CORONERS COURT OF SOUTH AUSTRALIA

DISCLAIMER - Every effort has been made to comply with suppression orders or statutory provisions prohibiting publication that may apply to this judgment. The onus remains on any person using material in the judgment to ensure that the intended use of that material does not breach any such order or provision. Further enquiries may be directed to the Registry of the Court in which it was generated.

INQUEST INTO THE DEATH OF JENNIFER MICHELLE MATTERS

[2026] SACC 41

Inquest Findings of her Honour State Coroner Kereru

30 September 2026

CORONIAL INQUEST

Examination of the cause and circumstances of the death of woman struggling with anorexia nervosa who took her own life after disengagement with support services. The Inquest explored the manner in which patients engage with eating disorder support services and whether there was systemic failure that led to a lack of treatment.

Held:

1. Jennifer Michelle Matters, aged 24 years of Kingswood, died at the Flinders Medical Centre on 6 June 2021 as a result of severe traumatic brain injury.

2. Circumstances of death as set out in these findings.

Recommendations made.

Counsel Assisting: MS E ROPER THEN MS R SCHELL

Interested Party: SOUTHERN ADELAIDE LOCAL HEALTH NETWORK & DEPARTMENT FOR HEALTH AND WELLBEING
Counsel: MS E DENBIGH - Solicitor: CROWN SOLICITOR

Witness: DR Y PETRUNIC, DR P APLIN & DR J KIRCHOFF
Counsel: MS E DENBIGH - Solicitor: CROWN SOLICITOR

Witness: MS A BURLOCK
Counsel: MR T DAYMAN - Solicitor: GILCHRIST CONNELL

Witness: DR R LONG
Counsel: MS J CLIFF - Solicitor: DW FOX TUCKER LAWYERS

Witness: DR S WILKSCH
Counsel: MR R HARMS WITH MS C LIVESEY - Solicitor: MINTER ELLISON

Hearing Date/s: 21/10/2024-28/10/2024, 30/10/2024 & 16/10/2025

Inquest No: 41/2024 **File No/s: 1162/2021**

This judgment contains discussion of suicide and may be distressing to some people

There is always help available

If you need support, contact

Lifeline Australia
Call 13 11 14 or Text 0477 13 11 14
or chat online at www.lifeline.org.au/crisis-chat

Aboriginal & Torres Strait Islander Support
Call 13YARN (13 92 76)

Kids Helpline
Call 1800 55 1800

MensLine Australia
Call 1300 78 99 78

Contents

Introduction **1**

These findings **2**

Statewide Eating Disorder Service **2**

Borderline personality disorder **5**

Anorexia nervosa **6**

Ms Matters' diagnosis and treatment journey **7**

Early years 7

Dr Vanessa Hughes and Amanda Burlock 7

Referral to SEDS 9

First presentation to the Flinders Medical Centre 11

First admission to Flinders 13

Dr Randall Long 15

Trial of outpatient co-therapy approach 17

Second admission to Flinders 19

Dr Yasna Petrunic 22

Third admission to Flinders 25

Dr Simon Wilksch 26

Fourth admission to Flinders 28

Ms Matters' own account 30

Cause of death **31**

Consideration of the issues and Recommendations **31**

Ms Matters' team (from time to time) 32

The number of eating disorder services available 32

SEDS and the new Residential Eating Disorder Service at the Repatriation General Hospital (the Repat) 33

Inability of SEDS to accept patients with dangerously low BMI 35

Guidelines for the management of medical complications of eating disorders 37

Education and training 38

Preventability **39**

Condolences **40**

INQUEST INTO THE DEATH OF JENNIFER MICHELLE MATTERS [2026] SACC 41

Introduction

1 Jennifer Matters was 24 years old at the time of her death. She was an intelligent young woman with a supportive and close-knit family, including two younger siblings. She achieved an Australian Tertiary Admission Rank of 96 upon her completion of high school,[1] following which she graduated university with a Bachelor of Nursing with merit. At the time of her death she was enrolled to study a Bachelor of Medical Science at the University of Adelaide.

2 Before she was able to commence her career as a nurse, Ms Matters developed anorexia nervosa, which very quickly took over her life. She sought treatment for her illness from general practitioners, psychologists, psychiatrists and dieticians, and experienced multiple admissions to hospital, both voluntary and involuntary.

3 While Ms Matters had the support of her very committed general practitioner, Dr Vanessa Hughes, as well as other clinicians, she encountered barriers to effective treatment which tragically proved insurmountable.

4 At the time of her death, Ms Matters was maintaining a weight of only 29.5 kilograms, and had disengaged from psychiatric and psychological treatment, as well as the care of Dr Hughes.

5 In these circumstances, Ms Matters attempted to take her own life in May 2021. She died on 6 June 2021 as a result of the injuries she sustained. The Inquest explored the health issues that Ms Matters faced and the services that were provided to her.

6 This principal hearing of this Inquest concluded on 30 October 2024, having heard oral evidence from a number of witnesses (listed below). During the hearing, counsel for the Southern Adelaide Local Health Network and Dr Petrunic indicated that an affidavit was to be prepared in order to provide authoritative evidence about:

- the status of the proposed Repat residential eating-disorder facility;
- future service planning;
- developments in
- eating-disorder services since 2021; and
- broader SA Health initiatives to improve services for those suffering from eating disorders in South Australia.

7 The affidavit was subsequently filed on 11 August 2025 by the Crown.

8 Following receipt of the affidavit (and two other outstanding documents), a directions hearing was listed to establish a timetable for the filing of written closing submissions. The final date for the filing of submissions was 30 January 2026.

---

[1] Exhibit C26 at [15]

9 I will comment later in this finding on the position of the Department of Health and Wellbeing (DHW) as detailed in the affidavit. However, it is relevant to note that this material was not received until well after the conclusion of the oral evidence and, consequently, after the Inquest had otherwise concluded. I make this observation not by way of criticism, but simply to explain the chronology by which the material came before the Court which then impacted the timing of the provision of these findings.

These findings

10 The civil standard of proof, the balance of probabilities, applies to the making of coronial findings. If findings which imply or express criticism of individuals are considered, I shall not make such a finding unless the evidence leads me to a comfortable level of satisfaction that the finding should be made. In this regard, I am guided by the principles enunciated in *Briginshaw v Briginshaw*.[2] The effect of this and similar authorities is that coroners should exercise caution when considering adverse findings against, or comments about, individuals or entities. Proof of facts underpinning a finding that would, or may, have an extremely deleterious effect on a party's character, reputation or employment prospects demands a weight of evidence commensurate with the gravity of the facts sought to be proved.

11 I have also remained cognisant of the potential intrusion of hindsight bias. A description of 'hindsight bias' is given in *The Australasian Coroner's Manual*, namely:

> The tendency after the event to assume that events are more predictable or foreseeable than they really were. What is clear in hindsight is rarely as clear before the fact. If it were, there would be far fewer mistakes made. It is an obvious point, but one that nonetheless bears repeating, particularly when Coroners are considering assigning blame or making adverse comments that might damage a person's reputation …
>
> Hindsight, of course, is a very useful tool for learning lessons from an unfortunate event. It is not useful for understanding how the involved people comprehended the situation as it developed. The distinction needs to be understood and rigorously applied.[3]

12 Throughout my consideration of the evidence, I have remained mindful of this risk and of the need to assess events by reference to what was known at the time.

Statewide Eating Disorder Service

13 The Inquest involved a close examination of the operation of the Statewide Eating Disorder Service (SEDS). This is a unit that is embedded within the Flinders Medical Centre.

14 SEDS is an organisation that supports people with eating disorders in a number of ways.[4] SEDS not only treats those living with an eating disorder but assists people caring for those with an eating disorder, whether that be families, friends, general practitioners or psychologists. Accordingly, there is the consultation assessment and treatment role, but also a liaison and support function. There is also an education component to SEDS which

---

2 (1938) 60 CLR 336
3 Hugh Dillon and Marie Hadley, *Australasian Coroner's Manual* (The Federation Press, 1st ed, 2015)
4 Broadly described by Dr Petrunic at T75-T90 and Exhibit C38 at [25]-[35]

is directed to medical students, nurses, psychology students and the education of general practitioners.[5]

15 SEDS provides a consultation-liaison psychiatry service. This facilitates contact between SEDS and other areas of the hospital. Dr Long is currently the consultation-liaison psychiatrist. As part of this role he attends to patients with an eating disorder who are in the hospital receiving unrelated treatment or are in the Emergency Department.

16 SEDS has an intake branch based at Brighton. This is a phone-based service staffed by nurses where referrals are received and information can be provided about the SEDS program. Referrals are first reviewed by the nursing staff to ensure all of the necessary medical information has been provided. Once they are screened by nursing staff, referrals are checked by Dr Yasna Petrunic (or another psychiatrist) to make an initial assessment as to where the patient could be directed based on whether they had been involved with SEDS previously, or whether they require an initial comprehensive assessment by a SEDS practitioner. SEDS commonly receive referrals from general practitioners and then undertake complex assessments (psychiatric and dietetic) and discuss the patient's care within the SEDS team. From that, a comprehensive care plan is developed that is discussed with, and tailored to, the patient.[6] Referrals to SEDS come predominantly from general practitioners, but they may also come from doctors within hospitals seeking specialist eating disorder input.

17 The concept of SEDS is a stepped model of care. Patients require different treatment at different stages of their recovery. The patient may commence with an admission to a general hospital as a result of a medical complication of an eating disorder and may then progress to an intensive SEDS inpatient program and from there it can progress to a SEDS day patient program. Finally, there is outpatient care with a multidisciplinary team.[7]

18 The intervention services provided by SEDS are divided into categories:

Initial psychiatric assessments

a. Initial assessments are provided by psychiatrists within SEDS to assess and follow-up patients who are referred for consideration of their services.

*SEDS Inpatient Program (**SEDS IPU**) (also referred to as Ward 4GP)*

b. The inpatient program is a six-bed facility within the Flinders Medical Centre which is a voluntary intensive 24-hour program for people with eating disorders who are medically stable. Treatment is provided by a variety of practitioners, including psychiatrists and dieticians. There is a consultant psychiatrist overseeing the unit, and psychological input is provided by experienced psychologists or psychology graduates, predominantly focusing on helping manage distress in the setting of an eating disorder.[8]

c. Patients can stay in the SEDS IPU for several months at a time. Places in the SEDS IPU are generally offered to those with severe, entrenched eating disorders.

---

5 T490
6 T489
7 T491
8 T77

It is the most intensive support available for people with eating disorders which focuses on their recovery, rather than their medical stabilisation.[9]

d. The inpatient unit waitlist is managed through a clinical triage system. The triage process is based on several issues, including wait time, motivation of the patient and severity of illness. The waitlist is substantial and can be up to many months.[10]

e. While the Inpatient Unit operates on a voluntary basis, Inpatient Treatment Orders under the *Mental Health Act* are occasionally used to prevent a patient suddenly leaving the program when they need to remain for lifesaving medical care. Otherwise, to achieve a successful outcome, the patient needs to cooperate with the treatment, which includes psychotherapy that will really only be successful with engagement.[11]

f. A person with an urgent medical condition cannot be treated in a specialist eating disorder bed at SEDS because the patient will require the clinical expertise of medical physicians. A patient therefore needs to be medically stable before they would be considered for transfer to the SEDS Inpatient Unit. This means that the patient cannot require an intravenous cannula, a central venous cannula or nasogastric feeding as these can involve levels of complication that must be managed on a medical ward to ensure safety.[12]

*SEDS Day Program (**the day program**) (also referred to as the outpatient day program)*

g. The day program is a three-and-a-half-day per week outpatient program for up to six patients at a time, predominantly providing psychology-led therapies, with a focus on support for patients to continue regular and adequate eating in their own living environment. The program is currently run at the Brighton facility.

h. The SEDS day program requires patients to have a minimum body mass index of 15. Dr Long told the Court that there are good reasons why there are criteria for entry into the specialist programs at SEDS. All specialist procedures in medicine have criteria for delivering that treatment appropriately so that it is safe and to maximise the efficient use of limited resources. Dr Long said that a BMI of 15 is used as a de facto indicator of cognitive state. He said that that level of BMI roughly correlates to when a patient has the neurocognitive capacity to do a more intensive psychologically-focused treatment recovery program. Below that, the patient has a dramatic down-regulation of frontal, prefrontal cortex and executive functioning and lacks the required cognitive capacity to engage.[13]

Adolescent Team

i. The Adolescent Team operates a program exclusively for young people providing evidence-based treatments for eating disorders. This is currently based at the Marion GP Plus Centre.

---

9 T76
10 T493
11 T494
12 T496
13 T495

Psychiatry, psychology and dietician outpatient appointments

j. Ongoing services are facilitated by psychiatrists, psychologists and dieticians within SEDS for patients in a less-formal outpatient setting.

19 The progress of patients who are involved in the different SEDS programs is also discussed at regular clinical review meetings where all of the different doctors and practitioners involved in SEDS services are present.

Borderline personality disorder

20 I heard evidence about the mental health conditions Ms Matters suffered from. A clinical psychologist who gave evidence, Amanda Burlock, described borderline personality disorder (BPD) as a condition where patients demonstrate:

a. pervasive affective instability
b. self-damaging impulsivity
c. recurrent suicidal behaviours or non-suicidal self-injury
d. problems with expression of anger
e. intense and unstable interpersonal relationships
f. transient and stress-related symptoms of either paranoia and/or dissociation
g. frantic efforts to avoid real or imagined abandonment; and/or
h. identity disturbance.[14]

21 Under the DSM-5-TR, a diagnosis of BPD requires a patient to meet five of nine diagnostic criteria. After diagnosis, treatment usually consists of psychotherapy which can encompass:

a. Dialectical behaviour therapy (DBT)
b. Cognitive behavioural therapy (CBT); and
c. Other therapies.

22 Dr Hughes gave evidence that BPD is often looked negatively upon or that there is at least a bias against patients presenting with those conditions. She said that clinicians can have a preconceived idea that it is not a 'worthy' psychiatric diagnosis because of a view that these patients should have more control over themselves, or a perception that they are attention seekers.[15]

23 Dr Long told the Court that patients with anorexia nervosa commonly have other comorbidities, including BPD. He said that many anorexia patients also have obsessive compulsive disorder (OCD) which can drive generalised anxiety disorder. He said that many are neurodivergent and meet the criteria for autism spectrum disorder or ADHD, or have a neuroconnective phenotype (which is a set of physical conditions which involve hypermobility of the joints, and lax ligaments around the gastrointestinal tract which leads to reflux and constipation). Further, he said that patients often have experiences of

---

[14] T276
[15] T201

trauma, with consequent post-traumatic stress disorder (PTSD). He explained that the PTSD often develops before the onset of anorexia and also has a high association with BPD.

Anorexia nervosa

24 Dr Petrunic described anorexia nervosa as a mental illness characterised by intense fear of weight gain and body image disturbance.[16] She said that it has a strong genetic component which causes distinct functional changes in the brain that creates a severe disturbance in body image and intense fear or loss of control of weight and shape, as well as numerous other cognitive and behavioural distortions. This drives the patient to exert relentless, painful and consistent control of body shape and weight. It leads to avoidance of the accumulation of body fat by dietary restriction, induced vomiting, over-exercising and abuse of laxatives. This extremely low body weight results in potentially deadly medical complications, malnutrition and other general health issues.[17]

25 Dr Long said that an eating disorder involves the perception in the person that the symptoms are not serious and they are not worthy of treatment. He explained:

> It's a physical condition and mental condition as well and they go hand-in-hand. The more starved you are, the less you can rationally think, the more prefrontal cortex downregulation you have. But there is also a really important symptom in anorexia called 'anosognosia', which is the denial of illness. So, it is actually an illness that makes the patient believe they do not have a problem. There is a common experience that the patient feels not sick enough, not worthy enough and even actually guilty receiving care, and this is a fundamental problem with anorexia nervosa that is distinguished from other eating disorders, such as binge eating disorder or bulimia nervosa or other similar disorders. So, it's not only you're starved and robbed of logic, but a fundamental symptom of the illness is it's almost like the neural network of the psychopathology seems to protect itself and try and hide itself and try and deny itself, which, of course, leads to great havoc in a person's life.[18]

26 Eating disorder recovery requires trained, skilled and experienced multidisciplinary clinicians to provide care, sometimes over many years.[19] Not one professional or specialist is adequate to treat anorexia nervosa alone. It requires at least a combination of a psychotherapist and the care of a general practitioner. It also requires a specialist dietician with skills in eating disorder care and families and carers who can provide 24-hour wrap-around care. Recovery is assisted by lived-experience peer therapists who have survived the illness. Treatment often encompasses the management of medical complications (including requiring the care of general physicians, surgeons and endocrinologists among other specialists). In short, the multidisciplinary team must deliver a combination of physical, psychological and nutritional care and all must work together as early as possible to create an environment which is conducive to recovery.[20]

27 According to Dr Long, the reason why anorexia nervosa is a deadly mental illness is not usually because people starve to death, but because of the high frequency of attempts at suicide. Anorexia has suicide as one of the main determinants of death from the disorder. Dr Long gave evidence that this may be a result of the combination of living with a

---

16 T69
17 Exhibit C35 at [6]
18 T525
19 Exhibit C35 at [7]
20 T481

tormenting underlying mental illness as well as the high degree of difficulty of treatment which leads to distress and misery on the road to recovery.[21]

28 Dr Long gave evidence that the quicker people are assisted to recover, the less likely they are to progress through to a stage where suicide attempts are more frequent and more often completed.[22]

29 I heard that the demand for appropriately skilled and experienced clinicians in the treatment of eating disorders is higher than the current supply.[23]

Ms Matters' diagnosis and treatment journey

Early years

30 Returning to Ms Matters, her mental health struggles began as early as 2011 when she was about 15 years old, with referrals to psychiatrists and psychologists for mental health management. Her issues around this time culminated in a presentation to the Women's and Children's Hospital following a polypharmacy overdose with suicidal intent in 2012. At that time, she was diagnosed with general anxiety disorder, chronic adjustment disorder and major depressive disorder. Ms Matters recounted in a much later session with her treating psychologist, Ms Amanda Burlock, that following this event her symptoms of BPD emerged for the first time,[24] although she was not actually diagnosed with BPD until 2017 followed by a PTSD diagnosis in 2019.

Dr Vanessa Hughes and Amanda Burlock

31 Dr Vanessa Hughes is a general practitioner working at Crafter Medical Centre in Hawthorn. She holds a Bachelor of Medicine/Bachelor of Surgery and was awarded a fellowship of the Royal Australian College of General Practitioners in 2016. At the time of Ms Matters' death, Dr Hughes had been working at the Crafter Medical Centre for five years.

32 Ms Matters had been a regular patient at Crafter Medical Centre since she was about six years old, and formally became a patient of Dr Hughes in October 2016, although they had at least one appointment together prior to this.[25] From 2017 onwards, Ms Matters presented to Crafter Medical Centre more regularly, about every four to six weeks. Her presentations became even more frequent from 2019 as her mental health worsened. Ms Matters developed a good rapport with Dr Hughes, feeling comfortable disclosing her struggles to her and also becoming more hesitant to see other doctors in her absence as time went on.[26]

33 Dr Hughes referred Ms Matters to Ms Burlock for the first time in December 2016 for her assessment and management of Ms Matters' anxiety and depression.

34 Amanda Burlock completed her Master of Psychology (clinical) in 2001 which saw her intensively trained in a range of therapeutic approaches, including DBT as a treatment

---

21 T486
22 Exhibit C35 at [22]
23 Exhibit C35 at [7] and T557
24 Exhibit C23 p126
25 Exhibit C29 at 2
26 Exhibit C29 at 3

approach for psychological issues. She has been working full time as a clinical psychologist since 2002 in a number of roles including within the community mental health services as well as inpatient services, in addition to private practice.

35 Ms Burlock gave evidence that Ms Matters made the decision to see her for consideration of undertaking DBT to manage her BPD.[27] She explained that the treatment plan she developed for Ms Matters was to provide individual DBT therapy sessions along with DBT skills training group sessions.[28]

36 Ms Burlock said that she began to notice weight loss in Ms Matters from their fifth session on 23 June 2017 and Ms Matters also began to report more concerning features of emerging anorexia, such as fatigue, light-headedness, as well as describing the urge to cut away her lower ribs. These concerning symptoms persisted through to their 35th session on 15 May 2019.

37 Throughout this period, Ms Matters continued to engage in acts of self-harm. At one point, she expressed in an email to Ms Burlock that she had begun to avoid Dr Hughes because she felt she had become a burden to her,[29] a thought pattern which sadly foreshadowed her eventual disengagement from Dr Hughes prior to her death.

38 In 2018, Ms Matters had some psychiatric input from Dr Bagvati Asokan, who undertook a medication review in September of that year.[30] She was also seen by the Southern Community Mental Health Team (SCMHT) in late 2019 in the context of auditory hallucinations and self-harm. Ms Matters had initially been referred in November 2018 and had some telephone consultations with various members of the SCMHT. She was ultimately referred back to the private sector, as she required a clearance from a psychiatrist to complete her last placement with Dr Asokan.[31]

39 Ms Matters engaged with another psychiatrist who worked with Dr Asokan, Dr Aartie Goel, but returned to see Ms Burlock on 15 May 2019, expressing uncertainty with Dr Goel's assessment of her. He had formed concerns that she had lost 5 kg over six months with active effort and believed that she met the criteria for an eating disorder.[32] She reportedly said that she thought Dr Goel was 'convinced [she has] a problem with eating and weight'.[33] Ms Burlock then noted her to be guarded about exploring this impression further and was dismissive about the concerns regarding her weight. Ms Burlock said that even prior to Dr Goel's assessment, she already had increasing concerns about Ms Matters' physical health and weight loss but felt it was outside of her scope of practice to assess whether these were attributed to other medical causes that Ms Matters had mentioned to her, or to restrictive eating.[34]

40 It was at this time that Dr Hughes had become concerned with Ms Matters' ability to undertake full-time work and had recommended that Ms Matters commit to reduced hours

---

27 Exhibit C32 at 3
28 T276-7
29 Exhibit C23 at 89
30 Exhibit C21 at 440
31 Exhibit C21 at 59, Exhibit C21c at 437 and Exhibit C28 at 112-113
32 Exhibit C13 at 26
33 Exhibit C23 at 130
34 T279-T280

for her training program. Ms Burlock said that she concurred with Dr Hughes' opinion but had not given Ms Matters this advice herself.[35]

41 Dr Hughes said that her concerns about work were multi-faceted. In particular that Ms Matters' physical health, including her fatigue and dizziness, might mean that she was not able to meet the physical demands of a job as a nurse, as well as the concern that potentially witnessing or having to treat sick patients, or simply being present in a medical department, could be triggering for her emotional or mental health.[36] In addition to this, she said that Ms Matters' physical capacity was of major concern to her, given her significantly reduced body weight and various other symptoms which affected her capacity to cope with the physical demands of nursing work.[37]

42 Ms Burlock expanded on this, telling the Court that Ms Matters had discussed with her many instances during her nursing training where interactions with certain types of patients and other staff in the workplace had caused her psychological distress and, at times, had led or contributed to her later self-harming.[38]

43 Dr Hughes wrote a letter to Dr Goel setting out her concerns in relation to Ms Matters having access to medications through work (in light of her prior overdose incident) and that due to her psychological health, she might have limited capacity to undertake full-time work.[39]

44 I have already described the evidence I heard about the degree of difficulty of treating the combination of conditions that Ms Matters had. Dr Hughes explained that the treatment of a severe eating disorder with comorbid psychiatric disorders is not only difficult but also takes a significant time commitment. Her view was that it would be very challenging to maintain a full-time workload during such intensive treatment.[40]

Referral to SEDS

45 On 12 June 2019, Ms Burlock wrote to Dr Hughes in relation to the care that Ms Burlock was providing. Ms Burlock reported that at this point, Ms Matters had told her that she was 'uncertain how treatment at SEDS will fit in with her goals for work' and was 'open to exploring what SEDS can offer (despite considerable discouragement by her family)'.[41] Notwithstanding this note, I did not receive any other evidence which suggested there was any actual discouragement by Ms Matters' family, who appear to always have been very supportive of her receiving the treatment she needed.

46 Ms Matters returned to see Dr Hughes on 14 June 2019, reporting that she had lost her job the previous day, as SA Health were not able to consent to her working reduced hours.[42] She disclosed passive suicidal thoughts and abuse of laxatives. She consented to a referral to SEDS, and this referral was compiled and faxed to SEDS the same day.[43]

---

35 T280
36 T196
37 T196
38 T278
39 Exhibit C13 and T197
40 T198
41 Exhibit C21c at 418
42 Exhibit C20 at 5
43 Exhibit C20 at 191

47 In the meantime, Ms Matters was again assessed by the SCMHT. She told them that she had cancelled an upcoming appointment with Dr Goel because she felt she had too many appointments.[44] Of course, she had already told Ms Burlock that Dr Goel wanted to explore whether there was an eating disorder and Ms Matters had not been eager to explore that. She also expressed that she had reservations about SEDS and that she did not want an eating disorder diagnosis confirmed.

48 Ms Matters had her first appointment with SEDS on 19 July 2019, where she underwent a comprehensive assessment with Dr Evan Papavasilliou. Dr Papavasilliou formally diagnosed Ms Matters with anorexia nervosa, and she was offered a place in the SEDS inpatient care unit. However Ms Matters refused, concerningly saying that she would prefer to receive advice about how to stay healthy while continuing to lose weight.[45] Ms Matters was then sent the inpatient program handbook. Dr Papavasilliou sent a letter to Dr Hughes reporting his assessment. In that letter, he said:

> Jennifer reported that she experiences regular passive suicidal ideation. This intermittently increased to active ideation approximately one to two times a week. She reported that this ideation has been longstanding and that she had no plan and was not preparing to harm herself at the time of the assessment. She denied any intent to self-harm or suicide through starvation. She had a past safety plan and was aware of emergency contacts should dangerous ideation occur. She reported that her first suicide attempt occurred in 2014 and she was uncertain of how many attempts have occurred since. She estimated approximately six ED presentations since that time with the most recent in November 2018. She reported that deliberate self-harm began in 2013 in the form of cutting with primary triggers being feelings of a need to punish herself or to help regulate emotions. Her longest time without any self-harm was one year and attributes this likely to engagement with DBT. She reported that she continues to self-harm but with reduced frequency of approximately once a month. Frequency has reduced as eating disorder behaviours have become more prominent. The current nature of self-harm is quite significant. While the frequency is not common she will cut quite deep, often into fat layers. She reported regular contact with her GP in order to seek support for this. She denied any ideation of harm to others and she denied access to firearms. She reported ongoing efforts to remove means and make her environment safer.
>
> …
>
> I will discuss with the Statewide Eating Disorder Service multidisciplinary team in regards to which stepped care option would be best suited for Jennifer at this time. I believe that the SEDS inpatient program may be a good option if Jennifer is currently motivated to consider this and I have recommended to her that she engage in the assessment process and receiving further information to what I discussed with her today. I will organise this.
>
> While Jennifer would benefit from eating disorder expertise, at this stage the SEDS Inpatient program seems the most viable option as weight restoration is required. At current severity there are likely only limited gains that could be expected from CBT-E until this is achieved.[46]

49 Dr Papavasilliou later reported Ms Matters' case to the SEDS clinical review meeting on 31 July 2019.[47]

---

44 Exhibit C21b at 303
45 Exhibit C20 at 198
46 Exhibit C20 at 200
47 Exhibit C21 at 93

First presentation to the Flinders Medical Centre

50 Following her assessment by Dr Papavasilliou, Ms Matters presented to the Flinders Medical Centre (Flinders) on 29 July 2019 reporting that she had experienced chest pain for the last few days, palpitations and regular episodes of fainting. She reported that she felt hopeless with the recent loss of her nursing placement. She was assessed by an Emergency Department doctor, Mary-Jo Flavel, who recorded the plan 'follow anorexia protocol, [chest x-ray], add on bloods, weight please'.[48] She was later discharged from the Emergency Department without admission to hospital.

51 During her time at hospital, Ms Matters' case was discussed by SEDS clinicians and it was decided that she should be booked for a pre-admission meeting. In conversation with Ms Matters, this was booked for 5 August 2019.[49]

52 Also during her admission, someone working at Flinders spoke to Ms Matters in an inappropriate way. I am satisfied that this person was not any of the people who gave evidence and that I am unable to determine who this person was.

53 A discharge summary for the visit was completed by another Emergency Department doctor, Julie Kirchoff. This included that Ms Matters had presented with dizziness and superficial self-harm on a background of complex PTSD and recent diagnosis of anorexia nervosa. Treatment while in the Department was recorded as consisting of cleansing and redressing the wound and oral rehydration. It was noted that Ms Matters was asked to see her psychologist in seven days and to bring her next psychiatrist appointment two weeks closer. It was further noted that she had been provided with education about incorporating tryptophan in the diet and the importance of hydration.[50]

54 In her affidavit, Dr Kirchoff said that she does not believe that she personally treated Ms Matters or was otherwise involved in her care. She also said that she does not know Dr Flavel. Having considered the discharge summary, she said that she does not believe she prepared it as it is not her usual practice to do so (this instead being the role of an intern or registrar). She also said that she would not have used the language that is contained in the discharge summary and she has never given a recommendation to a patient to implement the tryptophan diet.[51]

55 The reference to 'tryptophan' in the discharge summary was somewhat controversial in that it implied Ms Matters just needed to eat foods that would improve her mood. While it is not known exactly what the author of the summary meant by the reference to implement a tryptophan diet, it is not difficult to see how this could be construed as an insensitive and uneducated comment to someone suffering an eating disorder. That was certainly how Ms Matters perceived it.

56 Dr Philip Aplin (a consultant in the Emergency Department) also reviewed the discharge summary in relation to Ms Matters and gave evidence that he does not recall treating her. He said that his usual practice is to record a note in the record if he is directly involved in the patient's care. He said that he also does not know Dr Flavel and did not prepare the

---

48 Exhibit C21 at 494
49 Exhibit C21 at 83-84
50 Exhibit C21 at 487
51 Exhibit C37

discharge summary. He said that he is not aware of the tryptophan diet and simply would not have recommended a patient to eat foods high in tryptophan.[52]

57 Dr Flavel had moved overseas at the time of the Inquest and could not be invited to give evidence.

58 Ms Matters recounted this presentation to Ms Burlock during her appointment on 1 August 2019. She reported feeling frustrated and diminished by the psychiatric registrar who assessed her. She reported to Ms Burlock that the registrar decided to discharge her on the basis that admission to hospital might have been traumatising to her, as it would take away her control. In her notes, Ms Burlock reported that Ms Matters had told her that the 'psychiatry registrar stated that "my consultant wanted to admit you but I talked them out of it" due to Axis II diagnosis of BPD'.[53] This description of what happened is quite unusual, with the more senior medical practitioner ordinarily determining patient care. There is no reference to this difference of approach to Ms Matters' care in the medical records. I am therefore unable to conclude that this is what had actually happened, particularly given that Ms Matters was consistently ambivalent about the inpatient program at around this time.

59 Following the appointment, Ms Burlock wrote a letter to Dr Hughes and Dr Potter, summarising what she had been told by Ms Matters about her visit to Flinders, and disclosing her concern that Ms Matters' previous diagnosis of BPD may have overshadowed the seriousness of her need for medical intervention.[54] This letter was forwarded by Dr Potter to SEDS on 5 August 2019.

60 The same day, Ms Matters and her mother attended a pre-admission session with Victoria Branson of SEDS, and Ms Matters agreed to add her name to the inpatient program waiting list after discussing the pros and cons of treatment. She again brought up her presentation to Flinders and both Ms Matters and her mother reported feeling frustrated about being sent away.[55]

61 Ms Matters visited a GP, Dr Courtney Potter, on 7 August 2019. On this occasion, she reported that she was feeling a 'little better' this week, and that she was being assessed for inpatient admission but was unsure how she felt about this as it would need to be voluntary. She reported feeling 'frustrated about ebing [sic] turned away form [sic] ED early last week' and that her parents would like her admitted and said they were struggling to care for her at home.[56]

62 Ms Matters returned to Dr Hughes on 14 August 2019 and reported that she had 'lost all trust in the system', that she felt dismissed, had been told her BPD 'didn't exist' and that she had been told to go home and eat more. She said that she was on the waiting list for a SEDS admission but did not want to go anymore after her experience in the Emergency Department.[57] Dr Hughes noted some irrational decision making during this appointment.

---

52 Exhibit C39
53 Exhibit C23 at 162
54 Exhibit C21a at 70-72
55 Exhibit C21 at 83
56 Exhibit C20 at 12
57 Exhibit C20 at 13

63 Dr Hughes told the Court that she was concerned following this attendance that Ms Matters' BPD diagnosis was impacting her care and that she was concerned that Ms Matters was not given proper treatment for her wound because of her BPD diagnosis.[58]

First admission to Flinders

64 Ms Matters attended a follow-up appointment with Dr Hughes on 16 August 2019. During this appointment, Dr Hughes imposed an Inpatient Treatment Order under the *Mental Health Act*, citing impaired judgment and decision-making capacity.[59] During her evidence, Dr Hughes said that the process of reaching the conclusion that a patient had impaired judgment and decision-making capacity was to have a conversation about the nature of the medical condition and the recommended treatment, discuss the risks and benefits of all treatment options, including if no treatment is chosen and to ask her patient to retain and comprehend those risk and benefit scenarios and communicate them back to her.[60] It was after that process that Dr Hughes formed the view that Ms Matters had impaired decision-making capacity. Given their long-standing therapeutic relationship, this must have been particularly difficult for Dr Hughes. However, in my view it was entirely appropriate in the circumstances.

65 Dr Hughes then faxed a letter to SEDS informing them that Ms Matters was being sent to Flinders under an ITO.[61] She explained that she had actually prepared this letter prior to her consultation with Ms Matters, following receipt of a letter of concern about Ms Matters from Ms Burlock and obviously being alive to what might have been necessary. The effect was to ensure SEDS were aware of Ms Matters' situation even prior to her arrival at hospital.

66 Throughout her admission to the medical ward for stabilisation and assessment prior to psychiatric input, Ms Matters frequently sought out staff to express her fears and anxieties, maintaining that she did not need to be in hospital to be stabilised, and disclosing that she was struggling being in the Acute Medical Unit.[62] She would repeatedly pull out her nasogastric tube and absconded from the ward multiple times.[63] At one point, she left a note to the psychiatric team indicating that she was 'reasonable and rational' and that she would return within an hour to discuss her discharge. She wrote that there were no grounds for her detention and that she felt she was 'being held against my will to be fattened up'. She wrote:

> I do apologise for not following the rules, however, as I have mentioned many times - I never consented to play this game - let alone follow the rules.
>
> …
>
> I was moved to Meal Plan 5 yesterday and there is no way it is reasonable to expect anyone to eat in accordance with Meal Plan 5, which is OVER 3,000 calories per day. That is grotesque in its excessiveness and I am done with being compliant and calm and trying my best (through <u>significant</u> distress) to follow your rules.
>
> …

---

58 T202
59 Exhibit C20 at 14
60 T215
61 Exhibit C21 at 84
62 Exhibit C21 at 214 at 222 and 252
63 Exhibit C21 at 255 and 258

> I refuse to let you continue to make me obese and to feed me such an excess and call it a 'treatment' – it is not a treatment, it is more akin to torture – as you are making me gain weight (and thus severely raising my distress) … but in detaining me here you have removed all my ability to access help for my distress.
>
> I am medically stable enough for discharge. You have already made me gain a sickening amount of weight. And I am an adult and deserve the basic right to my own autonomy and freedom.
>
> I respectfully request you revoke this unjust ITO and discharge me immediately.
>
> Thank you,
>
> Jenni [64]

67 There also appear to have been unfortunate comments made by unknown staff members during this admission. Ms Matters sent a text message to Ms Burlock during this admission that read:

> The nurses are USELESS – one asked me 'how often do you eat because my Keto Diet isn't working and I need to lose weight' [65]

68 She also told Ms Burlock that another staff member had said to her, 'no offence but you don't look anorexic', which is an especially concerning comment to a patient whose self-perception was already skewed to feeling overweight.

69 Ms Matters' father also gave evidence about comments that he had heard first-hand. He said that a nurse commented to Ms Matters 'you're so skinny' and that nursing staff, away from Ms Matters, had referred to her as 'the anorexic in the corner'. He also said that he was aware that a nurse asked Ms Matters for 'dieting tips', saying 'you know… you're skinny, what's your secret', although this might have been on a different occasion.[66]

70 It was submitted to me by Counsel for the State that I cannot make a finding that these comments were made, as I did not hear evidence from each and every nurse who interacted with Ms Matters to give them the opportunity to refute the allegation and to otherwise explain why such comments were made.

71 I consider that examination of this issue must therefore necessarily include an assessment of the strength of my satisfaction that the comments were made and whether there is a genuine possibility that the identity of the person who made the comments could be ascertained.

72 In my view, the ability to narrow those who might have made these comments to a fairly small cohort is not the point, it is instead whether my criticism is directed to an individual who ought to be given procedural fairness. The allegation of these comments was not made against any specific person. Even if a list of candidates was produced, it would still not identify the person. In those circumstances, I consider that the identity of the person or persons who made these comments is not reasonably able to be ascertained.

---

64 Exhibit C21 at 255
65 Exhibit C23a at 80
66 T47

73 Having made those considerations, I find that these comments were made. There is clear contemporaneous evidence from Ms Matters herself. There was clear and unchallenged[67] evidence from Mr Matters that aligns with the nature of the comments Ms Matters reported and reinforces that there was not a strong level of compassion in the approach of staff generally.

74 These comments were absolutely inappropriate. I find that they were not in accordance with the harm minimisation principles of the Eating Disorder Safe Principles. Their nature undermines the therapeutic situation that all health care workers should bring to patients with all manner of conditions. I do not identify any individual staff member, as I simply do not know who made the comments. As I do not know who made the comments, I am unable to obtain their rationale for having made them, however I am satisfied that there is no explanation that would be consistent with the delivery of compassionate professional care. It is possible that the comments were made in an attempt to make Ms Matters feel better about her extremely low weight, but even viewed in that more benign light, encouraging a patient with anorexia nervosa to value an extremely low body weight is dangerous. This could therefore not be a properly considered professional interaction.

75 During this admission Ms Matters remained on the SEDS waitlist for an inpatient bed. However, as I will detail below, by the time Ms Matters had been medically stabilised, her willingness to transfer to a SEDS inpatient bed had waned. Accordingly, she was discharged back to the community.

Dr Randall Long

76 Dr Randall Long obtained a Bachelor of Medicine and Surgery in 1996 and became a fellow of the Royal Australian and New Zealand College of Psychiatrists in 2003. He is the Head of Unit for the Consultation-Liaison Psychiatry Service at Flinders and the Head of Unit for SEDS.[68]

77 The Consultation-Liaison Psychiatry Service is a small group comprised of a psychiatrist, two psychiatric registrars and a psychiatric nurse. The team works in the Flinders general hospital setting and see patients who are admitted with a medical or surgical condition who may or may not also have a mental illness. A component of the work naturally includes patients with a medical complication of an eating disorder.[69]

78 Ms Matters was seen by Dr Long for the first time during her admission, on 19 August 2019. Dr Long was asked to review Ms Matters in his capacity as a consultation-liaison psychiatrist, rather than being brought in through SEDS.

79 Dr Long noted that Dr Papavasilliou had assessed Ms Matters and had made a diagnosis of anorexia nervosa and BPD.[70] He noted that she was a survivor of trauma living with complex PTSD. He noted that she had developed anorexia after a history of irritable bowel syndrome and undergoing a FODMAP restrictive diet which appeared to have triggered a predisposition to an eating disorder. He assessed that she was in a 'starved' condition with syncope and pre-syncope with her heart in advanced hibernation which

---

67 T64
68 Exhibit C35 at [2]
69 Exhibit C35 at [4] and T487
70 Exhibit C21 at 198-202

had led to cerebral hypoperfusion. He found that she did not have a component of binging, purging or vomiting, but that she would over-exercise, including, concerningly, that she had continued to restrict her eating and over-exercise even when in hospital. Dr Long recorded that Ms Matters was 'out of control' at that time.

80 Dr Long found that Ms Matters had refused to eat 100% of the meals provided to her in hospital. He immediately turned his attention to investigating why a nasogastric feeding tube had not been used. He gave evidence:

> I said 'Why hasn't she received a nasogastric tube within 24 hours', I'm referring to the protocols that we all share at Flinders Medical Centre. I said there was an urgent need for this given her decreased heart rate, her increased postural tachycardia, low temperature and hypoglycaemia, all indicating medical complications of starvation.[71]

81 Dr Long made a diagnosis of anorexia nervosa, complex PTSD, BPD, starved, hypoglycaemia with cardiac compromise and out of control anorexia nervosa. He felt that the anorexia was defending against complex trauma symptoms, with vigorous starvation behaviour used to attempt to manage PTSD.[72] He reviewed the ITO and confirmed that it was necessary. He indicated that a 1:1 nurse special was required to supervise Ms Matters. He modified some of the medications prescribed to Ms Matters, including adding medications to ease her anxiety. He asked for a fresh medical review of whether Ms Matters did actually suffer from irritable bowel syndrome.

82 Dr Long's assessment of Ms Matters was ultimately that she was incapacitated by her illness and that she required life-saving care and facilitated that with the multidisciplinary team at Flinders. He told the Court he would have liaised with physician colleagues and started a plan but also committed to seeing her on a regular basis throughout the admission. He considered that he was offering treatment to Ms Matters at this time in the form of brief motivational interviewing, with a goal to let the patient realise that he understood the difficulty of her situation and to shift her towards cooperation, collaboration or acceptance of the care that is needed.[73]

83 Dr Long next saw Ms Matters on 26 August 2019 while she was still under the ITO. Dr Long said that Ms Matters was still medically unfit at this time. Ms Matters had removed her nasogastric tube and he suggested oral intake and bolus replacement as the best option. In relation to diet, he asked for a dietician review and if that did not work, that nasogastric feeding would have to be reconsidered.[74]

84 In his next review on 2 September 2019, Dr Long considered that Ms Matters' immediate risk of injury or death had been mitigated as she was starting to achieve a nutritional buffer. He commenced planning discharge care options at this time. He ordered checks of her postural heart rate and blood pressure three times a day to determine whether she

---

71 T503
72 T504
73 T505
74 T505 and Exhibit C21 at 236

was better conditioned.[75] Ms Matters was refusing to go to SEDS and Dr Long recorded that he was unable to shift her motivation. Dr Long said:

> A big thing I was working with Jenni was to try and convince her that she was very unwell, she needed to do high level recovery options with SEDS. She needs a maintenance and recovery dietetic plan, that was so that she could understand what just continuing to have enough energy to live would be, but also what is needed to recover, so she could make an informed choice.[76]

85 Dr Long considered that Ms Matters had a supportive general practitioner and psychologist that he was happy with, and that Ms Matters had specifically requested Advanced Psychology and Dr Yasna Petrunic. He discussed Ms Matters' case with doctors from general medicine and after considering discharge safety issues, he directed that Ms Matters' inpatient care continue for a bit longer.[77]

86 On 3 September 2019, Dr Long was awaiting medical advice as to whether Ms Matters was physically/medically safe for discharge to outpatient care, given she had turned down a SEDS placement. He noted that Ms Matters had 'comprehensive care options', meaning that she had comprehensive outpatient follow-up in lieu of agreeing to the SEDS inpatient program. He returned later that day and reviewed the opinion of the medical doctors who had supported discharge. He reiterated in his notes that Ms Matters had declined the SEDS inpatient program but had accepted Advanced Psychology Services. The ITO was then revoked and the discharge process commenced.[78]

87 Dr Long wrote a letter to Advanced Psychology Services and to Dr Hughes, requesting a co-therapy approach to Ms Matters' treatment in conjunction with Ms Burlock. He asked Dr Hughes to refer Ms Matters to Dr Petrunic.[79] Ms Matters was able to secure an appointment with Dr Anne O'Shea from Advanced Psychology Services for late September 2019.

88 Dr O'Shea qualified as a psychologist in 2008 and obtained a PhD in clinical psychology in 2014. Since then she has developed a clinical and academic specialisation in the treatment of eating disorders.[80]

Trial of outpatient co-therapy approach

89 Following her discharge, Ms Matters returned to Dr Hughes on 13 September 2019. She reported having put on 3.5 kg while in hospital but having already lost 1 kg since her discharge. Dr Hughes recorded:

> Underwhelmed by whole experience, also feels it caused more distress as medical admission, no Psych support
>
> Wanted more holistic experience however understands that she refuses SEDS inpatient/outpatient program (and still does as 'doesn't want to get better') which could have provided this

---

75 T507
76 T507
77 T507 and Exhibit C21 at 266
78 T509 and Exhibit C21 at 270
79 Exhibit C21 at 228
80 Exhibit C36 at [3]-[4]

> …
>
> Was suggested she see Dr Yasna Petrunic as psychiatrist as she has experience in eating disorders - keen for referral - to send today [81]

90 Dr Hughes gave evidence that she considered Ms Matters was able to appreciate and understand the risks involved in refusing SEDS treatment.

91 Dr Hughes made a referral to Dr Petrunic, however, was informed three days later that Dr Petrunic did not have capacity to see any more patients. After being informed that Dr Petrunic was unable to see Ms Matters, Dr Hughes faxed a letter to the Flinders Emergency Department advising that she had completely exhausted community supports and Ms Matters required inpatient management.[82]

92 Ms Matters attended her first appointment with Dr O'Shea on 27 September 2019 and once again said that she did not want to get better.[83] However, on 11 October 2019, Dr Hughes was able to convince Ms Matters to accept a referral to a dietician to obtain advice about how to maintain enough weight so that she could stay out of hospital.[84] She was referred to Tania Ferraretto, who noted that Ms Matters was in such a malnourished state, being 39.8 kg with a BMI of 13.9, that it would be difficult for her to understand and appreciate the risk that her condition was posing to her health.[85]

93 Ms Matters returned to Dr O'Shea on 17 October 2019. On this occasion she said that if her weight dropped to a point where she would need to be hospitalised, she would rather stop seeing her GP than increase her weight.[86] This raised very difficult issues of whether it was better to maintain engagement even though an improvement in health was not being achieved.

94 Dr O'Shea discussed the session with Dr Hughes, reporting that Ms Matters intended to lose more weight. They discussed the possibility of psychiatry input and Dr O'Shea advised she needed to see more motivation from Ms Matters before this could be beneficial. Dr Hughes noted that Ms Matters' judgment was impaired.[87]

95 On 26 October 2019 during a consultation with Dr Hughes, Ms Matters recorded a weight of 38.4 kg; the lowest she had ever been. At this time, she consented to a re-referral to SEDS, and a referral to a private psychiatrist, Dr Peter Gilchrist. Dr Gilchrist later advised he was not able to take Ms Matters as a patient due to capacity.

96 However, Dr Petrunic advised that she was able to see Ms Matters through SEDS in early December 2019, but continued to decline to consult with her privately, as her condition was too unstable. Essentially, Dr Petrunic considered it appropriate to engage with Ms Matters in the controlled inpatient environment, but that it would not be appropriate

---

81 Exhibit C20 at 15-16
82 Exhibit C21 at 115
83 Exhibit C25 at 20
84 Exhibit C20 at 22
85 Exhibit C20 at 240
86 Exhibit C25 at 29
87 Exhibit C20 at 23

to engage with her in a less controlled private context. A SEDS appointment was booked for 3 December 2019.[88]

Second admission to Flinders

97 On 29 November 2019 Ms Matters attended her appointment with Dr O'Shea from Advanced Psychology Services, advising that Dr Hughes was on leave and that she did not want to see any other GP in the meantime. This had resulted in two weeks without any GP support.[89]

98 Dr O'Shea was able to ascertain that Ms Matters was no longer working towards any goal for her weight, instead just wanting to see it decrease. She had lost 1.3 kg over the past two weeks.

99 Dr O'Shea discussed the upcoming SEDS inpatient placement, which was to be available in early January 2020, to which Ms Matters said she was 'pretty sure' she would accept the inpatient care. She expressed concern that she might be admitted to a medical ward and not to SEDS. Dr O'Shea noted an acceptance of the difficulty of increasing weight without support. They discussed a potential facility in Geelong if the wait for SEDS was too long. They discussed a potential need for Emergency Department treatment in the near future to deal with a generally low health condition. However, Ms Matters then expressed that she did not think many of the medical indicators of stable health mattered, and that she would only attend the Emergency Department if certain electrolytes were problematic.

100 At this time, Ms Matters was in a particularly critical position. She appeared to be accepting of the need for support to gain weight to improve her health and she appeared to be open to a SEDS placement, but she remained strongly resistant to any medical placement. Dr O'Shea identified that if her health condition worsened, she would likely not be accepted into SEDS and would instead be treated medically, which would likely not be successful, given Ms Matters' strong resistance.

101 Following the appointment, Dr O'Shea wrote a letter to Dr Hughes advising that outpatient treatment was not adequate or appropriate for Ms Matters, and inpatient admission was urgently required for her. She then called SEDS, advising that she was concerned about Ms Matters not being able to meet the criteria for an inpatient admission if she were to become medically unstable. She then made an appointment at Crafter Medical Centre for Ms Matters and let her know. She made a time to discuss Ms Matters with Dr Hughes by phone.

102 Dr Hughes spoke to Dr O'Shea on 2 December 2019, prior to seeing Ms Matters. Dr O'Shea advised that Ms Matters now had a BMI of 13 and had reduced her caloric intake. Dr O'Shea said that she had encouraged Ms Matters to follow the advice of Dr Petrunic in relation to any inpatient admission or presentation to the Emergency Department. Dr Hughes agreed to reinforce the same thing.

---

88 Exhibit C28 at 195
89 Exhibit C25 at 36

103 Ms Matters reported that she struggled to see any hope, even with a SEDS admission planned.[90] She reported her own weight as 35.7 kg but refused to be weighed. During her consultation with Ms Matters, Dr Hughes informed her that she was hypothermic and hypoglycaemic and that she needed to present to the Flinders Emergency Department immediately. Ms Matters said that she had an appointment with Dr Petrunic the following day and that she would rather wait for that. Dr Hughes recorded that Ms Matters tried to avoid going to hospital, but after a teary discussion, eventually agreed. Dr Hughes arranged for an ambulance transport. Dr Hughes called SEDS to notify them that Ms Matters was attending the Emergency Department voluntarily and asked them to notify Dr Petrunic, noting that she had an appointment the following day. Ms Matters was taken into hospital under an ITO. Given she had been admitted to hospital, the 3 December 2019 SEDS appointment was cancelled.[91]

104 Following her admission to hospital, Dr Hughes called Ms Matters on 5 December 2019.[92] Dr Hughes was advised by Ms Matters that there were significant issues with her blood glucose levels, and that she would be on the medical ward for some time, but that she felt the staff were more understanding this time and that she planned to stay for assessment. A tentative plan was made for a direct transfer to the SEDS inpatient unit once medically stable and a bed was available.

105 In a review by Dr Long on 17 December 2019, he continued to try to motivate Ms Matters towards accepting the inpatient program. He discussed Ms Matters' case with the general medicine team and they were happy for her to be discharged. Given this advice, Dr Long considered that she no longer required medical treatment and she was not without mental capacity at this time, therefore he was obliged to revoke the inpatient treatment order and the plan was made to discharge her home. Dr Long considered that Ms Matters knew the importance of seeing her GP. He noted that he would ask Dr Petrunic to consider Ms Matters for the next placement in the SEDS inpatient program and that he would support this if Ms Matters' motivation improved. Ms Matters had still not agreed to enter the program, but Dr Long mapped a pathway and made a referral in the hope that Dr Petrunic would continue motivational work and that this would lead her to take up the opportunity.[93] The ITO was revoked and Ms Matters was discharged.

106 The following day, Ms Matters' case was again discussed at a SEDS meeting. It was agreed that Ms Matters should see Dr Petrunic to build her motivation before being considered for the inpatient program.[94]

107 Ms Matters consulted with Dr Hughes on 23 December 2019 and reported that her most recent admission to Flinders had been challenging, but better than the last time she was there.[95] Dr Hughes noted that her insight had improved significantly.

108 On 13 January 2020, Ms Matters was seen by Angela Mignone (a dietician within SEDS) for follow-up from her December 2019 medical admission. Ms Mignone provided advice in relation to meal plans for promoting weight restoration for recovery and

---

90 Exhibit C20 at 30
91 Exhibit C21b at 351
92 Exhibit C20 at 32
93 T511 and Exhibit C21a at 260
94 Exhibit C28 at 46
95 Exhibit C20 at 32

encouragement to consider the impact of her eating disorder. Ms Matters declined further follow-up by Ms Mignone as she said she was considering admission to the SEDS IPU. She was provided with Ms Mignone's contact details to make a follow-up appointment if she wanted further support to normalise eating.[96]

109 Ms Matters then attended an appointment with Victoria Branson at SEDS on 16 January 2020 for assessment of her suitability for admission to the inpatient program and for motivation building purposes. Dr Hughes and Ms Branson had agreed that there was a strong need for Ms Matters to accept an inpatient admission voluntarily for it to be effective.[97] They were able to have her attend for assessment voluntarily with encouragement.

110 Ms Branson then saw Ms Matters again on 23 January 2020. Ms Matters had made lists of pros and cons for each of the three options for treatment. As for the second option (community follow-up with a plan to restore weight and consider the Day program in the future), Ms Matters reported that there was a 'tie' between the pros and cons. As for the third option (inpatient admission), Ms Matters reported the pros outweighed the cons (she identified the cons as struggling to be observed and being confined, triggering her PTSD history, weight gain targets being too high and the length of stay required). Ms Matters reported to Ms Branson that she was still overwhelmed by the prospect of hospitalisation and was unwilling to consider it further as an option and elected to remove her name from the SEDS inpatient program waitlist. She agreed that she would be motivated for a future inpatient admission if her psychologist disengaged, if she did not gain weight in the community, or if she had not made more substantial gains in treatment after three months.[98] Ms Branson sent Ms Matters a letter summarising their appointment.[99] Ms Matters also asked to see Dr Petrunic and Ms Branson indicated that Dr Petrunic would consider this once she had returned from leave.

111 On 3 February 2020 Ms Matters attended a consultation with Dr Hughes, advising that she had been accepted to study a medical science degree at university, and so she had made the decision to decline the offer of a SEDS inpatient bed. She said she had been told she would need to be admitted for 10-15 weeks and she was not willing to miss that much school.[100] She acknowledged she was ineligible for the outpatient program due to her low BMI and said she would try to get better in the community with the support of her mother and weekly sessions at Advanced Psychology Services.

112 Ms Matters spoke to Ms Branson on the phone. She said that she found it difficult to tell her mother of her decision not to accept a SEDS placement, but that her mother remained supportive.

113 During an appointment with Dr O'Shea on 20 February 2020, Ms Matters disclosed to her that she had been 'water loading'[101] as she was concerned her weight had decreased again. In a follow-up appointment on 27 February 2020, she showed a weight gain of

---

96 Exhibit C21c at 455
97 Exhibit C20 at 34
98 Exhibit C21b at 350-353
99 Exhibit C21b at 351
100 Exhibit C20 at 35
101 The act of drinking excessive amounts of water in order to make body weight appear higher than it actually is

1.1 kg, but denied having water loaded to achieve that.[102] She said during an appointment on 5 March 2020 that maintaining weight felt as bad as gaining it.

114 During an appointment with Dr Hughes on 21 February 2020, Ms Matters was borderline hypothermic, and she was made aware of the high risk of medical complications and death that accompanied her 35.9 kg body weight.[103] She was asked to make contact with Dr Petrunic during the week to see if she had capacity to take her on privately. Ms Matters said during her 6 March 2020 appointment that she was not yet ready to engage with a dietician or SEDS, and Dr Hughes prepared a crisis response plan for her university.[104]

Dr Yasna Petrunic

115 Dr Yasna Petrunic is a consultant psychiatrist for SEDS and is the clinical lead at the Brighton component of SEDS, (ie: the outpatient-based component). She has oversight of the referrals that are sent through, as well as oversight of the SEDS day program. As I have discussed, she also conducts private consultations in addition to her work at SEDS.

116 New referrals are given to Dr Petrunic on a weekly basis, where they are reviewed and then a recommendation is made as to what the next steps will be for the patient.[105]

117 Ms Matters attended an appointment with Dr Petrunic on 19 March 2020. She told Dr Petrunic that she felt well-supported and that she was working to increase her BMI to 15, to meet the criteria for the SEDS outpatient program.[106] Dr Petrunic recommended an inpatient admission, but Ms Matters refused.

118 Ms Matters saw Dr O'Shea on 20 March 2020 for the last of ten sessions scheduled under the Eating Disorder Plan. She reminded Ms Matters of the agreed parameters for her continuing outpatient treatment, that is, weekly medical monitoring, no more than three consecutive weight decreases, and no greater than a 2 kg weight loss over two weeks. This session saw Ms Matters' second consecutive weight decrease, and she disclosed that she had cancelled her last two appointments of medical monitoring with Dr Hughes.

119 Dr O'Shea noted that she was very concerned for Ms Matters' medical stability (given her weight of 35.6 kg) and strongly suggested that Ms Matters defer her university and instead commit to an inpatient stay. She made phone contact with Dr Hughes to request an urgent medical review of Ms Matters as soon as practicable.

120 Dr Hughes reviewed Ms Matters on 23 March 2020 in the company of her mother, noting her lowest BMI to date of 12.5 and a body temperature of 35.6°C. Ms Matters expressed that she was feeling anxious about her university moving online from Monday. She said she would be seeing Dr O'Shea again the coming Friday.

---

[102] Exhibit C25
[103] Exhibit C20 at 36
[104] Exhibit C20 at 298
[105] T84
[106] Exhibit C21b at 211

121 Dr Petrunic reported Ms Matters' case at a SEDS meeting on 25 March 2020. The notes from that meeting included:

> Dr Petrunic presented comprehensive ax (see file).
>
> Unable to work since June 2019 due to anorexia low weight health concerns. Has established diagnosis of BPD and Anorexia; sees Anne O'Shea and Amanda Burlock.
>
> BMI 12.7
>
> Patient reports she is motivated to recover as wants to attend uni and travel
> Reports mood as stable; has marked mood instability and frequent suicide and self-harm attempts in the past
> Low mood has blunted affect so not experiencing mood instability currently
> Has not self harmed for 4 months
> Ongoing anxiety driven by PTSD; says she talks about it with a psychologist
>
> Reports her eating disorder is the most disabling symptom
>
> Jennifer wants to work up to day program; aware of BMI 15 requirement
> **Plan:**
> Jennifer wants to aim to increase weight to be eligible for day program (BMI needs to improve BMI 15)
>
> Dr Petrunic will review in 4 weeks time[107]

122 Dr Petrunic then wrote to Dr Hughes with the plan formed.[108]

123 On 26 March 2020 Ms Matters had her final appointment with Dr O'Shea, with her third consecutive weight decrease, breaching the agreed parameters for continued outpatient treatment. Dr O'Shea said that further support in the community would send Ms Matters the wrong message about her prospects of recovery in the community, and so she was not appropriate for community care.[109]

124 Ms Matters returned to Dr Hughes to discuss her discharge from Dr O'Shea's care. Given her condition at this point, Dr Hughes made her aware that death was a very possible outcome of her eating disorder without urgent medical treatment. Ms Matters said that she did not want to lose her therapeutic relationship with Dr Hughes, but she was starting to become concerned that Dr Hughes would detain her which she did not want.[110] This placed Dr Hughes in an incredibly difficult situation. Dr Hughes explained to Ms Matters that she would continue to advocate for her and try to fast track a SEDS inpatient admission for her. She attempted to make phone contact with SEDS during the consultation but was not able to speak to an intake worker or psychiatrist. Dr Hughes strongly encouraged Ms Matters to accept an inpatient bed in SEDS.

125 Dr Hughes was able to speak with Dr Petrunic on 30 March 2020. Dr Petrunic said that she would try to triage Ms Matters in, given the severity of her illness, however noted that Ms Matters remained ambivalent about whether she would accept the bed.

---

[107] Exhibit C28 at 55
[108] Exhibit C21b at 347
[109] Exhibit C20 at 40
[110] Exhibit C20 at 40

Dr Petrunic's efforts were successful and Ms Matters progressed through the triage process. However, when SEDS staff tried to engage with her, Ms Matters refused an intake appointment and declined to be placed on the waiting list for an inpatient bed.[111] The referral to the SEDS inpatient program was closed. This was advised to Dr Hughes by letter on 6 April 2020.

126 Dr Hughes also received blood test results on 15 April 2020 which warned that Ms Matters was suffering from starvation hepatitis.[112]

127 Ms Matters had another appointment with Dr Petrunic on 16 April 2020 via telehealth, disclosing heightened distress and increased suicidal and self-harm urges.[113] She was strongly encouraged to request a re-referral to SEDS once she was willing to engage. Dr Petrunic said that she took Ms Matters at face value, but with residual concern that her statement that she was working towards a BMI of 15 for the day program might actually reflect a desire to allay concerns merely to delay intervention.[114] Ms Matters did not express a desire to see Dr Petrunic again at this appointment. Her preference was to continue to gain weight in the community and get back to see an individual therapist at Advanced Psychology Services with an aim to work towards participation in the SEDS day program.[115]

128 In an appointment with Dr Hughes on 5 May 2020, Ms Matters said that she did not want to be referred back to SEDS. Dr Hughes recorded that she had observed a 'genuine desire to put on sufficient weight to see Anne O'Shea again'.[116]

129 Ms Matters attended a consultation with Ms Burlock on 13 June 2020, feeling teary and hopeless about her prospects of recovery.[117] She said she had called Lifeline and the Butterfly Foundation, but was not able to get through due to excessive demand for their services. Ms Burlock phoned Dr Hughes advising her that Ms Matters appeared to have some motivation for an inpatient admission, but was saying she would only consent if she could go to the Royal Adelaide Hospital and not Flinders. Ms Burlock disclosed concerns that Ms Matters had lost insight into the severity of her condition and she was saying that she would not even consider an extra 10 calories per day. Ms Burlock said that Ms Matters' physical health concerns stemming from her weight had been increasing. This is why Ms Burlock had previously set a requirement that Ms Matters had to attend weekly medical reviews with Dr Hughes in order to continue receiving her psychological treatment.[118]

130 On 2 July 2020, Ms Matters had a further consultation with Ms Burlock. Ms Burlock said that Ms Matters had come to the appointment with anxiety and a low mood, but she was not able to assess whether Ms Matters had lost further weight, due to the bulky winter clothing she was wearing.[119] Ms Burlock said that Ms Matters' commitment to receiving focused treatment for her eating disorder and to achieve weight gain to improve her health

---

111 Exhibit C20 at 312
112 Exhibit C20 at 45
113 Exhibit C20 at 313
114 T110
115 T114 and T148
116 Exhibit C20 at 48
117 Exhibit C20 at 318
118 T286
119 T286

was constantly wavering. She said that her insight into the urgency of her health did seem to be limited, citing examples such as Ms Matters prioritising attending a family gathering rather than admission to hospital.[120]

131 She also said that she had a discussion where she told Ms Matters her intention was to discharge her from her care and into the care of her GP and the hospital system. Ms Burlock said she did this because she considered Ms Matters to have lost the capacity to be able to meaningfully participate in the treatment Ms Burlock was able to offer around non-eating disorder related symptoms and issues, and that she was about to undergo inpatient treatment.[121] Given the significant and lengthy relationship between Ms Matters and Ms Burlock by this time, I am not critical of this decision and place a great deal of weight on Ms Burlock to be able to decide what was the best way forward in all of the circumstances. Her decision was supported in retrospect by both Dr Hughes and Dr Wilksch.[122]

132 Following this consultation, Ms Burlock faxed a letter setting out her concerns to Dr Hughes. Ms Burlock noted again that a direct admission to SEDS inpatient medical ward for medical stabilisation would be ideal.[123]

Third admission to Flinders

133 Ms Matters attended her medical monitoring appointment with Dr Hughes on 3 July 2020, with a weight of 32 kg. Dr Hughes assessed her to have lost insight into the severity of her eating disorder and formed strong fears for her safety. During this appointment, Ms Matters left suddenly and Dr Hughes followed her. Ms Matters appeared to be heading towards a nearby train line. Dr Hughes called emergency services and reported that there was an immediate threat to Ms Matters' life.

134 When she was able to speak to her, Ms Matters reported that she was concerned about going to Flinders on a Friday due to the lack of teams and services available over the weekend and said that the nurses had said inappropriate things to her last time about her weight.[124]

135 Ms Matters was taken to Flinders by paramedics and was again admitted to the medical ward for stabilisation, as she was once again too unwell for the SEDS inpatient unit. On the second day of her admission, Ms Matters requested to be transferred to a SEDS inpatient bed, but it was determined that Ms Matters was too unwell and that a transfer would be a future option for her once she was in a better condition.[125] On 8 July 2020, Dr Long saw Ms Matters on the ward. He observed in a referral letter to the SEDS inpatient program that 'there is a distinct motivational shift where she is keen for recovery'.[126]

136 A bed was made available within the SEDS inpatient unit on 14 July 2020 and Ms Matters was transferred and reviewed by the consultant on 15 July 2020.[127] Ms Matters' ITO was

---

120 T287
121 T288-T289
122 T246 and T466
123 Exhibit C20 at 319, it is noted that there currently is no medical ward within the SEDS inpatient unit
124 Exhibit C20 at 54
125 Exhibit C21b at 169
126 Exhibit C21c at 34
127 Exhibit C21b at 231, see also letter of referral dated 8 July 2020 in Exhibit C21c at 34

revoked on 20 July 2020 and she began to ask to be discharged by 4 August 2020 so she could attend university. This was met with strong advice against an early discharge.

137 Notwithstanding this advice, Ms Matters chose to discharge herself against medical advice at a weight of 37.5 kg only a few weeks into her inpatient treatment.[128] She said she would engage with Dr Simon Wilksch (whom she had emailed during her admission and requested he take her on as a patient),[129] and dietician Angela Mignone as an outpatient.

Dr Simon Wilksch

138 Dr Simon Wilksch is a clinical psychologist who specialises in eating disorders. He is a co-founder of Advanced Psychology Services, a clinic with approximately ten clinicians all specialising in eating disorders.[130] Dr Wilksch took Ms Matters' case after she left SEDS.

139 In agreeing to treat Ms Matters, Dr Wilksch set down a number of non-negotiable requirements. He said that the requirements were intended as a safety net for Ms Matters due to the serious nature of her illness. The requirements were that medical stability would be maintained, there had to be weekly medical monitoring with her GP, a psychiatrist had to be regularly involved and Ms Matters had to participate in the SEDS day program (if that was recommended by SEDS). Dr Wilksch said that they would form a treatment plan that they could both agree upon. Dr Wilksch said that if Ms Matters could not keep to the requirements, it would indicate that outpatient work was not effective at that time due to the severity of the symptoms and hospital admission would be necessary instead.[131]

140 Dr Wilksch said that the Australian and New Zealand Academy of Eating Disorders (ANZAED) provides practice recommendations and guidelines for the treatment of eating disorders,[132] one of which is that ongoing medical reviews should be a non-negotiable element of treatment, as well as the crucial need for a multidisciplinary team to be involved in addition to a mental health professional.[133] Dr Wilksch said that the use of non-negotiables to establish boundaries around treatment is a significant part of mental health clinicians' work with patients with eating disorders.[134]

141 Ms Matters returned to see Dr Hughes on 7 August 2020, reporting a fairly positive experience in the SEDS inpatient unit, however Dr Hughes had yet to receive a copy of the discharge summary for this visit.[135] Dr Hughes had been requesting the discharge paperwork, but this was not received until 17 August 2020.

142 Ms Matters attended a review appointment by Ms Mignone on 25 August 2020. Ms Mignone reported that Ms Matters was at high risk of medical instability with a distorted perception of adequate intake, and that further weight loss was likely. A follow-

---

[128] Exhibit C21b at 263 and 267
[129] Exhibit C33
[130] T384
[131] Exhibit C33 at [6]
[132] Exhibit C33b
[133] T386-T387
[134] T387
[135] Exhibit C20 at 56

up appointment was booked for one month, but Ms Matters cancelled that appointment and did not rebook.[136]

143 On 31 August 2020, Dr Hughes noted that Ms Matters' neutropenia was persisting and the presence of hypoglycaemia. She discussed Ms Matters with Dr Wilksch, and both were in agreement that she 'really does need inpatient treatment'.[137] Ms Matters was concerned that Ms Mignone would not want to take her on as a patient due to her low weight.

144 Ms Matters saw both Dr Hughes and Dr Wilksch for separate consultations on 21 September 2020. During her consultation with Dr Hughes, Ms Matters refused to be weighed, disclosed that eating was still challenging for her and refused a referral back to the SEDS inpatient unit due to her university commitments.[138] She said she would reconsider this in November. Dr Hughes and Dr Wilksch made contact with each other following their respective consultations and Dr Wilksch expressed support for the idea of Ms Matters re-engaging with Ms Burlock. Dr Hughes told Dr Wilksch that Ms Matters said she might be willing to accept a re-referral to SEDS in November.

145 On 30 September 2020, Ms Matters attended an outpatient appointment with Dr Petrunic. Dr Petrunic once again strongly recommended inpatient SEDS treatment, however Ms Matters refused. Dr Petrunic noted that Ms Matters was medically stable and competent to make informed decisions about her care.[139] As a result, no further appointments were booked. Dr Petrunic explained that her usual practice was to invite consideration as to whether it would be helpful for patients to come back and I have no reason to doubt that Dr Petrunic would have had that discussion with Ms Matters.[140]

146 Dr Hughes phoned Dr Petrunic to discuss this consultation, and whether or not Ms Matters actually had capacity to make a decision to refuse necessary treatment. Dr Petrunic explained that she considered that Ms Matters understood the consequences of her decisions and had capacity to refuse a SEDS admission or other treatment. Dr Petrunic advised that all that could be done was continued medical monitoring, psychological treatment and a re-referral to SEDS if Ms Matters changed her mind.[141]

147 Ms Matters attended two further appointments with Dr Hughes on 16 and 26 October 2020. During these consultations, Dr Hughes says she counselled her at length about the increasing risk of sudden death. Dr Hughes noted that Ms Matters continued to show insight into the risks of declining voluntary treatment. This meant that she continued to have the capacity to make that decision.

148 Ms Matters began to miss appointments with Dr Hughes from 30 October 2020 onwards and avoided calls from Dr Hughes that were made to find out why she had not attended.

149 On 23 November 2020, Dr Hughes was able to speak to Ms Matters on the phone. She was advised that Ms Matters was looking to move out of home with a friend and was going to change GPs. She was evasive when Dr Hughes offered to facilitate a handover

---

[136] Exhibit C21c at 461-462
[137] Exhibit C20 at 59
[138] Exhibit C20 at 64
[139] Exhibit C20 at 349
[140] T155-T156
[141] Exhibit C20 at 66 and 70

to a new GP. Dr Hughes then made numerous calls to Dr Petrunic for advice but was not able to reach her.

150 Mr Matters became very concerned about his daughter at this point, raising concerns with his own GP, Dr Del Fante, who did what he could by notifying Dr Hughes. Unfortunately, Dr Hughes did not have the ability to do anything as Ms Matters had disengaged.

151 Following this disengagement from care, her sessions with psychologist Dr Wilksch were placed on hold as she no longer met one of the key criteria Dr Wilksch required for outpatient therapy, namely weekly medical monitoring. Dr Wilksch became concerned that Ms Matters was disengaging from all treatment and sent his concerns to Dr Hughes by email.

152 Dr Wilksch and Ms Matters exchanged numerous emails, with Dr Wilksch strongly recommending Ms Matters continue her medical monitoring, but Ms Matters was adamant that she would be switching GPs. Dr Wilksch was therefore left with no option but to hold his further appointments with Ms Matters until she engaged a new GP.

153 Dr Hughes eventually made contact with Dr Petrunic, who suggested that Dr Hughes send a letter to Ms Matters outlining her concerns and offering phone consultations in the interim. This proposal would have seen, at least, continued engagement even though it was not in the optimal face-to-face manner. This letter was sent by registered post.

154 On 3 December 2020, Dr Hughes managed to speak with Ms Matters on the phone again, asking if she had received the letter. Ms Matters claimed she had not. She refused to have further appointments by phone and told Dr Hughes that her weight was stable. Ms Matters gave Dr Hughes permission to speak to her father. Dr Hughes then informed him that Ms Matters had disengaged from medical monitoring for more than four weeks and told him to take Ms Matters to the Emergency Department if she became symptomatic.

Fourth admission to Flinders

155 On 8 December 2020, Mr Matters sent an email to Dr Wilksch requesting advice for how to manage Ms Matters' care in circumstances where she had withdrawn from all health services, including Dr Hughes.[142] In his evidence, Mr Matters described being desperate for advice about how to engage with the system as parents.[143]

156 The possibility of calling an ambulance for Ms Matters was discussed, as was convincing her to return to her GP where an ITO could then be placed on her. Mr Matters described having huge concerns about being the person who 'blew the whistle' and breaching the trust that his daughter would have in him in the future.[144] These were reasonable concerns to have, particularly given that Ms Matters had disengaged from all of her other supports; professionals and also her friends. Mr Matters told the Court that maintaining his relationship with Ms Matters was pivotal to her mental health as she had become more isolated.[145] Mr Matters then made the difficult decision in January 2021 to encourage her

---

142 Exhibit C24 at 19
143 T57
144 T58
145 T59

to visit the GP, with the explanation that she needed a blood test, knowing what was likely going to happen.

157 Ms Matters attended and had blood taken. She was told that the results had showed that she needed immediate medical treatment in hospital. She was told that she must either present herself to hospital otherwise her parents had been instructed by the doctor to call an ambulance to take her there.[146] Ms Matters was then voluntarily taken to Flinders and once again admitted to the medical ward for medical stabilisation.

158 Ms Matters was seen by Dr Long numerous times during her stay. A concerning note written by Dr Long on 25 January 2021 records, 'Staff: please never say 'the anorexic' to refer to her'.[147]

159 Through her admission, Ms Matters expressed a strong desire for outpatient treatment with Dr Wilksch and continued to refuse inpatient admission to SEDS.[148]

160 Dr Long noted that Ms Matters was very unwell and was unable to maintain vital physiology, noting 'I think she is too dangerously advanced to consider even a high-risk discharge. For context: discharge under 38kg-40 kg will be very risky'.[149] He requested a multidisciplinary huddle to explore discharge options and continued to stress his recommendation for inpatient care.

161 Ultimately, Ms Matters was discharged on 10 February 2021 after continuing to refuse inpatient care. She was at a weight that continued to cause concern to her parents, however they were under the impression that she was going to be receiving outpatient follow-up monitoring by SEDS. Ms Matters' mother would drop her to SEDS appointments and instead of attending, Ms Matters would take the train to university.[150]

162 Dr Long said that after February 2021, he did not believe there were any follow-up appointments with SEDS. The offers that had been made were for acceptance into the inpatient program, or the day patient program with ongoing care but that Ms Matters had declined those offers.[151]

163 During his evidence, Dr Long was asked to comment on the adequacy of the follow-up plan put in place.[152] He said that he thought the plan represented all that the medical team could do, in that they had ensured there was a GP review and repeat bloods taken, with a date for further follow-up. He also said that the GP could arrange any further appointments that were necessary.[153]

164 After leaving Flinders, Ms Matters began to seek the input of various doctors about perioral dermatitis that had developed from the adhesive used to fix her nasogastric tube.

---

146 T59-60
147 Exhibit C21c at 113
148 Exhibit C21c at 131
149 Exhibit C21c at 140
150 T60
151 T621
152 Exhibit C21c at 15
153 T621

She otherwise continued to be medically unmonitored. She had a dietician appointment in March that she did not attend, even when re-scheduled.[154]

165 On 28 May 2021, Ms Matters left her family home and travelled by train to Belair National Park. She hiked the trail to the Lower Waterfall and climbed over the rail of the lookout point to sit on the edge. While there, Ms Matters called police and explained to the call taker that she was intent on taking her life and wanted police to find her body so as not to traumatise any members of the public.[155]

166 Ms Matters eloquently explained to the call taker that she had been suffering from mental health problems for 10 years and that she had been struggling from an eating disorder for two years. She explained that she had been in and out of hospital and subject to inpatient treatment orders, but that she found the treatment to be inadequate. She said this comprised of having weight-restoring interventions and then being discharged without ongoing support. She said she had tried everything and did not want to spend another year in a cycle of being admitted and discharged from Flinders Medical Centre.

167 Ms Matters sounded calm during the conversation. Towards the end of the call, Ms Matters could be heard talking to a passerby who was attempting to persuade her to move away from the ledge, clearly sensing what was about to happen. Ms Matters asked this person not to come closer and to please be careful. After a short period of time, the phone was heard to abruptly drop to the ground.[156] The passerby then contacted police and reported that Ms Matters had jumped from the ledge.

168 Police attended and found Ms Matters. She was taken to the Flinders Medical Centre with traumatic injuries that were ultimately incompatible with life. Tragically, while efforts were being made to save her life, a letter was received by Dr Randall Long at SEDS in which Ms Matters expressed her frustration about the way she had been treated as a patient with anorexia nervosa and attributing her suicide to the illness.

Ms Matters' own account

169 Before her death, Ms Matters made a number of records of her views and in particular the manner in which she viewed her own health and the healthcare she was provided.

170 In a letter to Dr Long, Ms Matters wrote:

> I am not here to blame my death on anyone, least of all the wonderful people doing their best to look after us eating disorder patients with the limited resources, time, facilities and options available. I am here to say that maybe if things had been different and people along the way understood more about the cognitions involved in eating disorders I may not have been put so offside by treatment initially and struggled so much to believe I even had a problem at the beginning before it really set in to the point it is now impossible to escape or live with. The earlier intervention the better the outcome, or so I have been told. I don't know what more, if anything, could have been done in my case. More than likely nothing, but I just needed to write down the fact that I am dying and so desperately completely

---

154 Exhibit C21c at 462
155 Exhibit C12b
156 Exhibit C12

> exhausted from fighting and if treatment looked a tiny bit different I may not have walked the same path.[157]

171 Ms Matters told Dr Long that she was tired of living every moment of every day tortured by her mental health and failures and loss, tired of waking every morning at 5:30 am to get her exercise routine completed, tired of being tracked by numbers and constantly counting everything: calories, steps, exercise minutes, macros, meal times, allowed food, kilograms lost, opportunities lost, and tired of not being able to cope unless she weighed less than 30 kg. She told Dr Long:

> Thank you for the work that you do, fighting so hard to keep people with eating disorders alive, for working to reform the mental health system and address the inherent issues in treating these illnesses that are so firmly psychiatric and also psychological. It isn't perfect, but you and your team have made a huge difference and I am grateful for all the lives you've managed to save and improve and see to go on and thrive.

172 She asked Dr Long to thank Dr Wilksch and Dr Hughes, saying, 'They also gave it their all to save me'.[158]

Cause of death

173 An external examination of Ms Matters' body was conducted by specialist forensic pathologist, Dr John Gilbert.[159] Dr Gilbert noted residual bruising involving the left side of the face, the left shoulder, left upper arm, left posterolateral chest and left chin. A CT scan confirmed that there were multiple skeletal fractures as well as brain injuries resulting in subarachnoid, subdural, intracerebral and intraventricular haemorrhage.

174 Dr Gilbert concluded that Ms Matters had died as a result of severe traumatic brain injury. I accept Dr Gilbert's opinion and enter a finding to that effect.

175 Dr Long gave evidence that Ms Matters had succumbed to a severe and complex mental illness in the form of anorexia with comorbid trauma, borderline personality disorder and post-traumatic stress disorder.[160] I accept that opinion and enter a finding that this was the background that ultimately led to Ms Matters' death.

Consideration of the issues and Recommendations

176 I received helpful submissions on behalf of the National Eating Disorders Collaboration. They focused on the National Eating Disorders Strategy 2023-2033. Others involved in the Inquest focused on this strategy and spoke against certain improvements on the basis that the National Strategy did not indicate it was required. While I accept that a national approach is ideal, I do not consider that initiatives to improve care should not be pursued merely on the basis that a National Strategy had not identified the same initiative. The Strategy should be used as a guide, not as a limitation on what can and should be achieved.

---

157 Exhibit C7c at 60
158 Ibid
159 Exhibit C2a
160 T622

Ms Matters' team (from time to time)

177 Dr Long gave evidence that, upon reflection, Ms Matters had a very good team, including experienced psychologists Dr Wilksch and Ms Burlock (the latter whom he considered was an excellent choice for a patient with BPD). However, he also considered that it was Ms Matters' BPD that frustrated her ability to recover.

178 I accept Dr Long's opinion about the quality of Dr Wilksch and Ms Burlock's input. I also observe the consistent and supportive work by Dr Hughes who was, on numerous occasions, put in extremely difficult positions, but managed to make decisions that supported Ms Matters while continuing to maintain a working relationship.

179 I also find that Dr Petrunic's inputs were of a reasonable standard, albeit more highly focused. Dr Petrunic is obviously under high demand and needs to give her attention to patients that are willing to engage. She cannot be criticised for attempting to provide her limited resources where they are going to be the most effective. By the time she gave evidence, she had reflected on Ms Matters' case and had modified her practice to have more case conferences with other healthcare professionals in complex cases.[161] In this way, everyone involved has a greater understanding of what services are available and what each professional is providing or able to provide. I endorse this as a good approach to very difficult cases.

The number of eating disorder services available

180 It is clear from the notes left by Ms Matters that she herself considered that she did not receive enough support from the mental health system.[162] Further, that her decision to end her life was causally related to her eating disorder and the fatigue she felt from engagement with the services that were available.

181 The Department for Health and Wellbeing provided evidence that there were approximately 1.1 million Australians living with an eating disorder in 2023 (representing a 21% increase since 2012).[163] In 2024, approximately 83,400 South Australians were impacted by an eating disorder, with the number of people presenting at a South Australian hospital because of an eating disorder increasing significantly over the past five years.[164] Dr Wilksch gave the following concerning evidence:

> Unfortunately, there has been a perception that - that eating disorders might be a niche problem, or a non-high prevalence problem when it comes to mental health, and that is just not the case at all. There - you know - there's - there's data from Deloitte and the Butterfly Foundation about a 21% increase in the number of patients with eating disorder in 2024 versus 2012, and I've dug down into that a bit deeper, and that includes a 200% increase in 10 to 14-year-olds, and a 76% increase in 15 to 19-year-olds. So that's one of the reasons, on a different note, that I'm heavily involved in trying to seek greater regulation of social media and contributions to the environment of young people that can cause suffering in these areas, but yeah, we - we definitely need the Health System to be able to - to help people as effectively and as efficiently as possible.
>
> …

---

161 T166
162 Exhibit C7c
163 Exhibit C38
164 Exhibit C38

> I have looked at it through the lens of asking parents in that - parent research - what the kind of average out-of-pocket expenses that you have faced as parents. From memory, the median expense was $10-20,000. On average, households need to take 70 working days off during their child's illness to help them recover. The Butterfly Foundation - the report that I mentioned a moment ago - they have estimated with Deloitte that the economic and social cost of eating disorders has grown to $67 billion per annum in terms of - I mean, you look across treatment costs, lost of productivity, impact on carers, and so on, so it's enormous.[165]

182 Ms Sinead O'Brien, Deputy Chief Executive of Strategy and Governance at the Department for Health and Wellbeing, outlined that in 2023 and 2024, Flinders Medical Centre supported 259 inpatients with a principal diagnosis of an eating disorder.[166] Of those 259, 71 were treated in a SEDS bed with a primary diagnosis of an eating disorder. This means that 188 of the inpatient admissions were treated at Flinders for their eating disorder outside of the specialist SEDS inpatient program.

183 Dr Long agreed that there is a gap in the treatment options available to a person living with anorexia nervosa but that has a BMI of under 15. He said that he believes there is a gap in treatment for all patients with eating disorders, but that having a BMI of under 15 further limits the options available.[167]

184 Where demand outstrips supply, a waitlisting model is used, as it is in many medical services. Dr Long explained that placing people on a waiting list prolongs their experience of an eating disorder which risks the eating disorder becoming persistent, chronic, severe and enduring and deadly.[168] Insightfully, Ms Matters identified this as a factor that had worsened her illness in the letter she wrote to Dr Long. It logically follows that if things can be done to reduce the waitlist, one would expect to see a reduction in the more severe cases, or at least a reduction in the harm experienced by those who are forced to wait for long periods for treatment.

SEDS and the new Residential Eating Disorder Service at the Repatriation General Hospital (the Repat)

185 The SEDS organisation is not large enough to treat everyone in South Australia with an eating disorder, which results in significant waitlists for assessment and placement. I was advised that this is a challenge that affects eating disorder service providers around Australia, New Zealand and internationally.[169] The patients waiting on these lists are at risk.

186 I also heard that there are generally limited options to support patients with eating disorders who have a BMI of less than 15 and who do not wish to be admitted to hospital.[170]

187 Ms O'Brien advised me that even if additional beds in the SEDS inpatient program were able to be created promptly, it would not address the overarching issue which is the increasing numbers of patients seeking treatment in a hospital. Even if it did not keep up

---

165 T467
166 Noting that one person may have had multiple admissions across a year and that their admission may have been to a general or specialist eating disorder bed
167 T598
168 T564
169 T498
170 T418

with the precise demand, an increase in services would nevertheless assist in minimising instances of unsafe circumstances arising.

188 The Department said that, in any event, even if space could be found to create additional inpatient beds, finding appropriately skilled staff would be extremely difficult due to national shortages in mental health staffing, especially within the eating disorders subspecialty. I was advised that this issue has already interfered with the opening of 72 additional sub-acute mental health beds in South Australia.

189 These issues of insufficient staff might also have affected Ms Matters' journey. That is, she told Ms Burlock on one occasion that she thought she had been detained under the *Mental Health Act* because staff did not want her to discharge herself on the weekend when there would be no support available.

190 Dr Long told the Court that there is 24-hour-a-day psychiatric support available from nursing specialists at SEDS. A registrar, resident medical officer and a consultant psychiatrist operate throughout the whole hospital and often their work is focused on the Emergency Department, but they are available to come to SEDS beds to assist where needed. However, he acknowledged that one consideration in favour of imposing an ITO might be that the patient would be at greater risk in the community on the weekend. He said that it was appropriate for an ITO to be used for a short period of time to stop a patient walking out of the door where that would put them at risk, but that it cannot be used for a prolonged period to force psychotherapeutic, nutritional and other recovery.[171]

191 Without assessing the merits of what Dr Long spoke about on this topic, I am satisfied that there is no general or systemic misuse of ITOs to detain people that ought not be detained. That is particularly clear given that psychiatric support is available at all times and would likely be asked to provide input if such a scenario arose.

192 It was said that early, effective, community-based intervention provides the best opportunity for successful treatment of eating disorders in patients. In 2024, there were 5,376 contacts made by SEDS staff for people with eating disorders in the community.[172] Notwithstanding such a large level of service delivery, Ms O'Brien said that data held by the Department reveals that the largest gap in service provision for eating disorder sufferers is services in the community. She pointed out that research has suggested that individuals with an eating disorder prefer treatment in the community. Ms O'Brien said that this preference is reflected in the volume of patients attending outpatient services in South Australia.

193 Ms O'Brien explained to the Court what plans there were for addressing the rise in eating disorder patients. It has been determined that there should be a focus on community-based care with an increase in awareness of SEDS and the use of clinical protocols to determine how a patient should progress through a stepped system of care.

194 There is a plan for a new Residential Eating Disorder Service (REDS) at the Repat. The service will comprise a five-bed residential centre providing specialist clinical care as well as psychosocial support for day-to-day independent living. It is intended that the

---

[171] T609

[172] A contact is the record of a visit or appointment from a mental health clinician working in the community, one person may receive multiple contacts over the year

residential service will be an additional service offered by SEDS in conjunction with the existing services. That is, it is an expansion of overall services, not a replacement. The SEDS outpatient and day programs will move to the Repat to integrate day and outpatient care in a purpose-built SEDS clinic.[173] This initiative is well advanced, with design plans being assessed by local council for development approval.[174]

195 Dr Long told the Court that the new facility will be a step between intensive inpatient recovery and the day program, providing a home-like setting for the patients.[175] Dr Long said that the proposal comprises world-leading facilities including a genetics laboratory to continue research into the genetic underpinnings of eating disorders and that it may also have a neurostimulation service to forward the use of transcranial magnetic stimulation. At the time of giving evidence, Dr Long said that these plans had been delayed.[176]

196 Dr Long said that the current efficacy of SEDS treatment is fairly low and that is why investment in new therapies and approaches is necessary, including neurostimulation in transcranial magnetic stimulation, deep brain stimulation in severe and enduring anorexia patients and the use of novel psychotherapeutic agents, by way of examples.[177]

197 Dr Long was supportive of the new facility at the Repat, as this will bring the total number of available inpatient beds in South Australia to 11-12. However, when he was asked whether this number would be sufficient, he told the Court that there needs to be more and that, even with the additional beds, that he would still expect a significant waiting list.[178] He said that it would be reasonable to increase the current bed numbers to 18 to meet the actual demand of the patients waiting.[179] I therefore make the following recommendation to the Minister for Health and Wellbeing:

One That SA Health review the adequacy of the number of beds in SEDS and the new proposed REDS to determine whether additional beds are needed and how an increase could be achieved.

198 I was told that the current psychosocial support program has strengthened its links with SEDS and is anticipated to be critical for supporting people exiting the planned residential service at the Repat. For the three months ending June 2025, 50 consumers received ongoing care through the Eating Disorder Support Service and the program received 32 new one-to-one referrals. I was advised that psychosocial care will also be considered for further investment as part of the National Eating Disorder Strategy 2023-2033.[180]

Inability of SEDS to accept patients with dangerously low BMI

199 On a number of occasions in this finding, I have stated that Ms Matters had expressed an acceptance that she should be treated in SEDS, but that she could not be accepted due to being acutely unwell and with a very low BMI. I accept that SEDS provides psychiatric and psychological input and that it could not be expected to also provide all of the general

---

173 Exhibit C38 at [51]-[55]
174 Exhibit C38 and T498
175 T540
176 T563
177 Exhibit C35 at [8] and T541
178 T541 and T564
179 T564
180 Exhibit C38

medical care that a regular hospital ward is expected to provide. I therefore find that there is no criticism to be made of each of the decisions not to accept Ms Matters into SEDS when she was not medically well enough to be away from the regular ward.

200 I am also not critical of the efforts made by Ms Matters' treatment teams to try to encourage her to enter the SEDS program once she was well enough. It was clear to me that there were continuous and genuine efforts to instil into Ms Matters an understanding of how serious her need for inpatient treatment was. It appears that the effect of extended stays dealing with her physical health was to exhaust Ms Matters from healthcare and that this is what likely led to her decisions to return to the community once she was in a physical condition to participate in SEDS.

201 As Ms Matters' case tells us, patients with eating disorders on waiting lists for inpatient treatment sometimes become physically unwell due to their condition and require urgent medical care in medical wards. The treatment given in these wards is not aimed at addressing their eating disorder but is instead aimed at preventing serious injury and illness and achieving a condition that is well enough to either return to the community to continue to wait for inpatient care, or to otherwise be referred into inpatient care.

202 Dr Long gave evidence that it is sub-optimal for these patients to come into hospital for medical stabilisation in a general ward.[181] That observation is particularly apt given the impact that this process, repeated a number of times, had on Ms Matters. Dr Long said that this approach is bad for patients and is also more expensive for the healthcare system which needs to service a bed for physical health issues and then a bed for the eating disorder treatment if and when that becomes available.[182] Medical release without eating disorder treatment is likely to result in further medical admissions at some later time. Dr Long said that, for this reason, greater access to inpatient eating disorder treatment would have a positive impact on the overall healthcare system as there would be fewer occasions of patients deteriorating to the point of needing a medical bed.

203 Dr Long spoke about a contagion effect that can be seen where eating disorder patients interact with each other. He said that, for this reason, inpatient treatment facilities for eating disorder patients should ideally have separate rooms, or at least have patients spaced sufficiently apart to insulate against this effect.[183] This means that a regular medical ward is not readily modifiable into an eating disorder service.

204 Dr Long advocated for a dedicated medical unit for patients with eating disorder complications that takes into account issues such as contagion and the need for a specialist approach. Dr Wilksch agreed that it would be preferable for there to be a specialist ward for the refeeding process for patients with an eating disorder. This is because those patients would not be placed among others with different diagnoses that may cause distress, or an environment that otherwise makes it difficult for patients with an eating disorder to recover. The Department for Health and Wellbeing acknowledged that receiving treatment in a shared room on a general medical ward can be a difficult

---

[181] Exhibit C35 at [22]
[182] T558
[183] T592

experience for eating disorder patients.[184] A specialist unit would be able to have specialist staff and therefore a greater level of training and awareness.[185]

205 Counsel for the Department for Health and Wellbeing told me that the Department considers that the creation of a dedicated ward for eating disorders in South Australia is not supported by evidence of better outcomes. Further, it considers that patients should receive care as close to home as possible with clinicians supported by training and consultation-liaison input from SEDS and other specialists, which makes treatment in regular wards more appropriate.

206 The Department also highlighted that medical stabilisation is an emergency situation and patients cannot wait for a bed to become available on a specialised ward for their condition to be addressed. They said that a general ward offers an environment in which patients have access to a variety of different clinicians and that this is important because eating disorder patients can be cyclical and medically complex.[186]

207 The REDS is, quite obviously, an excellent initiative that will provide more placements for those in need of specialised services. However, more inpatient services would not necessarily have addressed the difficulties that arose in Ms Matters' case, as she was never physically capable of being treated there at any time when she was mentally able to contemplate it.

208 I make the following <u>recommendation</u> to the Minister for Health and Wellbeing:

Two That consideration be given to the establishment of an acute inpatient ward that is specifically set up for the treatment of patients with eating disorders who require medical stabilisation to alleviate the situation where these patients are treated in a regular ward that is not therapeutic for, and may even exacerbate, their eating disorder.

209 Ms O'Brien pointed out that there is no evidence of any better outcomes for patients who are medically stabilised in a specialised eating disorder environment. While there may not be scientific studies, Ms Matters' case is evidence of the negative impact a poor environment had on her motivation to continue into eating disorder treatment. While not a scientific study, I would encourage the Department not to dismiss the significance of what has been highlighted during this Inquest.

210 Concerns about the ability to house a facility of this nature in current infrastructure of ageing hospitals should not determine the outcome. New facilities can always be constructed and if that is what proper care for a not-insignificant component of the community requires, then that is what should be contemplated.

Guidelines for the management of medical complications of eating disorders

211 Flinders Medical Centre is the only tertiary hospital in South Australia which has specific clinical guidelines for the presentation of a person to an Emergency Department with a medical complication associated with their eating disorder.[187] As at the time of giving his

---

184 Exhibit C38
185 T464
186 Exhibit C38
187 Exhibit C35 at [20]

evidence at the Inquest, Dr Long told the Court that the other hospitals had still not adopted their own clinical guidelines.[188] The Women's and Children's Hospital were said to have excellent clinical guidelines, and the Royal Adelaide Hospital have been using the guidelines applicable at Flinders, but are preparing to modify their own. Dr Long said that part of SEDS' work is to encourage individual guideline development in each Local Health Network which has a specific clinical guideline and governance pathway within that network.[189]

212 In my view, while this work appears to have been commenced, it should be formalised. Each hospital should have access to clear protocols that guide them to what support can be provided to patients presenting with eating disorders and what ongoing care should be planned. I therefore make the following recommendation to the Minister for Health and Wellbeing:

Three That a clinical pathway or protocol for patients presenting with eating disorders, either with associated or unrelated medical conditions, or without any other medical conditions, be developed across SA Health.

Education and training

213 I heard evidence about a view that some health professionals in the health system can have a lack of empathy to those with eating disorders and that this can result in a poor experience by those with such conditions. I have made findings about particular examples of comments made that had this effect on Ms Matters and her family.

214 Research undertaken by Dr Wilksch found that patients had just a 14.7% chance of having a good experience with the first GP and mental health clinician who were seen in relation to eating disorder treatment. He also was aware that the experience of some patients was that they are seen as being ambivalent towards making change or not responsive to help, and anecdotally that clients had reported receiving lectures from medical staff about the need to 'just eat' and get better. He said that he assumes this is due to the lack of understanding within the medical sector and that this reflects a need for more training and understanding of eating disorders.[190] Dr Long said that he considers there is work to do with mental health and Emergency Department colleagues to understand more about eating disorders. He said that every doctor should be able to look for red-flag symptoms to know how to do a rapid screen for eating disorders.[191]

215 Given the evidence I heard, I am satisfied that there is a need for increased education among medical and nursing staff in relation to eating disorders and in particular about the language that is appropriate when engaging with these patients.

216 Dr Wilksch said that he believes the treatment of eating disorders should form part of standard training across psychology, medical and nursing staff (including those in Emergency Departments).[192] He said that this kind of training could be conducted by SEDS clinicians, or any clinicians who have expertise in this area (such as Dr Wilksch)

---

188 T555
189 T554
190 T407-T409, I note that the study was listed in the CV of Dr Wilksch at 4
191 T568
192 T427

or university academics with eating disorders as a specialised interest. Dr Long also considered that nurses could be supported and upskilled through his team.

217 I therefore make the following recommendation to the Minister for Health and Wellbeing:

Four That SA Health introduce training, to be delivered by SEDS or eating disorder clinicians, to medical and nursing staff working in hospitals about the identification of, and treatment of, eating disorders and in particular the Eating Disorder Safe Principles.

218 This would work hand-in-hand with new protocols to improve the overall knowledge and understanding of the issues that arise in the journey of a patient with an eating disorder and is likely to lead to more empathetic and understanding care which will be therapeutic. It would work hand-in-hand with SEDS' role as a liaison service. In Ms Matters' case, this had the potential to see her willing to stay in hospital for longer which might have made a transition to a SEDS bed more palatable to her on the occasions when she turned that down.

Preventability

219 Ms Matters received very high-quality care from numerous practitioners representing a range of specialties. She even received inpatient treatment at SEDS at one point. None of these supports were able to improve her general decline.

220 Dr Long agreed that it was possible that if earlier admission to the SEDS inpatient program was available to Ms Matters in December 2019, this would have improved her prognosis. It would have allowed her the treatment she needed at a time when she was motivated for it.[193] However, Dr Long also expressed caution in reaching the conclusion that earlier treatment would have prevented Ms Matters' death, explaining that SEDS treatments have been shown to be 42% effective. He said that, when a patient has complex comorbid disorders, as Ms Matters did, it is difficult to recover.[194] He explained:

> I've thought about this a lot, and I think that Jenni had a very good team. She had an expert, experienced psychologist in Simon Wilksch; she went and saw Amanda Burlock, who is excellent, who is top-notch for the management of borderline personality disorder - one of the issues that just frustrated Jenni's ability to recover; she had an excellent, dedicated, persistent, caring GP; she had parents who cared for her, and had skills in managing and caring for someone with anorexia nervosa. She had the opportunity to do some work in our inpatient programs; when she was able to do that, we were able to respond rapidly. I wish we could've done more. I could theorise about everything that could've been done, but unfortunately I see Jenni as having succumbed to a severe and complex mental illness in the form of anorexia with comorbid trauma, borderline personality disorder and post-traumatic stress disorder. I think it's tragic and regrettable.[195]

221 I accept Dr Long's overall opinion. Ms Matters had a number of demographic factors that made her susceptible to an eating disorder of a strong nature. I also observe that there were limited occasions where Ms Matters appeared to be willing to engage in inpatient treatment where voluntary engagement is necessary to the success of the intervention.

---

193 T608
194 T622
195 T621-T622

Given that recovery with SEDS treatment is more often unsuccessful than it is successful, I am unable to conclude that SEDS treatment would have prevented Ms Matters' death. It is simply too uncertain for me to reach that finding.

222 In my view, the only chance of preventing Ms Matters' death would have been if there was a service that operated to provide acute inpatient eating disorder treatments to patients with dangerously low BMIs, as I have recommended should be implemented above. As this service did not exist at the time of Ms Matters' illness, it is difficult to see how the trajectory of Ms Matters' deeply-entrenched mental health issues could have been altered.

Condolences

223 It was clear to me that Ms Matters' parents were trying their hardest to see Ms Matters get the care that she needed. She fell into an unfortunate cycle where she was sometimes too unwell to engage in the treatment that she needed, and at other times was well enough but did not wish to. It was particularly unfortunate that the times when she was too physically unwell to participate appear to be the times when she did wish to engage. The circumstances of her death are therefore tragic. I express my sincere condolences to Ms Matters' family and thank them for their brave and helpful assistance to the inquiry.

Keywords: *Anorexia Nervosa; Borderline Personality Disorder; Eating Disorder*