
[113] Exhibit C43a, page 9

12.49. However, the therapeutic relationship was tenuous. Ms McPherson-Smith found it very difficult to talk about her feelings and inner world. Near the end of most appointments she would threaten to self-harm which *Dr Ludbrook said related to a difficulty with separation, even after a 50 minute appointment*. For example, in December 2014 she threatened to burn herself after learning that Dr Ludbrook was taking two weeks leave. On several occasions she mentioned the idea of burning her legs and abdomen and taking pills. On one occasion she spoke about a suicide note.

12.50. Between 10 and 28 October 2014 Ms McPherson-Smith was an inpatient at TAC. No evidence of major depression or psychotic disorder was noted. On the date of discharge Fluoxetine and Quetiapine were prescribed (to decrease arousal and impulsivity).

12.51. Between 4 December 2014 and 31 December 2014 *there was an admission to the RAH Burns Unit with severe chemical burns to the arm, shoulder and chest. During this admission Ms McPherson-Smith told staff that she intended to continue burning herself. She mentioned, for the first time, the idea of burning her throat by drinking acid.*

12.52. On 31 December 2014 she was transferred from the RAH Burns Unit to TAC and remained there until 24 February 2015. The original plan was for a two week admission. However, by this stage Ms McPherson-Smith was refusing to return home to stay with her parents.[114]

12.53. She was generally cooperative on the ward apart from one occasion when, after absconding, *she was subsequently located by police having purchased dry ice with the intention of burning herself.*[115]

12.54. Post-discharge on 24 February 2015 Ms McPherson-Smith returned to Catherine House where she had been staying since 20 January 2015. Her family was concerned about the decision to stay at Catherine House but continued to provide support.

12.55. On the following day SAPOL conveyed Ms McPherson-Smith to the RAH ED due to intoxication and self-harm (albeit superficial.)[116]

12.56. *Despite psychotherapy twice weekly and community mental health nursing support the situation continued to deteriorate*. On 20 March 2015, at the end of an appointment with Dr Ludbrook, Ms McPherson-Smith threatened to hurt herself. In the following

---

[114] By this stage the deceased was aware that she could legally leave home.
[115] Exhibit C19, page 10: Exhibit C43a, pages 22 - 23
[116] Exhibit C43a, page 23

week there was an escalation of comments regarding self-harm. Catherine House and the Community Mental Health nurse were notified.

12.57. In May 2015 Dr Ludbrook referred her patient to the Kahlyn Day Centre, and she began a ten week emotional management/mindfulness course.

12.58. On 2 April 2015 Ms McPherson-Smith left a note at Catherine House after packing and labelling her bags. Then she self-harmed *by burning herself badly on the back and stomach with dry ice* and attended at the RAH ED where she was admitted overnight.[117]

12.59. Between 3 and 7 April 2015 there was a further period as an inpatient at TAC with *reports of constant thoughts of self-harm*. On discharge to Catherine House twice weekly psychotherapy sessions with Dr Ludbrook continued, together with attendance at Kahlyn and regular review by a community nurse.

12.60. On the date of discharge (7 April 2015) Ms McPherson-Smith *rolled on dry ice on the floor of a public toilet which resulted in burns to her back, hands and abdomen*. This led to a readmission to the RAH ED. Surgery was required and Ms McPherson-Smith spent three weeks in the RAH Burns Unit.[118]

12.61. Due to the rigid interface between the public and private sector, *Dr Ludbrook was precluded from providing clinical care during these hospital admissions. Thus essential psychotherapy was interrupted*. On the date of discharge, 28 April 2015, the treatment plan was for Dr Ludbrook to continue psychotherapy twice weekly together with ongoing community nurse involvement and attendance at Kahlyn.

12.62. On 4 May 2015 Ms Ranieri (Catherine House) states that an intake interview was conducted with the deceased by telephone but there were no vacancies.

12.63. Ms McPherson-Smith attended her appointments with Dr Ludbrook on 1 and 5 May 2015. However, on 5 May 2015 she refused to take part in the session unless Dr Ludbrook ceased ongoing contact with her parents. Dr Ludbrook would not agree to this demand and reminded her patient of their previous agreement in this regard. Ms McPherson-Smith walked out of the session.

[117] Exhibit C27, page 19
[118] Exhibit C43a, page 23

12.64. On 7 May 2015 she cancelled the next appointment. Dr Ludbrook advised her mother of the cancelled appointment and attempted to re-schedule it without success.

12.65. On 19 May 2015 Dr Ludbrook tried telephoning her patient but there was no answer. On 21 May 2015 there was successful contact by telephone. However, Ms McPherson-Smith continued the demands for contact with her parents to cease. She threatened to self-harm if Dr Ludbrook continued such contact. She then terminated the call. On the following day they spoke briefly by telephone again. On this occasion Ms McPherson-Smith said ‘I’ve gotta go’ and hung up the phone.

12.66. On 27 May 2015 Dr Ludbrook received an email from Ms McPherson-Smith asking her to call. During a subsequent email exchange Ms McPherson-Smith declined an invitation by Dr Ludbrook to meet because Dr Ludbrook was still seeing her parents. During this exchange Ms McPherson-Smith asked Dr Ludbrook what she would say if she knew she would never see her again. Dr Ludbrook replied that she hoped to see her again.

12.67. Ms McPherson-Smith made a further appointment for 3 June 2015. It had been almost one month since Dr Ludbrook had seen her. Five further sessions followed during June 2015. During these sessions Ms McPherson-Smith spoke intermittently about her inner world, *but she did not know why she was severely harming herself.*

12.68. *On 23 June 2015 she likened herself to a dead tree*.[119]

12.69. On 26 June 2015 (the last appointment) Dr Ludbrook said that she had become ‘more closed again’ and found it difficult to speak about her emotions and thoughts. Further self-harming was foreshadowed without any reference to specific plans.

12.70. An appointment was arranged for Tuesday, 30 June 2015 but on 29 June 2015 it was cancelled by Ms McPherson-Smith. Dr Ludbrook was subsequently advised of her death.

12.71. During the police investigation a number of items were seized from Ms McPherson-Smith’s handbag including receipts and a handwritten note. The police also examined her VISA debit card transactions.

---

[119] Exhibit C19, page 16

12.72. By reference to this information it was established that on 26 June 2015 a purchase in the amount of $6.00 was made at Bunnings Warehouse located at 66 Rundle Street, Kent Town. Hydrochloric acid is sold at Bunnings Warehouse in various sizes. A 500ml bottle retails for $6.00. This size bottle, along with 1L bottles, are sold on open shelves in the pool chemical section and the products are accessible to the public. The larger 4L and 10L bottles are kept in a locked secure cabinet and can only be accessed by staff members.

12.73. At 10:02am on 30 June 2015 a bottle of Gatorade had been purchased.

12.74. At 12:20pm Aurora had lunch with her father in the food court area of the Central Market on Gouger Street, Adelaide.[120]

12.75. At around 2:40pm on 30 June 2015 a 700ml bottle of Petrovska Vodka was purchased from the Thirsty Camel Bottle Shop at 18/19 Bank Street, Adelaide in the amount of $28.99. It was further established that at 4:07pm on 30 June 2015 a purchase of six packets of dry ice totalling $83.94 was made from the Caltex Star Mart Service Station located at 144 Hutt Street, Adelaide. Payment was made by a Visa debit card.

12.76. At 3:30pm she met with Ms Ranieri to sign some housing documents (for an application to Housing SA). Ms Ranieri said she seemed positive and happy.[121] They met for approximately 10 minutes. After completing the documents Ms Ranieri gave her a map and directions to Housing SA. She did not see Aurora again.

12.77. A further item of evidence relating to the deceased's state of mind on the afternoon of 30 June 2015 was a double sided handwritten note. The first page read:

> 'God, forgive me his name shall not be written in life his was own but in death, no, his power no longer reigns. The hope is for eternal embrace and without Gods approval this is done, I have total reassurance. The flicker of doubt is menacing but my faith is ever present. Please God reassure me, forgive me, save me. Aurora.'[122]

The rear of the note read:

> 'Everything in my bank account can go to my sponsor child Sophie Afi. Please contact – 0423 868 322 0403 925 783 and my Dad 0402 211 486 to inform them of my death.'

[120] Exhibit C13b
[121] Exhibit C17
[122] Exhibit C27c

12.78. The inference which is clearly open to be made from the circumstantial evidence is that after lunching with her father, Aurora purchased the bottle of vodka and dry ice. It is also open to infer that she had purchased a 500ml bottle of hydrochloric acid on 26 June 2015.

12.79. I am satisfied that when Ms McPherson-Smith went to the public toilet block at Rymill Park on 30 June 2015 she did so with the intention of ending her own life. This conclusion is reinforced by the presence of the note in her handbag which I find to be a suicide note.

12.80. As previously stated, later that evening Jonathan Smith reported his daughter as missing and she was located by the police at Rymill Park in circumstances which have already been described.

13. Expert evidence and opinion of the medical care provided to Miranda Howard and Aurora McPherson-Smith

13.1. Evidence of Dr Maria Naso

Dr Naso is a Specialist Psychiatrist and a Fellow of the Royal Australian and New Zealand College of Psychiatrists since 2002. Her current role is Senior Consultant Psychiatrist in charge of the consultation liaison service of the Modbury Hospital. Predominately Dr Naso works in the Emergency Department. The work includes teaching interns, registered medical officers as well as the psychiatric registrars, ED doctors and nursing staff. She has particular expertise and experience in the diagnosis and management of Borderline Personality Disorder.[123]

13.2. I find Dr Naso to be an expert in the field of psychiatry and in the diagnosis, management and treatment of Borderline Personality Disorder.

13.3. In Dr Naso's opinion, these cases highlight chronic problems in the treatment of BPD in South Australia. Firstly, there is the issue of misdiagnosis and delays in treatment. Secondly, due to the complexity of BPD and the input required, it is very difficult to find clinicians to take on these patients. Thirdly, Dr Naso cited the issue of inexperience. Fourthly, in South Australia there is no consistent practice or approach to the treatment of BPD.

[123] Exhibit C43b; Transcript, pages 30 - 33

13.4. Dr Naso was not unduly critical of any individual medical practitioner or health professional. Rather, the core criticisms were directed at systemic issues regarding the treatment of BPD in South Australia.[124]

13.5. The salient features of Dr Naso's opinion regarding the care provided by Dr Berce can be summarised as follows:[125]

> 'Dr Berce worked in a dedicated manner but her initial diagnosis of schizoaffective disorder was a misdiagnosis.[126] The clues that the diagnosis was incorrect were that Ms Howard did not respond to a number of different antipsychotics, antidepressants and mood stabilisers. Other clues were the inconsistencies of the 'psychotic symptoms' and the incongruous behaviours while stating that she was depressed.' [127]

13.6. Dr Berce continued to prescribe medications even though it was clear that they were ineffective, compliance was variable and there was a history of overdoses. Once her patient had taken an overdose Dr Naso said that it would have been prudent to no longer prescribe any medications since the risks outweighed any benefits.[128]

13.7. Dr Berce continued to admit Ms Howard to hospitals even though she herself documented that past admissions had been counterproductive.[129] Once the diagnosis of BPD was made the hospital admissions should have been no longer than three days with discharge back to DBT in the community so as not to interrupt essential therapy.[130]

13.8. Dr Naso opined that Dr Berce found treating Ms Howard complex and frustrating. Once she began getting frustrated, Ms Howard's care should have been fully transferred to the public sector.

13.9. As to the sudden termination of her services, better practice was to explain to Ms Howard (over several sessions) why their therapeutic relationship had reached the end of its purpose. Dr Berce should have continued management until Ms Howard had transitioned to another primary therapist.[131]

---

[124] Exhibit C43, page 34
[125] Exhibit C43, pages 23 - 25;
[126] C43, page 23
[127] Exhibit C43, pages 30-31
[128] Exhibit C43, page 24
[129] Exhibit C43, page 7
[130] Exhibit C43, page 33
[131] Transcript, page 88; Exhibit C43, page 25

13.10. Dr Naso noted with approval that Mr Gill (ECMHS) had begun to form a therapeutic relationship with Ms Howard and he followed manualised DBT principles. He was the only individual therapist who appeared to apply DBT as a primary therapy.

13.11. Dr Naso said that Ms Howard ought to have been taken back into the public sector, if not on 30 September 2014, at least on 4 October 2014, on receipt of Dr Galletly's letter. It was not suggested that early resumption of care in the public sector would have changed the ultimate outcome.

13.12. The decision to cease communication with Ms Howard's mother was considered to be reasonable. If Ms Howard could not trust Mr Gill (on account of his communication with her mother) then she would not benefit from the treatment she needed most.[132]

13.13. Dr Naso opined that that it was not entirely clear whether Ms Howard committed suicide or if her death was from misadventure. She had taken a similar overdoses before and had survived. At the same time, even after completing a full course of DBT, it was noted that Ms Howard could not imagine her life without self-harming.

13.14. Dr Naso concluded that if Ms Howard had access to consistent care, there is the possibility that her death would have been prevented.[133]

13.15. I turn now to discuss Dr Naso's opinion of the care provided to Ms McPherson-Smith. Primary care was provided by Ms Donna Broadhurst. Dr Naso noted that Ms Broadhurst was able to develop a therapeutic relationship with her client in circumstances where other therapists were unable to do so (eg Ms Hotich and Dr Shannon). Ms Broadhurst was highly motivated and truly had her client's best interests in mind.

13.16. That said, she was inexperienced. A number of problems arose from this inexperience. Firstly, Ms Broadhurst attempted to discharge the dual role of primary therapist to Ms McPherson-Smith as well as supporting her parents. Secondly, there was a failure to set clear therapeutic boundaries.

13.17. Dr Naso emphasised the need for boundaries with all patients. In patients with BPD they are vital because the individual with BPD has core issues and struggles with

[132] Exhibit C43, pages 27 - 28
[133] Exhibit C43, pages 35 - 36

boundaries. By maintaining consistent boundaries, over time, the patient will develop a sense of safety and trust in their therapist. It is in this relationship that changes can be made and self-harming can hopefully substituted with adaptive ways of dealing with emotional control.[134] The boundaries must be set at the start of therapy 'otherwise the typical scenario is that the patient controls the sessions with their moods and the therapist becomes the rescuer'.[135]

13.18. In Dr Naso's opinion this is precisely what occurred. Ms McPherson-Smith tried to control the therapy sessions and Ms Broadhurst 'fell into the trap' of consistently reassuring her client through excessive SMS contact and during therapy. Thus the client formed a very a strong attachment and unfortunately she developed a reliance on Ms Broadhurst for continued, and ultimately unsustainable, reassurance and emotional regulation.

13.19. These important boundaries were blurred for a significant period of time. It was not surprising that when Ms Broadhurst subsequently tried to implement clear boundaries she was met with a large amount of resistance.[136]

13.20. According to Dr Naso the situation was compounded by Ms Broadhurst providing her work mobile telephone number to her client and her parents. Dr Naso noted over 300 contacts from Ms Broadhurst to her client. These contacts did not include SMS messages and voicemails. In Dr Naso's opinion it is absolutely impossible for a therapist to maintain this level of intervention without exhaustion, burnout and negative countertransference setting in.

13.21. Dr Naso acknowledged that Ms Broadhurst was the first to document, 'emerging borderline personality traits'. However, in her opinion it was not an emerging disorder, but a severe and complex presentation of the disorder.[137]

13.22. Even after Ms McPherson-Smith had been diagnosed with BPD, it was noted that no Crisis Management Plan was put in place. All high risk patients should have a Crisis Management Plan.

[134] Exhibit C43a, page 12
[135] Exhibit C43a, page 12
[136] Exhibit C43a, page 12
[137] Exhibit C43a, page 11

13.23. In summary, Dr Naso said that reinforcing maladaptive behaviours is something which regularly occurs from health workers who, though well-meaning, are unaware of the complexities of self-harming dynamics.

13.24. I turn now to Dr Naso's opinion of the care provided by Dr Ludbrook. Dr Naso praised Dr Ludbrook's efforts stating that she offered her patient all available resources necessary to treat BPD. It was noted with approval that Dr Ludbrook set clear boundaries at the outset of treatment, mentalisation therapy was applied, a referral was made for DBT, community nurse support was provided and a Crisis Management Plan was put in place.

13.25. There was no criticism made regarding the continuation of prescription medication as this was done in the context of a therapeutic relationship and on a trial basis.[138]

13.26. Despite the excellent treatment plan, Dr Naso noted that essential psychotherapy was interrupted for significant periods of the time while Ms McPherson-Smith was hospitalised either in a burns unit or at The Adelaide Clinic.

13.27. As to the position taken regarding the monthly reviews with her parents, Dr Naso said that if Dr Ludbrook had been aware that her patient was continuing to see Ms Broadhurst she may not have taken such a firm position. On this issue I find it difficult to conclude, even with the benefit of hindsight, that it was too rigid. It is true that the stance taken appeared to make it easier for the Ms McPherson-Smith to disengage, but Dr Ludbrook had the difficult task of balancing the wishes of her patient and the need to protect her safety by maintaining the flow of critical information from her parents. She made a judgment call and I find no basis to criticise that decision.

13.28. Dr Naso concluded that it could not be predicted with any certainty if earlier engagement with Dr Ludbrook would have changed the ultimate outcome. In Dr Naso's opinion the risk of Ms McPherson-Smith ultimately ending her life was greater than 10% by reason of her high risk behaviours, regular intoxication and her consistent refusal to cease self-harming. Ms McPherson-Smith had maintained throughout that she would end her own life.[139]

---

[138] Exhibit C43a, page 19
[139] Exhibit C43a, pages 19- 20

13.29. Evidence of Dr Martha Kent OAM

Dr Martha Kent OAM is a Specialist Psychiatrist, a member of the Royal College of Physicians of the UK and Fellow of the Royal Australian and New Zealand College of Psychiatry.[140] Dr Kent's experience in psychiatry is extensive in both the public and private sectors and includes regular teaching and training of psychiatrists in South Australia. A particular area of specialisation is the assessment and treatment of women with Borderline Personality Disorder. Dr Kent is Patron of the Sanctuary Carer Support Group, a support group for carers of people who suffer from BPD.

13.30. In 2010 Dr Kent was appointed as Chair of the SA Borderline Personality Work Group and in 2011 she was appointed as a member of the national BPD expert reference group to advise the Federal Government on BPD services Australia-wide.[141]

13.31. In 2014 Dr Kent formed part of a research team which aimed to assist GP's in the assessment, treatment and management of BPD. In 2016 Dr Kent was appointed as Chair of the South Australian BPD Foundation (an Australia-wide organisation which seeks to increase awareness and understanding of BPD). In 2017 Dr Kent was awarded the Medal of the Order of Australia for services to medicine.[142] I regard Dr Kent OAM as an expert in the field of psychiatry and in the diagnosis, management and treatment of BPD.[143]

13.32. I turn now to Dr Kent's evidence regarding the care and medical management of the deceased.

13.33. Dr Kent described Dr Naso's overview reports as excellent in quality. Apart from minor differences of opinion, Dr Kent agreed with their contents. Her evidence focused on systemic issues.

13.34. Overall, Dr Kent concluded that neither Miranda Howard nor Aurora McPherson-Smith received 'good enough specialised care'. In Ms Howard's case Dr Kent's impression was that the service providers were becoming 'more and more desperate, nothing seemed to work'.

---

[140] Exhibit C44; Transcript, pages 123 - 132

[141] Refer Exhibit C44, '*Borderline Personality Disorder: An Overview of Current Delivery of Borderline Personality Disorder Services in the Public Sector across South Australia and a Proposed Way Forward (June 2014)*

[142] Transcript, page 132

[143] Transcript, pages 30 - 33

13.35. Dr Kent's opinion was that Ms McPherson-Smith's case highlights the difficulties for adolescents in South Australia. The reluctance to diagnose BPD in adolescents and the significant delay in diagnosis were described as troubling because a delay in diagnosis is a delay in effective treatment.[144]

13.36. As to diagnosis of BPD in adolescents, Dr Kent said that the literature is fairly clear that 'you can distinguish between BPD in teenagers and stormy days with teenagers.'[145]

13.37. Dr Kent applauded the system of care provided by Spectrum service in Victoria and Project Air in New South Wales. The public health system in South Australia, on the other hand, was described as 'too rigid and too inflexible and silo driven to respond flexibly to the needs of BPD patients'[146] The short term focus which is routinely offered in South Australia is unsuitable for patients with severe Borderline Personality Disorder. Dr Kent described the notion that timely and appropriate care is offered to people with BPD in the public system as 'a nonsense'.[147] One example given was an occasion when Ms Howard's case was closed because she hadn't harmed herself for three weeks. This decision was described as 'astonishing' and as 'covertly inviting further self-harm'. It was not surprising she said that Ms Howard harmed herself again and her case was re-opened.[148] In Ms Howard's case multiple workers were involved over time including psychologists, psychiatrists, public mental health service clinicians, Kahlyn staff and workers at accommodation centres such as Youth 110.

13.38. There was inconsistent access to acute crisis care services. Admissions were refused one day (such as to an Intermediate Care Centre) and then shortly after agreed to.[149] When Ms Howard was not staying with her parents Southern ACIS closed her case and referred her to the Eastern Mental Health Service 'so she had to start all over again in a whole new system'.[150] In such circumstances integrated and coordinated care cannot occur.

13.39. As to accommodation, Dr Kent highlighted the problems which arise from the lack of skilled supportive accommodation for BPD sufferers.[151]

---

[144] Transcript, page 173
[145] Transcript, page 173
[146] Transcript, page 159
[147] Transcript, page 160
[148] Transcript, page 169
[149] Transcript, page 170
[150] Transcript, page 170
[151] Transcript, page 172

13.40. As to the care provided by individual medical practitioners, in both cases, Dr Kent's evidence reinforced and supported the evidence and opinions given by Dr Naso.

13.41. Dr Kent described Dr Berce as an example of a well-motivated practitioner, but an example of how 'even people who are well motivated to offer care also become exhausted and depleted and hopeless and despairing and in that context they often act in a hostile fashion towards the patient…' Dr Kent said this is common when people do not have the skills or the interest to offer an assessment or care of people with BPD.

13.42. After Dr Berce terminated her services it was noted that no suitable psychiatrist could be found to care for Ms Howard in the private or public mental health system. This led to a 'suite of serious consequences' including Ms Howard's preclusion from essential therapy at Kahlyn. In Dr Kent's opinion Ms Howard was left 'high and dry and stranded without the usual supports…'.[152]

13.43. Dr Galletly's recommendation of transfer to the public health system was acknowledged, but this was described as 'in the realm of wishful thinking rather than reality-based because the public mental health system wasn't able to give her the flexible, sensitive care she needed.'[153]

13.44. As to the care provided by Mr Gill, Dr Kent's view was that he tried but the rest of the system could not be fashioned around his intensive (and appropriate) therapy plan.

13.45. According to Dr Kent, the 'very major issue' in Ms McPherson-Smith's case was Ms Broadhurst's apparent lack of skill and experience to manage a client with such complex needs. She was clearly well-intentioned and very committed to her client, but the lack of skill was demonstrated by 'the significant boundary issues' which continued throughout the period of treatment. Dr Kent described these transgressions as understandable 'but not very skilful'.[154]

13.46. Dr Kent suspects that Ms Broadhurst was desperate to develop rapport with her client. However, it was postulated that she became somewhat intimidated by her client's threats to harm or kill herself and 'lost the sense of boundary perspective in that

---

[152] Transcript, page 171
[153] Transcript, page 172
[154] Transcript, page 151, 173

process.'[155] The decision to offer care simultaneously to Ms McPherson-Smith and her parents was a patent conflict of interest. It simply could not work.[156]

13.47. Dr Kent expressed concern that although Ms Broadhurst was allegedly having supervision by a senior clinician, it was clearly 'not successful because the boundary incursions continued throughout.'[157] Ms Broadhurst was commended for making efforts to change the boundaries. However, her attempts 'simply threw a spanner in the works.'[158] It was confusing for Ms McPherson-Smith and her family who presumably experienced it as some sort of rejection and abandonment.[159]

13.48. Dr Kent's evidence as to the fundamental importance of boundaries mirrored the evidence given by Dr Naso. Put simply, the effect of her evidence was that without boundaries in place one cannot deliver good care.

13.49. A further difficulty identified by Dr Kent was Ms McPherson-Smith's transition to adult care. Efforts were made to address this transition but 'one would have to say it didn't work very well'.[160]

13.50. No criticism was made of Dr Ludbrook's care.

13.51. Dr Kent concluded that it is at the severe end of the spectrum of BPD where the services in South Australia seem to be the most sub-optimal:

> 'These people have the greatest need, clearly, are at the greatest risk of suicide and self-harm…and yet the services that they need are simply inadequate to their requirements.' [161]

13.52. Having carefully considered the unchallenged expert evidence given by Dr Naso and Dr Kent as to the medical management and treatment of the deceased, I have no hesitation in accepting their evidence in its entirety.

13.53. In the course of their evidence Dr Naso and Dr Kent canvassed a range of specific matters relating to the diagnosis and treatment of BPD. I turn now to those matters.

[155] Transcript, page 173
[156] Transcript, page 173
[157] Transcript, page 174
[158] Transcript, page 174
[159] Transcript, page 174
[160] Transcript, pages 173 - 175
[161] Transcript, page 146

14. Diagnosis of Borderline Personality Disorder

14.1. On the topic of the diagnosis of BPD, the thrust of the expert evidence was that any failure to identify BPD or a delayed diagnosis is very serious indeed. When BPD is left untreated maladaptive behaviours develop. In a condition which is characterised by chronic suicidal ideation and self-harming, the consequences of misdiagnosis and/or a delayed diagnosis are life-threatening.

14.2. One of the issues which causes diagnostic confusion is that when highly stressed, BPD patients can go into dissociative states and they will describe visual and auditory hallucinations as well as delusional beliefs.[162] To compound matters there has been an historical reluctance by psychiatrists to avoid the label of BPD, in a misguided effort to protect the patients from stigmatisation.

14.3. The experts agreed that the reluctance to diagnose BPD is more pronounced in relation to adolescents. Some clinicians avoid the label in the hope that during this time of emotional transition the adolescent may ultimately no longer fulfil the diagnostic criteria. Yet there is 'solid evidence that the diagnostic criteria for BPD are as reliable, valid and stable in adolescents as they are in adults.'[163]

14.4. The evidence has established that misdiagnosis occurred in both cases and I so find. I further find that by the time the deceased were diagnosed with BPD, both had developed entrenched maladaptive behaviours and were using self-harm (and the ED hospital admissions which followed) as a means of alleviating their internal distress.

15. Role of medication in the treatment of Borderline Personality Disorder

15.1. I turn now to the evidence regarding the role of medication in the treatment of BPD. The expert evidence, which I accept, was that no medication has been approved for the treatment of BPD. However, most if not all patients end up on medication.[164] That was certainly the case for Ms Howard and Ms McPherson-Smith.

---

[162] Exhibit C43, page 30; Transcript, page 42
[163] Exhibit C43a, page 26; Transcript, page 173; see also National Guidelines
[164] Exhibit C43, page 32; Transcript, page 172

15.2. If a medication is to be trialled it should be done within a therapeutic relationship framework, be time-limited and always with just one person (ie the primary therapist) in charge of supplying prescriptions.[165]

15.3. In Dr Naso's opinion, once a patient overdoses the medications should be ceased.[166] Dr Kent's evidence differed on this point. Dr Kent described medication as a 'sensitive issue' but her opinion was that the reality is that BPD patients usually do need some medication at least to modify and ameliorate some of their intense symptoms (eg depression, anxiety, obsessive compulsive disorder and psychosis).[167]

15.4. In light of the evidence, I am satisfied that the risk of dangerous polypharmacy was evident in both cases.[168] Ms Howard, for example, was able to stockpile medication. Her mother had noted this well before her daughter's tragic death.

15.5. That said, I am satisfied that there is a role for medication in the treatment of BPD, namely to provide symptom relief (eg for comorbid depression, anxiety or mood swings) and in this respect I prefer the evidence of Dr Kent.[169]

16. Role of hospitalisation in the treatment of Borderline Personality Disorder

16.1. I turn now to the role of hospitalisation in the treatment of BPD.

16.2. The effect of the evidence of both experts, which I accept, was that with the exception of short 48/72 hour crisis admissions, hospitalisation simply does not work.[170] Even short hospital admissions need to be goal directed and focused on therapy such as DBT (and/or similar therapies). If the hospital stay is too long there is regression and any level of resilience that has been gained in the community seems to be lost.[171] I accept the expert evidence that hospitalisation should play a limited role in the treatment of BPD.[172]

16.3. While hospitalisation may provide a sense of security (to the patient and their family) the experts agreed that standard psychiatric admissions reinforce maladaptive

---

[165] Exhibit C43, page 32
[166] Exhibit C43, page 32
[167] Transcript, pages 172 - 173
[168] Exhibit C43, page 32; Transcript, page 173
[169] Transcript, pages 172 - 173
[170] Exhibit C43, page 32; Transcript, pages 46 - 47, 85
[171] Exhibit C43, page 33; Transcript, page 77
[172] Exhibit C43, page 32; Transcript, pages 46 - 47; see also page 80 and short term admissions to Intermediate Care Centres

behaviours and cause patients to regress. The sufferers become virtually addicted to self-harming to control their mood. I find this to be so in both cases.

16.4. Dr Naso and Dr Kent were at pains to point out that standard psychiatric hospitalisation does not involve psychotherapy. The evidence was plain, namely, that hospitals do not provide the very therapies that are so essential for recovery. Indeed, periods of hospitalisation interrupt that therapy.

16.5. Dr Naso believes that patients with BPD are admitted to hospitals mostly out of inexperience and fear. No doctor wants to be the last one to see a patient who then commits suicide. The practice of 'defensive psychiatry' was described as very real.[173] This opinion is supported by the evidence. On several occasions threats of suicide led to immediate inpatient admissions being arranged by the clinician.

16.6. In summary, the experts were unified in their view that prescription medications, periods of hospitalisation and short-term crisis management in hospitals are simply inadequate tools with which to address the core of the problem.

17. Evidence based therapies for the treatment of Borderline Personality Disorder

17.1. The Court heard that the primary aim of psychotherapy (group and individual) is to assist the sufferer to develop the insight and skills to manage their own intense moods and to change their focus over time from thinking about suicide, death and wanting to die, to reasons to live. By maintaining solid, consistent boundaries within the group and in individual therapy, the patient can develop ways of dealing with their internal moods rather than relying on external sources (such as acting-out, self-harming, parasuicide and presentations to hospital ED's).'[174]

17.2. Dialectical Behaviour Therapy was described by both experts as a well-researched evidence-based treatment for BPD.[175] Dr Kent was instrumental in setting up the first DBT group in Adelaide.[176] DBT can be conducted in individual and group sessions. Best practice is for the patient's family to be referred to support services while the patient undergoes therapy. The group sessions usually comprise two sessions of 2½ hours each week over 40 weeks (one module). After a module is completed patients

---

[173] Exhibit C43, page 33
[174] Transcript, pages 51 - 56, 80 - 81
[175] Transcript, page 126
[176] Transcript, page 126

can attend 'booster' sessions to reinforce the skills they learned during the module. In severe presentations of BPD effective treatment requires highly trained and experienced clinicians. The most severe patient usually requires two modules of DBT. With individual DBT, usually one hour per week with an individual therapist is required.[177]

17.3. In South Australia however, Dr Naso said it is very difficult to access group DBT in the private and public sector. In the public sector there is a huge waiting time. By way of example Dr Naso saw a patient at the beginning of 2017 but DBT was not available until early 2018.[178] In my view it follows as a matter of logic that effective treatment of the patient is obviously compromised by such delay.

17.4. Dr Naso mentioned that in the early 1990s there was a day hospital at Glenside or Hillcrest. This hospital was directed fully toward patients with BPD. The patients attended the hospital and spent the day learning various psychological techniques and behavioural techniques. They would then go home in the evening. Dr Naso said that South Australia has not had such a facility for 20 years[179]. I find this to be a regrettable state of affairs.

17.5. Dr Kent pointed to other evidence-based treatment therapies which, successfully applied, produce a similar improvement. These therapies include Mentalisation-Based Therapy (MBT), Commitment and Acceptance Therapy (CAT), Transference Focused Therapy (TFT) and Cognitive Behaviour Therapy (CBT).[180] Dr Kent says that flexibility is the key. While DBT was acknowledged as an effective treatment for BPD, Dr Kent said that in Adelaide, when it is used, DBT is 'almost a mono-culture' to the exclusion of other equally effective therapies.

17.6. In light of the evidence I am persuaded that these essential therapies are not available to BPD patients during periods of hospitalisation and that access to them in the community is limited and spasmodic.

---

[177] Transcript, page 56, 89
[178] Transcript, pages 148 - 149
[179] Transcript, page 46
[180] Transcript, page 149; Dr Naso's opinion was that while CBT has excellent evidence base for the treatment of major depression, anxiety disorders, obsessive compulsive disorder and panic disorders, it is less useful for patients with BPD.

18. Are there enough skilled clinicians in South Australia for the treatment of Borderline Personality Disorder?

18.1. I turn now to the evidence of Dr Naso and Dr Kent about the availability of experienced BPD clinicians in South Australia.

18.2. The combined effect of the unchallenged expert evidence was that there is ‘a very real issue’ in South Australia around lack of experienced BPD clinicians, most especially in respect of severe presentations. It is difficult for clinicians to gain experience and thus to source experienced clinicians to work directly with patients who have the severe spectrum of the disorder.[181]

18.3. Dr Naso and Dr Kent agreed that accurate diagnosis requires experience. The issue is vital because well-meaning, but inexperienced, clinicians can make the situation worse.[182]

18.4. Dr Kent acknowledged that there are many people who are trying their very best to do a good job, but she said the system does not serve them well. Furthermore, due to the input required and the demands of providing care for BPD, mental health clinicians require mentoring, ongoing training and peer support which is sadly lacking in South Australia.

18.5. Overall Dr Naso described the treatment of BPD in South Australia as inconsistent, chaotic and under-resourced. Dr Naso said that she and her colleagues would ‘welcome with relief’ a service modelled on Victoria’s Spectrum Personality Disorder Service.’[183]

18.6. Dr Kent acknowledged the good work that is done by some people, both in the public and private sectors. Some are highly trained and offer tailored evidence-based care.[184] However, leaving aside these pockets of excellence, Dr Kent described the system of care in South Australia as ‘a dog’s breakfast’.[185]

18.7. The combined effect of the expert evidence was that the system for treatment of BPD in South Australia is underfunded, uncoordinated, inconsistent and lacking in

---

[181] Exhibit C43a, page 27; Transcript, page 44
[182] Exhibit C43, page 31
[183] Exhibit C43a, pages 26, 28; Transcript, page 50
[184] Transcript, page 142
[185] Transcript, pages 142 - 143

specialised and sustainable training, education and support of clinicians.[186] In rural South Australia it appears that there are large areas where there are virtually no, or at best, very basic services for BPD.

18.8. The expert evidence can be described as a damning assessment of current services in this State for BPD.

19. Families and carers

19.1. Both experts acknowledged the enormous daily degree of stress that BPD inflicts on families, carers and loved ones.[187] Dr Kent observed that it is the families who bear the burden on a daily and hourly basis, much more than the mental health service. Dr Naso described the treatment of BPD as a frightening area for clinicians and even more frightening for the family.[188]

19.2. In Dr Kent's experience the families, carers and loved ones often feel helpless to intervene productively in the distress and self-harming behaviours of their children and loved ones and they also feel immense frustration at not being able to get the services that they believe would help.[189]

19.3. Presently there is no service in South Australia where families can gain professional advice. There is a support service only.

19.4. Dr Kent opined that families and carers must be acknowledged and welcomed as an integral part of the care system for people with BPD because it is the families who are the experts in the behaviours. They must be included.

19.5. The inclusion of families is a complex matter which requires striking a balance between the patient's hostility towards parental involvement and the patient's own safety. Even if the patient insists that the family must not be engaged in sessions, Dr Kent advocated for families to have the means to communicate as freely as they need to with the caregivers, even if it is in the form of an e-mail.

[186] Transcript, pages 155 - 156,159
[187] Transcript at page 142;
[188] Transcript at page 49
[189] Transcript at pages 142-143, 163; N.B The statements of Robyn Pettigrew, Julie-McPherson and Jonathan Kent Smith provide a compelling first-hand accounts of the frustrations and complexities for families of BPD sufferers-refer Exhibit C1c, Exhibit C 21 and Exhibit C13b

19.6. Dr Naso considers it to be essential for patient safety for carers to have access to updated information and that, arguably, this need trumps notions of confidentiality.[190]

19.7. The frustration felt by families who seek to engage with the mental health system is reflected in statements made by the mothers of both of the deceased. Ms Howard's mother stated *inter alia*:

> 'I feel extremely disappointed, upset and frustrated with the mental health system and the processes in place for exchanging information between agencies… The mental health system failed Miranda multiple times. The mental health system is fragmented and uncoordinated and uncaring in so many ways. I personally have been spoken to in a disdainful and accusing tone by ACIS, The Adelaide Clinic and Eastern ICC.
>
> I continuously fought for Miranda but could not win when up against the chaos which is the mental health system. Nigel and I never stopped loving Miranda despite the way she treated us at times. If Miranda had any other illness she would not have been left untreated and it would not have been my responsibility to find her the help she needed. I believe the inadequacy of all sectors of the mental health system including the public sector, private sector, hospitals and emergency departments must be held primarily accountable for Miranda's death. Each sector within the mental health system always wanted some other sector to take over responsibility for Miranda. It was subsequently left up to me to get Miranda the help she needed but it was impossible for one person to do this despite the fact that I never stopped trying.'[191]

Ms McPherson-Smith's mother stated *inter alia:*

> 'We went through so much with Aurora, there is so much we kept from family members to protect them, including my mother and brother who were very close to her, along with her sister Cordelia. Cordelia (now 16) has been exposed to so much and will have been affected in many ways. We had a completely loving, caring and seemingly normal daughter whose life through mental illness turned into a complete horror, a nightmare that no parent would want their child to go through. We could see she was in so much pain and it broke our hearts…
>
> We felt we were excluded and unsupported through most of it…We had no sense of feeling like anyone knew what they were doing with our daughter. It was confusing, uncoordinated and unprofessional, giving us no confidence in her care-with the exception of Dr Ludbrook who didn't have Aurora for long…
>
> It is my hope for the near future that SA will eventually be able to have a state specialist facility for BPD like 'Spectrum' based in Victoria, Melbourne.
>
> She was trying so hard to survive.'[192]

---

[190] Transcript at page 163

[191] Exhibit C1c at page 25-26; See also Exhibit C1d, C1e and C1f including e-mail dated 23 May 2016 from Robyn Pettigrew to the Coroner's Office

[192] Exhibit C21 at pages 33-36

19.8. A number of common features were present in the cases of both Ms Howard and Ms McPherson-Smith:

1) There was an initial misdiagnosis;
2) Both were trialled on a range of prescription medications with little effect;
3) There was a significant delay before BPD was diagnosed;
4) Both developed maladaptive behaviours and a revolving door pattern of self-harming, ED presentations and admissions;
5) Access to private psychiatrists (and essential therapy) was interrupted during hospital admissions;
6) The maladaptive behaviours became entrenched. Even after they were diagnosed with BPD neither had the benefit of a clear management plan or intensive psychotherapy;
7) Access to skilled clinicians came late in their presentations; and
8) Despite being under ongoing medical supervision (in the public and private sectors) for several years there was little improvement in their condition.

20. What steps have been taken by the State Government since June 2013 to address and improve service delivery for Borderline Personality Disorder in South Australia?

20.1. Borderline Personality Disorder: An Overview of Current Delivery of Borderline Personality Disorder Services in the Public Sector across South Australia and a Proposed Way Forward' (June 2014)[193]
In 2010 the SA Health Clinical Network appointed the SA Borderline Personality Disorder Work Group and commissioned a report into current delivery of services for the treatment of BPD within the public mental health service in South Australia.

20.2. In June 2013 the SA BPD Work Group presented its final report to SA Health[194]. The report comprised a comprehensive set of recommendations to the State Government for a workable, multi-dimensional, State-wide service delivery model for patients with BPD in South Australia.[195] Dr Kent confirmed that the report and its recommendations

---

[193] Exhibit C44
[194] The initial report was delivered to SA Health in 2012. At the request of SA Health the report was re-written.
[195] Exhibit C44, page 77

are 'entirely consistent' with the Commonwealth guidelines for Health Professionals Caring for People with Borderline Personality Disorder (the National Guidelines).[196] Dr Kent described these guidelines as 'a critical benchmark' against which to compare treatment, assessment and management of people with BPD.

20.3. It is noteworthy that the June 2013 report was not released by SA Health until June 2014.[197] No explanation has been provided to the Court for the delay in its release.

20.4. Significant deficiencies were identified across virtually all areas of service delivery. For example, in country South Australia it was identified that there is currently no mental health service specifically established to work with people with BPD. The traditional reluctance to diagnose adolescents with BPD was identified.[198] Nearly every region across South Australia identified major barriers to providing a quality BPD service including the lack of available funding and resources and a lack of trained BPD therapists.[199]

20.5. Primary Recommendations

The primary recommendations made were:

1) That the Mental Health Service commit to the development of BPD services across the state of South Australia.

2) That *a State-wide specialist BPD service be established to provide specialist expertise and support for clinicians working in both the public and private sectors including the primary health care sector and non-government organisations* (NGO's).

3) *That a Clinical BPD Coordinator position be created.*

4) That the person with clinical expertise who is appointed as the BPD Coordinator:

   a) develop an agreed State-wide work plan, incorporating the recommendations of the report and involving a 'hub and spoke model of service of which Spectrum Personality Disorder Service in Victoria could be considered a prototype model';[200]

---

[196] Transcript, page 137
[197] Transcript, pages 134 - 135
[198] Exhibit C44, page 14
[199] Exhibit C44, page 15
[200] Exhibit C44, page 12 - 14, 23

b) work with local health networks to implement the agreed recommendations and to identify the resources required to meet these recommendations;

c) develop a business case which clearly articulates the resources required;

d) work to develop a state network of experts who will assist in the development of the State-wide specialist BPD service; and

e) explore the future provision of a day patient/outpatient service for people with moderate to severe BPD supporting Community Mental Health Teams across the State.[201]

20.6. It was envisaged that the service would take carriage for the upskilling of the current workforce in evidence-based therapies and interventions for BPD. Targeted agencies would include primary care, EDs, inpatient units, drug and alcohol units, the NGO sector, ambulance services and police.

20.7. The SA BPD Work Group provided a detailed policy framework whereby:

- service providers within the mental health system multidisciplinary framework with an interest in BPD are encouraged to pursue specialised training in BPD assessment and therapy;
- a system of ongoing supervision and support is provided to service providers who work with people with BPD;
- clinical practice development activities are provided for all staff to attend specific education, training and ongoing professional development opportunities relating to BPD;
- the Clinical BPD Coordinator will work with the psychiatry training body to improve psychiatric training in the area of BPD;
- the Clinical BPD Coordinator will work with universities to improve training in the area of BPD for medical, psychological and multidisciplinary undergraduate programs;
- the Clinical BPD Coordinator will work with designated BPD clinicians in local health networks to support and develop local training and support networks for GPs on the diagnosis and management of consumers with BPD;

[201] Exhibit C44, page 23 (N.B the recommendations include the creation of a video linkage site for the development and maintenance of outreach clinical BPD services in rural South Australia)

- the Clinical BPD Coordinator will explore opportunities to work with the education sector to increase awareness of BPD;
- Current educational resources will be explored, made available and developed for people with BPD, their families and carers, taking into consideration culturally and linguistically diverse populations;
- A BPD-sensitive data collection system will be developed and implemented within the public mental health system, taking into account and adjusting for the multiple diagnostic comorbidities associated with the diagnosis and life course of BPD;
- Attention will be given to understanding and addressing the reluctance by some mental health workers to commit to the diagnosis of BPD.[202]

20.8. The report set out the Hybrid Model or Stepped Approach which focused on strategic recommendations. Importantly, *these recommendations built upon current service delivery arrangements and, if adopted, were amenable to implementation as a transitional stage of BPD service development whilst working over time towards the goal of developing a specialist network of BPD clinical expertise.*[203]

20.9. One suggested strategic approach was a roving BPD Clinical Specialist Service (as per the DASSA model) where visiting expert BPD assessors and therapists provide skilled clinical, consultation and education/training services to public hospital EDs and other relevant organisations, clinicians or systems.[204]

20.10. Another suggested strategy was the development of a system of scholarships for public mental health workers (especially rural mental health workers) for the purpose of specialised training in BPD assessment and treatments. These scholarships could contain linkage requirements (eg bond payments) such that the recipient of the BPD scholarship is committed to providing a BPD clinical service for an agreed period of time as well as supervision, support and training of other mental health and general health workers.[205]

20.11. In my opinion it is difficult to fault this body of work. The recommendations are comprehensive, sound and pragmatic.

---

[202] Exhibit C44
[203] Exhibit C44, page 23
[204] Eg as per the Drug and Alcohol Service of SA (DASSA) model
[205] Exhibit C44, page 23 - see also the recommendation for the ‘urgent development’ of a reliable BPD date surveillance program across the public mental health and general health systems at pages 22 - 23.

20.12. The SA BPD Work Group recommended the Spectrum Personality Disorder Service for Victoria (Spectrum) as a prototype model for South Australia. Dr Kent referred to 'the remarkably low number' of patients lost to suicide in the past 20 years while under treatment by the Spectrum service in Victoria (ie eight patients). Dr Kent said that *in the last two years in South Australia a higher number than that have suicided probably with BPD*.[206] This portion of the evidence is reinforced by the evidence of Julie McPherson, namely that of the 100 BPD Carers in her support group (Sanctuary) '*our group has had four suicides of those cared for in the last two years*'.[207]

20.13. In relation to the treatment of adolescents, Dr Kent considers Victoria to be fortunate as it has two systems of care, namely, Spectrum and also the Orygen Youth Service, Helping Young People Early (HYPE) program. This program is the government-funded youth mental health service in western, northwest and metropolitan Melbourne.[208]

20.14. Spectrum: Personality Disorder Service for Victoria

Professor Sathya Rao is a legally qualified medical practitioner and a consultant psychiatrist. He is the Executive Clinical Director of Spectrum, Personality Disorder Service for Victoria, Australia. He is also the Vice President of the Australian Borderline Personality Disorder Foundation. Professor Rao provided a statement to the Inquest.[209] His evidence was unchallenged.

20.15. Professor Rao has specialised in the field of BPD and can speak for and on behalf of the Spectrum service in Victoria.[210] Spectrum was established in 1999. *Significantly, Professor Rao confirmed that since 1999 Spectrum has lost only eight patients to suicide while they were under Spectrum's Care*.[211]

20.16. The range of services provided by Spectrum can be summarised as follows. Spectrum works with people aged 16-64 years with complex and/or severe personality disorders who are highly suicidal[212]. Spectrum has the capacity to provide direct and indirect clinical services for about 500 patients annually in Victoria. Up to two years of

[206] Transcript, page 168
[207] Exhibit C21, page 36
[208] Transcript, page 166
[209] Exhibit C50
[210] Exhibit 50, page 1
[211] Exhibit C50, page 4
[212] Exhibit C50, pages 2 - 3; see also Attachment 1 (Spectrum Services December 2016), Attachments 3 and 4 (Spectrum Treatment Principles and Spectrum Model of Care 2015) and Attachment 5 9A Guide to Accessing Services for BPD in Victoria 2nd ed_web)

psychological treatment can be provided for about 50 patients. A typical patient in the BPD Clinic would have one hour of individual psychotherapy and two hours of group psychotherapy and additional telephone support every week. Complex and severely unwell patients are treated within the Complex Care Service which has the capacity to treat 25 patients in this program. Five of these 25 patients belong to the Intensive Care Service which comprises a highly resourced and supported team. Patients can be seen twice weekly if required. Secondary consultations and supervision is available for clinicians involved in caring for these patients. Secondary consultations are available for all clinicians of mental health services through Spectrum's Telehealth program. This program runs from 9am to 5pm, five days per week.

20.17. *For clinicians of mental health services managing complex personality disordered patients, Spectrum provides face to face secondary consultations throughout the State of Victoria. It provides second opinions to public and private psychiatrists for complex personality disordered patients. Spectrum also provides one-off assessments for patients referred by general practitioners via its Medicare clinics as well as carer and consumer support services.*

20.18. In relation to training, on average, *Spectrum provides training for about 1000 clinicians every year and has psychiatry, psychology, and nursing and social work students on rotation through various Spectrum programs*. Two psychiatric registrars take up training at Spectrum every year and sabbatical training positions are provided to psychiatrists. Four psychiatrists from rural Victoria and metropolitan Melbourne have undertaken sabbatical placements at Spectrum in the last few years.[213]. Professor Rao said that recently Spectrum has developed *a 10 week brief intensive group intervention* which he states '*can be easily implemented within the context of resource deprived mental health services at a relatively low cost*'.[214]

20.19. In relation to cost savings, Professor Rao referred to a Sydney based study and an overseas study which identified cost benefits of providing evidence based interventions.[215] Professor Rao also cited a preliminary cost benefit study of the effect of outpatient psychotherapy, twice per week for one year in 30 BPD patients (reported

---

[213] Exhibit C 50 - Attachment 7 (Training Paper) and Attachment 8 (Spectrum Training Calendar 2017)
[214] Exhibit C50 - Attachment 6 (Spectrum Brief Intervention (2))
[215] Exhibit C50, page 3

in the Australian and New Zealand Journal of Psychiatry). This study suggested that there is a significant cost benefit in the appropriate treatment of BPD patients.[216]

20.20. Spectrum has published a twelve month follow-up study which contends that 'the importance of the study lies in the demonstration of clinically meaningful gains in a group of patients characterised by severe personality pathology, past unsuccessful treatment attempts, and heavy use of health services, including costly impatient services.' The results 'are consistent with preliminary findings showing that, with the provision of specialist treatment integrated with generalist public mental health services, improved clinical outcomes are achievable for some patients with BPD'.[217]

20.21. Spectrum undertook a Randomised Controlled Trial of its Acceptance and Commitment Therapy program for BPD which found the following: [218]

> 'When a 12 session Acceptance and Commitment Therapy (ACT) group intervention and treatment as usual (TAU) for BPD were compared, the ACT and TAU patients had significantly better outcomes with respect to overall BPD symptoms, thoughts and feelings, negative behaviours, anxiety, hopelessness, psychological flexibility, emotion regulation skills, mindfulness, and fear of emotions. These were large improvements and both clinically and statistically significant (with the exception of anxiety). They were maintained at three month follow-up. The TAU clients demonstrated no significant improvements.' [219]

20.22. Spectrum undertook a collaborative study with St Vincent's Mental Health Service using mentalisation-based intervention to recurrent acute presentations and self-harm in a community mental health service setting.[220] A further study (yet to be published) highlighted the effectiveness of Spectrum treatment in reducing self-harm. *The preliminary results of the Spectrum Service-Wide Evaluation study suggest that 12 months of psychotherapeutic treatment significantly reduced BPD symptom frequency and severity, disassociation, and auditory hallucinations.* Professor Rao stated that there were also clinically and statistically significant reductions in deliberate self-harm and suicidal behaviours, as well as a trend towards a reduction in seeking medical services for wounds.[221] He further stated that a recent Spectrum publication has demonstrated significant reduction with regard to BPD symptoms. There were

---

[216] Exhibit C50, Annexure 9 of 'Psychotherapy with borderline patients: A preliminary cost benefit study: Janine Stevenson, Russell Meares

[217] Exhibit C50, page 4 and table 6: Descriptive statistics for the number of suicide attempts and of self-harm episodes and related mean medical risk for Time 1 (self-harm and suicide attempts at baseline) and Time 3 (at 12 month follow up)

[218] Moreton and Snowdon-2011

[219] Exhibit C50, pages 4 - 5

[220] For summary of findings see Exhibit C50, pages 5 - 6

[221] Exhibit C50, pages 6 - 7

significant reductions in the clinical domains of unstable relationships, suicide and self-harm, affective instability and dissociation.[222]

20.23. Professor Rao perused the reports of Dr Naso and Dr Kent, however he did not have an opportunity to provide a considered response to the specific contents of each report. That said, I accept Professor Rao's opinion that a State-wide specialist centre for South Australia would provide coordination and support for therapists (both public and private sectors) and general practitioners, support for families and treatment for the patients with the most severe symptoms. Professor Rao is well placed to express such an opinion and I accept the unchallenged evidence that Spectrum has achieved outstanding results for BPD sufferers as a result of its program.

20.24. <u>Orygen Youth Health: HYPE (Helping Young People Early)</u>
Professor Andrew Chanen provided a statement to the Inquest which addressed the services provided by the HYPE program in Victoria.[223] His evidence was unchallenged.

20.25. The HYPE program is part of Orygen Youth Health, the government-funded youth mental health service in western, northwest and metropolitan Melbourne. Orygen services a catchment population of approximately 160,000 15 to 25 year olds and offers a comprehensive mental health service for severe mental disorders including BPD. Referrals are made to Orygen's single point of entry and are usually precipitated by symptoms of another disorder (eg major depression), not BPD per se. It was noted that diagnosing personality disorders prior to the age of 18 years has been more controversial than diagnosing such disorders in adults.[224] However, *according to Chanen, McCutcheon and Kerr, this is no longer justified*.[225]

20.26. HYPE includes both a service model and an individual therapy, and incorporates the principles of cognitive analytic therapy (CAT) into both components. CAT has been described as practical and collaborative in style, with a particular focus upon understanding the individual's problematic self-management and interpersonal relationship patterns. A central feature in CAT is the joint (patient-therapist) creation of a shared understanding of the patient's difficulties and their developmental origins, using plain-language written and diagrammatic 'reformulations'. CAT is said to have particular advantages for early intervention in BPD, especially because it is integrative

222 Exhibit C50, page 7 - 8
223 Exhibit C49
224 Exhibit C49, page 362.
225 Exhibit C49; see also NHMRC guidelines

and 'trans-diagnostic' approach encompasses the myriad of co-occurring problems, which are the norm in this patient group, within the overall treatment model.

20.27. Prevention and early intervention for BPD primarily aims to alter the life-course trajectory of young people with borderline personality pathology by attenuating or averting associated adverse outcomes and promoting more adaptive developmental pathways.[226]

20.28. I accept the unchallenged evidence of Professor Chan. The HYPE program is one that is squarely aimed at prevention and early intervention in severe mental health disorders for young people in Victoria. It is apparent that no similar service exists in South Australia.

20.29. Evidence of the South Australian Mental Health Commission and Office of the Minister for Mental Health and Substance Abuse

Given the central issues arising in this Inquest it is a matter of disquiet that, at the commencement of these proceedings, no counsel sought leave to appear on behalf of the SA Mental Health Commission (SAMHC), the Minister for Mental Health and Substance Abuse or the Minister for Health. Ms Sloan had been instructed by the Crown to appear only for the Central Adelaide Local Health Network, the Women's and Children's Health Network and Southern Adelaide Local Health Network.

20.30. Many key questions were not covered by the statements and documentary material which had been received into evidence. Given the importance of the issues, the Court invited Ms Sloan to seek further instructions and to advise whether the Crown intended to instruct counsel to represent these parties. Examples are:

1) Why have the National Guidelines (2013) not been implemented in South Australia?

2) What caused the twelve month delay in the release of the June 2013 report of the SA Borderline Personality Work Group?

3) Were the relevant Ministers provided with a copy of the report and briefed on its contents and recommendations?

4) What actions or directions were given by the respective Ministers to advance and implement the recommendations?

---

[226] Exhibit C49, pages 361 - 362; See also evidence of Dr Kent at page 148 on effective treatment modalities for adolescents

5) Given that the SA BPD Work Group was appointed in 2010 and provided its final report to SA Health in June 2013, why have its recommendations not been implemented?

6) Given that the SA BPD Work Group identified serious deficiencies in the delivery of BPD services in South Australia why has it taken over four years for an 'Action Plan' to be finalised?

7) Why does the 'Action Plan' (2017-2020) propose further scoping and research when a clear pathway forward was identified and recommended in June 2013 by a group of eminent professionals?

8) What efforts have been made to identify and allocate funding to implement the recommendations of the SA BPD Work Group?

9) Has the State Government considered the Spectrum Personality Disorder Service for Victoria as a prototype model for South Australia?

10) Has the State Government considered the HYPE (Helping Young People Early) program as a prototype model for the treatment of adolescents with BPD in South Australia?

20.31. On 14 September 2017 Ms Sloan confirmed that she had received instructions to act for the Minister for Mental Health and Substance Abuse, the Minister for Health and the SA Mental Health Commission. Ms Sloan sought leave to tender two affidavits:

1) Affidavit of Amelia Traino, Executive Director of the SA Mental Health Commission[227]; and

2) Affidavit of Donald Duncan Hay Frater, Deputy Chief Executive of the Department for Health and Ageing, SA Health.[228]

These affidavits were tendered by consent. No leave was sought to call any witnesses for oral examination.

20.32. I turn now to consider this further evidence.

20.33. Evidence of Ms Traino (SA Mental Health Commission-SAMHC)

The South Australian Health Commission (SAHC) was established in October 2015 under the *SA Public Sector Act, (2009).* Ms Amelia Traino is the Executive Director of

[227] Exhibit C47
[228] Exhibit C48

the SA Mental Health Commission. One of her key roles was to lead the development of South Australia's new Mental Health Strategic Plan.

20.34. Ms Traino stated that during his tenure from October 2015 to April 2016, Dr Steven Christley identified that effective treatment for people living with BPD was 'an area of concern'. In response, the SAMHC engaged a Principal Project Officer, Ms Tracey Hutt, to develop an action plan. Ms Hutt commenced at the SAMHC on 2 May 2016. A Project Steering Group was convened.

20.35. The Project Steering Group oversaw the development of an 'Action Plan for people living with BPD.[229] Dr Kent did not form part of this group. A Consultation Draft was prepared and completed. On 25 August 2016 the Consultation Draft was sent out to a wider stakeholder group for review.[230] Feedback was invited by 7 September 2016. The feedback was received by 8 September 2016 and was considered by the Project Steering Group.

20.36. *The finalised Action Plan was sent to the office of the Minister for Mental Health and Substance Abuse on 10 November 2016.* The plan was for the Action Plan to go to Cabinet to be noted. Ms Traino had a number of informal discussions with the Minister's office regarding the progress of the Action Plan. She was told on a number of occasions that '*work was being done within SA Health to locate the resources to implement the Action Plan*'.

20.37. Evidence of Mr Frater (Department for Health and Ageing, SA Health)

Mr Frater has been the Deputy Chief Executive of the Department for Health and Ageing, SA Health since 20 June 2016. From late January 2017 Mr Frater assumed responsibility for Mental Health within the Department for Health and Ageing. In late January or early February 2017 Mr Frater learned that the SAMHC was developing an Action Plan for People Living with Borderline Personality Disorder. He was aware that in November 2016 a consultation draft was provided to the Minister for Mental Health and Substance Abuse.[231]

20.38. Mr Frater's evidence was that the Action Plan did not go to Cabinet on the proposed date 'as the Government of South Australia prefers to have a response to any such plan

[229] Exhibit C47
[230] For list of stakeholder group see C47
[231] Exhibit C47

before it is sent to Cabinet.' However, the overall budget for 2016/2017 had already been allocated at that time and *no resources were available to deliver SA Health's response to the Action Plan in the short term.* Within the department attempts were made to negotiate resources with the various Local Health Networks to fund a BPD program but this was unsuccessful.

20.39. In March 2017 funding was identified which could be allocated to SA Health's response to the Action Plan in the current financial year.

20.40. In June 2017 Mr Frater discussed SA Health's response to the Action Plan with the Minister for Mental Health and Substance Abuse who agreed that SA Health's planned approach was a valid one. A Minute was sent to the Minister on 6 July 2017 outlining where the funding for SA Health's response to the Action Plan would come from. This was noted by the Minister on 26 July 2017.

20.41. I make the following observations: Firstly, this affidavit focused almost exclusively on the Action Plan (2017-2020) and the difficulties in locating resources to fund SA Health's response to it. Secondly, the affidavit provides no information regarding the most relevant period, namely 2010-2016, and the actions, if any, taken by the Minster to advance the implementation of the National Guidelines or the recommendations of the SA BPD Work Group.

20.42. The evidence is insufficient to draw any definitive conclusions about why the two affidavits fail to address key issues. To do so would be mere speculation.

20.43. I turn now to the SA Mental Health Commission Action Plan for people living with BPD (2017-2020).

20.44. <u>SA Mental Health Commission Action Plan for people living with BPD (2017-2020)</u>[232]
I have read and considered the finalised Action Plan. I do not intend to repeat its contents for the purpose of these findings. The document speaks for itself. Interestingly, the policy framework makes a passing reference only to 'earlier reviews and policy documents' including the SA Borderline Personality Work Group's final report (June 2014) and the National Guidelines. The affidavit then focuses on many

[232] Exhibit C46 - Consultation Draft, South Australian Action Plan for People Living with Borderline Personality Disorder (2017-2020)

areas which, in my view, had already been comprehensively addressed by the National Guidelines and the SA BPD Work Group.

20.45. In the course of her evidence Dr Kent OAM welcomed and endorsed the plan as a comprehensive report, albeit with some reservations. Dr Kent described it as '*over-comprehensive*' and '*bigger than Ben Hur*'. In Dr Kent's opinion the plan is trying to cover all bases and runs the risk of not being able to cover any or many.[233]

20.46. I agree with Dr Kent that a comprehensive, coordinated and centralised State-wide service is urgently required in this State. What is not needed is a piecemeal approach which fiddles at the edges of the current chaotic system or, as some might say, amounts to little more than moving the deck chairs on the Titanic. *In my opinion, a piecemeal approach will fail to deliver the services that are needed in South Australia.*

21. Summary

21.1. In determining the cause and circumstances of the deaths of Miranda Robyn Howard and Aurora Holly Violet McPherson-Smith, the Court had the benefit of hearing expert evidence from two psychiatrists. Dr Naso and Dr Kent OAM are experts in the field of psychiatry with particular expertise in the diagnosis, management and treatment of BPD. I am grateful for their evidence and the guidance it has provided to the Court. It is noteworthy that the evidence and opinions given by both experts was entirely unchallenged.

21.2. Having considered the whole of the evidence, in my view, there are serious systemic issues and deficiencies in the current delivery of services for BPD in South Australia. The current system and, in particular, the interface between public and private mental health services can be properly characterised as fragmented, inconsistent and chaotic. I accept the expert evidence that the current system is fragmented and inconsistent. It leads to misdiagnosis, delayed diagnosis, dangerous polypharmacy, multiple admissions to EDs and bewilderment for the families who must engage with mental health services in this State. Essentially the current services for the treatment of BPD amount to little more than short term crisis management. Even when the condition is correctly diagnosed, treatment options are limited and, significantly, they are not

[233] Transcript, page 176

centred around evidence-based therapies which have been demonstrated to provide the best chance of recovery.

21.3. I accept the expert evidence that there are pockets of excellence in some areas of metropolitan Adelaide, but other areas and rural areas of South Australia have virtually no or, at best, very basic services for BPD.

21.4. Furthermore, I am satisfied that there is a shortage of skilled clinicians, especially in relation to treatment of patients with a severe presentation of the disorder. The skilled clinicians and health professionals who do attempt to provide an effective service do so without access to adequate mentoring, ongoing education and peer support and thereby expose themselves to the very real risk of burnout.

21.5. Borderline Personality Disorder is an insidious condition. One of its core features is an inner feeling of emptiness and lack of self-worth so profound in the sufferer that it manifests as chronic suicidal ideation, self-harming, parasuicide and suicide. Having considered the evidence, it is difficult to find words which can adequately reflect the level of frustration, stress and despair that the families of the deceased have endured in their quest to access consistent and competent care for their loved one. Each day they lived with the sickening fear that their cherished child may end their life. In these tragic cases that is precisely what occurred.

21.6. The State Government has been well aware of the deficiencies in service delivery for BPD for a long period of time. In my opinion it is scandalous that in 2010 the State Government commissioned a high-level group of experts and professionals specifically to assess the adequacy of service delivery in this State and, despite receiving comprehensive policy and strategic recommendations in June 2013, none of the recommendations have been implemented. Had the State Government acted in a timely manner, in my view, the transition of current services towards a centralised State-wide service for BPD, as recommended, would have been well on its way.

21.7. The Australian Government National Health and Medical Research Council Guidelines for Health Professionals Caring for People with Borderline Personality Disorder was released in 2013. These evidence-based guidelines have been implemented in other states including New South Wales and Victoria, but not in South Australia.

21.8. As to the work of the SA Borderline Personality Disorder Work Group, the evidence is insufficient to make concrete finding(s) as to why the recommendations have not been implemented. The Work Group was chaired by eminent psychiatrist, Dr Martha Kent OAM, and its final report was the culmination of several years of painstaking research and analysis (including an assessment of interstate models for the treatment of BPD).

21.9. What is the point of commissioning such a high level group to report to government if its recommendations are apparently ignored? With the exception of general references to resource constraints, no reasonable explanation has been proffered as to why some eight years later its recommendations have apparently been left to gather dust.

21.10. On the available evidence I am unable to determine whether, at the very least, the recommendation to consider the Spectrum Personality Disorder service in Victoria as a prototype model for South Australia was considered by the State Government.

21.11. Neither is the evidence sufficient to determine whether the Orygen Youth Service, HYPE (Helping Young People Early) was considered as a possible prototype model for the treatment of adolescents with BPD in South Australia, or why the National Guidelines have not been implemented in South Australia.

21.12. Ample opportunity was provided, through counsel for the Crown, for those with an interest in these proceedings (eg the Minister for Mental Health and Substance Abuse, the Minister for Health and the South Australian Mental Health Commission) to come forward and provide some answers to these questions. To the extent that further evidence was provided (by affidavit only), the affidavits were silent on the most important issues. In my view, their contents raised more questions than they answered.

21.13. It is difficult to determine whether the lack of response to these key questions has arisen out of a lack of fortitude, or perhaps indifference on the part of those who are positioned to answer them.

21.14. Overall I have reached the conclusion that there has been a lack of effective governance. Good governance is accountable. Accountability is a fundamental requirement of good governance. A belated Action Plan with no allocated funding or guarantee of wholescale implementation in the near future is no answer.

21.15. The statement made by Dr Marth Kent OAM is apposite:

> '… There is an urgent need to do what all these reports have been recommending for years now. I think there's enough reports, enough talk, enough committees, enough dodging the responsibility for this and dodging the need to apply resources…
>
> …I'm not sure where the money and the resources is planned to come from. I am very concerned that small amounts of this action plan will be put into action and the rest will disappear and that troubles me because it is time, in my opinion, for action…' [234]

22. Were the deaths of Miranda Howard and Aurora McPherson-Smith preventable?

22.1. The ultimate question of whether the deaths of Miranda Howard and Aurora McPherson-Smith could reasonably have been prevented is a complex one. If a centralised State-wide service or critical mass of experts had been available to them, their families and their mental health workers, it is possible that the outcome may have been different, particularly I think in Ms Howard's case. That said, I accept the expert evidence that patients who have a severe presentation of BPD tend to have a poor outcome with ongoing suicidal behaviours and, even with the best of care, there will be a percentage of patients who still end their lives. The many challenges which exist by reason of the inherent complexity of BPD cannot however absolve those who are in a position to do so from acting to bring forth positive change.

22.2. Miranda Howard and Aurora McPherson-Smith were profoundly ill and vulnerable. They and their families reached out to the mental health services of South Australia in a bona fide attempt to access skilled and competent care. In my opinion the integrated and skilled care that was needed, and to which the deceased were entitled, was not available to them in South Australia.

23. Findings

23.1. I preface these findings by stating that there are aspects of the care delivered by individual medical practitioners and health professionals which, with the benefit of hindsight, could have been improved. That said, any criticism made of individuals must be viewed in the context of the mental health system within which they were operating and the rigid interface between the public and private sectors.

23.2. It is plain that there are serious deficiencies in the current delivery of services for Borderline Personality Disorder in South Australia. A key deficiency is the ad hoc

---

[234] Transcript, page 177

nature and inconsistency of the services. Other deficiencies include the use of prescription medications and hospitalisation as primary treatment options, the lack of skilled clinicians (especially for severe presentations of the disorder) and the lack of ongoing training, mentoring and peer support for clinicians. These are essential prerequisites in order to provide clinicians with the skills and knowledge they need to accurately diagnose, manage and treat complex cases of Borderline Personality Disorder.

23.3. Miranda Robyn Howard

In relation to Ms Howard I find that:

1) At the time of her death Miranda Howard suffered from Borderline Personality Disorder in its most severe form.

2) Possible BPD features were not documented for the first time until January 2012 (ie almost one year after Dr Berce had assumed care).

3) The deceased was not diagnosed with BPD until 21 May 2012.

4) Despite the BPD diagnosis, no clear treatment plan or crisis management plan was put in place.

5) The Southern Assessment and Crisis Intervention Service declined a referral, citing Ms Howard's high level of risk. The explanation provided to the Court for this decision was inadequate. I find that the referral of the deceased by SACIS to intermediate care could only ever amount to a band-aid solution until the next crisis inevitably occurred.

6) On 17 September 2012 Ms Howard was assessed to be at chronic risk. Notwithstanding the identifiable risk she was discharged back to Youth 110.

7) Accommodation services such as Youth 110 are not geared to provide therapeutic services and/or to manage such risks.

8) On 17 December 2012 Ms Howard was diagnosed with Borderline Personality Disorder in crisis. Notwithstanding the diagnosis no substantive change was made to her medical treatment and management when clearly a change was warranted.

9) From this time onwards there was a rapid decline in her condition which culminated in multiple further presentations and admissions to EDs.

10) On 28 April 2013 Ms Howard was assessed to be at chronic risk and at risk of misadventure. Notwithstanding the identification of these risks her treatment plan essentially remained unaltered.

11) On 10 June 2013 the Fullarton Private Hospital sent Ms Howard in a taxi to the RAH unaccompanied and in possession of prescription medications (after a self-harming incident). An overdose of the prescription medication followed shortly thereafter. For obvious reasons any such practice should neither be condoned nor continued.

12) In mid-June 2013 Dr Berce discharged Ms Howard from her care. No meeting was held with the patient and/or her family to explain the sudden termination of services. No transition plans were put in place.

13) Without a referral from a private psychiatrist Ms Howard was precluded from the Kahlyn Day Centre.

14) Despite considerable efforts Ms Howard's mother was unable to find a private psychiatrist in Adelaide who was willing to take on a new patient or a patient with BPD.

15) Between 9 September 2013 and 7 November 2013 Ms Howard found herself with no psychological and/or psychiatric support in the private or public sector. The lack of care placed her at an increased level of risk.

16) By the time Mr Gill assumed care of Ms Howard her maladaptive behaviours were entrenched and less amenable to change. Despite the application of evidence-based therapy by Mr Gill, Ms Howard's mental condition continued to deteriorate.

17) At about 9:50pm she was found at her home in a semi-conscious state and taken to RAH ED and admitted to the ICU with a suspected prescription drug overdose.

18) On 27 November 2013 the deceased suffered from an unexpected arrhythmia of the heart and later from a fatal cardiac arrest. Her life was declared extinct at 11:05pm on 27 November 2013.

<u>Medical Management</u>

19) There is no basis to criticise the treatment provided by Dr Turnbull. The referral to Dr Berce for a psychiatric assessment was appropriate.

20) The diagnosis of depression and schizoaffective disorder made by Dr Berce in the early stages of treatment was a misdiagnosis. I further find that:

   a) Dr Berce trialled several antidepressants and antipsychotic medications for an extended period with disappointing results;

   b) Even when Ms Howard was diagnosed with BPD by another psychiatrist, Dr Berce continued to doubt the diagnosis;

   c) The decision in mid-June 2013 to terminate her services without meeting Ms Howard or her parents and without transitioning her patient to another clinician was an abdication of professional responsibility. Clearly such conduct falls far short of best practice and was likely to have triggered feelings of distress and abandonment in Ms Howard;

   d) The most plausible explanation for such conduct is clinician burnout arising from Dr Berce's attempt to provide long-term care for a complex BPD patient and without peer support;

   e) There is insufficient evidence to determine whether Dr Berce had adequate training and experience to manage a complex presentation of BPD;

   f) With the benefit of hindsight Dr Berce ought to have fully transferred Ms Howard's care to the public sector at a much earlier stage.

21) The treatment provided by Mr Gill was skilled and appropriate.

22) Ms Howard ought to have been accepted back into the Eastern Community Mental Health Service (even on an interim basis) in late September 2013 or at the very least on about 4 October 2013.

23) That said, there is no basis to find that earlier resumption of treatment by Mr Gill would necessarily have changed the outcome for Ms Howard.

24) In all of the circumstances I find that Ms Howard's death was the result of misadventure rather than a deliberate decision to end her own life. The circumstantial evidence and the reasonable inferences which are open therefrom point to this conclusion.

23.4. Aurora Holly Violet McPherson-Smith

In relation to Ms McPherson-Smith I find that:

1) At the time of her death Aurora McPherson-Smith suffered from Borderline Personality Disorder in its most severe form.

2) A referral was made to the Child and Adolescent Mental Health Service on 25 September 2012.

3) On 6 November 2012 CAMHS psychiatrist, Dr Sue Shannon, diagnosed depression with compulsive behaviours and trialled an antidepressant.

4) Psychological therapy with Ms Hotich (a CAMHS caseworker) was recommended and 15 sessions of DBT were conducted with the deceased before she disengaged from Ms Hotich and Dr Shannon.

5) As at 4 February 2013, and after the overdose which lead to the six week admission at Boylan Ward, the diagnosis was major depression. The multiple hospital presentations, the overdoses, the reported daily thoughts of suicide (including thoughts of stabbing herself and hanging herself) could be said to have pointed to a diagnosis of BPD. However, I find that Dr Shannon (and Ms Hotich) had a relatively limited timeframe within which to diagnose and treat the deceased before she disengaged. It is also possible that BPD was considered by Dr Shannon and the diagnosis of major depression reflects a reluctance to diagnose such a condition in adolescents. It is not possible on the available evidence to make a definitive finding on this issue.

6) Dr Brock diagnosed depression. It is unclear whether Dr Brock's diagnosis reflects a reluctance to diagnose BPD in an adolescent or a misdiagnosis. It is not possible on the available evidence to make a definitive finding.

7) Ms Broadhurst was a committed and well-motivated health professional who attempted to the best of her ability to provide long-term therapy for Ms McPherson-Smith.

8) Ms Donna Broadhurst was the first person to recognise features of Borderline Personality Disorder and, on 8 August 2013, she documented 'behaviours consistent with emerging Borderline Personality Disorder'.

9) Ms Broadhurst showed an extraordinary level of commitment to her client, but she had neither the skills nor the experience to identify the condition, its severity

and/or to manage a person with Ms McPherson-Smith's complex needs. I further find that:

a) Ms Broadhurst had a conflict of interest in seeking to treat both Ms McPherson-Smith and to provide support to her parents;

b) The failure to put clear therapeutic boundaries in place with her client and her parents at the outset of treatment fundamentally compromised Ms Broadhurst's ability to provide effective care;

c) The level of telephone contact between Ms Broadhurst and the deceased was excessive and inconsistent with the necessary degree of professional detachment required in order to deliver effective care;

d) Ms Broadhurst's level of skill and inexperience led to her acting as a friend and 'rescuer' rather than discharging the role of a therapist;

e) The attempt to create and enforce boundaries with the deceased and her parents came too late and served only to upset and confuse them; and

f) To the extent that Ms Broadhurst was supervised by a senior clinician at CAMHS, it was inadequate as evidenced by the conflict of interest which occurred and the ongoing boundary issues in the therapist/patient relationship.

10) I find that Dr Ludbrook was well qualified to diagnose and treat a severe presentation of BPD. I further find that:

a) Dr Ludbrook was the first person to put an assertive management plan in place for the treatment of BPD;

b) Dr Ludbrook offered Ms McPherson-Smith and her parents all available resources necessary to treat BPD and provided appropriate evidence-based treatment and support;

c) Dr Ludbrook's ability to form a therapeutic relationship with Ms McPherson-Smith was compromised by Ms Broadhurst's decision to continue contact with the deceased after Dr Ludbrook had assumed primary care.

d) Dr Ludbrook's decision to maintain her stance regarding her patient's demands that Dr Ludbrook cease contact with her parents was an appropriate judgment call and one which was consistent with the recognised need to establish clear therapeutic boundaries. It is only with the benefit of hindsight

that one may postulate that a more flexible approach may have been warranted.

11) On 26 June 2015 Ms McPherson-Smith attended at Bunnings Warehouse at Kent Town and purchased a 500ml plastic bottle of hydrochloric acid for the sum of $6. There is no evidence as to the time of the purchase. Nothing turns on this particular fact. I further find that:

a) On 30 June 2015 Ms McPherson-Smith had lunch in Gouger Street with her father, Jonathan Kent Smith;

b) At around 2:40pm she attended at the Thirsty Camel Bottle Shop located at 18/19 Bank Street Adelaide. There she purchased a 700ml bottle of Petrovska Vodka for the amount of $28.99. The purchase was made using a VISA debit card;

c) At around 4:05pm the deceased attended at the Caltex Star Mart Service Station on Hutt Street, Adelaide and purchased six packets of dry ice totalling $83.94. Payment was made by a VISA debit card;

d) Later that day she attended at Rymill Park and consumed alcohol, burned herself with dry ice and consumed hydrochloric acid; and

e) I find that the deceased acted with the intention of ending her own life.

23.5. In relation to both Ms Howard and Ms McPherson-Smith I find that:

1) Accommodation services such as Youth 110 and Catherine House are not geared to provide therapeutic services;

2) There are no short-term accommodation services in South Australia which provide such services;

3) By the time the deceased were diagnosed with BPD they had developed entrenched maladaptive behaviours which included self- harming and regular ED presentations as a means of alleviating their internal distress;

4) As a matter of logic significant health cost implications must arise from the frequent use of ED services (and other psychiatric services by BPD sufferers). The application of evidence based treatments which reduce the use of such services is likely to result in significant cost savings;

5) The deceased were each prescribed a range of prescription medications before and after their Borderline Personality diagnoses. The medications provided some relief, but did not address the underlying issues;

6) The practice of patients being prescribed medications by more than one medical practitioner amounts to dangerous polypharmacy and creates a significant risk of overdosing;

7) Overnight ED admission and extended periods of hospitalisation provided short-term relief only and interrupted essential psychotherapy;

8) No psychotherapy or evidence-based treatments were provided to the deceased during their hospital admissions;

Overall I find:

9) That neither Miranda Howard nor Aurora McPherson-Smith received enough specialised care; and

10) That without urgent changes to the current service delivery for Borderline Personality Disorder in South Australia patients will continue to be treated in a haphazard, inconsistent and damaging manner and the risk of death, already high due to the nature of this disorder, will continue unabated.

24. Recommendations

24.1. Pursuant to section 25(2) of the Coroner's 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.

24.2. I recommend that the Fullarton Private Hospital adopt and implement a policy which prohibits transport of any patient by taxi or other chauffeured delivery service who has self-harmed or has otherwise been deemed to be at risk unless accompanied by a nurse or other suitably qualified employee of the Fullarton Private Hospital.

24.3. The following recommendations are directed to the Minister for Mental Health and Substance Abuse, the Minister for Health and the South Australian Mental Health Commissioner.

24.4. I recommend that the State Government take immediate steps to identify and allocate funding for a full assessment of:

- The Spectrum Personality Disorder Service for Victoria as a prototype model for South Australia; and
- The Orygen Youth Service Helping Young People Early (HYPE) as a prototype model for the treatment of Borderline Personality Disorder in adolescents in South Australia.

24.5. I recommend that the State Government adopt and implement as a matter of urgency, the recommendations contained in the final report of the South Australian Borderline Personality Work Group entitled '*Borderline Personality Disorder: An Overview of Current Delivery of Borderline Personality Disorder Services in the Public Sector across South Australia and a Proposed Way Forward (June 2014).*

24.6. I recommend that immediate steps are taken to create the position of Borderline Personality Disorder Coordinator and that the position is advertised nationally and internationally in order to find a suitably qualified person with appropriate clinical expertise to undertake this role.

24.7. I recommend that Dr Martha Kent OAM be engaged as a consultant to the State Government for the following purposes:

a) To provide advice on the development and implementation of the recommendations contained in the final report of the South Australian Borderline Personality Disorder Work Group (June 2014);

b) To oversee a revision and simplification of the South Australian Mental Health Commission Action Plan for People Living with Borderline Personality Disorder (2017-2020);

c) To provide supervision and advice to any Project Steering Committee and/or other group which is tasked to develop and implement the recommendations;

d) To ensure that the new Action Plan incorporates the key tenets of the National Health and Medical Research Council Guidelines for Health Professionals Caring for People with Borderline Personality Disorder (2013);

e) To Chair any panel which is convened to interview, assess and select any applicant for the position of Borderline Personality Disorder Coordinator in South Australia.

24.8. I recommend that the State Government enter into negotiations with key public sector stakeholders regarding any policies which exclude private psychiatrists from having a clinical role in the management and treatment of a patient who has been diagnosed with Borderline Personality Disorder, is under their care and who has been admitted to a public hospital or other public sector health facility.

Key Words: Borderline Personality Disorder; Psychiatric/Mental Illness; Suicide

In witness whereof the said Coroner has hereunto set and subscribed her hand and

Seal the 5th day of March, 2018.

Deputy State Coroner

Inquest Number 12/2017 (1975/2013 & 1142/2015)