CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Olivia Gilfillan
Hearing dates:	5 and 6 November 2024
Date of findings:	18 December 2024
Place of findings:	NSW Coroners Court - Lidcombe
Findings of:	Magistrate Rebecca Hosking, Deputy State Coroner
Catchwords:	CORONIAL LAW – Can cause and manner of death be established? Mental health diagnosis and treatment; medical response to suicide risk.
File number:	2018/39288
Representation	Counsel Assisting the Inquest: Jake Harris instructed by Leanne Kohler, NSW Crown Solicitor's Office Illawarra and Shoalhaven Health District: Patrick Rooney instructed by Kate Hinchcliffe of Makinson D'Apice
Findings	**Identity** The person who has died is Olivia Gilfillan **Place of death** Unascertained **Date of death** Between 1 and 5 February 2018 **Cause of death** Unascertained **Manner of death** Unascertained
Recommendations	Not applicable.

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Introduction

1. Section 81(1) of the *Coroners Act 2009* (NSW) (**the Act**) requires that when an inquest is held, the coroner must record in writing their findings as to various aspects of the death.

2. These are the findings of an inquest into the death of Olivia Gilfillan, born at Maitland Hospital on 18 August 1994 to Nerilee and Craig Gilfillan. Much loved daughter, granddaughter and sister.

The role of the coroner

3. Pursuant to section 81 of the Act, a coroner holding an inquest concerning the suspected death of a person must make findings as to whether the person has died and if so, the date and place of the person's death, and the cause and manner of their death.

4. In addition, the coroner may make recommendations in relation to matters which have the capacity to improve public health and safety in the future, arising out of the death in question.

5. This inquest was held pursuant to section 21(1)(b) of the Act in circumstances where no death certificate was available.

The issues examined at inquest

6. An inquest into the circumstances of Olivia's death was held on 5 and 6 November 2024. Tendered to the court was an electronic brief of evidence compiled by the then Officer in Charge of the coronial investigation, Leading Senior Constable Anthony Riordan.

7. At the inquest the court received evidence from:

   a. Dr Wael Wahaib, Senior Consultant in Psychiatry, Illawarra Shoalhaven Local Health District (**ISLHD**) (Shellharbour Hospital)

   b. Dr Harsha Ediriweera, former Staff Specialist Psychiatrist, ISLHD (Shellharbour Hospital)

   c. Professor Matthew Large, Conjoint Professor in the Discipline of Psychiatry and Mental Health, University of New South Wales (expert).

8. The inquest considered the adequacy and the appropriateness of Olivia's mental health diagnoses and her treatment by ISLHD including:

   a. What was the nature of Olivia's mental health condition?

   b. Was adequate and appropriate care provided to Olivia by ISLHD? In particular:

      i. What were the reasons for changes to Olivia's treatment plan, following her transfer to ISLHD?

      ii. Was there an adequate plan to discharge Olivia to the community?

      iii. Would it have been appropriate to modify that plan, following Olivia's further attempts at self-harm in the period November 2017 to January 2018?

      iv. Did Olivia receive adequate and appropriate care, during her final admission from 25 to 31 January to 2018?

   c. What were the circumstances of Olivia's disappearance?

   d. What was the date and place of Olivia's death?

e. What was the manner and cause of Olivia's death?

9. As will be seen, I reached the conclusions that follow.

a. Olivia died between 1 and 5 February 2018, the place, cause and manner of death remain unascertained.

b. Olivia received extensive treatment for her mental health over a 9 year period from age 14 to 23. During that time her presentation was severe, complex and prolonged. As would be expected, her transition from child to adult and her medication/treatment regime including extensive Electroconvulsive Therapy (**ECT**), impacted her diagnoses over time.

c. Olivia suffered from:

i. anorexia nervosa (**anorexia**)

ii. obsessive compulsive disorder (**OCD**)

iii. cognitive impairment

iv. psychosis giving rise to the diagnosis of schizoaffective disorder in her earlier years

v. borderline personality disorder (**BPD**) in the absence of psychosis in her adult years

vi. trauma caused by the adverse effects of prolonged hospitalisation causing institutionalisation and lack of individuation.

d. The changes made in Olivia's treatment plan on her transfer to ISLHD were necessitated by her change in diagnosis and concerns regarding the adverse effects of ECT and clozapine as well as the efficacy of ECT and clozapine.

e. The change in her treatment plan was reasonable in all the circumstances.

f. The decision by the Shellharbour Mental Health Rehabilitation Unit (**SMHRU**) to discharge Olivia was appropriate and the proposed discharge plan was adequate. Significantly, Olivia was not connected with a psychiatrist in the community notwithstanding that this was an important element of the plan. It is not clear on the evidence why this did not occur.

g. Olivia's discharge plan remained adequate despite her further presentations.

h. The care provided during Olivia's admission to Shellharbour Hospital was adequate and appropriate, including the decision to discharge and the plan on discharge.

i. Olivia went missing after the review by her case worker, Leanne Grech on 1 February 2018, on being informed that she would be taken to hospital for assessment.

j. Olivia died between 1 and 5 February 2018.

k. The cause and manner of Olivia's death remains unascertained.

Background

10. Olivia was a much-loved daughter, sister and granddaughter. As a young girl, Olivia did well at school, had lots of friends and enjoyed sport. At the age of 7 she suffered a head injury and lost consciousness.

11. Between the ages of 13 and 14, her grades in maths began to suffer, she became anxious and had difficulties eating. In March 2009 she was diagnosed with anorexia.

She was initially treated as an outpatient at Nowra Hospital before being transferred to Westmead Children's Hospital.

12. From her diagnosis to her death in February 2018, age 23, Olivia received extensive treatment as an inpatient and outpatient for her anorexia and her associated mental health issues.

Medical history

13. Much of the facts of this matter are not in dispute and I am grateful for submissions by counsel assisting from which I have drawn extensively and, in relation to non-contentious issues, directly at times, in these findings.

Westmead Hospital: December 2009 to March 2011

14. From December 2009 to March 2011, Olivia had a series of admissions to Westmead Hospital for her anorexia. She was treated on a voluntary basis. She was fed with a nasogastric tube. She was prescribed olanzapine (antipsychotic).

15. A psychiatric assessment in January 2010 found she had anorexia, generalised anxiety disorder and possibly OCD, with a differential diagnosis of depression. She had unusual thoughts, described as "magical and obsessive thinking", rather than psychosis.

16. In March 2010, she was moved to the Children's Hospital Westmead, for treatment of her anorexia. She was commenced on different medications: fluoxetine (antidepressant), temazepam (sedative), quetiapine (antipsychotic). She was discharged in May 2010, and re-admitted in August 2010 with more weight loss. That 5-month period was the last time she was out of hospital, other than periods of leave, during her childhood. During that admission, she reported suicidal ideation and was detained as an involuntary patient.

17. On 28 September 2010, she was transferred to the Hall Ward at the Children's Hospital Westmead, on an involuntary basis. Her condition deteriorated. She self-harmed, and she was subject to restraint, sedation and seclusion. She continued to attempt self-harm even when in the presence of a 1:1 special nurse. She repeatedly removed her nasogastric tube.

18. Various medications were trialled, including quetiapine, olanzapine, risperidone (antipsychotics), lithium (for mood disorder), and different antidepressants. Second opinions were sought about her diagnosis and treatment. There were discussions about ECT to which Olivia and her family were initially opposed. She remained in the Hall Ward for about 7 months, until March 2011. This appears to have been a traumatic episode for Olivia.

19. The notes of this admission, as with others, refer to a complex family dynamic.

20. At the time of discharge from the Hall Unit, Olivia's diagnoses were believed to be anorexia, major depressive disorder, OCD, and a "parent-child relational problem". She was prescribed quetiapine and clomipramine (for OCD).

Walker Unit, Concord: March 2011 to June 2013

21. On 21 March 2011, Olivia was transferred to the Walker Unit, which is an acute adolescent mental health unit at the Concord Centre for Mental Health. She remained at that unit, mostly as an involuntary patient, for over 2 years, until June 2013.

22. She experienced obsessive compulsive behaviour, suicidal ideation and psychosis (namely auditory hallucinations commanding her to self-harm) and persecutory

delusions about her treatment team. Her behaviour was at times extreme and required sedation and seclusion, including for assaults on staff. About a month into the admission, she became mute or catatonic.

23. She was again trialled on different medications, including antipsychotics quetiapine, olanzapine, haloperidol, aripiprazole and ziprasidone. She was given methylphenidate (Ritalin) for a brief period in 2011. On 16 June 2011, she commenced clozapine, which she continued to take until 2016.

24. On 13 May 2011, Olivia was administered ECT for the first time. That treatment appeared to improve her catatonia, although there were concerns about its impact on her cognition. Over the next five years, the records show she was administered over 200 ECT treatments, on about a weekly basis, all but two of which were involuntary (pursuant to orders from the Mental Health Review Tribunal, (**MHRT**)).

25. By the end of this admission, her diagnosis was considered to be schizoaffective disorder, involving both psychosis and mood disorder, with periods of catatonia and a suspected seizure disorder absent seizures. She was prescribed clozapine, olanzapine and sertraline (antidepressant).

26. Her presentation gradually improved, with increasing periods of wellness. She began to access increasing leave, and in 2012 she began attending a school in a specialist unit, Rivendell, and worked in a café. She turned 18 in August 2012. At the end of the year, her family acquired 'Housing and Accommodation Support Initiative' funded accommodation in Concord, and she began to take periods of leave there.

27. The plan to discharge Olivia there did not work out. Olivia's parents found it difficult to travel from Nowra to Concord to support her. In May 2013, there was a plan to discharge Olivia to her parents' home in Nowra instead. However, that lasted 2 days, before Olivia presented to hospital. On return to the Walker Unit, Olivia became highly agitated and required further ECT treatments.

Kirkbride Unit, Concord: June 2013 to June 2016

28. On 13 June 2013, Olivia was transferred to the Kirkbride Acute Recovery Unit, which is an adult acute rehabilitation unit, at the Concord Centre for Mental Health, under the care of psychiatrist Dr Chris French.

29. She continued to experience episodes of severe agitation, suicidal ideation, catatonia or mutism, and episodes of self-harm including refusal of food and medications. This behaviour continued, despite treatment with clozapine and ECT.

30. She had a significant deterioration in August 2013, where her body became stiff, and she had a fast heart rate. A medical cause was suspected, and she was transferred to the ICU. Her medication was ceased. She was given further treatments of ECT.

31. In early 2014, Olivia presented relatively well. Her medication was stable, and she had less frequent maintenance ECT. She accessed leave and went home to her family. However, she continued to experience deterioration regularly.

32. In mid-2014, there was a further plan to transition her to independent living, and she accessed her supported accommodation. In early 2015, she had prolonged periods of leave in this accommodation, or at her family home.

33. In September 2015, she accepted a change to voluntary status, although this only lasted about 2 weeks before a further deterioration. There were also growing concerns about the impact of ECT on her cognition, and formal testing suggested that her prolonged illness and ECT had affected her memory and attention.

Nonetheless, it was considered that ECT had been the only treatment to reliably prevent relapse.

34. In early 2016, Olivia was offered accommodation at Auburn (Casa Venegas). However, the plan was again not successful, and Olivia exited that accommodation after a couple of days.

35. With multiple failed attempts to arrange accommodation for Olivia in the Sydney area, a new plan was formulated, with the aim to discharge Olivia near to her family in Nowra, where she had been spending most of her leave. The plan was to transfer her to a rehabilitation unit at Shellharbour for that purpose.

36. By the time of discharge from the Kirkbride Unit, the treating team considered Olivia's diagnoses to be schizoaffective disorder, depressed type, an eating disorder, anxiety disorder, and a mild cognitive impairment. Her medications included clozapine, olanzapine, desvenlafaxine (an antidepressant) and lamotrigine (for seizures). It was felt she had gradually improved over the previous 18 months, with a reduction in the frequency and duration of relapses.

37. At the time of discharge, her status was involuntary. She had a current order for ECT. The discharge plan records that treating staff at the Kirkbride Unit considered ECT to be the only treatment which could reliably prevent relapse. Second opinions from external psychiatrists had supported that view.

Shellharbour Mental Health Rehabilitation Unit: June 2016 - November 2017

38. On 14 June 2016, Olivia, aged 21, was discharged from the Kirkbride Unit and transferred to the SMHRU.

39. The team at SMHRU took a different view regarding Olivia's condition and treatment. The team, initially led by Dr Al-Taie, were concerned that the ECT treatments were not clinically necessary, and that Olivia's acute relapses and catatonia were due to poor stress tolerance, maladaptive interpersonal relationships, and instability of affect, rather than psychosis. As a result, she ceased ECT on 10 August 2016.

40. The team also did not agree with the diagnosis of schizoaffective disorder. She was diagnosed with BPD and anorexia. Her personality disorder was said to be "precipitated by maternal invalidation and perpetuated by the trauma of chronic institutionalisation". A second psychiatrist, Dr Chandasekaran, ceased Olivia's antipsychotics and mood stabilisers. Importantly, Olivia did not experience further psychosis following their withdrawal. She was maintained on quetiapine for anxiety management.

41. A third psychiatrist, Dr Ediriweera, took over Olivia's care in March 2017, and planned for her discharge.

42. During this admission, Olivia's contact with her family including her mother was limited.

43. Supports were put in place to plan for Olivia's discharge. She was referred to the Illawarra Community Mental Health Rehabilitation Service. Grech, a clinical psychologist from that service, began seeing Olivia while still at the SMHRU. She continued seeing Olivia regularly while in hospital and following her discharge into the community.

44. On 28 March 2017, Olivia signed a lease on a unit in East Corrimal.

45. A discharge was first attempted on 28 June 2017. Olivia returned to the ward a few hours later in a taxi. She was nonetheless granted increasing periods of leave from this point, returning to the hospital for review by Dr Ediriweera's registrars.

46. The discharge plan prepared on 28 June 2017 provided that Olivia was to be case managed by Grech. It was recommended that Olivia undergo long-term dialectical behaviour therapy (**DBT**), a treatment for her personality disorder. She was to be supported by workers from NEAMI and Wellways, who would assist with daily living activities, socialisation and daily structure. There was a plan to have neurocognitive assessment in the community, to assess and support the impact of her ECT.

47. In the event of a deterioration, the plan was as follows. Olivia was encouraged to use psychological coping interventions, and if those were not effective, to escalate to her caseworker. If the risk was not considered manageable, she could be assessed by a psychiatrist in the emergency department of a hospital at any time. However, the plan stated, "admission should be avoided as a last resort for acute containment of risk only. If admitted, a time limited admission to the psychiatric emergency care centre (**PECC**) would be highly preferred" and that this "should only last one night with prompt follow-up in the community upon discharge".

48. The plan noted that there were complex family dynamics. It cautioned against accepting collateral information from Nerilee.

49. The team believed that Olivia was at medium chronic risk of self-harm and suicide, which was "not modifiable with ongoing in-patient care", and that her risk profile was highly changeable in the context of crisis or intoxication.

Discharge into the community

50. Over the subsequent months, Olivia accessed leave and returned to hospital, sometimes in crisis. For example, on 23 July 2017 she was discharged on leave, but presented back to Wollongong Hospital Emergency Department (**ED**) within 4 hours, with superficial self-inflicted injuries.

51. Nonetheless, the impression of the treating team was of gradual improvement.

52. On 9 November 2017, Olivia initially refused to attend hospital for her final review prior to discharge. She sent Grech messages in which she said the following:

> *Please don't get me wrong about the staff at shellharbour rehab, its just the negative experiences I had there still affect me now in a bad way. The staff at rehab pretty much gave me my life back, im so grateful for that and cant thanks them enough. They put in a lot of time and hardwork to get me better and they never gave up.*

53. She did attend hospital that day and was reviewed by Dr Ediriweera. She told him she felt she was going well and could recognise when she was becoming more anxious. She acknowledged she had benefitted from the SMHRU. She did not appear to be in distress or to be exhibiting any psychotic symptoms or pervasive mood symptoms.

54. A decision was therefore made to discharge Olivia from the SMHRU that day. The discharge plan prepared on 10 November 2017 was in the terms described above. No changes were made to her medication, and she was discharged on quetiapine.

55. Notably, the plan included an intention to link Olivia with a community psychiatrist.

Further admissions (2017-2018)

56. Olivia had four further admissions to hospital following her discharge into the community, prior to the events that resulted in her death. Consistent with the discharge plan, these admissions were of brief duration.

Admission to Wollongong Hospital (18 to 23 Nov 2017)

57. On 18 November 2017, Olivia went out to lunch with her support workers. She self-harmed by making superficial cuts to her forearm. An ambulance was called, and she was admitted to Wollongong Hospital, and then transferred to the PECC. On assessment, she did not appear psychotic, although she reported hearing voices during the admission. She was detained as an involuntary patient for what was considered a situational crisis.

58. A case conference was held on 23 November 2017, in which Olivia stated she wanted to be discharged, and agreed with the plan for only short admissions. She was discharged that day, with a slight adjustment to her medication (spacing her medication out during the day and a higher dose at night).

59. Grech attended hospital and took Olivia home. She had regular contact with Olivia over the next couple of weeks, and they discussed strategies to manage Olivia's low mood and anxiety. She reviewed Olivia's crisis plan with her on 30 November 2017.

60. Grech was on leave during December 2017. During that month, Olivia had support from her key workers from NEAMI and Wellways.

Presentation to Wollongong Hospital (13 December 2017)

61. In the evening of 12 December 2017, Olivia took an overdose of her prescribed medication, Seroquel (950mg) and made cuts to her arm. She was taken to Wollongong Hospital by ambulance. She appeared calm but low in affect. She did not cooperate with the mental health assessment. She walked out of the hospital at about 7.45pm.

62. A couple of days later, on 15 December 2017, Olivia attempted to contact her usual GP, who was unavailable. She sounded distressed.

Admission to Wollongong Hospital (18 to 22 December 2017)

63. On 18 December 2017, Olivia went to North Wollongong beach and walked into the ocean, fully clothed. She threatened to drown herself. Police and an ambulance were called. She told paramedics she had not been compliant with her medication since the last admission. She was taken by police to hospital under section 22 of the Mental Health Act 2007.

64. At hospital she was uncooperative and attempted to abscond. She was restrained and sedated. She did not appear to be psychotic. She said she wanted to see Grech, who was away.

65. Olivia was admitted on an involuntary basis for 5 days. She initially remained in the ED, as there were no beds in the PECC. During the admission she reported problems with a neighbour. She said she did not want further treatment. She reported some hallucinations, but these were not considered to be evidence of psychosis. Her main issues were considered a mood disorder and anxiety. The plan was to discharge her with an increase in quetiapine, and add an antidepressant, desvenlafaxine, and an anti-epileptic, lamotrigine. Her medication was to be restricted to 3 days' supply at a time. She was discharged on 22 December 2017.

66. Following discharge, the Acute Care Team had daily contact with Olivia over the holiday period, until her regular support services were back in place.

Admission to Wollongong Hospital (25 to 26 January 2018)

67. On 25 January 2018, Grech attended Olivia's home. Olivia told her she had taken an overdose of her medication (quetiapine, desvenlafaxine and magnesium). Grech called an ambulance, although Olivia pleaded with her not to. While awaiting the

ambulance, Olivia made superficial cuts to her forearm with a knife. She was persuaded to attend Wollongong Hospital voluntarily, and then admitted as an involuntary patient.

68. Olivia disclosed she had been feeling low since her previous discharge but had pretended to her caseworker that she felt okay. She had been distressed by recent weight gain. She said she had Googled methods to kill herself, because her pharmacist was only dispensing 3 days of medication at a time. She had read that magnesium could stop the heart. She was frustrated she had not been successful.

Admission to Shellharbour Hospital (26 to 31 January 2018)

69. On 26 January 2018, Olivia was transferred to the Eloura East ward at Shellharbour Hospital. She remained scheduled as a mentally disordered patient until 29 January 2018. Her presentation settled and she did not appear psychotic.

70. On 29 January 2018, Olivia was reviewed by psychiatrist Dr Wael Wahaib. While this was the first time she had come into Dr Wahaib's care, he was aware of her case as it had been discussed in the context of peer reviews and ECT procedures given the severity and complexities involved.

71. Olivia said she had been stockpiling medication. She was asked whether she would overdose again, and stated, "I don't know". She asked to be discharged, although agreed to remain for 2 nights, and signed an application seeking voluntary admission.

72. On 30 January 2018, Dr Wahaib reviewed Olivia again. She reported feeling better, although had poor eye contact and was speaking in short sentences.

73. Dr Wahaib reviewed her again the following day, 31 January 2018. She denied thoughts of self-harm. She said she felt safe for discharge. Significantly, Dr Wahaib noted that she had not yet been connected with a community psychiatrist.

74. The discharge plan was for Olivia to be discharged, with a plan for daily medication dispensing, follow up from the acute care team, and referral to a community psychiatrist. It was recognised on discharge that Olivia remained at chronic risk of self-harm.

75. Grech transported Olivia home. She noted that Olivia was ruminating over the admission and was complaining that staff believed her suicidal ideation was "attention seeking". Grech planned to visit Olivia the following day.

76. It was later discovered that Olivia wrote the following entry in her diary that day:

> *Nearly the whole time I couldn't stop thinking about trying to drown myself in the beach or the rock pool. I imagined myself doing it and pushing myself to completely end my life forever, the thought didn't scare me, I felt determined instead. I just have no energy left or feel anything positive in myself to keep on going on with…*

From 1 February 2018

77. At 9.30am on 1 February 2018, Grech visited Olivia at home. Olivia appeared withdrawn. She said she had been looking up methods for suicide online, although she did not describe these. Grech performed a metal health assessment. She believed Olivia remained at ongoing medium risk of self-harm and suicide and required closer monitoring over the next few days. She planned to visit Olivia on the following Monday, 5 February, and to contact the Acute Care Team regarding follow up.

78. Grech then left Olivia and returned to her office to prepare her clinical notes. At about 11:30am, she contacted Omar Houri, a nurse at the Acute Care Team. Mr Houri advised Grech to call an ambulance for Olivia.

79. Prior to doing so, at about midday, Grech called Olivia. She told her of the plan to have Olivia assessed at hospital. Olivia was distressed by this and said she did not want to go to the ED again. Grech understood Olivia was going to be home at 1pm, to see her keyworker Mr Short, and was also due to see her mother at 3pm.

80. Following this, Grech called 000. At some stage prior to the arrival of paramedics, Olivia left her home. There was no further confirmed sighting of Olivia.

81. Paramedics attended Olivia's home, but she was not there. They contacted Grech to tell her Olivia was not answering the door, and then contacted police. Olivia was also not answering calls to her mobile. Mr Short attended at 1pm, for his appointment with Olivia. While he was present, Fire and Rescue gained access to the unit. Olivia's bike and phone were missing, but her wallet was found inside.

82. Police viewed the search history on Olivia's tablet, and noted it included methods to commit suicide, including hanging.

The search for Olivia

83. In the days following, police conducted an extensive search for Olivia. This included contact with State Rail, patrols of the local area (including the beach) and canvasses with witnesses. Family and friends also searched for Olivia.

84. A phone triangulation was initially ruled out on 1 February 2018, as it appeared Olivia's phone was switched off. However, the following day, on 2 February 2018 at about 1.30pm, Nerilee called Olivia, and received a text reply, "Sorry, can't talk right now". As a result, Nerilee contacted police, who called the phone and sent a text message, receiving the same reply. A phone triangulation was commenced. This revealed Olivia's phone to be within 500m of Woonona station. Police searched the area. A further phone triangulation was conducted the same evening, which revealed the phone to be within 500m of Campbell/Carrington Streets, Woonona. Following this, calls to Olivia's phone went straight to voicemail suggesting her phone was turned off.

85. I accept the submission of counsel assisting that it is unclear whether those messages indicate that Olivia was still alive. There were no confirmed sightings. An alternative would be that Olivia gave away her phone, or that it was located by a third party.

86. The police search continued on 3 and 4 February 2018. On 4 February, Olivia's sister informed police she believed she had located Olivia's bike in a river, although when police attended, they formed the view it had been there for some time. Police also conducted a search of the Botanic Gardens at Wollongong, following information received from the family.

87. At about 7am on 5 February 2018, two members of the public were walking on Bellambi beach, about 1km south of the location where the phone triangulation had indicated. They found what they believed to be human remains and attended a café nearby to call police. Police attended and confirmed the remains were human and took photos of the body in situ. The remains were later conveyed to Wollongong Hospital.

88. The remains were identified to be Olivia by comparative dental records.

Autopsy

89. A post-mortem exam was performed by Dr Bernard I'Ons on 9 February 2018. Toxicology could not be performed. The cause of death was unascertained. There was evidence of marine predation.

Issues

1. What was the nature of Olivia's mental health condition?

Professor Large

90. As highlighted by the summary of her medical history, the nature of Olivia's presentation was severe and complex. Professor Large considered Olivia's presentation to be rare in someone so young.

91. The prominent diagnosis was anorexia. Professor Large considered her anorexia to be "fairly typical" but with some rare and unusual features including:

    a. the co-existence of psychotic symptoms and anorexia

    b. catatonia, and

    c. fluctuating symptoms.

92. Professor Large reported that anorexia is the single most dangerous psychological condition. Consequences of prolonged anorexia can include problems with the heart and nerves, amenorrhea, cerebral atrophy and cognitive deficits which are only partially reversable.

93. Olivia's early treatment involved significant concerns around the urgency of treatment to avoid irreversible damage. However, there is a tension between the need for hospitalisation to treat anorexia and the risks of institutionalisation caused by lengthy periods as an inpatient.

94. Professor Large opined that Olivia's extensive hospitalisation in her teenage years was traumatic and contributed to ongoing severe mental illness giving rise to the diagnosis of post-traumatic stress disorder and the absence of individuation (living independently as an adult including making your own decisions about health, education and life).

95. Professor Large reported a history of psychosis in Olivia's earlier years including the presence of catatonia. In that context, Professor Large considered the diagnosis of schizoaffective disorder to have been appropriate while she was presenting with psychotic elements.

96. Professor Large reported that at the time she was assessed at the SMHRU, following extensive ECT, her presentation had changed. He found no evidence of 'true' psychosis during this period and opined that the diagnosis of BPD was appropriate.

97. Olivia suffered a cognitive impairment, likely a result of her anorexia and extensive ECT.

Findings

98. Olivia received extensive treatment for her mental health over a 9 year period from age 14 to 23. During that time her presentation was severe, complex and prolonged. As would be expected, her transition from child to adult and her medication/treatment regime including extensive ECT, impacted her diagnoses over time.

99. Olivia suffered from:

   a. anorexia
   b. OCD
   c. cognitive impairment
   d. psychosis giving rise to the diagnosis of schizoaffective disorder in her earlier years
   e. BPD in the absence of psychosis in her adult years, and
   f. trauma caused by the adverse effects of prolonged hospitalisation causing institutionalisation and lack of individuation.

2. Was adequate and appropriate care provided to Olivia by ISLHD? In particular:

What were the reasons for changes to Olivia's treatment plan, following her transfer to ISLHD?

100. The significant changes in both diagnosis and treatment when Olivia moved into the ISLHD were:

   a. given her transition to adulthood and the absence of symptoms of psychosis, Olivia's diagnosis changed from schizoaffective disorder to BPD
   b. clozapine and ECT were not indicated treatments for BPD
   c. Olivia's cognitive function was deteriorating which was attributed to her ECT
   d. clozapine was a last resort antipsychotic, which had potentially serious adverse effects on the heart and the blood cells (neutropenia), and
   e. Olivia ceased ECT when treated within the ISLHD and she was weaned off clozapine.

101. Professor Large opined that ceasing ECT was appropriate in the circumstances. He considered that could have been given to continuing with clozapine for a period but acknowledged that this may have been difficult given it was not an indicated treatment for BPD.

102. He reported that by the time Olivia came to ISLHD, her personal development had been seriously derailed by her institutionalisation and complications of ECT. The effectiveness of her treatment was questionable in circumstances where relapses were prevalent. Olivia was the main driver of her individuation and to achieve a life outside of hospital required a dramatic change to her treatment.

103. Significantly, Olivia's symptoms of psychosis did not re-emerge when these treatments ceased.

Findings

104. The changes in Olivia's treatment plan were necessitated by her change in diagnosis and concerns regarding the adverse effects of ECT and clozapine as well as the efficacy of ECT and clozapine.

105. The change in her treatment plan was reasonable in all the circumstances.

Was there an adequate plan to discharge Olivia to the community?

106. As a preliminary matter, I wish to address an issue raised by Olivia's parents, that given her presentation, there was a plan to discharge.

107. Professor Large addressed this in his discussion about the fundamental changes in policy surrounding the treatment of chronic mental health issues. He confirmed that the concept of a lifetime within the restrictive framework of a hospital scenario is no longer considered to be accepted practice.

108. In a complex case like Olivia's, Professor Large acknowledged the tension between the risks posed by institutionalisation and the need for hospitalisation in severe cases.

109. As a child, the balance weighed in favour of hospitalisation. Professor Large did not criticise this approach. However, he highlighted the adverse outcomes being that Olivia, as an adult, struggled with everyday living given the absence of friends, the inability to tolerate being on her own, the lack of practical skills, difficulty making decisions and the lack of human agency.

110. As an adult, Olivia expressed a desire to live in the community and that she did not want to return to hospital. The need to re-integrate Olivia into the community was not just the desire of her treating specialists, it was what Olivia wanted and it was what society expected her treatment goals to be.

111. Consistent with that goal, Dr Ediriweera confirmed that discharge planning was a process undertaken during the whole of Olivia's hospital admission. The purpose of the SMHRU was to equip Olivia to live independently with the assistance of a multidisciplinary team.

112. This did not mean that Olivia's discharge was rushed. She was admitted in June 2016 and was not formally discharged until 9 November 2017. This, of itself, was a significant period of time to be hospitalised.

113. Olivia expressed trepidation at living in the community. This is understandable given her history of institutionalisation. The path was also not smooth. She experienced setbacks however her adaptive techniques began to improve.

114. As a preliminary issue, I consider the decision to discharge Olivia and to take active steps to both limit future hospitalisation and address the trauma of institutionalisation, to have been an appropriate treatment goal.

115. Olivia's discharge plan contained the following elements:

    a. that Olivia be discharged into her own care, with supports including Grech, to provide case management and DBT, and NEAMI and Wellways to assist with activities of daily living

    b. a GP to provide medication and physical health care

    c. neurocognitive testing, and

    d. a plan for responding to a crisis, which would involve Olivia using her own psychological interventions: contacting her caseworker and if the risk could not be managed, assessment in the ED with admission to the PECC as a last resort for acute containment of risk only - which was to be time limited.

116. There was also a detailed plan in the event of admission to the ED.

117. The plan specifically anticipated Olivia would be reviewed by a psychiatrist from the Community Health Team following her discharge. Dr Ediriweera considered this important, given her complexity, and expected this would occur. A psychiatrist would assess Olivia and consider her medication. Dr Wahaib also considered a community psychiatrist was required, at the point of his review in January 2018.

118. Professor Large considered the plan to be adequate. He acknowledged that the involvement of a psychiatrist was a significant component of the plan – which was not complied with.

119. The records do not show why no appointment was made with a psychiatrist following Olivia's discharge in November 2017. Resources, availability over Christmas and Olivia's willingness to attend appointments may have played a role. There are references to plans to make appointments with a named psychiatrist. However, the evidence suggests no appointment was made and it is apparent Olivia did not see a psychiatrist in the community following her discharge.

Findings

120. The decision to discharge Olivia was appropriate and the proposed discharge plan was adequate. Significantly, Olivia was not connected with a psychiatrist in the community notwithstanding that this was an important element of the plan. It is not clear on the evidence why this did not occur.

Would it have been appropriate to modify the discharge plan, following Olivia's further attempts at self-harm in the period November 2017 to January 2018?

121. Olivia's four presentations to hospital following her discharge from the SMHRU were, to some extent, an anticipated aspect of her presentation. She had been experiencing chronic suicidal ideation, and while this had not been prominent in the months prior to discharge it had been a long-term issue.

122. Critically, the process of allowing Olivia to individuate, and to develop independence, in the face of her institutionalisation, carried risk. There were also risks of not allowing her independence. Monitoring her too closely, or returning her to hospital against her will, risked prolonging her condition and undermining her recovery.

123. Professor Large noted that further admission would have been an available option. The research does not show that admissions reduce suicide risk on discharge, in particular in the case of a person with BPD.

124. An alternative would have been to transfer Olivia into supported accommodation with 24-hour supervision. Such arrangements are currently available with substantial NDIS support. However, this may have taken a long time to organise (if available) and would have brought with it risks similar to hospitalisation, in terms of prolonging Olivia's institutionalisation and lack of individuation.

Findings

125. Olivia's discharge plan remained adequate despite her further presentations.

Did Olivia receive adequate and appropriate care during her final admission from 25 to 31 January to 2018?

126. Dr Wahaib had knowledge of Olivia, through peer review meetings. He understood her history and would have reviewed notes of her admissions. He understood she had BPD and PTSD. He believed she was at chronic risk of suicide, and that the plan for such patients was a short duration stay and discharge with support to address stressors within the community.

127. Dr Wahaib reviewed Olivia on 29 January 2018 in the Eloura Ward for the first time. She had been detained as a mentally disordered person pursuant to section 15 of the *Mental Health Act* 2007 (NSW). As a consequence, she could not be detained

for more than 3 days, excluding weekends unless she accepted voluntary admission or met the definition of a mentally ill person.

128. Although Olivia initially resisted a voluntary admission, she agreed to stay two further nights on 29 January 2018. She was ultimately discharged on 31 January 2018.

129. During the admission, appropriate contact was made with Grech. She opined that a longer hospital stay would exacerbate Olivia's symptoms because it was stressful for her. Contact was also made with a nurse who had seen Olivia during her stay at the SMHRU. She attended the ward and considered Olivia to be at her 'baseline'.

130. The plan on discharge was:

   a. for Olivia to be discharged into the care of Grech

   b. for daily medication dosing at a pharmacy (to minimise the risk of overdose)

   c. follow up from the Acute Care team, which Dr Wahaib expected to occur within 48 hours, and

   d. referral to a psychiatrist in the community.

131. Professor Large considered that a longer hospital stay on a voluntary basis would have been available. However, Olivia wanted to leave hospital, and was not detainable. In any event, he noted that longer hospital stays are not associated with reduction in suicide risk.

Findings

132. The care provided during the admission was adequate and appropriate, including the decision to discharge and the plan on discharge.

3. What were the circumstances of Olivia's disappearance?

133. Olivia was reviewed by Grech on 1 February 2018. During the review Olivia disclosed she had searched methods to kill herself online. Grech proposed closer monitoring of Olivia in the following days and booked an appointment on 5 February 2018. She also told Olivia that she would speak to the Acute Care Team.

134. Grech sought advice from a colleague in the Acute Care Team, RN Houri. He advised Grech to call an ambulance.

135. Grech called Olivia to advise her that she planned to call an ambulance to take her to hospital for assessment. Importantly, Olivia indicated that she did not want to be taken to hospital. Nevertheless, an ambulance was called, and Olivia went missing prior to the attendance of paramedics.

136. Professor Large considered these circumstances. He observed it was a very difficult decision for Grech to make. Professor Large was not critical of Grech's actions and nor am I.

137. Professor Large opined that this may have been a situation where a psychiatrist who knew Olivia well could have determined a less restrictive approach, which did not involve her being transported to hospital against her will. It would have remained a difficult decision to balance competing risks.

Findings

138. Olivia went missing after the review by Grech on 1 February 2018, on being informed that she would be taken to hospital for assessment.

4. What was the date and place of Olivia's death?

139. The last confirmed sighting of Olivia was by Grech at about 10.30am on 1 February 2018. Her remains were discovered at about 7am on 5 February 2018.

140. There was an unconfirmed sighting of Olivia on 1 February 2018 at around the time she went missing, near the Woonona chicken shop.

141. When Nerilee tried to call Olivia at about 1.30pm on 2 February 2018, she received a text message response, "Sorry, I can't talk right now". Police were contacted and received the same message. The fact that the same message was sent twice suggests it was a template response. I cannot determine whether these messages were sent by Olivia or a third party.

Finding

142. Olivia died between 1 and 5 February 2018.

5. What was the manner and cause of Olivia's death?

143. Olivia's extensive medical history includes many attempts at self-harm and expressions of suicidal ideation. Specifically, in December 2017 she walked into the ocean in an apparent attempt at self-harm and had specifically referred to a desire to drown herself.

144. A finding that death is intentionally self-inflicted should not be made lightly and should only be made where the evidence of intention meets the standard set out in *Briginshaw v Briginshaw* 60 GLR 336.

145. There was no evidence before me as to how Olivia came to be in the water.

146. The cause of death was unable to be determined at autopsy. While there is no doubt it is possible that Olivia's death was the consequence of intentional self-harm, given the absence of any evidence to support that theory, I am not satisfied on the balance of probabilities that her death was the consequence of self-harm.

Finding

147. I find the cause of death to be unascertained.

Recommendations

148. The findings made did highlight a gap in the application of Olivia's discharge plan being engagement with a psychiatrist in the community. In their submissions, ISLHD have highlighted that current practice involves:

    a. discharge to a community team for follow up on leaving an inpatient unit

    b. high risk patients are discharged to the Continuing Care Team (**CCT**) at Community Mental Health

    c. a psychiatrist is embedded to the CCT

    d. alternatively, a patient whose primary needs are rehabilitative, is referred to the Rehabilitation Team which also has the capability of referral to a psychiatrist.

149. Given the information as to current practice provides some certainty around access to a psychiatrist on discharge, I make no recommendations as a consequence of this inquest.

Conclusions

150. I will close by conveying to the Gilfillan family my sympathy for the loss of Olivia.

151. I thank the assisting team for their outstanding support in the conduct of this inquest and the officers in charge, Leading Senior Constable Riordan and later Acting Inspector Owen Barnes for their work in conducting the investigation and compiling the brief of evidence.

Findings required by s 81(1)

152. As a result of considering all the documentary and the oral evidence heard at the inquest, I make the following findings:

Identity

The person who died is Olivia Gilfillan.

Place of death

The evidence does not enable a finding as to the place of Olivia's death.

Date of death

Olivia died between 1 and 5 February 2018.

Cause of death

The evidence does not enable a finding as to the cause of Olivia's death.

Manner of death

The evidence does not enable a finding as to the manner of Olivia's death.

153. I close this inquest.

Magistrate R Hosking
Deputy State Coroner
Lidcombe
Date: 18 December 2024