JURISDICTION	**:**	CORONER'S COURT OF WESTERN AUSTRALIA
ACT	**:**	CORONERS ACT 1996
CORONER	**:**	PHILIP JOHN URQUHART, CORONER
HEARD	**:**	1, 3 - 12 May 2023
DELIVERED	**:**	8 APRIL 2024
FILE NO/S	**:**	CORC 1531 of 2020
DECEASED	**:**	CHILD SK

Catchwords:

Nil

Legislation:

Nil

Counsel Appearing:

Mr W. Stops assisted the coroner
Ms R. Hartley and Mr D. Harwood (State Solicitor's Office) appearing on behalf of the Child and Adolescent Health Service, the Department of Communities and the Mental Health Commission
Mr G. Droppert SC (instructed by Maurice Blackburn) appearing on behalf of the family
Mr S. Denman (Denman Lawyers) appearing on behalf of Dr K. Morton

Case(s) referred to in decision(s):

Nil

Coroners Act 1996
(Section 26(1))

RECORD OF INVESTIGATION INTO DEATH

*I, Philip John Urquhart, Coroner, having investigated the death of **Child SK** with an inquest held at Perth Coroners Court, Central Law Courts, Court 51, 501 Hay Street, PERTH, on 1 May and 3 - 12 May 2023, find that the death of **Child SK** occurred on 23 July 2020 at Royal Perth Hospital, Wellington Street, Perth, from complications of a head injury in the following circumstances:*

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LIST OF ABBREVIATIONS AND ACRONYMS

Abbreviation/Acronym	Meaning
ACRT	Acute Care and Response Teams
the ACT	the Australian Capital Territory
ASD	autism spectrum disorder
BFC	the Bentley Family Clinic
the ***Briginshaw*** principle	the accepted standard of proof the Court is to apply when deciding if a matter adverse in nature has been proven on the balance of probabilities
CBT	cognitive behavioural therapy
CAHS	Child and Adolescent Health Service
CAMHS	Child and Adolescent Mental Health Service
CIT	the Department's Central Intake Team
CITS	Community Intensive Treatment Services
the clinic	Curtin University Psychology Clinic
the Court	the Coroner's Court
Crisis Connect	CAMHS Crisis Connect Service
CSI	Child Safety Investigation
the Department	the Department of Communities
ED	emergency department
EUPD	Emotionally Unstable Personality Disorder (also known as Borderline Personality Disorder)
the first Referral	the Child Protection Concern Referral by Bobbie Kavanagh to the Department on 10 June 2020
FSN	Family Support Network
GP	general practitioner
ICA	infants, children and adolescents
IR	immediate release
ICU	intensive care unit

the Interaction Tool	the Department's tool that measures the nature and severity of the risk reported, and which must be used by its staff when assessing child protection concerns
MDT	multi-disciplinary team
mg	milligrams
the MHC	the Mental Health Commission
the Ministerial Taskforce	the Ministerial Taskforce into Public Mental Health Services for Infants, Children and Adolescents aged 0-18 years in WA
PCH	Perth Children's Hospital
RPH	Royal Perth Hospital
the second Referral	the Child Protection Concern Referral by Bobbie Kavanagh to the Department on 26 June 2020
the Strategy	the Department's "At-Risk Youth Strategy 2021-2026"
SUSD	step-up/step-down
the Targeted Review	the review by the Chief Psychiatrist of Western Australia into the treatment provided to Child SK by CAHS
the third Referral	the Child Protection Concern Referral by Dr Kalliste Black to the Department on 14 July 2020
Touchstone	CAHS's Touchstone day service for children aged 12 to 17 years with symptoms or a diagnosis of EUPD
WACHS	Western Australian Country Health Service
WAPF	Western Australian Police Force
Ward 5A	the mental health in-patient unit at PCH
XR	extended release

SUPPRESSION ORDER

Suppression of the deceased's name from publication and any evidence likely to lead to the child's identification.

The deceased is to be referred to as Child SK.

INTRODUCTION

"*We do not 'get over' a death. We learn to carry the grief and integrate the loss in our lives. In our hearts, we carry those who have died. We grieve and we love. We remember*."
Nathalie Himmelrich, author, Grieving Parents: Surviving Loss as a Couple

1. Child SK died at Royal Perth Hospital (RPH) on 23 July 2020 from complications of a head injury. Tragically, two days earlier, she had intentionally stepped in front of an oncoming car on Albany Highway in the presence of her parents. Child SK was 13 years old.

2. During the last six months of her life, Child SK had attended the emergency department (ED) at Perth Children's Hospital (PCH) on 11 occasions and had seven admissions to the mental health in-patient unit (Ward 5A), six of which had occurred in the six weeks between 3 June and 17 July 2020. During those six weeks, she had attended the ED at PCH eight times and spent a total of 30 days in Ward 5A. All these attendances and admissions related to self-harming incidents and/or expressed intentions to suicide.

3. Child SK's parents were very protective of her and loved her very much. And that love in the final months of Child SK's life extended to daily activities that most parents would never contemplate having to undertake for their teenage child. These activities included ensuring all doors and windows to their home were completely secured and doors were key locked from inside, keeping all sharp objects within the home hidden, and securely storing all medications. They even had to prevent Child SK from sitting in the front seat of their car. All these measures were taken to reduce the risk of Child SK self-harming and the burden on the already fragile mental health of Child SK's parents would have undoubtedly been immense.

4. Child SK's death was a reportable death within the meaning of section 3 of the *Coroners Act 1996* (WA) as it was unexpected. However, an inquest into her death was not mandatory as it did not fall within any of the circumstances set out in section 22(1) of the *Coroners Act 1996* (WA).

5. Nevertheless, on 10 May 2021, Child SK's mother, wrote to the Coroner's Court (the Court) requesting an inquest into her daughter's death.

6. On 7 June 2022, the State Coroner determined that an inquest into Child SK's death was desirable pursuant to section 22(2) of the *Coroners Act 1996* (WA) in order to investigate the standard of the mental health care and treatment provided to Child SK, and the standard of community support services (including step-down facilities) after a hospital admission for children in Child SK's age group with serious mental health issues. For the purposes of the coronial investigation, I have determined this age group is to be children who are 13 years and under 16 years.

7. I held an inquest into Child SK's death at Perth for nine days on 1 May, and 3-12 May 2023. The following 19 witnesses gave oral evidence:[1]

   i. Smitha Kutty (senior child protection worker at Department of Communities);

   ii. Wanita Ewings (senior child protection worker at Department of Communities);

   iii. Cassie Pollard (senior child protection worker at Department of Communities);

   iv. Holly Williams (senior child protection worker at Department of Communities);

   v. Steven Gotti (acting team leader at Department of Communities);

   vi. Bobbie Kavanagh (senior speech pathologist and case manager at Bentley Family Clinic);

   vii. Rachelle Johnson (enrolled nurse at Bentley Family Clinic);

   viii. Dr Jason Tan (psychiatric registrar at Bentley Family Clinic);

   ix. Dr Rachel Hudson (consultant psychiatrist at Bentley Family Clinic);

   x. Cassey Ferrari (child protection worker at Department of Communities);

   xi. Dr Richard Clarke (psychiatric registrar at PCH);

   xii. Jeremy Singer (clinical psychologist at PCH);

   xiii. Dr Michael Light (general practitioner at Fulham General Practice);

   xiv. Dr Nejra Kostic-Garner (supervised medical officer at PCH);

[1] The job descriptions for the witnesses who treated or dealt with Child SK in 2020 are the positions they held at the relevant time.

xv. Dr Leenika Wijeratne (consultant psychiatrist at PCH);

xvi. Dr Katinka Morton (consultant psychiatrist at PCH);

xvii. Ben Whitehouse (Executive Director, Statewide Services, at Department of Communities);

xviii. Dr Vineet Padmanabhan (acting Director for Clinical Services at Child and Adolescent Health Service);

xix. Dr Sophie Davison (Chief Medical Officer at the Mental Health Commission)

8. In addition, Child SK's mother, accompanied by Child SK's father, spoke at the inquest about the many happy times that Child SK had with her family and the fond memories they have of her.

9. The documentary evidence at the inquest comprised of three volumes that were tendered as exhibit 1 at the commencement of the inquest. A report from Dr Vineet Padmanabhan (Dr Padmanabhan), acting Director for Clinical Services at Child and Adolescent Health Service (CAHS), was also tendered at the start of the inquest and became exhibit 2. Further material was tendered during the inquest and these became exhibits 3 to 11.

10. During the inquest, I requested further information from CAHS. This information was provided after the inquest was completed on 20 July 2023.[2] That material became exhibit 12.

11. After the inquest, I also sought some additional information. This included clarification regarding those adolescents who are suitable for CAHS's Touchstone service (Touchstone). That information was provided to the Court by email on 2 March 2024.[3]

12. Two other inquiries arising from Child SK's death had been completed prior to the inquest commencing. The Office of the Chief Psychiatrist of Western Australia conducted a Targeted Review into the treatment provided to Child SK by CAHS (the Targeted Review) and its report was completed in December 2020.[4]

13. The Targeted Review recommended that "*after so many years of neglect*", there was a need to build confidence among young people, their families,

[2] Email with attachments from Amelia Westerside from State Solicitor's Office to counsel assisting dated 20 July 2023

[3] Email with attachment from David Harwood from State Solicitor's Office to counsel assisting dated 2 March 2024

[4] Exhibit 1, Volume 2, Tab 3, Targeted Review by Dr Nathan Gibson, Chief Psychiatrist of WA, dated December 2020

and their treating clinicians to ensure "*their voices are being heard and their concerns will be acted on*".[5] The Targeted Review stated that a Child and Adolescent Mental Health ministerial taskforce will go some way to restoring confidence and "*beginning the journey towards rebuilding the CAMHS system*."[6]

14. That taskforce was established and was titled "Ministerial Taskforce into Public Mental Health Services for Infants, Children and Adolescents aged 0-18 years in WA" (the Ministerial Taskforce). The Ministerial Taskforce's final report was publicly released in March 2022.[7]

15. I mention these other inquiries and their reports to put this inquest into a context. A large number of recommendations arose from these two reports and action has already been taken to implement a number of them. I need to consider those recommendations and the response to them when determining whether any further recommendations arising from the coronial inquiry are appropriate. It should be noted that the primary purpose of an inquest is not to make recommendations.

16. The focus of this inquest was on the treatment and care provided to Child SK at Bentley Family Clinic (BFC) and PCH for her complex mental health needs, with an emphasis on the final six months of her life. Nevertheless, where I have seen fit, I have made recommendations designed to improve the treatment and care for children and young people with serious mental health conditions.

17. Section 25(5) of the *Coroners Court Act 1996* (WA) prohibits me from framing a finding or comment in such a way as to appear I have determined any civil liability. It is not my role to access the evidence for civil (or for that matter, criminal) liability and I am not bound by the rules of evidence.

18. In making my findings I have been mindful of the standard of proof set out in ***Briginshaw v Briginshaw*** (1938) 60 CLR 336, 361-362 (Dixon J) which requires a consideration of the nature and gravity of the conduct I am investigating when deciding whether a finding adverse in nature has been proven on the balance of probabilities (the ***Briginshaw*** principle).

19. I am also mindful not to insert any hindsight bias into my assessment of the actions taken by mental health clinicians and other providers in their

[5] Exhibit 1, Volume 2, Tab 3, Targeted Review by Dr Nathan Gibson, Chief Psychiatrist of WA, dated December 2020, p.45
[6] Exhibit 1, Volume 2, Tab 3, Targeted Review by Dr Nathan Gibson, Chief Psychiatrist of WA, dated December 2020, p.45
[7] Exhibit 1, Volume 2, Tab 4, Final Report – Ministerial Taskforce into Public Mental Health Services for Infants, Children and Adolescents aged 0-18 years in WA

treatment and care of Child SK. Hindsight bias is the tendency, after an event, to assume the event was more predictable or foreseeable than it actually was at the time.[8]

20. In addition, I must note that Child SK's treatment in 2020 took place during the initial months of the COVID-19 pandemic when there were unprecedented restrictions in place to prevent the spread of the virus.

21. On 8 June 2022, the State Coroner made the suppression order outlined on page 5 of this finding. That suppression order was mandatory as Child SK fell within the definition of "*an identified person"* in section 237(2) of the *Children and Community Services Act 2004* (WA). This provision stipulates that there is to be no publishing of any information or material that identifies, or is likely to lead to the identification of, an identified person.

22. It would be appropriate at this point to outline how the various public health services involved in the treatment and care of Child SK interact.[9]

23. The Mental Health Commission (the MHC) was established in 2010 to lead mental health reform throughout the state and implement a modern effective mental health system.

24. The MHC works closely with the Department of Health and five public health service providers that deliver clinical mental health services. One of these providers is CAHS. The MHC funds CAHS to provide mental health services for children and young people in the Perth metropolitan area. These services can be broken down into three categories.

25. One category is Child and Adolescent Mental Health Service (CAMHS). CAMHS offers mental health assessment and multi-disciplinary intervention for children up to the age of 18 years who are experiencing severe and persistent mental health symptoms that impact on their psychosocial functioning and/or who have significant risk of harm to themselves and/or others. There are ten CAMHS clinics operating throughout the Perth metropolitan area, one of which is BFC.

26. The second category are hospital-based services located within PCH and includes Ward 5A which has beds for children up to the age of 16 years who have complex and acute mental health issues.

[8] Dillon H and Hadley M, *The Australasian Coroner's Manual* (2015) 10
[9] Exhibit 1, Volume 3, Tab 9, Statement of Dr Sophie Davison dated 26 April 2023, pp.3-5

27. The third category comprises of specialised services for children and adolescents and includes Touchstone.

CHILD SK [10]

28. Child SK was born on 23 October 2006. She lived with her parents and younger sister in a suburb of Perth.

29. Growing up, Child SK was a fun and outgoing child. She loved animals and enjoyed visiting pet shops. She had a variety of pets that she looked after which included dogs, cats and guinea pigs.

30. Although Child SK was social and active at kindergarten, during her early primary school years she encountered difficulties forming friendships and had become self-conscious about her weight. When she was eight years old, Child SK first showed signs of trichotillomania.[11] She also began having nightmares, experiencing anxiety and behaving abusively towards her family.

OVERVIEW OF THE TREATMENT AND CARE PROVIDED TO CHILD SK FOR HER MENTAL HEALTH [12]

April 2015: Child SK's first referral to BFC

31. In April 2015, Child SK was referred by her GP to BFC for behaviours relating to anxiety, which included trichotillomania and violent nightmares. BFC arranged for Child SK to attend a private counselling service; however, Child SK and her family did not find that service helpful and it was discontinued.

32. At an appointment with BFC on 2 September 2015, Child SK's mother advised that Child SK had engaged with a psychologist at Curtin University Psychology Clinic (the clinic) and would rather continue with that arrangement. Child SK's referral to BFC was subsequently closed.

November 2015: Child SK's second referral to BFC

33. On 27 November 2015, a referral from the clinic was received by BFC for Child SK relating to her trichotillomania, temper tantrums and conflict with

[10] Exhibit 1, Volume 1, Tab 9.1, Coronial Investigation Squad Report of 1st Class Constable Jessica Towie (undated); ts 11.5.23 (Child SK's mother) pp.744-750

[11] The pulling of eyelashes and/or eyebrows out.

[12] Exhibit 1, Volume 1, Tabs 12.1-12.4, Statements of Child SK's mother dated 27 July 2020, 8 December 2020, 4 April 2023 and 7 May 2023; Exhibit 1, Volume 1, Tab 25.1, Letter from Dr Ross Manners dated 9 March 2021; Exhibit 1, Volume 2, Tab 1.1, Report from Rachael Green, the Department's Deputy Director, dated 17 September 2021; Exhibit 2, Report from Dr Vineet Padmanabhan dated 1 May 2023

her younger sister. Child SK subsequently underwent regular reviews at BFC for the next 12 months.

34. Child SK's referral was closed in November 2016. It was noted there had been significant improvement in Child SK's anxiety levels and emotional expression. Child SK was discharged back into the care of her GP for a review of the medication, sertraline, that had been prescribed for her anxiety, and for her to engage in informal counselling with her school chaplain.

March 2018: Child SK's third referral to BFC

35. On 6 March 2018, Child SK was referred to BFC by her GP with worsening symptoms of anxiety and trichotillomania, despite increases in her sertraline medication.

36. On 19 April 2018, a psychiatry registrar at BFC completed a review for Child SK. Although Child SK's mother believed her daughter may have bipolar affective disorder, the psychiatry registrar was of the view that Child SK did not currently meet the diagnostic criteria for this disorder.

37. The recommendations from this review were for ongoing follow-up with the GP and Tier 2 mental health services. Although Child SK was discharged from BFC, a further referral to BFC was recommended if there was deterioration or no improvement with the Tier 2 services.

Mid-2018: Child SK's appointments with a private psychiatrist

38. On 20 June and 3 July 2018, Child SK's parents arranged for their daughter to see a private psychiatrist, Dr Ross Manners (Dr Manners). Dr Manners' provisional diagnosis was bipolar affective disorder and Child SK was initially prescribed lithium. However, this medication was ceased due to thyroid issues.

October 2019: Child SK's fourth referral to BFC

39. On 7 October 2019, Child SK was referred to BFC by her GP due to escalating anxiety associated with her transition to high school. The referral noted truancy, shoplifting and being the subject of bullying. Child SK's anxiety was constant and she had expressed self-harm.

40. Following an appointment at BFC on 25 October 2019, it was determined that Child SK would benefit from individual support and for her family to attend family therapy.

41. On 14 November 2019, an assessment was undertaken by a consultant psychiatrist at BFC. Child SK was diagnosed with agoraphobia and anxiety. The consultant psychiatrist endorsed the recommendation for family therapy and individual behaviourally-focused therapy for Child SK.

42. Child SK and her family attended another appointment with the consultant psychiatrist on 12 December 2019. As she had done previously, Child SK reiterated her unwillingness to attend psychotherapeutic appointments, stating that she was fine and did not need therapy. As Child SK also did want to engage in family therapy, her parents agreed that there was no benefit continuing with BFC. The referral to BFC was closed and it was arranged at this appointment that medication would continue to be prescribed through Child SK's GP.

23 January 2020: Child SK attends PCH for the first time

43. On 23 January 2020, Child SK was taken to the ED of PCH after cutting her wrist. This occurred after her mother had discovered she met an adult male at a local park whom she had made contact with online.

44. The following day Child SK was admitted to Ward 5A at PCH, where she remained until 31 January 2020.

45. Part of Child SK's multi-disciplinary assessment included one undertaken by Dr Leenika Wijeratne (Dr Wijeratne), a consultant psychiatrist at PCH.

46. Dr Wijeratne's principal diagnoses comprised of a situational crisis, and a mixed disorder of conduct and emotion that was complicated by suicidal ideation. The discharge medication was sertraline at a daily dose of 150 mg.

24 January 2020: Department of Communities' first involvement

47. On 24 January 2020, the Department of Communities (the Department) received a mandatory report concerning Child SK. This had concerned the meeting Child SK had with the adult male she had met online.

48. On 30 January 2020, the Department assessed that Child SK's parents could assist their daughter in maintaining her safety and had taken appropriate steps to seek support regarding her risk-taking behaviours. Accordingly, the Department referred the matter to the Child Abuse Squad of the Western Australia Police Force (WAPF) and took no further action.

6 February 2020: Child SK has an urgent assessment at BFC

49. On 6 February 2020, Child SK and her parents attended an urgent assessment at BFC. Child SK presented with ongoing suicidal thoughts on a background of continuing conflict with her parents.

50. At another meeting on 19 February 2020, Child SK indicated that she did not want to engage in individual therapy; however, the family was keen to attend a family therapy organised by BFC. Unfortunately, the family therapy session operated by BFC only occurred during business hours and Child SK's mother could not attend due to her work commitments.[13]

51. On 26 February 2020, Child SK was subsequently discharged from BFC back to the care of her GP and information was provided to the family regarding alternative options for family therapy.

52. On 16 March 2020, Child SK's mother attended her daughter's GP seeking a referral to a private psychiatrist due to Child SK's worsening low mood, self-harming behaviour and refusal to attend school.

13 April 2020: Child SK attends PCH for the second time

53. On 13 April 2020, Child SK was admitted to a medical ward in PCH following an intentional paracetamol overdose.

54. Following an assessment by a psychiatry registrar, under the supervision of a consultant child and adolescent psychiatrist, Child SK was referred to BFC for ongoing cognitive behavioural therapy (CBT). A safety plan was developed with Child SK's parents which included keeping medications and sharps locked. The dose of sertraline was reduced to 100 mg once daily.

55. Child SK was discharged from PCH on 14 April 2020.

20 April 2020: Child SK has a telehealth appointment with BFC

56. On 20 April 2020, following a referral, Child SK had another appointment with BFC via telehealth. She did not disclose ongoing suicidal ideation and the risk to herself was considered to be low. Child SK remained ambivalent about engaging with therapy and the family remained unable to attend the family therapy sessions at BFC. The referral was subsequently closed with a recommendation for therapy with external agencies.

[13] Child SK's mother was the sole income earner for the family.

1 May 2020: Child SK attends PCH for the third time

57. On 1 May 2020, Child SK presented to the ED at PCH following an altercation with her grandmother. She had self-harmed by making a significant laceration to her right forearm and was expressing suicidal thoughts.

58. Child SK's mother reported worsening trichotillomania symptoms since the dose of sertraline had been reduced.

59. After being treated for her lacerations, Child SK was discharged and a safety plan was provided to her family. Another referral was made to the BFC.

7 May 2020: Child SK has an assessment at BFC

60. On 7 May 2020, Child SK had an urgent appointment with two acute response clinicians from BCF. After she had expressed thoughts of wanting to die without any intent or plan, the clinicians assessed her as being at a high risk for future self-harm. A risk assessment and safety plan were completed and follow-up appointments were scheduled, including one for a psychiatry review.

61. At a second appointment with the two clinicians on 12 May 2020, Child SK continued to present as a high risk for impulsivity and misadventure. She reported ongoing and persistent suicidal ideation without a clear plan or intent.

15 May 2020: Diagnosis of possible EUPD is made

62. On 15 May 2020, a psychiatry review was undertaken by Dr Jason Tan (Dr Tan), a psychiatric registrar at BFC. Dr Rachel Hudson (Dr Hudson), the consultant psychiatrist at BFC, was unavailable as she was on sick leave. Child SK's parents also attended. At this review Child SK admitted to ongoing thoughts to self-harm. Dr Tan was advised that Child SK's sleep remained disrupted, she frequently had nightmares and was frequently feeling anxious. She expressed a desire to be helped with her symptoms.

63. Dr Tan suggested that the "off-label"[14] use of quetiapine (an anti-psychotic medication) may assist with Child SK's sleep and anxiety symptoms. Parental consent was then obtained for a daily dose of 12.5 mg of quetiapine

[14] An "off-label" prescription by a doctor occurs when the medication is prescribed for a condition that is not included in the approved product information document for the medication. There is no legal impediment to prescribe a medication "off-label". If the doctor is of the view that the prescription is supported by reasonable evidence and it is in the patient's best interests, then the prescription should proceed: https://australianprescriber.tg.org.au/articles/off-label-prescribing.html

for five days, increasing to 25 mg daily if symptoms persisted. Sertraline was maintained at a daily dose of 150 mg.

64. Dr Tan's clinical impression was mixed anxiety disorder and trichotillomania. Dr Tan also noted Child SK may have symptoms of Emotionally Unstable Personality Disorder (EUPD).[15] A risk assessment and management plan were also completed.

65. On 20 May 2020, Child SK had her first appointment via telehealth with her case manager, Bobbie Kavanagh (Ms Kavanagh). However, after saying hello to Ms Kavanagh, Child SK became upset and left the room. After Child SK had left, her mother advised Ms Kavanagh that she was unsure if quetiapine was helping her daughter. Although she had been sleeping better, her nightmares remained. A follow-up face-to-face appointment was scheduled for 27 May 2020.

66. On 25 May 2020, Child SK's mother spoke to Dr Hudson. She advised Dr Hudson that Child SK had been experiencing worsening nightmares and suicidal ideation since the commencement of quetiapine and she wanted this medication stopped. A follow-up psychiatry appointment was then arranged.

67. On 26 May 2020, Dr Tan saw Child SK. Ms Kavanagh and Child SK's mother also attended.

68. Child SK was observed to be noticeably brighter in her mood compared to her previous appointment. She had been going to school most days and reported no current acute risk to herself. It was decided to reduce the dose of quetiapine to 12.5 mg daily and if the nightmares persisted, a switch could be made to clonidine at 50 mg daily to assist with sleep.

69. On 27 May 2020, Child SK's appointment with Ms Kavanagh was cancelled as Child SK had a headache. That appointment subsequently went ahead on 29 May 2020 where Child SK reported experiencing fleeting suicidal ideation without plan or intent. She reported that the dose of clonidine was helping her get to sleep and there was an improvement with her nightmares. A follow-up appointment was planned for 5 June 2020.

3 June 2020: Child SK attends PCH for the fourth time

70. On 3 June 2020, Child SK was taken by ambulance to the ED at PCH after her mother had found notes written by her expressing suicidal ideations with

[15] EUPD is also known as Borderline Personality Disorder.

a plan to hang herself, and evidence of inappropriate online interactions with adult males.

71. On 4 June 2020, Child SK was admitted to Ward 5A at PCH under the care of Dr Wijeratne.

72. On 8 June 2020, Dr Wijeratne met with Child SK's parents. Dr Wijeratne advised that Child SK's presentation, including emotional dysregulation with frequent mood fluctuations, did not indicate bipolar affective disorder. Instead, Dr Wijeratne noted that Child SK's presentation was suggestive of EUPD.

73. On the afternoon of 8 June 2020, a clinical review meeting[16] was held via a video conference. Dr Wijeratne and Dr Nejra Kostic-Garner (Dr Kostic-Garner), a supervised medical officer, attended from Ward 5A, and Dr Hudson and Dr Tan were present from BFC. The four doctors agreed that Child SK had significant emotional dysregulation in the context of emerging EUPD. The possibility of undisclosed sexual trauma was discussed; however, it was noted that Child SK's parents did not believe this had occurred. Dr Wijeratne also confirmed that quetiapine and clonidine had been ceased during Child SK's current admission to Ward 5A as she was not experiencing sleep difficulties on the ward, and clonidine was not noted to have had any significant benefits since it commenced. Instead, Dr Wijeratne had begun an off-label trial of aripiprazole, an anti-psychotic medication, of 2.5 mg daily to assist with Child SK's emotional dysregulation.

74. On 10 June 2020, Child SK was discharged from PCH following a family meeting. In that meeting Child SK said she wanted to retry quetiapine as she did not remember having any nightmares whilst she used that drug. That did not accord with her mother's recollection and the clinical record of the discussion was that Child SK would go back to a trial of quetiapine and monitored for nightmares and if there was an increase to nightmares then to change over to clonidine. Child SK's discharge diagnoses was acute stress reaction in the context of emerging EUPD. The discharge medications included sertraline (150 mg daily), aripiprazole (2.5 mg daily), and quetiapine (25 mg at night).

4 June 2020: Department of Communities' second involvement

75. On 4 June 2020, the Department received a mandatory report concerning Child SK. This concerned online messages from three males to Child SK

[16] A clinical review meeting discusses and reviews the clinical care of the patient by a multi-disciplinary team.

that were of a sexual nature. It was also apparent that explicit photos had accompanied those messages.

76. The Department assessed there were no safety issues as the matter had been reported to WAPF, that Child SK was receiving mental health support through PCH, and that her mother was acting protectively. Accordingly, no further action was taken by the Department.

10 June 2020: Department of Communities' third involvement

77. Late in the afternoon of 10 June 2020, the Department received a notification of concern via email from Ms Kavanagh regarding Child SK. This notification included the concerns that Ms Kavanagh held regarding Child SK's self-harming and her parents not being unable to keep her safely at home.

78. After assessing the matter, the Department determined that no further action was required. The Department notified Ms Kavanagh of that decision by email just after 9.30 am the next day.

15 June 2020: Child SK attends PCH for the fifth time

79. On 15 June 2020, Child SK was assessed by her school's social worker as high risk with increasing suicidal ideation. The night before, she had attempted to break into the medicine cabinet at home. Child SK was subsequently taken to the ED at PCH and was admitted on the same day to Ward 5A under Dr Wijeratne, with a plan for a brief admission for risk containment.

80. During this admission, Child SK initially experienced chronic and persistent thoughts of wanting to die and was noted to have concrete thought pattens. She received psychiatry review, psychological review and exercise physiology to improve her general health through re-engaging in exercise and consuming a healthy diet.

81. In addition to her previous diagnoses (including EUPD), a possible diagnosis of autism spectrum disorder (ASD) was considered. The dose of sertraline was increased to 200 mg daily in an attempt to reduce Child SK's anxiety and help with her obsessive fixation on suicide. Quetiapine was also increased to 50 mg at night to manage sleep difficulties.

82. On 19 June 2020, Child SK was discharged with Dr Wijeratne noting that Child SK felt safe to return home and her family felt able to manage her.

20 June 2020: Child SK attends PCH for the sixth time

83. One day after being discharged from PCH, Child SK was admitted again to Ward 5A under Dr Wijeratne on 20 June 2020. Her mother decided to take her to PCH after she had cut her arm at home. As she was being taken to PCH, Child SK attempted to unbuckle her seat belt in order to jump out of the moving car. Child SK's mother then called police and Child SK tried to run onto the road before police were able to intervene. She was then taken to PCH by police. The basis of Child SK's admission to Ward 5A was deliberate self-harm and increasing suicidal ideations.

84. An initial attempt to discharge Child SK from PCH on 23 June 2020 failed after she refused to get into her mother's car and absconded. She was readmitted to Ward 5A by police and hospital security where she remained for a further three days.

85. On 23 June 2020, a multi-disciplinary complex case review[17] was held at BFC. It was attended by a number of staff members at BFC, including Ms Kavanagh and Dr Tan.

86. On 26 June 2020, a video conference was held between Ward 5A and BFC health professionals. These clinicians included Dr Kostic-Garner and Dr Wijeratne from Ward 5A, and Ms Kavanagh and Dr Tan from BFC. At the instigation of Child SK's parents, a mental health advocate also attended via telephone. On the parents' behalf, the advocate requested that Child SK have a different treating team at PCH as they were unhappy with the current ward management plans and the team. That request could not be implemented as Ward 5A did not have multiple treating teams.

87. It was reported at this meeting that Child SK had been assessed for obsessional compulsive disorder and had not met the diagnostic criteria. Another assessment noted that Child SK scored high for introversion, social disconnection and negative self-image.

88. Later on 26 June 2020, Dr Wijeratne and Dr Kostic-Garner met with Child SK's parents who were provided with the results of the above two assessments. Safety planning was discussed, and Child SK was discharged later that day, with a follow-up appointment at BFC scheduled.

89. Child SK's discharge medications included sertraline at 200 mg daily, quetiapine XR[18] at 50 mg twice daily, and quetiapine IR[19] at 25 mg at night.

[17] This review is an in-depth discussion about the case and is designed to provide a plan for further work.
[18] extended release
[19] immediate release

Other medications included amlodipine at 5 mg daily. Child SK's final diagnoses was EUPD, suicidal, deliberate self-harm.

26 June 2020: Department of Communities' fourth involvement

90. On 26 June 2020, Ms Kavanagh lodged another notification of concern to the Department. She stated that Child SK's parents were struggling to contain her and were reaching a crisis point. Ms Kavanagh sought assistance from the Family Support Network (FSN)[20] through its intensive case management stream.[21]

91. On 10 July 2020, the Department consulted with FSN and was advised that the intensive case management stream was at capacity. As an alternative, FSN recommended that the Department make a referral to FSN's assessment and coordination stream.[22] The Department made this referral to FSN on the same day.

29 June 2020: Child SK attends PCH for the seventh time

92. On 29 June 2020, when at school, Child SK attempted to run in front of traffic. She was taken by ambulance to the ED at PCH. Child SK reported suicidal thoughts with plans and intent. She had recently attempted an overdose with vitamin tablets and had self-inflicted cuts to her ankle. Child SK claimed she was not finding hospital admissions helpful and said she wanted to go home.

93. After Child SK and her mother had discussions with the ED consultant psychiatrist, Dr Alex Thompson, Child SK was discharged home the same day with her mother. A review at BFC was scheduled for the next day.

30 June 2020: Child SK has an appointment with her BFC case manager

94. On 30 June 2020, Child SK had a face-to-face appointment with Ms Kavanagh at BFC. It was noted Child SK described thoughts of running in front of traffic and her thoughts about dying were so repetitive that she felt she had to act on them. She also said she had felt better after cutting herself and that it replaced her need to die for a short time. In addition, Child SK stated that she had a strange feeling that the only option to deal with her problems was to die.

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[20] Family Support Network is a partnership between the Department and the community sector and is designed to provide a common entry point to services to deliver targeted support to families with complex problems.

[21] This stream only accepts referrals from the Department and is for families that require intensive support to keep their children safely at home and involves in-home practical "hands-on" support.

[22] This stream is for vulnerable children and families and referrals are accepted from other agencies in addition to the Department. This service will assess the family's needs and will arrange the coordination of a range of services to work with the family.

95. Distress tolerance strategies were reviewed with Child SK at this appointment and a follow-up telephone call was scheduled for 2 July 2020, with another appointment arranged for 7 July 2020.

1 July 2020: Child SK attends PCH for the eighth time

96. After being taken to the ED at PCH by police, Child SK was admitted to Ward 5A on 1 July 2020. On this occasion she was under the care of Dr Katinka Morton (Dr Morton), a consultant psychiatrist at Ward 5A.

97. This admission had occurred after Child SK had contact with police who were following up the report of her online contact with older males. She later tried to escape through a window at the family home with the intention of running in front of traffic. Child SK subsequently became violent and had to be physically restrained by police. She was admitted to Ward 5A for risk containment, with her mother later informing PCH staff that she was at her "wits end" and was not willing to take Child SK home over the forthcoming weekend (4 and 5 July 2020).

98. On 1 July 2020, Child SK received a psychiatry review from Dr Morton who confirmed the diagnosis of EUPD. Dr Moron later met with Child SK's parents to discuss the preferred method of treatment for people with EUPD. That method involved management of EUPD in the community, with the focus being on community-based therapeutic work with hospital admissions being provided for brief risk containment only. No changes were made to Child SK's medications during this admission and she was discharged on 6 July 2020.

6 July 2020: Child SK attends PCH for the ninth time

99. On the evening of 6 July 2020, Child SK ran away from home. She stole a pair of scissors from premises in a nearby shopping centre and attempted to cut her wrists with them. Child SK then stole a packet of Panadol tablets from a local chemist and attended a café where she swallowed all the tablets. She used the scissors to prevent witnesses from intervening. Emergency services were contacted and ambulance officers who attended noted that Child SK had superficial lacerations to her wrists. She was taken by ambulance to the ED at PCH.

100. The next morning, whilst still at the ED, Child SK continued to state her wish to kill herself. Her mother expressed concerns regarding her escalating behaviour and said she did not feel she could keep Child SK safe at home. Following a mental health assessment by an ED nurse, Child SK was admitted to Ward 5A for risk containment.

101. On 10 July 2020, a clinical review via a video conference was held between Ward 5A and BFC clinicians. Child SK was discharged later that day.

102. The diagnosis at the time of discharge was EUPD, and Child SK was discharged on various medications that included sertraline at 200 mg daily, quetiapine at 50 mg at night time, and amlodipine at 5 mg daily. Aripiprazole was also recommenced due to feedback from Child SK's parents that it might have been helpful and there had been no concerns about adverse side effects with this medication during Child SK's latest admission in Ward 5A.

10 July 2020: Child SK attends PCH for the tenth time

103. On the same day as her discharge, Child SK planned to abscond from her home by removing screws from window frames. She had used her father's pocket knife to do this and when her father tried to stop her from leaving, his hand was accidentally cut by the pocket knife. Child SK was subsequently brought to the ED at PCH by ambulance and escorting police. She was initially seen by the weekend on-call consultant psychiatrist and was subsequently admitted to Ward 5A.

104. Following the weekend, Dr Morton reviewed Child SK on 13 July 2020. On that same day a teleconference was held between clinicians from PCH and BFC. It was agreed that Child SK could attend an appointment at BFC whilst on day leave from the ward.

14 July 2020: Child SK has day leave from PCH to attend BFC

105. On 14 July 2020, Child SK had a face-to-face appointment at BFC with Ms Johnson completed a risk assessment management plan which noted Child SK had a chronic risk of misadventure due to ongoing poor impulse control.

106. On 16 July 2020, a video conference was held with Ward 5A and BFC clinicians in which the scheduling of daily activities for Child SK were designed in order to reduce her boredom at home. Child SK had also expressed her desire to stay out of hospital and engage in therapy.

107. Following this video conference, Child SK was discharged from PCH on 16 July 2020. EUPD remained as the discharge diagnosis and the discharge medications also remained the same. A follow-up appointment with BFC was organised for 21 July 2020.

14 July 2020: Department of Communities' final involvement

108. At about 1.30 pm on 14 July 2020, a duty officer at the Department's Central Intake Team (CIT) received a telephone call from Child SK's mother outlining what had occurred on 10 July 2020. Child SK's mother also said she and her husband had done all they can to keep their daughter safe at home but it was now beyond their coping capacity. In a clear sign of how dire the situation at home had become, Child SK's mother said she would like a 24-hour security guard who is trained on how to manage her daughter.

109. At 4.30 pm on 14 July 2020, the Department received a notification of concern via email from a psychiatry registrar at Ward 5A. This notification again outlined that Child SK's parents felt they were unable to manage their daughter's aggression and self-harm risk at home. As part of Child SK's intended discharge plan from PCH, the multi-disciplinary team treating Child SK required the Department to open an investigation into the significant risk that Child SK's discharge posed to her family.

110. On 16 July 2020, the Department made the assessment there was evidence that Child SK's parents were unable to provide adequate care pursuant to section 28(2)(d) of the *Children and Community Services Act 2004* (WA). An intake was completed to Child Safety Investigation (CSI)[23] for Child SK and the matter was referred to the Department's Cannington District on the same day.[24]

17 July 2020: Child SK attends PCH for the eleventh time

111. Child SK had slept well on the night of her discharge and had presented no issues for her parents. On 17 July 2020, as a reward, Child SK's mother arranged for her to have a manicure. However, later that evening, Child SK was taken to the ED at PCH after deliberately ingesting an excessive amount of toothpaste at home. She was seen by a psychiatry registrar, Dr Richard Clarke (Dr Clarke), who noted that despite the complex presentation, Child SK appeared to be settled with no evidence of ongoing distress.

112. After conferring with the on-call consultant psychiatrist, Dr Clarke discussed safety planning with Child SK's mother, who agreed to take her home from the ED.

[23] A CSI is undertaken by the Department to determine if harm to a child can be substantiated.

[24] Although the matter was allocated to a child protection worker on 20 July 2020, no further action had been taken before Child SK was struck by a car on 21 July 2020.

EVENTS LEADING TO CHILD SK'S DEATH [25]

113. At 10.00 am on 21 July 2020, Dr Tan and Ms Johnson had their scheduled appointment with Child SK at BFC. Although Child SK reported feeling "okay", she also disclosed experiencing ongoing suicidal thoughts. However, she said she had been able to distract herself from acting on these thoughts.

114. Child SK was provided with advice as to how to identify signs of escalation and she recognised palpitations, irritability and fidgeting as warning signs of becoming dysregulated. She expressed a desire to return to school soon and that she was hopeful about going horse riding on the weekend and playing games with her family in the evenings. Child SK denied any current plan or intent to end her life; however, she did identify ongoing suicidal thoughts.

115. At a concurrent face-to-face meeting with Child SK's parents and a BFC clinician, her parents stated feeling anxious as Child SK had continued to express negative emotions and behaviours since her discharge from Ward 5A on 16 July 2020. Although they had been able to de-escalate Child SK, they said they continued to feel unsafe at home. They noted that Child SK managed during the day; however, she became more irritable as the day went on and there was worsening emotional and behavioural dysregulation in the evening.

116. At 10.50 am, a joint meeting took place with Child SK and her parents. Structured activities for the evenings were agreed and the safety plan was reviewed. Child SK became animated when talking about the planned horse riding and agreed to receive a telephone call from BFC on 23 July 2020. Another face-to-face appointment at BFC was also arranged for 28 July 2020.

117. After leaving BFC with her parents, Child SK appeared happy, although a little guarded. She asked if she could be taken to a pet shop that was on Albany Highway and a short distance from BFC. As she enjoyed doing that, her parents agreed. Once at the pet shop, Child SK spent some time looking at the animals, and talking to her mother about what animals she wanted.

118. At about 11.45 am, Child SK and her parents walked back to their car which was in a car park adjacent to Albany Highway. As Child SK walked to the car it appeared she was going to get into the front seat. Her mother said that

[25] Exhibit 1, Volume 1, Tab 12.1, Statement of Child SK's mother dated 27 July 2020; Exhibit 1, Volume 1, Tab 13, Statement of Child SK's father dated 27 July 2020; Exhibit 1, Volume 1, Tab 14.1, Statement of Donna Gardiner dated 7 August 2020; Exhibit 1, Volume 1, Tab 20.2, St John Ambulance Patient Care Record; Exhibit 2, Report from Dr Vineet Padmanabhan dated 1 May 2023

she was to sit in the back seat. This was standard practice for Child SK's parents as it meant the child door locks could be activated to prevent their daughter from getting out of the car and running away.

119. When her mother said that to her, Child SK turned to her mother and gave her a "weird smile". Without saying anything, Child SK turned around and walked directly towards Albany Highway. Child SK's father began to follow her, making sure that he did not startle her. Both parents also began calmly calling out to Child SK to come back, reminding her that her bedroom was going to be painted when they got home. This had no effect and after walking to the edge of Albany Highway, Child SK looked back at her parents and smiled before she stepped directly into the path of an oncoming car.

120. The driver of the car had no time to brake and the front left-hand side of the car struck Child SK. Eyewitnesses contacted emergency services and ambulance officers attended a short time later.

121. Child SK was rendered unconscious from the impact and had sustained multiple head wounds. She was non-responsive with agonal breathing[26] when ambulance officers initially assessed her. Child SK was lifted onto a stretcher and placed into the ambulance. CPR and other resuscitative measures were commenced and the decision was made by ambulance officers to transport her under Priority 1 conditions to RPH.

122. Child SK was admitted to the ICU at RPH. Sadly, scans revealed that she had sustained non-survivable head injuries. After being placed on life support, Child SK later died on the afternoon of 23 July 2020.[27]

CAUSE AND MANNER OF DEATH

Cause of death [28]

123. Following an objection by Child SK's family to an internal post mortem examination, Dr Daniel Moss (Dr Moss), a forensic pathologist, conducted an external examination on Child SK's body on 30 July 2020.

124. A CT scan was also performed as part of this examination which found evidence of a severe head injury, pelvic fractures and resuscitative intervention.

[26] Agonal breathing is insufficient breathing that indicates the person is having a severe medical episode.
[27] Exhibit 1, Volume 1, Tab 4.2, Death in Hospital Form dated 23 July 2020
[28] Exhibit 1, Volume 1, Tabs 5.1-5.3, Supplementary Post Mortem Report, Full Post Mortem Report and Interim Post Mortem Report dated 30 July 2020; Exhibit 1, Volume 1, Tab 6, Toxicology Report dated 3 August 2020

125. Toxicological analysis of blood samples taken on Child SK's admission to RPH detected no evidence of alcohol or drugs (although these was an insufficient volume of blood from the samples to undertake a full drug screen).

126. At the conclusion of the external post mortem examination, Dr Moss expressed the opinion that the cause of death was complications of a head injury.

127. I accept and adopt the conclusion expressed by Dr Moss as to the cause of Child SK's death.

Manner of death

128. As noted above, Child SK had been diagnosed with an emerging EUPD in the months before her death. EUPD is defined as a personality disorder in which there is a tendency to act impulsively without consideration of the consequences. The ability to plan ahead may be minimal and outbursts of intense anger can lead to violence. It is characterised by chronic feelings of emptiness and recurrent suicidal behaviour. There is also a pervasive pattern of instability regarding marked impulsivity, interpersonal relationships and self-image, usually beginning by early adulthood.[29]

129. For reasons that I have outlined later in this finding, I am satisfied that Child SK's mental health issues were due to emerging EUPD. I am also satisfied that on 21 July 2020, she made the impulsive decision to end her life by deliberately stepping onto a busy highway in front of an oncoming car.

130. Accordingly, I find that Child SK's death occurred by way of suicide.

ISSUES RAISED BY THE EVIDENCE

What was Child SK's most likely mental health diagnosis?

131. Prior to the inquest commencing, Child SK's parents were of the view that the diagnosis of EUPD for their daughter was not accurate. Their belief was that Child SK had bipolar disorder.

132. I can fully understand why they held that view. There was a family history of bipolar disorder and it is the mental health disorder that is the most likely to be passed down from family, with genetic factors accounting for about

[29] Exhibit 2, Report from Dr Vineet Padmanabhan dated 1 May 2023, attachments 11 and 12

80% of its cause.[30] It had also been the provisional diagnosis made by Dr Manners in mid-2018.

133. In light of this issue, the Court obtained an independent expert report from Dr Joey Le (Dr Le), a forensic psychiatrist from New South Wales, who specialises in child and adolescent psychiatry. One question the Court asked of Dr Le was what he considered to be Child SK's most likely diagnosis/diagnoses. After reviewing the relevant material that the Court had provided to him, Dr Le expressed the following opinion:[31]

> The considerable diagnostic overshadowing and overlap of symptoms from a range of conditions potentially affecting Child SK at the time of her death made it difficult to make a definitive diagnosis with any certainty. The clinical evidence suggested that the most likely diagnosis affecting Child SK was an emerging Emotionally Unstable Personality Disorder (EUPD).
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> …
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> The writer found no evidence within the clinical records of Bentley CAMHS or Perth Children's Hospital to support a diagnosis of bipolar mood disorder. There was no evidence within the clinical records of medical nursing or allied health staff to suggest the presence of pervasive periods of hypomania or mania that are the hallmark feature of a bipolar mood disorder.

134. Towards the completion of the inquest, Mr Droppert SC, counsel for Child SK's family, made the following submission to me:[32]

> Taking into account all of the evidence that you've heard, I won't be making a submission that any of the medical practitioners should positively have reached a diagnosis of bipolar disorder. Nor am I going to make a submission that EUPD was not a diagnosis that could have been made, or at least used, as a framework diagnosis in the case of a 13-year-old child. And thirdly, that the practitioners who came to that diagnosis clearly believed they had an appropriate basis to reach the diagnosis, and I won't be saying something different to that.

135. Based on the documentary evidence in exhibit 1, the oral evidence at the inquest and the concession made by Mr Droppert SC on behalf of the family, I am satisfied that it was appropriate for the psychiatrists treating Child SK to make the diagnosis of an emerging EUPD.

136. In making that conclusion, I commend Dr Tan (a psychiatric registrar at the time) for being the first clinician to note that Child SK may have symptoms of EUPD at his very first review of her on 15 May 2020. I also share

[30] https://www.blackdoginstitute.org.au
[31] Exhibit 1, Volume 2, Tab 7.1, Report from Dr Joey Le dated 20 June 2022, pp.16-17
[32] Ts 10.5.23 (Mr Droppert SC), p.661

Mr Droppert SC's observation at the inquest that Dr Tan, "*was obviously a caring and concerned doctor*".[33]

Was it appropriate to prescribe quetiapine for Child SK?

137. As outlined above, quetiapine was prescribed off-label to Child SK by Dr Tan on 15 May 2020 to assist with her insomnia and anxiety. The documentary evidence before me clearly shows that Child SK's mother expressed a concern to several of her daughter's clinicians that quetiapine was not assisting, particularly with respect to Child SK's nightmares and suicidal ideation. This began as early as 25 May 2020 when she had a telephone conversation with Dr Hudson.[34] Although the dosage of quetiapine was sometimes varied, and at one point ceased during Child SK's admission to Ward 5A that began on 4 June 2020, it continued to be prescribed, despite the reservations of Child SK's mother.

138. As late as 7 July 2020, Child SK's mother was stating that quetiapine was not effective for her daughter and that it should be reviewed.[35] In those circumstances, I can understand why a submission was made at the inquest by counsel for Child SK's family that, "*a more rigorous assessment of the 'off-label' use* [of quetiapine] *for a child may have been required.*"[36] At the time of her death, Child SK remained on a daily dose of 50 mg of quetiapine to assist with her sleep.[37]

139. Notwithstanding her mother's concerns, Child SK had expressed a view that she wanted to retry quetiapine as she did not remember having any nightmares when she had previously used it. This occurred during a family meeting at PCH on 10 June 2020. In addition, the concerns of Child SK's mother had been documented, which supports the contention that these concerns were not being ignored. Although it would appear that the mother's reporting of increased suicidal ideation after quetiapine had been prescribed was not always recorded.

140. Although quetiapine is an anti-psychotic/psychotropic medication that was primarily intended to be used for people with schizophrenia and bipolar disorder, it has recently been increasingly used as an "off-label" medication for not only anxiety and sleep disturbance but also for depression and other disorders such as emotional dysregulation and personality disorders.[38]

[33] Ts 12.5.23 (Mr Droppert SC), p.773
[34] Exhibit 1, Volume 3, Tab 2, Perth Children's Hospital medical records, pp.254-255
[35] Exhibit 1, Volume 3, Tab 2, Perth Children's Hospital medical records, p.119
[36] Written closing submissions from Mr Droppert SC dated 12 May 2023, p.1
[37] I also note that Child SK had been prescribed 5 mg of aripiprazole which her mother had recommended as a substitute for quetiapine: Exhibit 1, Volume 3, Tab 2, Perth Children's Hospital medical records, p.119
[38] https://www.britishjournalofcommunitynursing.com/content/treatments/off-label-use-of-quetiapine/

141. I also note that Dr Le was asked whether Child SK's medication was appropriate, given her age and diagnosis. Dr Le's opinion was, "*that given the working formulation of Child SK's difficulties being explained by a predominant diagnosis of EUPD, her treatment with psychotropics was not unreasonable*."[39]

142. Based on the information available, I am satisfied it was appropriate for Child SK to be prescribed quetiapine and that her treating clinicians did modify her doses in a satisfactory manner in an effort to minimise its side effects. Had there been an absence of literature indicating that quetiapine is being increasingly used as an "off-label" medication to treat the conditions that Child SK had, or if Dr Le had raised questions as to its use, then I would have agreed it ought to have had "*a more rigorous assessment*". However, neither scenario existed.

Were the actions taken by Department of Communities appropriate?

143. Although the Department's role with respect to the treatment and care of Child SK was not as significant as BFC and PCH, it nevertheless became involved on a number of occasions in 2020. Each of those occasions will now be examined.

144. The Department's first involvement took place on 24 January 2020. This occurred when its Mandatory Reporting Service received a mandatory report regarding Child SK's meeting with a man she had met online.

145. After conducting further enquires, the mandatory report was allocated to a senior child protection worker with the Department's Mandatory Reporting Service, Ms Smitha Kutty (Ms Kutty). After reviewing the information obtained, Ms Kutty completed the Department's Interaction Tool. The purpose of the Interaction Tool is:[40]

> … to provide a consistent approach to child protection assessment and to prompt child protection workers to consider all aspects of a child's safety and wellbeing. Child protection workers must utilise this tool in every Interaction to inform a decision on whether Communities has a role to assess child protection concerns. The Interaction Tool will produce a final score between 0-10. Referrals with information generating scores over 5 recommend an Intake; however, the final decision to Intake is always based on professional judgement.

146. Ms Kutty completed the Interaction Tool with a resulting score of 2. She noted that Child SK's family had no prior contact with the Department and

[39] Exhibit 1, Volume 2, Tab 7.1, Report from Dr Joey Le dated 3 June 2022, p.18
[40] Exhibit 1, Volume 2, Tab 1.1, Report from Rachael Green, the Department's Deputy Director, dated 17 September 2021, p.2

no incidents of family violence had been recorded. Ms Kutty assessed that Child SK had demonstrated a capacity to disclose abuse to clinicians and that her parents were able to assist her in maintaining her safety by taking her to PCH to seek support for her risk-taking behaviours. Ms Kutty referred the matter to the Child Abuse Squad at WAPF and recorded an outcome of no further action.[41]

147. I am satisfied that the actions taken by the Department with respect to this mandatory report were appropriate.

148. On 4 June 2020, the Department received another mandatory report regarding Child SK. It concerned online messages from three males sent to Child SK that were of a sexual nature. Photographs had also been sent, and although they could not be viewed by Child SK's mother as they expired after a certain time, their content was very likely to have been of a sexual nature. Ms Wanita Ewings (Ms Ewings), a child protection worker in the Department's Mandatory Reporting Service, was allocated the matter.

149. After reviewing the material, and consulting with a senior child protection worker, Ms Ewings completed the Interaction Tool with a resulting score of 2.5. Again, following consultation with the senior child protection worker, Ms Ewings concluded that there were no safety issues for Child SK, noting that the matter had been reported to WAPF, that she was receiving support through PCH, and that her mother was acting protectively.

150. After referring the matter to the Child Abuse Squad at WAPF, Ms Ewings recorded that there be no further action.[42]

151. I am satisfied that the actions taken by the Department with respect to this mandatory report were appropriate.

152. The next involvement the Department had was a notification of concern that Child SK's case manager at BFC, Ms Kavanagh, sent by email at 5.01 pm on 10 June 2020.[43] Attached to this email was a Child Protection Concern Referral (the first Referral) that had been completed by Ms Kavanagh. After outlining Child SK's inappropriate contact with adult men that were the subject of the two previous mandatory reports, Ms Kavanagh detailed the following:[44]

> [Child SK] has significant anxiety, emotional dysregulation and suicidal ideation. Her suicidal risk is moderate and chronic and worsened by her impulsivity. She has had a number of emergency department presentations and two admissions

[41] Exhibit 1, Volume 2, Tab 14, Statement of Smitha Kutty dated 18 April 2023, p.5
[42] Exhibit 1, Volume 2, Tab 16, Statement of Wanita Ewings dated 21 April 2023, p.4
[43] Exhibit 1, Volume 3, Tab 7, Statement of Bobbie Kavanagh dated 24 April 2023, attachment 15
[44] Exhibit 1, Volume 3, Tab 7, Statement of Bobbie Kavanagh dated 24 April 2023, attachment 15, p.4

> to PCH due to attempts to harm herself and parents being unable to contain her safely at home.
>
> …
>
> Father has significant mental health disorder impacting on daily functioning. Mother has significant social anxiety and is struggling to cope with [Child SK's] dysregulation and other family factors.

153. Ms Kavanagh also noted that Child SK's suicidal ideation and dysregulation "*increases significantly*" when attempts are made to raise her inappropriate interactions with adult males.[45]

154. On 11 June 2020, Cassie Pollard (Ms Pollard), a senior child protection worker at the Department's CIT, was allocated the first Referral from Ms Kavanagh.

155. At 9.33 am on the same day, Ms Pollard sent an email to Ms Kavanagh that stated: "*… given this information has recently been reported to the Department and assessed, there will be now* [sic-no] *further action taken regarding your referral at this time*."[46]

156. Ms Kavanagh was asked at the inquest what she was hoping the response from the Department would be regarding the first Referral. Ms Kavanagh answered:[47]

> I was really – you know, it was early on in me knowing this family. I was very concerned about [Child SK's] mum having found a lot of, you know, inappropriate contact with adult males, talking about, you know, meeting adult males in park, inappropriate sexual behaviour, also you know, the emotional dysregulation and the escalation and suicidal ideation. I was hoping that they would get more – well, intensive family support to support them, basically to kind of, I guess, manage behaviour.

157. This is consistent with the information that Ms Kavanagh provided to the Department in the first Referral. In answer to the question in the first Referral: "*What response do you think the Department of Communities could give to best meet the needs of this family?*", Ms Kavanagh identified a Child Protection Assessment and parent support.[48]

158. As part of her assessment, Ms Pollard undertook a review of the Department's electronic records systems and noted the two previous

[45] Exhibit 1, Volume 3, Tab 7, Statement of Bobbie Kavanagh dated 24 April 2023, attachment 15, p.4
[46] Exhibit 1, Volume 3, Tab 7, Statement of Bobbie Kavanagh dated 24 April 2023, attachment 15
[47] Ts 4.5.23 (Ms Kavanagh), p.189
[48] Exhibit 1, Volume 3, Tab 7, Statement of Bobbie Kavanagh dated 24 April 2023, attachment 15, p.3

Interactions in 2020. She also attempted to make telephone contact with Child SK's mother; however, her calls were not answered.[49]

159. Ms Pollard completed the Interaction Tool with a resulting score of 3.

160. After Ms Pollard consulted with her team leader, it was agreed that the Interaction would be completed with no further action required by the Department as:

- the previous inappropriate contact with adult men had been reported;
- Child SK's parents were protective and accessing supports; and
- the information had not changed since the previous assessments.[50]

161. At the inquest, Ms Pollard said she would generally try to contact a parent, "*two times in quite quick succession*".[51] She agreed that the first Referral was a matter where she did not regard it as absolutely necessary or essential to speak with Child SK's mother.[52]

162. Ms Pollard stated that had she made contact with Child SK's mother, and the mother had requested further support, then the most likely referral would have been to FSN.[53] Ms Pollard later said a referral cannot be made to FSN without the consent of a parent.[54]

163. In light of this evidence from Ms Pollard, I asked her these questions:[55]

> Ms Pollard, do you accept that given the circumstances of this referral and given that one of the reasons for the referral was that the parents were unable to contain her safely at home, that really what was required was some further follow-up with respect to the mother? --- And again with the attempt to contact [Child SK's mother] would have been exploring that more and getting additional information.
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> And actually waiting until you have had the opportunity of speaking to [Child SK's] mother before making a final decision? ---- Yes. And I imagine that was probably part of the reason I had a consultation [with the team leader] around, you know, what, what's the next step here.

[49] Exhibit 1, Volume 2, Tab 10, Statement of Cassie Pollard dated 14 April 2023, pp.4-5
[50] Exhibit 1, Volume 2, Tab 10, Statement of Cassie Pollard dated 14 April 2023, p.6
[51] Ts 3.5.23 (Ms Pollard), p.78
[52] Ts 3.5.23 (Ms Pollard), p.79
[53] Ts 3.5.23 (Ms Pollard), p.83
[54] Ts 3.5.23 (Ms Pollard), p.88
[55] Ts 3.5.23 (Ms Pollard), p.94

164. After Ms Pollard was reminded of the small timeframe between Ms Kavanagh's email late on 10 June 2020, and her response the following morning, I asked:[56]

> So on the decision to wait longer, can you give any explanation then as to why you didn't wait longer to see if either [Child SK's] mum would ring you back, or make another attempt to call her? --- I don't have the information at hand on that, no. It potentially could have been impacted on, unfortunately, my workload and many other competing priorities. I don't have the specifics.

165. Ms Pollard then accepted that if more time was required to determine the outcome of a referral, a decision did not necessarily have to be made within the same day.[57]

166. Ben Whitehouse (Mr Whitehouse), the Executive Director of Statewide Services at the Department, gave evidence at the inquest. With respect to the first Referral from Ms Kavanagh, I asked Mr Whitehouse:[58]

> Was the response to that referral appropriate by the Department, i.e. that no action would be taken? --- Some learnings from that that I've reflected on is that we should have made more attempts to be in touch with [Child SK's] mother; we should have. Two phone calls were not sufficient. That could have provided clarifying context and information both to either increase the risk or concern or decrease the risk and concern. My view is that and, again, this is no criticism for individual workers who are dealing in a very complex environment is that we could have considered the family support pathway into the district at that stage.
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> …
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> … there is an encouragement and recommendation for workers to contact parents and the referrer but there is no hard and fast non-negotiable, "This is the expectation". So that's the context, but in this scenario I agree with you that what would have been really important given the complexity … of this situation is that context from [Child SK's] parents or families or significant others would have been really important, yes.

167. When I raised the apparent over-reliance on the outcomes of the earlier mandatory reports, Mr Whitehouse answered:[59]

> Yes, I think you're correct in saying that what could of been done more and [that] is potential investigation or further assessment or inquiries regarding … some of the referrals around [Child SK's] parent's ability to be able to contain [Child SK] in regards to both [Child SK's] presenting behaviours as well as

[56] Ts 3.5.23 (Ms Pollard), p.95
[57] Ts 3.5.23 (Ms Pollard), p.96
[58] Ts 3.5.23 (Mr Whitehouse), pp.636-637
[59] Ts 3.5.23 (Mr Whitehouse), p.639

> [Child SK's] sister's presenting behaviours. As well as some of their own mental health concerns and issues. That could have been explored further.

168. In light of those concessions made by Mr Whitehouse, Ms Hartley, counsel for the Department, accepted at the inquest that:

- the response to the referral by Ms Kavanagh on 10 June 2020 was not appropriate;
- the assessment of that referral should have involved a conversation with Child SK's mother and Ms Kavanagh; and
- Ms Pollard placed an over-emphasis on the previous assessments regarding the two mandatory reports.[60]

169. With respect to the last point, Ms Hartley noted that the decision to close the first Referral was approved by Ms Pollard's team leader.[61] I accept that this fact is necessary to place the decision in its proper context.

170. Having considered all the available information regarding the first Referral, I am satisfied the Department failed to give an appropriate consideration to whether it should refer the matter to FSN. There was a lack of attention given to the information the Department had received regarding Child SK's high risk of self-harm and her parents' inability to keep her safely at home. Had more consideration been given to these aspects of the first Referral, I am satisfied there was every likelihood a referral to FSN would have been made via its intensive case management stream.

171. The next involvement of the Department was another Child Protection Concern Referral (the second Referral) from Ms Kavanagh that was attached to an email she sent to the Department on 26 June 2020.[62] In her email, Ms Kavanagh made it abundantly clear that Child SK's family desperately required assistance. The email's contents included the following:[63]

> … we are very concerned for [Child SK] due to her chronic moderate to high risk of misadventure due to impulsivity.
>
> Things in this family are reaching crisis point as the family are struggling to contain [Child SK] who is very emotionally dysregulated at present.
>
> We are really hoping that this one can get intensive case management through FSN as the parents have not been able to make any significant gains through multiple interventions they have received here at Community CAMHS.

[60] Ts 12.5.23 (closing submissions by Ms Hartley), p.838
[61] Ts 12.5.23 (closing submissions by Ms Hartley), p.838
[62] Exhibit 1, Volume 3, Tab 7, Statement of Bobbie Kavanagh dated 24 April 2023, attachment 28
[63] Exhibit 1, Volume 3, Tab 7, Statement of Bobbie Kavanagh dated 24 April 2023, attachment 28

172. In the second Referral, Ms Kavanagh explained in detail the background to the matter. She concluded:[64]

> To this point the family have struggled to make any progress in Community CAMHS interventions they have participated in over the years. They also have not engaged in recommended systemic interventions due to the level of anxiety it results in for both parents to attend these interventions and the ongoing chaos in the family system. This family is at a crisis point and requires an intensive level of in-home intervention and parenting support.

173. The second Referral was initially allocated to Ms Holly Williams (Ms Williams), a senior child protection worker at the Department's CIT. The person responsible for that allocation was Steven Gotti (Mr Gotti), an acting team leader. Mr Gotti's evidence at the inquest was that if he had not allocated the second Referral to Ms Williams on 26 June 2020, it would have been on 27 June 2020. [65] However, I note that 26 June 2020 was a Friday and so I am prepared to accept that this allocation may not have occurred until the following work day i.e. Monday, 29 June 2020.

174. The Court was advised that Ms Williams went on unplanned personal leave from 7 July to 9 July 2020.[66] Regrettably, there is no record of any action having been taken by Ms Williams to progress the second Referral before she took this leave. As to why this occurred, Mr Gotti stated that it could be "*a multitude of reasons*", including the volume of other interactions allocated to Ms Williams and their level of priority.[67] During Ms William's leave, the second Referral was reallocated to Ms Cassey Ferrari (Ms Ferrari).

175. Ms Ferrari commenced her employment with the Department as a child protection worker in January 2011.[68] However, she did not undertake the role of a child protection worker with the Department's Crisis Care Unit until 6 July 2020. On that date she commenced a two week training period with the CIT. During that training period she shadowed Mr Gotti and did not perform a referral assessment by herself.[69]

176. At the inquest, Ms Ferrari agreed that the assessment for the second Referral was one of the most complicated she had to deal with in the three years she had worked at CIT since July 2020.[70] However, she also clarified at the

[64] Exhibit 1, Volume 3, Tab 7, Statement of Bobbie Kavanagh dated 24 April 2023, attachment 28, p.4
[65] Ts 4.5.23 (Mr Gotti), p.138
[66] Ts 12.5.23 (closing submission by Ms Hartley), p.839
[67] Ts 4.5.23 (Mr Gotti), p.138
[68] Exhibit 1, Volume 2, Tab 13, Statement of Cassey Ferrari dated 15 April 2023, p.1
[69] Ts 8.5.23 (Ms Ferrari), pp.335-336
[70] Ts 8.5.23 (Ms Ferrari), p.342

inquest any decisions she made regarding the assessment of the second Referral was in consultation with Mr Gotti.[71]

177. On 8 July 2020, Ms Ferrari contacted Ms Kavanagh to seek further information regarding the second Referral. Ms Kavanagh advised that Child SK's parents required "*home parenting intervention*" and that they "*were struggling to manage*".[72]

178. At the direction of Mr Gotti, Ms Ferrari contacted Child SK's mother on 10 July 2020. Child SK's mother provided detailed information regarding her daughter's self-harming, suicidal ideation and the family's struggles to protect Child SK. Not surprisingly, Child SK's mother supported the Department making a referral to FSN for support.[73]

179. On the same day, Ms Ferrari contacted FSN and was advised that the intensive case management stream was at capacity. Instead, and at the recommendation of FSN, Ms Ferrari made a referral to the assessment and coordination stream of FSN.

180. At the inquest, Ms Ferrari agreed that the information provided to her by Child SK's mother on 10 July 2020 showed that Child SK's behaviour had considerably escalated since 26 June 2020. Nevertheless, notwithstanding that information, Ms Ferrari was of the view that the FSN option was the most suitable.[74] Even with the benefit of hindsight, Ms Ferrari said she would not have made an intake for Child SK to undergo a CSI.[75]

181. On 10 July 2020, Ms Ferrari completed the Integration Tool with a resulting score of 3. Following a consultation with Mr Gotti, she recorded an outcome of no further action.[76]

182. At the inquest, I was concerned about the Department's delay to finalise its assessment of the second Referral as ten business days had passed since it was sent to the Department. Notwithstanding the second Referral detailing the significant concerns held by Ms Kavanagh for the wellbeing and safety of Child SK, Mr Gotti agreed that "*a combination of workload and other priorities meant this matter wasn't assessed until 10 July*".[77]

[71] Ts 8.5.23 (Ms Ferrari) p.348
[72] Exhibit 1, Volume 3, Tab 7 Statement of Bobbie Kavanagh dated April 2023, attachment 42
[73] Exhibit 1, Volume 2, Tab 13, Statement of Cassey Ferrari dated 15 April 2023, pp.4-5
[74] Ts 8.5.23 (Ms Ferrari), p.341
[75] Ts 8.5.23 (Ms Ferrari), p.340
[76] Exhibit 1, Volume 2, Tab 13, Statement of Cassey Ferrari dated 15 April 2023, p.19
[77] Ts 4.5.23 (Mr Gotti), p.141

183. At the inquest, Mr Whitehouse acknowledged that the assessment of the second Referral should have commenced earlier than 8 July 2020 when Ms Ferrari began her enquiries.[78]

184. In her closing submissions at the inquest, Ms Hartley accepted there was an inappropriate delay in assessing the second Referral.[79] In my view, that concession was entirely appropriate. Ms Hartley also accepted that nothing was done with respect to an assessment of the second Referral from the time it was initially allocated to Ms Williams to when it was reallocated to Ms Ferrari. I am satisfied this timeframe would have been at least six work days.

185. It is not in issue that with respect to the FSN option, the appropriate pathway for Child SK's family was through its intensive case management stream. However, as clarified by Ms Ferrari at the inquest, the Department's referral to the assessment and coordination stream of FSN was an interim measure until such time as a vacancy became available in the intensive case management stream.[80]

186. Although the Department ultimately did what Ms Kavanagh was requesting in her second Referral, I find that there was an inappropriate delay in referring the matter to FSN. That ought to have taken place no later than 1 July 2020.

187. The Department's final involvement occurred on 14 July 2020 when it received another notification of concern. This Child Protection Concern Referral (the third Referral) was completed by Dr Kalliste Black (Dr Black), a psychiatry registrar at Ward 5A, when Child SK was an in-patient there. The contents of the third Referral were very similar to the first and second Referrals by Ms Kavanagh, emphasising the inability of Child SK's parents to manage their daughter's aggression and self-harm risk at home.[81]

188. The third Referral also noted that as part of Child SK's discharge plan from PCH, the multi-disciplinary team required the Department to investigate the significant risk Child SK's discharge posed to her family.[82]

189. The third Referral was allocated to Ms Williams who completed the Interaction Tool with a resulting score of 3.5. Although the general rule requires a threshold score of 5 before a matter is assessed as an intake for a CSI, Ms Williams considered that an intake may be appropriate for

[78] Ts 10.5.23 (Mr Whitehouse), p.635
[79] Ts 12.5.23 (closing submissions of Ms Hartley), p.839
[80] Ts 8.5.23 (Ms Ferrari), pp.348-349
[81] Exhibit 1, Volume 2, Tab 9, Statement of Holly Williams dated 14 April 2023, p.4
[82] Exhibit 1, Volume 2, Tab 9, Statement of Holly Williams dated 14 April 2023, p.5

Child SK as her aggressive, suicidal and risk-taking behaviour was placing her and her family at risk.[83]

190. Consequently, Ms Williams had a meeting with Mr Gotti and Carmen Sampson (Ms Sampson) who was a senior practice development officer at the Department. At this meeting, Ms Sampson raised the circumstances of what encompasses a child "*in need of protection*" as defined in section 28(2)(d) of the *Children and Community Services Act 2004* (WA).[84] At the completion of that meeting it was agreed that the matter would be progressed to a CSI and it was referred to the Department's Cannington District.[85]

191. I am satisfied that this was the appropriate course of action for the Department to take. There was strong evidence that Child SK was "*in need of protection*" because she was a child who "*suffered or is likely to suffer harm as a result of the child's parents being unable … to provide… adequate care for the child*."[86]

192. The question, however, arises as to whether such convincing evidence existed prior to the third Referral and, more specifically, whether such evidence existed when the Department was assessing the second Referral. For the following reasons, I am satisfied that there was compelling material before the Department that warranted, at the very least, consideration of the matter being progressed to a CSI when the second Referral was assessed.

193. At the inquest, Ms Williams was asked whether there was any new or particular information since the second Referral that "*tilted the scale"* in favour of an intake to a CSI. Ms Williams said that there was not. Significantly, Ms Williams also added that she was "*unclear*" whether section 28(2)(d)(i) of the *Children and Community Services Act 2004* (WA) was actually considered in the assessment of the second Referral.[87]

194. On the information before me, I am satisfied that no consideration was given to section 28 (2)(d)(i) of the *Children and Community Services Act 2004* (WA) when the second Referral was assessed. I am satisfied of that for the following three reasons.

195. The first time there is a record of this provision being discussed was at the meeting on 16 July 2020 between Ms Williams, Ms Sampson and

[83] Exhibit 1, Volume 2, Tab 9, Statement of Holly Williams dated 14 April 2023, p.5
[84] Exhibit 1, Volume 2, Tab 9, Statement of Holly Williams dated 14 April 2023, p.5
[85] Exhibit 1, Volume 2, Tab 9, Statement of Holly Williams dated 14 April 2023, pp.5-6
[86] Section 28(2)(d)(i) of the *Children and Community Services Act 2004* (WA)
[87] Ts 4.5.23 (Ms Williams), p.109

Mr Gotti when Ms Sampson raised it.[88] There is no evidence before me that Ms Sampson was consulted regarding the assessment for the second Referral, and it would appear this meeting was the first time she became involved in the Department's decision-making process for Child SK.

196. The second reason is that Ms Kavanagh was asking the Department to refer the matter to FSN, and not as an intake for a CSI.

197. The third reason is that the score of 3 completed by Ms Ferrari on the Interaction Tool did not meet the threshold for an intake to CSI.[89]

198. As to the Department's oversight to properly consider an intake to a CSI when it assessed the second Referral, I accept this was a very unusual case that is not ordinarily dealt with by the Department's CIT. It concerned a case that involved self-harming by a child, rather than the more common case of harm or neglect to the child by the child's parents. Ms Williams, an experienced child protection worker at the Department, had never encountered a similar case.[90]

199. In addition, as already noted, Ms Kavanagh was requesting a referral to FSN and this obviously was a factor in the decision to take that course of action. Nevertheless, it was the Department that possessed the necessary expertise in order to determine the most suitable course of action following its assessment.

200. I am also mindful of the closing submissions made by Ms Hartley on this matter that included the following:[91]

> Up until 14 July, all that was ever being requested was family support. Appropriately, there was a focus on diversion within the Department of Communities rather than racing to intake to conduct what can be a very difficult and distressing child safety investigation.

201. Notwithstanding that submission, and after a careful consideration of the information available, I am satisfied there was a missed opportunity by the Department to consider whether Child SK should become an intake for a CIS when it assessed the second Referral.

Were the actions taken by Bentley Family Clinic appropriate?

202. As already outlined above, Child SK had been referred to BFC on four separate occasions prior to 2020. As the inquest was primarily focused on

[88] Exhibit 1, Volume 2, Tab 9, Statement of Holly Williams dated 14 April 2023, p.5
[89] For reasons that I have outlined later in this finding, I am not satisfied the Interaction Tool is suitable for an assessment involving the circumstances that existed in Child SK's case.
[90] Ts 4.5.23 (Ms Williams), p.111
[91] Ts 12.5.23 (closing submissions by Ms Hartley), p.841

the treatment and care Child SK received in 2020, my analysis of the actions by BFC to Child SK is confined to that year.

203. In my assessment of BFC's treatment and care of Child SK, it is necessary to note that it was very fragmented throughout 2020 due to her repeated admissions to PCH. I must also note that until May 2020, Child SK was very reluctant to engage with BFC clinicians. In addition, her mental health presentations were very complex and the diagnosis of an emerging EUPD was not confirmed before mid-2020.

204. Finally, I accept that BFC clinicians frequently had very limited time to discuss therapy options with Child SK and her family. This was because Child SK often presented in crisis and emotional distress. It therefore became necessary for clinicians to address safety issues for Child SK as a priority before therapy could begin. As Dr Padmanabhan noted:[92]

> Ensuring safety is a fundamental aspect of effective therapy. It lays the foundation for a positive therapeutic relationship that the patient can feel supported and empowered to work through their challenges.

205. In addition to these four significant factors, BFC's interactions with Child SK occurred during a period when COVID-19 restrictions were in place.

206. The treatment of EUPD for young people requires therapeutic engagement within the community, with an emphasis on two general principles:[93]

> First, the treatment does not only correspond to the implementation of specific therapies but is also a management plan that relies on the therapist's ability to work cooperatively for the patient's benefit.
>
> Second, treatment requires commitment from the youngster and from the parents. The family definitively has a critical influence on treatment efficacy.

207. Even before the provisional diagnosis of EUPD was made in May 2020, Child SK did not want to engage in individual therapy with BFC. In addition, due to the work commitments of Child SK's mother, attendance at family therapy sessions at BFC could not be arranged.

208. Unsurprisingly, Ms Kavanagh recognised the importance of establishing a relationship with Child SK built on trust. As she described at the inquest:[94]

> Also being able to build a relationship. I guess the basis of all treatment for young people who are emotionally dysregulated like [Child SK] was, is

[92] Exhibit 2, Report from Dr Vineet Padmanabhan dated 1 May 2023, p.31
[93] Exhibit 2, Report from Dr Vaneet Padmanabhan dated 1 May 2023, attachment 13, p.205
[94] Ts 4.5.23 (Ms Kavanagh), p.202

> relationship, and we were trying to form a relationship with her and her parents, and that was very hard because she was in and out of hospital.
>
> So is the continuity aspect an important part of that? --- Definitely, because if she didn't trust us then you can forget about therapy gains. Trust is the number one thing. She needed to believe that the people around her and our team in community were going to really get to know her, really understand her, and really want to work with her, alongside her and alongside her parents. But I guess it's hard to do that, you know, when you have that back and forth [of hospital admissions].

209. On behalf of Child SK's family, Mr Droppert SC submitted that there were "*missed points for intervention*" by BFC before the formal diagnosis of EUPD was made.[95] He also submitted that BFC should have considered a referral for Child SK to Touchstone in February 2020 and/or April 2020.[96]

210. Touchstone is a structured day service operated by CAMHS for children aged from 12 to 17 years and their families. Its multi-disciplinary team comprises of a consultant child and adolescent psychiatrist, a service manager, an experienced therapy team of nurses, psychologists and social workers, and occupational art and creative therapists. Touchstone operates for young people with impulsive self-destructive behaviour, interpersonal difficulties and emotional dysregulation. The program offers an evidence-based intervention called mentalisation based therapy. It is focused on supporting young people and their families to increase their capacity to better understand the link between feelings and behaviours and how they impact on their day-to-day lives.[97]

211. In this process, the young person is encouraged and supported to develop their own ability to manage life stressors and access help when and where it is needed. For this reason, the commitment of the young person and their family to engage with Touchstone is essential. Young people attend for at least three days weekly, with on-site school sessions as part of the program. A young person must be referred by their community CAMHS team for an assessment.[98]

212. It is clear from this summary that Child SK had the conditions that included her in the cohort of young people that Touchstone treats. I also note that she was known to have exhibited those conditions (emotional dysregulation, self-harming behaviour and interpersonal difficulties) by early 2020.

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[95] Ts 12.5.23 (closing submissions by Mr Droppert SC), p.771
[96] Ts 12.5.23 (closing submissions by Mr Droppert SC), p.778
[97] https://cahs.health.wa.gov.au/Our-services/Mental-Health/Specialist-services-and-day-programs/Touchstone
[98] https://cahs.health.wa.gov.au/Our-services/Mental-Health/Specialist-services-and-day-programs/Touchstone

213. However, the Touchstone intake criteria states that the young person must have attempted individual and family (where available) therapy in a Tier 3 mental health service (such as BFC) from which they have not benefited, and not only because of a lack of engagement with the Tier 3 mental health service.[99]

214. Child SK only began effective individual therapy engagement with BFC towards the end of May 2020. Consequently, she did not meet the Touchstone intake criteria at any time before then. As Dr Padmanabhan explained: [100]

> Child SK's lack of engagement in both individual and family therapy for an extended period in Bentley Family Clinic led to the non-fulfilment of a crucial admission criteria indicator for Touchstone.

215. On 12 June 2020, Ms Kavanagh completed a referral form for Child SK's acceptance into Touchstone.[101] On 9 July 2020, a nurse at Touchstone advised Ms Kavanagh that Child SK and her family had been accepted for an assessment.[102] This meant that 8 September 2020 was the earliest date Child SK could have commenced the Touchstone program had she been assessed as suitable. This was the commencement date for the four week Introductory Group. If that had been successfully completed by Child SK, then the start date for the six month Day Program would have been 12 October 2020.[103]

216. The Touchstone program before this one commenced on 16 July 2020 for the four week Introductory Group, followed by the commencement date of 24 August 2020 for the six month Day Program. However, the referrals for this program were received between 8 May and 28 May 2020.[104] As outlined above, Child SK had barely commenced her individual therapy with Ms Kavanagh as of 28 May 2020.

217. In those circumstances, I am satisfied that Ms Kavanagh referred Child SK to Touchstone in a timely manner and there was no undue delay in making that referral. Any referral before that date was in danger of failing to satisfy the intake criteria for participation.

218. I am also satisfied that BFC had previously acted in an appropriate manner when it provided Child SK's parents with alternative family therapy

[99] Exhibit 12, Letter from David Harwood and Amelia Westerside to counsel assisting dated 20 July 2023, p.4
[100] Email from David Harwood to counsel assisting dated 2 March 2024, attached letter from Dr Vineet Padmanabhan (undated)
[101] Exhibit 1, Volume 3, Tab 7, Statement of Bobbie Kavanagh dated 24 April 2023, attachment 19
[102] Exhibit 1, Volume 3, Tab 7, Statement of Bobbie Kavanagh dated 24 April 2023, attachment 41
[103] Exhibit 12, Letter from David Harwood and Amelia Westerside to counsel assisting dated 20 July 2023, p.4
[104] Exhibit 12, Letter from David Harwood and Amelia Westerside to counsel assisting dated 20 July 2023, p.4

options. This first took place on 26 February 2020 when it was confirmed that the work commitments of Child SK's mother clashed with the times of BFC's family therapy sessions (none of which was held outside office hours).

219. Based on the information available, and being mindful not to insert hindsight bias, I am not satisfied there were any missed opportunities (or "missed points of intervention") by BFC to consider any other alternative therapeutic path for Child SK's emotional dysregulation, either before or after the diagnosis of emerging EUPD was confirmed.

220. Another question raised at the inquest regarding BFC was that Dr Hudson had not personally reviewed or seen Child SK. As the consultant psychiatrist, the ideal practice was for Dr Hudson to see all patients who have been referred to BFC. Nevertheless, in the six months during 2020 that Child SK was a patient at BFC, Dr Hudson did not see her.

221. Although Dr Hudson was scheduled to see Child SK at the appointment on 15 May 2020, she was unwell and not at work that day.[105] Instead, Dr Tan reviewed Child SK by himself. Dr Hudson was also scheduled to see Child SK at a face-to-face appointment on 7 July 2020. However, that appointment did not occur as Child SK had been admitted to Ward 5A.[106]

222. There were two occasions when Child SK personally attended BFC for appointments close to 7 July 2020. One was on 30 June 2020 when she saw Ms Kavanagh, and the other was on 14 July 2020 when she saw Dr Tan and Ms Johnson. Mr Droppert SC noted in his written closing submissions at the inquest that no assessment by Dr Hudson occurred on these occasions. However, there is evidence before me that Dr Hudson was actually on leave on 14 July 2020.[107]

223. When determining this question, I must be mindful of the heavy workloads that all consultant psychiatrists at community mental health services inevitably have. Accordingly, I am satisfied that the efforts made by Dr Hudson to see Child SK were appropriate. It was only an unfortunate set of circumstances that prevented her from seeing Child SK at either of the appointments that had been made.

[105] Exhibit 1, Volume 1, Tab 21.1, Report from Dr Rachel Hudson dated 14 September 2020, p.11
[106] Exhibit 1, Volume 1, Tab 21.1, Report from Dr Rachel Hudson dated 14 September 2020, pp.20-21
[107] Exhibit 1, Volume 1, Tab 21.1, Report from Dr Rachel Hudson dated 14 September 2020, p.23

224. I also accept the following submission made by Mr Harwood at the inquest:[108]

> Dr Hudson oversaw and coordinated [Child SK's] care intimately and supervised all the clinicians who saw her in person. Whilst it would have been Dr Hudson's preference to have seen [Child SK] in person, it remains highly unlikely, given her intimate knowledge of the case from her colleagues, the constant meetings and the way that the MDT[109] operates as well as the extensive liaison between Perth Children's Hospital and Bentley Family Clinic, that her diagnosis or care recommendations would have been different had she seen her in person.

225. Finally, I should note that I am satisfied that there was a high level of commitment and dedication from the BFC mental health professionals who directly treated and cared for Child SK. The manner in which several of these clinicians gave evidence at the inquest clearly indicated to me that, notwithstanding the intervening years, they remain deeply affected by the death of Child SK. I have no hesitation accepting the following answers given by Ms Kavanagh at the inquest:[110]

> So I guess is it fair to say that Bentley Family Clinic was doing as much as Bentley Family Clinic could, taking into account what it is that your service offers but also taking into account limits, perhaps, on [Child SK's] level of engagement? --- Yes. We were probably doing above and beyond what we would normally do and probably at our maximum of, you know, in terms of contact per week. Definitely because her needs were so significant and the family's needs were very, you know, significant as well.
>
> Yes. So she starts at one level. You recognise the needs, and you push it up to the maximum service that Bentley can provide? --- Yes.

Were the actions taken by Perth Children's Hospital appropriate?

226. As I have already noted, the unchallenged evidence before me was that the primary treatment for a young person with EUPD is psychotherapy delivered in the community. As stated by Dr Lee, the court appointed independent psychiatrist, "*the mainstay of treatment for a young person for this condition is community based management emphasising distress tolerance skills*".[111]

227. There was also agreement from the psychiatrists called at the inquest that long hospital admissions are counterproductive for patients with EUPD. As Dr Wijeratne explained:[112]

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[108] Ts 12.5.23 (closing submissions by Mr Harwood), p.826
[109] Multi-disciplinary team
[110] Ts 5.5.23 (Ms Kavanagh), p.243
[111] Exhibit 1, Volume 2, Tab 7.1 Report from Dr Joey Lee dated 3 June 2022, p.21
[112] Exhibit 1, Volume 3, Tab 12, Statement of Dr Leenika Wijeratne dated 26 April 2023, p.19

> The treatment recommendation for EUPD is short admissions.
>
> The ward is an artificial environment where the patient is shielded from the stress and difficulties they face outside the ward.
>
> The longer the patient stays on the ward, the higher the chances of becoming dependent on the ward and the harder it is to get back into the community and face challenges.
>
> There is also a contagion effect, where young people on the ward spend time with other children with similar problems and may learn more maladaptive coping skills and potentially increase their risk in the future.

228. As Mr Harwood neatly summarised in his closing submissions at the inquest, there was a number of potential negative outcomes if Child SK had extended admissions in Ward 5A:

- an undermining of the therapeutic relationship between BFC and Child SK;
- as an in-patient, Child SK would be unable to practice the coping mechanisms she needed to develop in the community;
- the contagion issue that operated in both directions;
- the undermining of family attachment and the inappropriate attachment to staff at PCH; and
- the undermining of school and friendship relationships.[113]

229. In addition, it was not in dispute that for patients with EUPD, hospital admissions should only be utilised to address and contain the current risk of self-harm and that community-based psychotherapy delivered in the community is required for long-term care.

230. Furthermore, Child SK frequently asked to be discharged (including during her final admission to Ward 5A) and became very upset when told that would not be happening.[114] In contrast, there were times when Child SK's parents objected to a planned discharge date for their daughter simply because of their well-founded fears they would not be able to keep her safe at home.

231. I must also have regard to the fact that Ward 5A is not a long stay unit, and no such unit exists in Western Australia for children with significant mental health conditions.[115]

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[113] Ts 12.5.23 (closing submissions by Mr Harwood), p.822
[114] Ts 10.5.23 (Dr Morton), p.609
[115] Exhibit 1, Volume 1, Tab 22.3, Report from Dr Katinka Morton to the Medical Board of Australia (undated), p.34

232. I am satisfied that Child SK had the most complex case of EUPD and associated suicide risk that clinicians at PCH had encountered. It was therefore not surprising to hear Dr Padmanabhan describe Child SK's presentation as "*complex and challenging*".[116]

233. Once it is noted there were no step-down facilities available for Child SK upon her discharge from PCH, it can be readily appreciated how challenging her presentations were for her treating clinicians at PCH. In addition, as she needed to be a community patient to access the Touchstone program,[117] these challenges were amplified when it came to a decision to discharge Child SK during her final admissions when recent history had clearly demonstrated an elevated risk of self-harm within a week of discharge.

234. With the above factors in mind, I will now address those matters regarding PCH's treatment and care of Child SK that I regard as warranting specific consideration.

235. The first matter regarded the confusion surrounding Dr Kostic-Garner's qualifications at the time she was treating Child SK in Ward 5A.

236. At the relevant time, Dr Kostic-Garner was a supervised medical officer working within Ward 5A. This meant she was having supervision as she had been an internationally trained doctor who has had their medical degree verified in Australia and was now commencing work as a medical practitioner within Australia.[118]

237. Dr Kostic-Garner was a member of the multi-disciplinary team looking after Child SK during her admissions to Ward 5A from 3 June 2020 to 10 July 2020.[119] Dr Kostic-Garner had also performed a risk assessment of Child SK at the emergency department of PCH on 14 April 2020.[120] Consequently, Child SK and her mother had regular contact with Dr Kostic-Garner.

238. However, in all her dealings with Dr Kostic-Garner, Child SK's mother was under the impression that the doctor was the resident psychiatrist at Ward 5A.[121] The confusion as to Dr Kostic-Garner's classification also extended to BFC, which had recorded her as a psychiatric registrar in its

[116] Exhibit 2, Report from Dr Vaneet Padmanabhan dated 1 May 2023, p.35
[117] Exhibit 1, Volume 1, Tab 22.3, Report from Dr Katinka Morton to the Medical Board of Australia (undated), p.33
[118] Ts 8.5.23 (Dr Kostic-Garner), p.423
[119] Exhibit 1, Volume 3, Tab 13, Statement of Dr Nejra Kostic-Garner dated 28 April 2023, p.5
[120] Exhibit 1, Volume 3, Tab 13, Statement of Dr Nejra Kostic-Garner dated 28 April 2023, p.7
[121] Exhibit 1, Volume 1, Tabs 12.2 and 12.3, Statements of Child SK's mother dated 8 December 2020 and 4 April 2023.

documentation of joint meetings held between PCH and BFC. Dr Kostic-Garner was unaware of these errors.[122] As she explained at the inquest:[123]

> When I was introducing myself to family and to parents, I would introduce myself as Dr Nejra and had on my badge marking to say that I was a supervised medical officer, and I would say that I am a junior doctor working together with consultant psychiatrists and in contact with community mental health services.

239. At the completion of the inquest, I sought clarification from CAHS as to the current name tags for doctors working in Ward 5A. I was subsequently advised that a standard identification badge template is used throughout PCH and: "*Medical staff are identified by an orange strip at the bottom of their badge and within the orange strip is the staff member's name and position title, as per their contract of employment.*"[124] I was also provided with examples of these identification badges. From those examples, I am able to conclude that Dr Kostic-Garner would have been identified on her name tag as: [125]

Dr Nejra
Kostic-Garner
SMO

240. In the circumstances, I am not at all surprised Child SK's mother had the impression that Dr Kostic-Garner was a "*resident psychiatrist*". I am satisfied it was not adeqquately explained to Child SK's mother that Dr Kostic-Garner had not actually commenced a psychiatry residency. In those circumstances, I can readily understand why she inferred from Dr Kostic-Garner's introduction (i.e. a junior doctor working together with consultant psychiatrists) that she was a resident psychiatrist in Ward 5A. The abbreviated description of Dr Kostic-Garner on her identification badge as a "SMO" would not have provided any clarification.

241. It was unfortunate that Child SK's mother, through no fault of her own, was not aware of Dr Kostic-Garner's precise qualifications. There is merit in Mr Droppert SC's submission that a clinician's status ought to be made clear from the start so that Child SK and her parents would not be left with the impression that what the clinician communicates is not at, or near, the same level of experience as a psychiatrist.[126]

242. The second matter concerned the submission made by Mr Droppert SC that Dr Morton, when deciding to discharge Child SK on 16 July 2020, had taken

[122] Ts 8.5.23 (Dr Kostic-Garner), p.422
[123] Ts 8.5.23 (Dr Kostic-Garner), pp.422-423
[124] Exhibit 12, Letter from David Harwood and Amelia Westerside to counsel assisting dated 20 July 2023, p.3
[125] Exhibit 12, Letter from David Harwood and Amelia Westerside to counsel assisting dated 20 July 2023, p.3
[126] Written closing submissions from Mr Droppert SC dated 12 May 2023, p.3

into account the opportunity for her to participate in the assessments for the Touchstone program that were scheduled in August 2020.[127] At the inquest Dr Morton agreed that had these assessments been a month later, she would have been a little more concerned about whether Child SK could get to that point safely and "*it would have influenced my management*."[128]

243. By the conclusion of the inquest, it was not entirely clear what the earliest date was before Child SK could commence the Touchstone program. However, it was subsequently clarified that this date would have been 8 September 2020 had Child SK been accessed as suitable.[129] This necessarily meant that the assessment for Child SK's inclusion would have taken place in August 2020.

244. I am therefore satisfied that Dr Morton had not made an error regarding when Child SK would be assessed for the Touchstone program.

245. I should also add that I commend Dr Morton's efforts to have Child SK engage in Touchstone. Child SK was not interested in talking about Touchstone during her admission to Ward 5A that commenced on 1 July 2020. However, during her next admission on 6 July 2020, she had become "*very curious about it and very interested* ".[130]

246. The third matter concerned the communications Dr Morton had with Child SK's mother following their daughter's escalation in behaviour from early July 2020 and specifically, the incident between Child SK and her father with the pocket knife on 10 July 2020.

247. The account given by Child SK's mother was as follows:[131]

> On 13 July 2020 the team at PCH told us that they would be reporting us to CPS because we would not go to the police and charge [Child SK] for the "assault" (a scratch on [Child SK's father's] hand from tackling her to the ground) or for the damage to property (she broke a door trying to escape). They said that we were promoting violence from her and not providing boundaries for her behaviour, which would make her worse. They said that they would have to report that we didn't think that we could provide a safe home for her and that her younger sister was in danger.
>
> …
>
> [Dr Morton] told [Child SK] that she had told us to press charges against her for her "attack". [Child SK] told Dr Morton that her parents wouldn't do that. [Dr Morton] took this to mean that we would not enforce any boundary around

[127] Written closing submissions from Mr Droppert SC dated 12 May 2023, p.4
[128] Ts 10.5.23 (Dr Morton), p.602
[129] Exhibit 12, Letter from David Harwood and Amelia Westerside to counsel assisting dated 20 July 2023, p.4
[130] Ts 9.5.23 (Dr Morton), p.556
[131] Exhibit 1, Volume 1, Tab 12.3, Statement of Child SK's mother dated 4 April 2023, pp.27-28

> what she thought was [Child SK's] violent behaviour. [Child SK] knew that we loved her and wanted her to get help and get better and would never try to send her to jail for this.
>
> [Dr Morton] stated that this was telling [Child SK] that she could be violent without consequence.
>
> I still strongly disagree with that statement.

248. Dr Morton stated that her conversations with Child SK's mother on 13 July 2020 should be placed in context. That context included Child SK's escalating violence and threats of violence in Ward 5A and in the community prior to the incident with her father regarding the pocket knife.[132] Dr Morton's account of the conversations she had with Child SK's mother on 13 July 2020 included the following:[133]

> I spoke with [Child SK's mother] by phone on 13 July 2020 to talk about [Child SK] attending her Bentley Family Clinic appointment from the ward. However, after talking with [Child SK], I also "flagged my concern about [Child SK's] risk of progression in violence and her stated sense that her parents will not enforce any consequences for that violence at home".[134]
>
> …
>
> [Child SK's mother] agreed to talk with [Child SK's father] about making a police report, and I noted that [Child SK] had ceased any aggression on the ward, when the ward made one such report. I agreed to contact them back later in the day to see what they had decided. When I contacted [Child SK's mother] later in the day, she confirmed that she and [Child SK's father] did not wish to make a police report.

249. As to the reason why she raised making a police report with Child SK's parents, Dr Morton stated:[135]

> I believed that the family making a police report would be very likely to be helpful for the risk of violence at home, for [Child SK] having a sense of containment, and for her longer term risk of developing threatening behaviours as way of interacting with others, with no significant risk to [Child SK] or her family.

[132] Exhibit 1, Volume 1, Tab 22.3, Report by Dr Katinka Morton to the Medical Board of Australia (undated), pp.29-30
[133] Exhibit 1, Volume 1, Tab 22.3, Report by Dr Katinka Morton to the Medical Board of Australia (undated), p.30
[134] Exhibit 1, Volume 3, Tab 2, Perth Children's Hospital medical records, p.654
[135] Exhibit 1, Volume 1, Tab 22.3, Report by Dr Katinka Morton to the Medical Board of Australia (undated), p.31

250. Dr Morton also said she had been concerned that if Child SK's aggression towards others continued, she could be excluded from activities that were protective of her, most notably her participation in Touchstone.[136]

251. As to her account of the conversations with Child SK regarding potential police reports, Dr Morton said:[137]

> I had talked with [Child SK] about making threats to kill and interpersonal violence on the ward potentially resulting in more police reports, and that these reports may result in charges being laid. [Child SK] described being motivated to avoid police charges and agreed that this was an important reason to engage in treatment before her violence risk progressed.
>
> I believe that this was a therapeutic conversation for [Child SK]. It was not intended, nor do I believe that [Child SK] understood it to be threatening. [Child SK's] behaviour noticeably improved afterwards. Her rapport with myself also improved.

252. From a treatment perspective, I completely understand the reasoning behind Dr Morton's decision to raise the making of a police report with Child SK's parents. The purpose was to establish boundaries and reduce the risk of Child SK's violent behaviour that had disturbingly increased. However, my concern was whether Dr Morton gave sufficient consideration to whether such a conversation would achieve her desired aim; namely, persuading the parents of a 13-year-old child with a significant mental health condition to make a complaint to police that alleged a serious offence.

253. In her conversations with the mother about this matter, I have no doubt whatsoever that Dr Morton had no intentions of being overbearing.[138] Nevertheless, I was also concerned as to how Dr Morton would be able to raise such a sensitive subject without the parents feeling pressured; which was exactly their reaction.

254. As to these discussions between Dr Morton and Child SK's mother, Mr Droppert SC submitted that the following contemporaneous note by the psychiatry registrar, Dr Black,[139] on 16 July 2020 was closer to the account by Child SK's mother than the more neutral explanation provided by Dr Morton.[140] That note read: "*Parents aware that if family do not follow through with limits to violence/property damage i.e. report to police, it will*

[136] Exhibit 1, Volume 1, Tab 22.3, Report by Dr Katinka Morton to the Medical Board of Australia (undated), p.30
[137] Exhibit 1, Volume 1, Tab 22.3, Report by Dr Katinka Morton to the Medical Board of Australia (undated), p.31
[138] I am also satisfied that Dr Morton was not acting in a threatening manner when she spoke to Child SK about the prospect of police reports if her behaviour in Ward 5A escalated again.
[139] Letter from Dr Katinka Morton to the Court dated 27 March 2024, p.3
[140] Written closing submissions from Mr Droppert SC dated 12 May 2022, p.7

be very problematic and high risk. Father states that he is not well enough to make a decision about reporting to police."[141] (underlining added)

255. Mr Droppert SC's submission was that as Child SK's parents had been told of the "*very problematic and high risk*", it placed them in an invidious position as the clear implication was they were very likely to cause a worsening of Child SK's problems if they did not make a police report.[142]

256. As Dr Morton had not been questioned regarding this matter at the inquest, I provided her the opportunity, through her counsel, to answer questions arising from Mr Droppert SC's submission. The Court received a response from Dr Morton on 28 March 2024.[143]

257. Dr Morton stated that her desired aim was not the making of a police report itself, rather she "*was seeking to work with Child SK and her family to reduce her risk of harm to herself and others, and to optimise her likelihood of engagement with evidence-based care*".[144]

258. Dr Morton also pointed out that Child SK's risk of violence was because of her diagnosis of an emerging EUPD. That meant it would not be resolved with treatment over days or weeks but was likely to persist over months, even with evidence-based treatment that was to include engagement in Touchstone.[145]

259. Dr Morton noted that she "*did believe that there was some likelihood of Child SK's family making a police report at that time*[146] *or soon after discharge, with the continued support of the Bentley Child and Adolescent Mental Health Service to do so.*"[147] Dr Morton submitted that her main focus in raising the issue of a police report was that she thought it would be beneficial for Child SK herself.[148]

260. As to the question of the prospect of Child SK's parents making a complaint to the police, Dr Morton noted that there "*is no evidence-based structured professional judgement tool which enables prediction of this decision making.*"[149] However, she also said that she has had experience with parents making a report to police regarding threatened or actual interpersonal violence from their child, and it was her experience that was more likely

[141] Exhibit 1, Volume 3, Tab 2, Perth Children's Hospital medical records, p.663
[142] Written closing submissions by Mr Droppert SC dated 12 May 2022, p.7
[143] Letter from Dr Katinka Morton to the Court dated 27 March 2024
[144] Letter from Dr Katinka Morton to the Court dated 27 March 2024, p.1
[145] Letter from Dr Katinka Morton to the Court dated 27 March 2024, p.1
[146] That time being her conversation with Child SK's mother on 13 July 2020.
[147] Letter from Dr Katinka Morton to the Court dated 27 March 2024, p.2
[148] Letter from Dr Katinka Morton to the Court dated 27 March 2024, p.3
[149] Letter from Dr Katinka Morton to the Court dated 27 March 2024, p.4

where police have already had a past involvement.[150] In addition, Dr Morton said that other families do not do so in the first instance, but then decide to do so at a later date.[151]

261. Nevertheless, Dr Morton did comment that Child SK's parents held strong beliefs their daughter had bipolar affective disorder:[152]

> With the benefit of hindsight, I have therefore come to the realisation that, in holding that belief, the family of Child SK may not have been inclined to make a police report because they believed that Child SK had no control over her behaviour, and that her behaviour was driven entirely by bipolar affective disorder.
>
> …
>
> Whilst I therefore now believe that the likelihood of Child SK's parents making a police report was lowered by their belief that she had a medical disorder that rendered her unable to control her behaviour, that was not my understanding of their belief at the time (before Child SK's death).

262. As to the PCH records that stated it was conveyed to Child SK's parents that a failure to make a police report would be "*very problematic and high risk*",[153] Dr Morton responded:[154]

> The medical record that has been referred to was written by the Registrar, Dr Black, and not by myself. I do not recall whether I used the words "problematic and high risk", but accept that I may have done so, given that was what Dr Black has recorded. However, my intention was to refer to the problems and risk associated with Child SK's escalating pattern of behaviour and if it wasn't contained. The possibility of submitting a police report was identified as a means of achieving the setting of boundaries, and it was the failure to achieve that result (boundary setting), rather than the failure to actually submit a police report itself, that I was referring to as being the problem/risk.
>
> … I believe that the context for what I said at the time has been lost from the way she [Dr Black] recorded it.

263. Dr Morton concluded her letter with the following:[155]

> I at all times acted in good faith and on the basis of the statements made to me by Child SK and her family. I believe that they were entitled to information about ways in which they could held [sic – help] Child SK, and that the provision of this information was part of the work to assist them to develop their understanding of the ways in which they could help Child SK become less distressed and dysregulated.

[150] Letter from Dr Katinka Morton to the Court dated 27 March 2024, p.5
[151] Letter from Dr Katinka Morton to the Court dated 27 March 2024, p.5
[152] Letter from Dr Katinka Morton to the Court dated 27 March 2024, p.5
[153] Exhibit 1, Volume 3, Tab 2, PCH medical records at p.633
[154] Letter from Dr Katinka Morton to the Court dated 27 March 2024, p.3
[155] Letter from Dr Katinka Morton to the Court dated 27 March 2024, p.6

> I definitely do not believe that there was such a low likelihood of Child SK's parents making a police report that this conversation should not have occurred. I believe that it would have been unethical not to have discussed all options for intervention with Child SK's parents, and to have been sure that they were aware of the risks and the benefits associated with each.

264. After a careful consideration of the available information regarding this matter, I am satisfied that the prospect of Child SK's parents making a complaint to the police was very low. However, I am satisfied that Dr Morton, for the reasons she has stated, would not have known of that fact. I am also satisfied it was appropriate for Dr Morton to have this conversation with Child SK's mother.

265. Nevertheless, I accept that no matter what decision Child SK's parents made, the outcome of Dr Morton's conversation with the mother was only going to place an even greater burden upon them in the short-term. They were both already grappling with their own fragile mental health and the stresses of their daughter's repeated expressions of suicidal ideation, self-harm episodes and admissions to Ward 5A.

266. The final matter that involved PCH's treatment and care of Child SK concerned a significant and disturbing gap in the system which I am satisfied existed for Child SK. This gap arose due to the fact that, as already identified, extended hospital stays are not conducive to the treatment of a young person with EUPD. Yet a discharge from Ward 5A to live with her parents was clearly not conducive to Child SK's safety, particularly in the weeks before her death. There was no alternative option for Child SK to reside in the community after her discharge that would have provided a safer environment.

267. This matter will be considered in more detail later in this finding.

CHANGES AND IMPROVEMENTS SINCE CHILD SK'S DEATH

268. As would be expected, governmental departments are always on pathways of continual improvement with respect to their operations.

269. There is frequently a gap of some duration between the date of the death that is the subject of an inquest and inquest's date. In those circumstances, the entities connected to the death will often implement changes that are designed to improve practices and procedures before the inquest is heard. In addition, with respect to this particular case, the Targeted Review and the Ministerial Taskforce have already made a large number of recommendations.

270. Unsurprisingly, various changes have been made by the Department, CAHS, CAMHS and PCH since Child SK's death that are designed to make improvements and/or reduce the risk of the missed opportunities identified at the inquest from occurring again.

Department of Communities

271. I was advised of the Department's enhancements to its policy and casework practice. This included the development of the "*At-Risk Youth Strategy 2021-2026*" (the Strategy) and its implementation plan. The Strategy is for young people aged from 10 to 24 years with multiple and complex problems who are at risk of harm and increased vulnerability of experiencing poor life outcomes.[156]

272. The Department has also been involved with various intergovernmental working relationships which included having representatives on the Ministerial Taskforce. It has also revised those sections of its Casework Practice Manual dealing with mental health issues in families.[157]

273. One aspect that caused me some concern at the inquest regarded the low scores on the Department's Interaction Tool from the assessments of the mandatory reports and referrals regarding Child SK.[158] Those scores ranged from 2 to 3.5.[159] As I have already noted, as a general rule, a threshold score of 5 is to be reached before a matter is considered for an intake to a CSI.

274. I was not satisfied the Interaction Tool (as it existed in 2020) was appropriate for scoring an assessment that involved the inability of a child's parents to keep their child safe from self-harming behaviours that stem from a serious mental health condition. In particular, the Interaction Tool did not appear to specifically consider the question of the child's risk of self-harm or suicidal ideation. With that in mind, I asked Ms Williams the following questions regarding the Interaction Tool's score of 3.5 for the third Referral:[160]

> That doesn't adequately address the crisis situation that has been reached here? --- No. And this is why essentially, it's just a guide.
>
> Yes? --- We can override that. And thankfully in this situation we did. It is just a guide and, you know, again Mr Gotti and I felt that regardless of a 3.5 we needed to intake this.

[156] Exhibit 1, Volume 2, Tab 1.1, Report from Rachael Green, the Department's Deputy Director, dated 17 September 2021, p.11
[157] Exhibit 1, Volume 2, Tab 1.1, Report from Rachael Green, the Department's Deputy Director, dated 17 September 2021, p.111
[158] The same Interaction Tool is used for assessing mandatory reports and referrals.
[159] Exhibit 1, Volume 2, Tab 1.10, Interaction Report
[160] Ts 4.5.23 (Ms Williams), p.111

> So this is a guide that doesn't really work for the situation that was presented to the Department; would that be fair to say? --- It could be fair to say. Yes.
>
> Because, I would think that a proper guide addressing the issues would have this [as] a score above 5? --- Mmm.

275. Mr Whitehouse also agreed that the Interaction Tool, "*provided no assistance in terms of the child's safety investigation pathway*."[161]

276. Thankfully, changes have been made to the Interaction Tool following a review that identified, *"self-harm and suicidality was not adequately guided to the practitioner in undertaking the Interaction Tool.*"[162] In addition, further assistance has been provided to the Department's staff through changes to its Casework Practice Manual regarding self-harm and suicidal ideation.[163]

277. I am satisfied these changes should reduce the risk of a potentially misleading low score in the Interaction Tool occurring when a matter is being assessed by the Department that has similar issues to those that faced Child SK's parents in mid-2020.

Child and Adolescent Health Service, Child and Adolescent Mental Health Service & Perth Children's Hospital

278. As I noted at the commencement of this finding, a large number of recommendations were made by the Targeted Review and the Ministerial Taskforce.

279. The Targeted Review contained the following recommendations:[164]

1) It is recommended that funded positions for family peer workers be established; initially at PCH, but to be extended to all CAMHS services.
2) It is recommended that a formal structure be established for independent review for diagnoses and treatment in children and young people with complex problems where there is an unresolved difference in opinion between clinicians, families or other relevant agencies.
3) It is recommended that consideration be given to a WA review of the application of the current guideline for the management of

[161] Ts 10.5.23 (Mr Whitehouse), p.630
[162] Ts 10.5.23 (Mr Whitehouse), p.627
[163] Ts 10.5.23 (Mr Whitehouse), p.627
[164] Exhibit 1, Volume 2, Tab 3, Targeted Review by Dr Nathan Gibson, Chief Psychiatrist of WA, dated December 2020, pp.7-9

Emotionally Unstable Personality Disorder in early adolescents; and that this review be undertaken in partnership with families.

4) Establish Community Intensive Treatment Services (CITS).
5) Establish a CAMHS Emergency Service at PCH.
6) Immediately uplift to the Community CAMHS clinical workforce.
7) Establish a "Child and Adolescent Mental Health Ministerial Taskforce" to rebuild CAMHS.

280. CAHS and CAMHS have taken steps to implement recommendations 1 to 6. These steps were outlined in Dr Padmanabhan's report.[165]

281. From June 2022 to March 2023, and in preparation for the implementation of the recommendations from the Ministerial Taskforce, CAMHS undertook a project "*to develop and implement more clearly refined criteria and a triage process across all teams.*"[166] This has led to exploring changes in the following areas:

- alternative community service delivery models;
- consolidating the ten community CAMHS into North, South and East hubs to improve consistency in delivery services;
- a review of specialised CAMHS teams (including Touchstone);
- changes to Ward 5A; and
- addressing the workforce shortages within CAMHS.[167]

282. With respect to the changes at Ward 5A, I (and no doubt Child SK's family as well) am pleased to know that a new model of care and improved infrastructure is underway. As Dr Padmanabhan explained:[168]

> The work being undertaken is underpinned by the principles of trauma-informed practise, recovery-focused care and will be strength based. <u>This is being done in collaboration with young people, families, and staff</u>. (underlining added)

283. The Ministerial Taskforce identified eight key actions to reform the mental health system for infants, children and adolescents. These key actions were:

1) Improving the experience and ensuring the involvement of children and families.

[165] Exhibit 2, Report from Dr Vineet Padmanabhan dated 1 May 2023, pp.36-38
[166] Exhibit 2, Report from Dr Vineet Padmanabhan dated 1 May 2023, p.38
[167] Exhibit 2, Report from Dr Vineet Padmanabhan dated 1 May 2023, pp.38-39
[168] Exhibit 2, Report from Dr Vineet Padmanabhan dated 1 May 2023, p.38

2) Creating an integrated and person-centred ICA[169] mental health system.
3) Collaboratively developing new models of care for all parts of the specialist ICA mental health system.
4) Collaborating with other government and community services to ensure that they can appropriately support children and families.
5) Investing in the capability and wellbeing of the ICA mental health workforce.
6) Growing and sustaining the capacity of the ICA mental health workforce to meet needs.
7) Deploying ICA mental health services with contemporary infrastructure technology and research.
8) Driving the sustained performance of the ICA mental health system through governance and leadership.

284. To deliver these eight key actions, the Ministerial Taskforce made 32 recommendations.[170]

285. On 15 March 2022, the State Government publicly announced it was committed to implementing all 32 recommendations.[171] It has recently confirmed this commitment on 20 March 2024.[172]

286. The Ministerial Taskforce described why change is needed. As noted by Dr Sophie Davison (Dr Davison), Chief Medical Officer at the MHC: "*The* [Ministerial] *Taskforce found that current ICA mental health services are unable to meet increasingly high level of need among children across the state*."[173]

287. The 32 recommendations from the Ministerial Taskforce were broken down into four time achievement horizons of immediate, short, medium and long term. It also described five pillars of the future ICA mental health and wellbeing system:

- prevention and early intervention;
- enhanced primary care;

[169] infants, children and adolescents
[170] Exhibit 1, Volume 2, Tab 4, Final Report – Ministerial Taskforce into Public Mental Health Services for Infants, Children and Adolescents aged 0-18 years in WA, pp.16-17
[171] Exhibit 1, Volume 3, Tab 9, Statement of Dr Sophie Davison dated 26 April 2023, p.7
[172] https://www.wa.gov.au/goverment/media-statements/Cook-Labor-Goverment/Expanding-mental-health-crisis-support-for-children-and-adolescents
[173] Exhibit 1, Volume 3, Tab 9, Statement of Dr Sophie Davison dated 26 April 2023, p.6

- Community Infant, Child and Adolescent Mental Health Services to be the re-imagined and adequately resourced evolution of current Community CAMHS services;
- state-wide services; and
- acute and intensive responses.[174]

288. Following the release of the Ministerial Taskforce's report, the MHC established an implementation program with the initial primary focus on applying the immediate and short-term recommendations.[175]

289. Dr Davison outlined the progress that had been made on the recommendations that are particularly relevant to Child SK's family.[176] These included additional funding from the State Government to create an additional 25 full time positions across the ten CAMHS clinics, and the establishment of the Acute Care and Response Teams (ACRT) and the extension of the Crisis Connect service. I have referred to these two services in more detail later in this finding.

290. Another recommendation from the Ministerial Taskforce of interest to Child SK's family was recommendation 13 which stated: "*Establish an ICA-specific model of care for mental health ED presentations, and safe places in the community*."[177]

291. These models of care have been developed in child safe spaces and EDs as outlined by Dr Davison:[178]

> The new model includes a range of recommended features to improve the capacity of EDs to provide a safe, therapeutic and culturally safe experience for children presenting in a mental health crisis.
>
> Child safe spaces are to be co-located with EDs. They are peer-led environments that provide a safe, non-clinical alternative to EDs for children in crisis that require respite and stabilisation.

292. I am satisfied with the changes and improvements that have been made, and will continue to be made, at CAHS, CAMHS and PCH as a result of Child SK's death. The desperate need for these reforms were emphasised by the Targeted Review and the Ministerial Taskforce. It is reassuring to

[174] Exhibit 1, Volume 3, Tab 9, Statement of Dr Sophie Davison dated 26 April 2023, p.7
[175] Exhibit 1, Volume 3, Tab 9, Statement of Dr Sophie Davison dated 26 April 2023, p.7
[176] Exhibit 1, Volume 3, Tab 9, Statement of Dr Sophie Davison dated 26 April 2023, pp.8-14
[177] Exhibit 1, Volume 2, Tab 4, Final Report - Ministerial Taskforce into Public Mental Health Services for Infants, Children and Adolescents aged 0-18 years in WA, p.16
[178] Exhibit 1, Volume 3, Tab 9, Statement of Dr Sophie Davison dated 26 April 2023, p.10

know that the State Government is committed to implementing these reforms which I regard as an absolute priority.

Discharge summaries at Perth Children's Hospital

293. One matter that arose at the inquest concerned the discharge summaries for children who had been admitted to Ward 5A. Specifically, whether discharge summaries recorded oral advice provided to parents that they may adjust or increase the listed dosage of the discharge medications.

294. At his closing submissions at the inquest, Mr Harwood advised that a communication had recently been sent to PCH clinicians which had addressed this issue.[179] A copy of that email was subsequently provided to the Court as part of the material that became exhibit 12.

295. This email was sent by the Head of Department, Acute CAMHS to consultant psychiatrists and registrars in Ward 5A and noted that the following was to be included in discharge summaries: "*Please include any information about advice to use prn*[180] *medication post-discharge, indications for same, duration/frequency/max daily dose, and when this review* [sic - reviewed] *and by whom (GP, CAMHS psychiatrist).*"

296. I am satisfied this email addressed the concern that was raised at the inquest.

PROPOSED RECOMMENDATIONS

Acute Care and Response Teams

297. Recommendation 4 in the Targeted Review was designed to address the critical community service gaps for young people requiring acute care for their complex mental health conditions. As the Targeted Review stated:[181]

> It is recommended that three multi-disciplinary Community Intensive Treatment Services (CITS), operating in each of the Northern, Eastern and Southern metropolitan areas of Perth, be established to ensure that young people with complex mental health needs can receive appropriate, timely care in the community. The aim is to reduce ED presentations and in-patient admissions, as well as to facilitate more intensive community care to assist the timely and safe transition of children from hospital. The CITS will:
>
> - operate 7 days a week over extended hours to deliver mental health care into a range of settings, including the young person's home and school; and

[179] Ts 12.5.23 (closing submissions by Mr Harwood), p.830
[180] "taken as needed"
[181] Exhibit 1, Volume 2, Tab 3, Targeted Review by Dr Nathan Gibson, Chief Psychiatrist of WA, dated December 2020, p.8

- function with the Community CAMHS Directorate.

298. As Dr Padmanabhan explained:[182]

> The team would be able to offer a higher level of support in the community, more than what a community CAMHS service can offer. The CITS team aims to offer an enhanced package of community support to help young people avoid having to go into Ward 5A in the first place (where this is avoidable) or to help get young people out of psychiatric hospital quicker (where difficulties can be safely managed in a community setting). This team can get involved quickly and see young people 2-3 times a week to offer a high level of support to keep young people safe and well in the community.

299. In line with recommendation 4 of the Targeted Review, the Ministerial Taskforce recommended the establishment of ACRT within community CAMHS hubs in metropolitan, rural and remote WA.[183] ACRT were to operate in the same manner as CITS and the only essential difference between the two is the name as ACRT represents the crisis and acute care arm of CAMHS to ensure an all-hours response to children in crisis.

300. On 27 April 2023, the Minster for Health announced that funding would be allocated in the amount of $3.6 million to pilot an ACRT in the East metropolitan area.[184]

301. As this announcement had only been made a matter of days before the inquest commenced, I sought an update regarding the pilot ACRT. That update was provided by letter dated 22 February 2024 from Ms Maureen Lewis (Ms Lewis), the Commissioner of the MHC.

302. Ms Lewis advised that funding for the ACRT pilot was secured for two and half years via the 2023/2024 State Budget. It commenced with its first phase in March 2024, and is funded to continue operation until June 2026. The first phase has ACRT available to children and families currently engaged with the Swan/Midland CAMHS team. The second phase is to extend to the Bentley and Armadale CAMHS teams by May 2024.

303. As Ms Lewis set out in her letter:[185]

> The Mental Health Commission (Commission) is seeking recurrent funding for ACRT via the 2024-2025 budget process. The Commission's vision is to establish a permanent network of ACRTs across the state, with one in each region, and three in the metropolitan areas (North, East and South). All three metropolitan

[182] Exhibit 2, Report of Dr Vineet Padmanabhan dated 1 May 2023, p.33
[183] Exhibit 1, Volume 2, Tab 4, Final Report – Ministerial Taskforce into Public Mental Health Services for Infants, Children and Adolescents aged 0-18 years in WA, p.16
[184] Exhibit 1, Volume 3, Tab 9.1 addendum statement of Dr Sophie Davison dated 28 April 2023
[185] Letter from Maureen Lewis, Commissioner at the Mental Health Commission to counsel assisting dated 22 February 2024, p.2

> ACRTs would be governed by CAHS/CAMHS. Funding will be required to achieve this.

304. On 20 March 2024, the State Government announced it had allocated $46.6 million to establish new ACRT in the North and South metropolitan regions, and in the Great Southern region of the state. The existing East metropolitan pilot service was also going to be extended.[186]

305. I am firmly of the view the permanent introduction of ACRT across the state is desperately needed. It clearly provides an essential service for children facing a crisis with their mental health. I am confident that this service will inevitably save the lives of children and young people.

CAMHS Crisis Connect

306. CAMHS Crisis Connect service (Crisis Connect) provides 24 hour/seven days a week telephone and online video call support for children and young people aged 17 years and under who are experiencing a mental health crisis. It also provides support and advice to families, carers and professionals in the community. The service provides specialist mental health consultation and liaison, crisis management, mental health and risk assessment, and follow-up within 24 hours of being assessed at, or discharged from, PCH. It aims to provide expert help to children and young people quickly and when they need it most.[187]

307. Ms Lewis also provided the following information regarding the funding of Crisis Connect:[188]

> CAMHS Crisis Connect is funded recurrently. Additionally, a two-year uplift was provided by the 2022-2023 State Budget to expand CAMHS Crisis Connect. This expansion enabled the introduction of a virtual follow-up clinic to provide up to two weeks of psychological intervention following contact with CAMHS Crisis Connect. Funding for this uplift ends in June 2024. The Commission will continue to advocate for the uplift investment to be recurrent.

308. On 20 March 2024, the State Government announced that Crisis Connect will be extended through a further allocation of $19.5 million.[189]

309. The evidence I heard at the inquest regarding the benefits of Crisis Connect was overwhelming. Once again, I have no doubt it is another service that

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[186] https://www.wa.gov.au/goverment/media-statements/Cook-Labor-Goverment/Expanding-mental-health-crisis-support-for-children-and-adolescents
[187] https://cahs.health.wa.gov.au/our-services/mental-health/camhs-crisis-connect
[188] Letter from Maureen Lewis, Commissioner at the Mental Health Commission to counsel assisting dated 22 February 2024, p.2
[189] https://www.wa.gov.au/goverment/media-statements/Cook-Labor-Goverment/Expanding-mental-health-crisis-support-for-children-and-adolescents

will save the lives of children and young people who may be contemplating self-harm or suicide. I was therefore very supportive of the MHC's efforts to have its funding for the uplift investment made recurrent.

Communication between mental health clinicians and family members

310. The Targeted Review provided some startling statistics in relation to the presentation of children with mental health disorders and/or suicide risk:[190]

> Within the hospital system, over the past decade metropolitan EDs have experienced a 214% increase in self-harm/suicide risk/attempted suicide presentations of 13 to 17-year-olds and a 403% increase in the under 13s. The mental health in-patient unit at PCH is under growing pressure with high rates of 28-day readmission and an increasing number of children and young people with mental health disorders admitted to other wards in the hospital because of a lack of available specialist mental health beds in Ward 5A (52 to date in 2020 compared with 15 for the whole of 2019).
>
> Within the CAMHS community clinics there has been a 62% increase in referrals of 12 to 17-year-olds over the last four years. In 2019 this age group accounted for 85% of all those accepted for treatment. Essentially, Community CAMHS has become largely a service for complex, high-risk adolescents, which has had a substantial impact of the way that clinicians are able to practice.

311. Parents of children with complex mental health conditions are able to provide invaluable information to health professionals who are treating their child. Yet, at times, Child SK's parents felt that their input regarding their daughter was not valued as highly as it ought to have been. Whether that was true or not does not require a determination from me.

312. However, what is important is that Child SK's parents had a perception their input was either not sought or appreciated. There is some merit in the recommendation proposed by Mr Droppert SC that ongoing training of health professionals working in child and adolescent mental health services recognise the importance of communicating with the parents or guardians of the children they are treating.[191]

A step-up/step-down facility for children aged under 16 years

313. Notwithstanding the improvements made with respect to crisis treatment services within the community since Child SK's death, those services would not have assisted Child SK and her parents had they existed in 2020. With

[190] Exhibit 1, Volume 2, Tab 3, Targeted Review by Dr Nathan Gibson, Chief Psychiatrist of WA, dated December 2020, p.36
[191] Written closing submissions from Mr Droppert SC dated 12 May 2023, p.10

respect to the service that has now become ACRT, Dr Padmanabhan stated:[192]

> In Child SK's case, this service may not have been helpful in supporting her in the days leading up to her death due to the frequency of the crisis presentations, which may have been very difficult to even manage with 2-3 times a week of high-level support. The family were struggling to keep her safe at home and there was evidence of carer fatigue in the clinical records, which would have made it even more difficult to support Child SK using Community Intensive Treatment Service.

314. The Targeted Review and the Ministerial Taskforce found there was a need to bridge the gap between community and hospital treatment for children who require intensive care in the community. However, as noted by Dr Davison, both concluded that the bridging of this gap could be provided by intensive community treatment in the child's own home, with neither recommending that a step-up/step-down (SUSD) residential facility be established for children under the age of 16 years.[193]

315. Community mental health SUSD facilities provide a combination of psychosocial and clinical support programs within a residential-style setting. They provide short-term support and are close to personal supports from family and friends. The "step up" part of the service allows for a person to step up from the community and manage a deterioration in their mental health, without an admission to hospital. The "step down" part of the service allows a person to step down from an in-patient facility such as a hospital and provides additional support to people who no longer require acute in-patient care but do require assistance in re-establishing themselves in the community.[194]

316. Presently the MHC funds non-government organisations to provide residential mental health beds that are based in the community. Although Dr Davison said these beds only service people who are aged 18 years and over,[195] a fact sheet on the MHC website says that these SUSD services "*may accept young people aged 16 to 17 on a case-by-case basis, where assessed as clinically appropriate.*"[196] Child SK's young age excluded her from being considered for a bed in these facilities.

317. In Western Australia it has been recognised for over ten years that SUSD residential facilities are necessary for those members of the community who

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[192] Exhibit 2, Report of Vineet Padmanabhan dated 1 May 2023, p.33
[193] Exhibit 1, Volume 3, Tab 9, Statement of Dr Sophie Davison dated 26 April 2023, p.13
[194] https://www.mhc.wa.gov.au/stepupstepdown
[195] Exhibit 1, Volume 3, Tab 9, Statement of Dr Sophie Davison dated 26 April 2023, p.14
[196] Community mental health step/step down services – Fact Sheet – November 2021: www.mhc.wa.gov.au/stepupstepdown

are 18 years or older. There are currently six such services operating in the state at the following locations:[197]

- Joondalup, 22 beds (opened May 2013)
- Rockingham, 10 beds (opened October 2016)
- Albany, six beds (opened November 2018)
- Bunbury, 10 beds (opened March 2020)
- Geraldton, 10 beds (opened January 2021)
- Kalgoorlie, 10 beds (opened January 2021)

318. Further adult SUSD services have been allocated funding by the State Government and are to be opened in Broome, South Hedland and Karratha.[198]

319. Dr Davison also noted that a SUSD facility for 16 to 24 year olds was an election commitment made by the State Government in 2021, and she added: "*Preparatory work has been completed to operationalise this youth SUSD.*" [199] Had such a facility existed in 2020 it would not have been available to Child SK due to her age.

320. SUSD residential facilities for children aged under 16 years exist in other parts of Australia. For example, the Australian Capital Territory (the ACT) has a voluntary mental health residential program operated by a non-government organisation in partnership with the ACT's CAMHS. This SUSD provides support to young people aged between 13 to 17 years, for a period of up to three months. It is staffed 24 hours a day, seven days a week by the non-government organisation's youth mental health support workers, and a CAMHS staff member during business hours. It supports young people in this age bracket who are linked with CAMHS and are experiencing moderate to severe symptoms of mental illness, and who either require support but not hospitalisation or are about to be discharged from hospital and are not ready to return home.[200]

321. The ACT also has a SUSD residential facility for young people aged between and 18 to 25 years who are experiencing mental illness. It aims to fill the gap between in-patient care and less structured community-based services. It has a focus on recovery and support. People in this age bracket can stay up to 12 weeks, with an additional six weeks of outreach support

[197] https://www.mhc.wa.gov.au/about-us/major-projects/community-mental-health-step-upstep-down-services/
[198] https://www.mhc.wa.gov.au/about-us/major-projects/community-mental-health-step-upstep-down-services/
[199] Exhibit 1, Volume 3, Tab 9, Statement of Dr Sophie Davison dated 26 April 2023, p.13
[200] https://www.canberrahealthservices.act.gov.au/services-and-clinics/services/supporting-young-people-through-early-intervention-prevention-strategies

offered after leaving the SUSD. The only criterion for intake is that the person is linked with mental health or other community services.[201]

322. Towards the end of the inquest, Dr Davison, through counsel for the MHC, provided the Court with a 2017 report from Queensland that contained relevant information regarding SUSD facilities for young people.[202] The following passage was in that report:[203]

> Age-appropriate sub-acute, non-acute residential and accommodation services that are able to address the developmental needs of adolescents and young people should be available as an important component of the range of services required. These should be located in the community with the capacity to support adolescents and young people with high needs through collaboration with intensive clinical treatment services provided on an in-reach basis. While only a minority of the target group are likely to require these services at any point in time, the lack of availability of suitable age-appropriate and residential and accommodation services of this nature was identified as a major factor in increasing the likelihood of extended in-patient stays.

323. Although the MHC accepts the current ACRT and a SUSD residential facility for children aged under 16 years can operate together,[204] Ms Hartley made the following submission on behalf of the MHC at the inquest:[205]

> The desire of the Mental Health Commission is to make it a focus to get the ACRTs rolled out and happening and available to as many potential clients across the state as possible. If you're minded to make a recommendation about step up/step down, it will absolutely be considered because, as set out in the article that I sent through to you last night, your Honour, provided to me by Dr Davison, it's clear that the more the suite of services can wrap around these children and their families the better.

324. I have already referred to the alarming figures cited in the Targeted Review that highlight the disturbing statistics of children under the age of 17 years who have complex and high-risk mental health conditions. In addition to those statistics, I have been advised that from 2018 to 2023, there were 192 children aged up to 17 years in Western Australia who were diagnosed with confirmed EUPD.[206]

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[201] https://www.canberrahealthservices.act.gov.au/services-and-clinics/services/youth-step-up-step-down-program

[202] "A review of existing clinical and program evaluation framework for extended treatment services for adolescents and young adults with severe, persistent and complex mental illness in Queensland", Final Report, March 2017

[203] "A review of existing clinical and program evaluation framework for extended treatment services for adolescents and young adults with severe, persistent and complex mental illness in Queensland", Final Report, March 2017, p.37

[204] Ts 12.5.23 (closing submissions by Ms Hartley), p.846

[205] Ts 12.5.23 (closing submissions by Ms Hartley), p.845

[206] Exhibit 12, Letter from David Harwood and Amelia Westerside to counsel assisting dated 20 July 2023, p.2

325. These worrying numbers provide cogent evidence for the need of a SUSD facility in this state for children and young people who are under the age of 16 years.

326. Adult SUSD facilities have existed in Western Australia since 2013, with current funding for another three such facilities in regional areas. Planning is underway for a SUSD facility for adolescents and young people aged between 16 and 24 years. Yet a young person under the age of 16 years has no such option available to them.

327. It is my firm view that is now time to begin plans for a SUSD facility in the Perth metropolitan area for children who are 13 years old and under the age of 16 years.

328. Had such a facility existed in 2020 then Child SK could have had the option of being placed there. And her parents would have avoided the "*impossible dilemma*" they were in that required them to take their daughter home from hospital so she could participate in Touchstone, "*even though they were very worried about what that would mean*".[207] Sadly, Child SK's parents' worst fears were realised shortly after their daughter's last discharge from Ward 5A.

329. Should further evidence be required for the need of a SUSD facility for children and young people in Child SK's age bracket, I cannot articulate it better than the words from Child SK's family:[208]

> We agree that some form of step-up, step-down may well have been able to fill the void. Leaving a child alone in a hospital is horrendous for anyone, but doing so knowing how utterly fragile and worthless that child feels is untenable for any parent. It is not a decision that anyone would take lightly.
>
> A facility that is warm and welcoming that provides not just risk containment, but also encourages life and family engagement in a safe setting with therapeutic intervention and skilled staff, with the ability to retain a bed while the child begins to make small excursions into society could make a vast difference. There are examples of exemplary facilities working with very troubled children within the community, a great example being St Clare's CARE School which provided such a safe, therapeutic environment that even in June [2020], [Child SK] was keen to get back [to]. These places can be useful models for the type of re-engagement care that could make a difference, were it to be available in a residential, family-oriented facility.

330. Had a suitable SUSD facility been available in mid-2020, Child SK's tragic trajectory may well have been averted.

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[207] Ts 10.5.23 (Dr Morton), p.590
[208] Written closing submissions from Mr Droppert SC dated 12 May 2023, p.10

COMMENTS RELATING TO THE PROPOSED RECOMMENDATIONS

331. On 19 March 2024, four draft recommendations were forwarded by the Court via the State Solicitor's Office to the entities they concerned, namely the MHC and CAHS. These recommendations related to the four topics that appeared under the heading "Proposed Recommendations" in this finding. I invited submissions to be made regarding these draft recommendations by 28 March 2024. Responses from the MHC and CAHS were provided to the Court on 28 March 2024.

332. The MHC and CAHS supported a recommendation that a permanent network of ACRT is established across the state, with one in each region, and one in each of the North, South, East metropolitan areas.

333. On behalf of the MHC, Ms Lewis noted that this had been:[209]

> Partially completed as [in a] pre-budget announcement, [the] government successfully announced three teams for metro and one in Great Southern to develop a WACHS model as it will be quite different in the regions due to geographical dislocation and specific needs of the community which may differ to metropolitan Perth.

334. As it is supported by the MHC and CAHS, I have made a recommendation that funding be provided for the equivalent of ACRT that is suitable to each region be introduced across the remainder of the state.

335. As to my proposed recommendation regarding funding for Crisis Connect to continue the operation of a virtual follow-up clinic, Ms Lewis advised that since the inquest, Crisis Connect has been funded recurrently to offer this service.

336. In those circumstances, it is not necessary to make a recommendation for this matter and I commend the MHC for successfully negotiating recurrent funding for this important service.

337. The third recommendation I had proposed concerned communications between health professionals working in child and adolescent mental health services and parents or guardians regarding their knowledge of, and their concerns for, their child. My intended recommendation was to the effect that the training of these health professionals emphasises the importance of these communications.

[209] Email from Maureen Lewis, Commissioner of the MHC, to the State Solicitor's Office dated 27 March 2024.

338. CAHS provided a detailed response to this proposed recommendation, together with various attachments, outlining the training that is already provided to health professionals in this area.[210] CAHS submitted:

> Effective communication with parents or guardians is a fundamental aspect of providing comprehensive care to children and adolescents accessing CAHS services. By engaging in open, transparent and empathetic communication, we aim to foster trust, collaboration, and understanding between healthcare professionals, families and children accessing CAMHS services including mental health services based at Perth Children's Hospital.
>
> CAHS training packages for clinicians emphasis communication skills specifically tailored to engage parents or guardians. We recognise that parents and guardians possess invaluable insights into their child's history, behaviours, and needs, which can inform our assessment and intervention strategies.
>
> We strive to create opportunities for meaningful dialogue, shared, decision-making, and ongoing support to ensure that families feel informed, respected, and supported throughout their journey.

339. Having considered the training material in this area that was provided to me by CAHS, I am satisfied that the present training does stress the importance of communications with parents and/or guardians regarding their knowledge of, and their concerns for, their child. In those circumstances, I do not regard it is necessary to make a recommendation to this effect.

340. Nevertheless, I would urge that CAHS incorporates into its training material the submission from Mr Droppert SC that I have quoted in the penultimate paragraph of this finding.

341. My final proposed recommendation concerned the creation of a SUSD facility in the Perth metropolitan area for children and young persons from 13 years old and under the age of 16 years.

342. On behalf of the MHC, Ms Lewis submitted:[211]

> We do not recommend a step-up/step-down residential facility for this cohort due to age range and nature of how a step-up/step-down operates and governance model as we believe this would be high risk. Rather, we suggest a step-up/step-down intensive day program which is akin to the old Transition Unit (which featured throughout the coronial) and the current Touchstone program without the restrictive barriers in relation to admission criteria/access for children and their families. If you like, a hybrid model bringing the best of Transition Unit and Touchstone with easy access and an alternative to hospitalisation.

[210] Email with attachments from Robyn Hartley from State Solicitor's Office to the Court dated 28 March 2024
[211] Email from Maureen Lewis, Commissioner of the MHC, to the State Solicitors Office dated 27 March 2024

343. CAHS supported this submission from Ms Lewis:[212]

> With regards to [a] step-up/step-down facility, CAHS proposes an approach that aligns with contemporary practices and addresses the developmental needs of children and adolescents.
>
> This unit would operate Monday to Friday and service as a transitional space for children and young people, transitioning from acute care (such as Ward 5A) to community-based mental health services. This unit would also serve as [a] step-up for children who require intensive input which cannot be provided by an Acute Care and Response Team (ACRT) and other community-based CAMHS teams. This model emphasises continuity of care while providing a structured environment, conducive to rehabilitation and support.
>
> CAHS believe that an intensive day unit, along with the network of ACRTs and CAMHS Crisis Connect, with virtual follow-up, will represent a progressive and contemporaneous approach to step-up/step-down care that prioritises holistic needs of children.

344. My proposed recommendation was that a residential SUSD facility be established for children from 13 years and under the age of 16 years with complex mental health issues. However, as can be seen from the above submissions, the MHC and CAHS support the creation of a unit that operates an intensive day program from Monday to Friday as the appropriate transitional space for children in this age bracket who have significant mental health issues.

345. This Court must always exercise caution when making a substantial recommendation that does not have the support of the relevant entities. Accordingly, I have re-drafted my proposed recommendation regarding a SUSD residential facility so that it aligns with the submissions received from the MHC and CAHS.

[212] Email from Robyn Hartley to the Court dated 28 March 2024

RECOMMENDATIONS

346. In light of the observations I have made, and after consideration of the responses from the MHC and CAHS, I make the following recommendations:

Recommendation No.1

In order to provide an appropriate level of community-based care to children and young people aged 17 years and under who have complex mental health conditions, that funding be provided to the Mental Health Commission as a matter of priority so that a permanent network of suitable models based on the Acute Care and Response Teams operating in the Perth metropolitan area can be established throughout the remainder of the state.

Recommendation No.2

In order to provide a step-up/step-down facility for children and young people under the age of 16 years who have complex mental health conditions, that funding be provided to the Mental Health Commission as a matter of priority for a facility with an intensive day program. This facility should be a hybrid model that applies the best features of the now closed Transition Unit and the current Touchstone program so as to provide an easily accessible service and an alternative to hospitalisation.

QUALITY OF THE TREATMENT AND CARE PROVIDED TO CHILD SK FOR HER MENTAL HEALTH.

347. With respect to my assessment of the treatment and care provided to Child SK, I have carefully considered the documentary evidence and closing submissions from the interested parties at the inquest. In addition, I have heard and read the transcript of the oral evidence provided by the witnesses at the inquest. I have also taken into account the additional

material that has been provided to the Court since the completion of the inquest.

Department of Communities

348. As to the treatment and care provided by the Department to Child SK and her family, I have found, to the required standard, it was wanting in three areas. First, I am satisfied there was a failure by the Department to give an appropriate consideration to whether the first Referral should be referred to FSN. Secondly, I am satisfied there was an inappropriate delay by the Department in its assessment of the second Referral. Thirdly, I am satisfied there was a missed opportunity by the Department to consider whether Child SK should become an intake for a CIS when it assessed the second Referral.

349. In making these findings, I stress that I am not critical of those individual employees at the Department who were involved in these matters. With respect to the first and third findings, that is because I am satisfied the Interaction Tool that the Department had provided for its staff to use as a guide did not adequately measure the risk of harm to Child SK. As there was a requirement that the Interaction Tool had to be used, "*in every Interaction to inform a decision on whether Communities has a role to assess child protection concerns*",[213] I can understand why there was a reliance placed on the low scores generated by the Interaction Tool.

350. As to the second finding, I am satisfied that heavy workloads and the unexpected absence from work of the child protection worker who was initially allocated the referral were the primary reasons for the delay.

351. As I have noted earlier, changes have been made to address the low scores the Interaction Tool provided in the various assessments made for Child SK. It is therefore the Court's expectation that assessments with similar circumstances to those that existed for Child SK and her family will not have the same low scores from the Interaction Tool.

Bentley Family Clinic

352. As to the treatment and care offered by BFC to Child SK, I have found it was necessary to consider a number of factors that impacted the ability of the health professionals at BFC to provide optimal care. These included the fragmentation of care due to Child SK's frequent admissions to PCH, her initial reluctance to engage, the complexity of her mental health presentations, and the very limited time available to discuss Child SK's

[213] Exhibit 1, Volume 2, Tab 1.1, Report from Rachael Green, the Department's Deputy Director, dated 17 September 2021, p.2

therapy options due to her frequent presentations in crisis and emotional distress. In addition, BFC's interactions with Child SK and her family largely occurred during a period when COVID-19 restrictions were in place. Finally, I must also consider the resources available to BFC and the heavy workloads of its staff.

353. Once those factors are taken into account, I am satisfied that the treatment and care provided by BFC to Child SK was appropriate.

Perth Children's Hospital

354. As with BFC, there were external factors out of the control of the health professionals at Ward 5A that had an effect on the treatment and care they were able to provide Child SK. These factors also impacted on their ability to provide optimal care. The most notable of these factors was that Child SK's emerging EUPD and the associated risk of suicide was the most complex that health professionals at PCH had encountered. In addition, there was no SUSD facility available for Child SK upon her discharge from PCH, and with the exception of Touchstone, there was a lack of intensive community services for young people with complicated EUPD and a high risk of suicide.

355. In those circumstances, I am satisfied that the mental health professionals caring for Child SK at PCH did their best to look after her. Apart from the one isolated incident that I have already addressed in this finding,[214] I am satisfied that the treatment and care of Child SK at PCH was appropriate.

CONCLUSION

356. Child SK was only 13 years old when she died on 23 July 2020 from the complications of a head injury she had sustained two days earlier when she deliberately stepped into the path of an oncoming car.

357. Only the month before, Child SK had a confirmed diagnosis of emerging EUPD which was to become the most complex and challenging of EUPD cases for a child that mental health professionals in Perth had ever encountered. Consequently, the treatment and care that Child SK required was very demanding. This intensified when her admissions to Ward 5A following episodes of self-harm and/or suicidal ideation rapidly increased from 4 June 2020.

358. It also placed a heavy toll on Child SK's parents who were unable to keep her safe at home due to her driven impulsivity to self-harm. To their credit, Child SK's parents frequently made it clear that they could not protect their

[214] This concerned the confusion Child SK and her parents had regarding Dr Kostic-Garner's qualifications.

daughter from her self-harming behaviour and suicidal ideation. However, as long hospital admissions are counterproductive in the management of EUPD, there was no option other than to return Child SK into the care of her parents after every discharge from Ward 5A. The earliest time she could start participating in Touchstone (the community-based program designed to assist young people with EUPD) was not until 8 September 2020, and during the intervening period there was no SUSD facility available for her.

359. Although Child SK's parents were very protective of her and did their very best to keep her from harm, I am satisfied there was a significant gap in the community-based services that could keep Child SK safe after she had been discharged from Ward 5A in the weeks before her death.

360. Although improvements have been made to these services since Child SK's death through the creation of ACRT and the expansion of Crisis Connect, I am firmly of the view that a SUSD facility for children under the age of 16 years is necessary for the Perth metropolitan area. Such facilities are available for adults throughout Western Australia and planning is underway for a SUSD facility for 16 to 24 year olds.

361. As the inquest progressed, it made little sense to me not to also have plans for a SUSD residential facility for children under the age of 16 years. What happened to Child SK may have been prevented had an SUSD facility been available for her to reside in following her discharges from Ward 5A.

362. However, having considered the submissions from the MHC and CAHS since the inquest and re-examined the services provided by the expanding ACRT and the expanded Crisis Connect, I have determined that the residential aspect of such a facility is not desirable. I have been persuaded that the alternative SUSD day facility proposed by the MHC and CAHS will be a better fit for the changes that have already been made to community mental health services for children and young people in Child SK's age bracket since her death.

363. Accordingly, the creation of a non-residential SUSD facility for children and young people under the age of 16 years is one recommendation I have made. I have also made a recommendation regarding the funding of suitable models for all regional areas in the state based on the ACRT that currently operate in the Perth metropolitan area.

364. Whilst the changes to child and adolescent mental health services that have already been made are welcome, I am aware that Child SK's family must continue to deal with the sorrow caused by her death. I wish to acknowledge the courage and resilience displayed by Child SK's parents, particularly her

mother. Without her concerted efforts to highlight the plight of her daughter, I seriously doubt whether there would have been such a rapid response to address the deficiencies in the system as occurred with the Targeted Review, which then led to the Ministerial Taskforce.

365. What happened to Child SK was incredibly sad. At the inquest, her mother spoke eloquently about her beloved daughter, and her participation honoured Child SK's memory. Included in the mother's remarks was the following:[215]

> [Child SK] was a loving, caring person with goals and dreams and a huge urge to protect and to make the world a better place in terms of equality and making sure that everybody and every animal was treated well. And I think she would have really made a difference if she had been able to. I'm really glad that we were able to experience all the things that we did with her while we had her, and that there was never a moment wasted. She wasn't one for watching TV or sitting on a device or anything; she was full power ahead all the time. We had so many holidays and so many activities and so many experiences together that I will never forget. So as much as it hurts having lost her, I am grateful for all of the time and all of the experiences that we had together.
>
> And I would like people to know that even in those final couple of months, when she was home, when we were talking with her, she was still most concerned about how it was all impacting us and her sister … She worried about us and making us sad. She told me not to visit her in the hospital because that would just make me sad.
>
> When she was home, she tried to follow the plans the hospital had done. So, she was playing cards with us, making slime with her sister, doing arts and crafts with us. And she was so much more than just the symptoms and things that you've heard about in the inquest and that's why I am glad I had the opportunity to share some moments of her life.

366. I have no doubt that the health professionals at BCF and PCH did their very best to look after Child SK with the resources they had. I am also satisfied that the Targeted Review and the Ministerial Taskforce have already emphasised the urgent need for change and reform in the area of child and adolescent mental health in this state.

367. Child SK's family can take some solace, however small, that these ongoing changes and reforms to child and adolescent mental health services are designed to reduce the risk of self-harm and suicide amongst our children and young people.

368. Nevertheless, I must stress it is imperative that actions continue to be undertaken so that the mental health system is ready for the inevitable influx

[215] Ts 11.5.23 (Child SK's mother), p.750

of children and young persons with complex and challenging mental health conditions. If these actions are not prioritised, then more families like Child SK's will bear the heartbreaking loss of a loved one.

369. It is also vital that the treatment and care of children with serious mental health conditions recognise the importance of a collaborative approach between health professionals and families. As Mr Droppert SC submitted at the inquest:[216]

> [Child SK] died by suicide, but it was not inevitable or even likely that this would be so. If there is one overarching message, [Child SK's] mum would like your Honour, the community and the dozen or so mental health professionals who have sat here for days listening to everyone have their say about what they did or didn't do for [Child SK] and it's this: Whatever training or expert knowledge you have, it is vital and potentially life-changing for your patients that you not only hear what those who know their children best are saying to you, but that you truly try to understand that when they try to tell you what's not working for their child, you should hear that, give it full weight knowing that it might make a difference.

370. As I did at the conclusion of the inquest, and on behalf of the Court, I extend my condolences to Child SK's family for their heart-rending loss.

PJ Urquhart
Coroner
8 April 2024

[216] Ts 12.5.23 (Mr Denman), p.792