STATE CORONER'S COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Adam Hayward
Hearing dates:	12 – 14 March 2014
Date of findings:	9 May 2014
Place of findings:	State Coroner's Court, Glebe
Findings of:	Magistrate Sharon Freund, Deputy State Coroner
Catchwords:	CORONIAL LAW – Borderline personality disorder, Care and treatment, Psychiatric Care, Liverpool Hospital Mental Health Unit
File number:	2011/388777
Representation:	Mr **Stephen Kelly**, Advocate Assisting the Coroner; Ms **Sophia Beckett** (Barrister) i/b Ms **Violeta Stojkova** from Curwoods Lawyers on behalf of South Western Sydney Local Health District.. Mr **James Herrington** (Legal Aid NSW) for Hayward family.

FINDINGS

Adam Hayward was only 33 years old when he passed away on between 24-26 October 2009 at Unit 52, 10 Woodward Crescent, Millar from multi drug toxicity.

He leaves behind his loving and devoted parents Judith and Gordon Hayward, and his four children Summer, Jarrod, Kane and Brianne.

Adam's mental health history can only be categorised as a complicated one. After an assault in 1997, which saw him hospitalised and treated for a severe head injury, Adam overtime became, dependent on prescription medication. This eventually spiraled into a problem with both over the counter drugs and prescription medication, including codeine, for which Adam was ultimately put on the methadone maintenance program between 2005- 2008.

Adam's first admission, to the Mental Health Unit was on the 17 September 2006 when he was brought in by his mother in a state of confusion after taking an overdose of Dramamine. He was admitted as an Involuntary Patient and developed psychotic symptoms.

On 13 October 2006, some 4 weeks after his initial admission, Adam was reviewed by Dr Bren Broster, psychiatrist at which time it was reported that he was still psychotic with thought disorder and expressed the suicidal ideation of jumping off a building. He had expressed a number of paranoid persecutory ideas namely that the treating team were harming him and letting his neighbors into his house. He was treated with antipsychotics. Adam was discharged on 18 October 2006, however was readmitted the following day and remained until the 30 November 2006. On 16 November 2006 he was seen by Dr Broster and it is recorded that Adam continued to express the belief that his thoughts were being broadcast, inserted into and taken out of his mind.

Adam's next significant admission was on 31 July 2007, when he was brought in by Ambulance after being found unconscious at home from an overdose of benzodiazepines. He was in hospital for 12 days and was managed by the Drug

Health and Medical team and was discharged into the care of Dr Broster at the Community Health Centre.

On 17 September 2008, Adam was brought into Liverpool Hospital after another overdose. He was found in a supine position on his mattress, with two empty packets of Endep next to him. He was admitted to ICU and discharged four days later.

Thereafter, between late September 2008 and his death in October 2009 Adam had over 20 mental health admissions, to the Liverpool Mental Health Unit and Psychiatric Emergency Care Centre (PECC).

It was at about this time Adam was rediagnosed with having an Emotionally Unstable Personality Disorder Borderline Type in accordance with the International Classification of Diseases (ICD-10). The grounds for diagnosing this disorder included

"*long standing emotional disregulation, impulsive behaviour, recurrent self-harm, destructive and aggressive behaviour, poor relationships and longstanding depression"*[1]*.*

On 7 October 2008, there was a '*Chronic and Complex Care Plan Meeting'* attended by Dr Pauline Byrne and others involved in Adam's ongoing care. At that meeting two major care decisions were made in relation to Adams future and ongoing care. Firstly a 'summary and management plan' was agreed upon. Adam became the subject of a *'Frequent Presentations Plan'* , firstly, for the purpose of limiting Adams admission to the Mental Health Unit and that if he required admissions to either PECC unit or the high dependency unit, then those admissions were to be brief. Secondly, that he should be managed as a Voluntary Patient rather than being detained under the Mental Health Act and in the event that he become threatening or violent then he was to be discharged and removed from the hospital.

The plan listed the following:

1. *Frequent recurrent presentations to Emergency, with inclination to stay as inpatient for long term admission, as a voluntary patient, so that he may come and go as he pleases.*

[1] Tab 19 Report of Dr Matthew Large at page 6.

2. *Constant threats of suicide – Adam is at high risk of having a successful suicidal attempt, judging by the increasing severity / seriousness of his recent attempts.*

3. *Prescription Drug overdoses.*

4. *Cognitive functioning being affected by substance misuse.*

5. *Adam verbalising constructive plans which appears to various clinicians as hollow statements only, without any attempt to follow through with same after discharge.*[2]

As part of the plan Adam was offered psychotherapy with Dr Andrew Phipps, clinical psychologist, which was overseen by Dr Pauline Byrne, consultant psychiatrist, who would review his overall plan and medication management. At this meeting it was also decided that Adam would no longer be under the care of Liverpool Community Mental Health Team and would be henceforth followed up by the Community Mental Health Team ("**COMHET**") , which generally provides short term assistance anywhere from days to months until the person is stable or no longer in crisis.

Accordingly, from 7 January 2009, Adam officially came under the care of Dr Phipps. The goal of Adam's referral to Dr Phipps was to attempt to develop a therapeutic clinical relationship aimed at increasing his coping strategies for managing his emotions and distress and reduce his self-harming behaviour.

The therapy involved both *'Cognitive Restructuring'* and *'Exposure Therapy'.* According to Dr Mark Cross the Clinical Director of Psychiatry and Senior Psychiatrist at Liverpool Hospital, one of the rationales of this form of treatment is for the person to gain insight into their behaviours and to foster self-containment, responsibility and control of self-destructive patterns of behaviour[3].

It was the evidence of Dr Phipps that despite a reasonably good rapport, Adam's attendance at appointments was often an issue as he would miss appointments and was difficult to get in contact with. In his statement, he stated that

[2] Exhibit 4 – Medical Notes – Document titled "Chronic and Complex Care Plan Meeting dated 07/10/08 page 2 of report prepared by Sandra Hourn – Clinical Care Co-Ordinator.

[3] Exhibit 2, Volume 1, Tab 6 page 2;

"*substance use was also a barrier to active engagement in therapy. On several occasions Adam appeared to be under the influence of a substance. On these occasions he was very drowsy and had difficulty following our conversation*"[4].

On 11 February 2009, Adam was reviewed by Dr Bryne. Her statement indicates that at this assessment Adam initially denied substance abuse and then admitted some relapse of alcohol use. He reported that he was sleeping well and stated he was taking Quetipine at night in addition to fluoxetine in the morning. He stated he was not going out much and he mostly had contact with his parents and New Horizons workers. He denied any recent self-harm thinking. He stated he rang his mother when he was not coping and stated he found it hard to identify triggers for self-harm thoughts[5].

On 5 March 2009[6] Adam was admitted to Liverpool Emergency Department after having taken an overdose of Quetiapine (Seroquel) in an attempt to kill himself[7]. It was noted in the ED Discharge referral that he had been brought in conscious at 8.00pm but fitted at 4.00am. Recorded in the Progress Notes at New Horizons was an entry which stated, *"Adam admitted to Liverpool Emergency last night he had a relapse taking 30 Seroquel tablets – mother phoned this A.M. Adam is in an induced coma due to frequent seizures"*. Adam had spoken to his Dad earlier in the evening as he was paranoid, think the police were taking photos of him from outside his kitchen window and would use them as evidence to arrest him. The Ambulance records state: "*pt states he wanted to kill himself as he thinks he may be going to gaol"*[8].

During his admission he was seen by Dr Lal, psychiatrist, who noted:

"at present not suicidal, but unsure of his safety. Took overdose as he believed that police would come and get him as he was masturbating in his home. Describes paranoid feelings for 2-3 weeks regarding the issue. Believes people have been watching him do that and everyone around him is wanting to bust him. He thinks he is under surveillance. But his belief is not to delusional extent"[9].

[4] Exhibit 2, Tab 3, paragraph 7;
[5] Exhibit 2, Tab 4, paragraph 15;
[6] Exhibit 4 – Medical Records – Liverpool Hospital under Hospital Notes for 22nd Admission
[7] Exhibit 4 Ibid
[8] Exhibit 4 Ibid
[9] Exhibit 4 Ibid

Adam was discharged the same day with his mother to pick him up. He was referred to the COMHET team for home visits within 24 hours. Dr Lal reviewed Adam again on 11 March 2009 as an outpatient and wrote, *'still a bit paranoid but is not going to act on his feelings'.*[10]

In June 2009, Adam was admitted to Blacktown Hospital ICU for an overdose of Seroquel[11]. He was found only about 24 hours after he ingested the overdose and most likely would have died had he not been discovered at the time.

Dr Phipps made a note on 16 June 2009 after a case review with Dr Byrne and Patrick Parker the community manager where it was agreed that given Adam's history that he was a *'very high risk of suicide'*[12].

It was also noted that

"it was agreed that given Adam's history, a 'traditional' case management and acute admission approach to treatment is not ideal and likely to lead to increased risk of suicide through reinforcement of self-harm behaviours and a decreased emphasis on Adam using his own mechanisms and strategies to cope"[13].

In July 2009, Adam attended a 4 week residential drug and alcohol program at Rozelle. According to Dr Phipps his mental state as a result of his attendance in this program appeared to have improved dramatically. Over the two weeks after his discharge Dr Phipps's notes reveal that "*his mood was euthymic, he engaged well in therapy and he was positive about the future*"[14].

However, on 14th August 2009 Adam was again brought into the Emergency Department as a result of another overdose. A mental health Assessment was conducted where it was recorded in the Section titled "History of Presenting Problem:"

"*He was brought into ED after he took an impulsive overdose. …I felt a bit low yesterday", "I don't know why". "I was stupid". I won't do it again. It is just one of*

[10] Ibid
[11] Report of Dr Guiffrida dated 9.12.13 at page 3.
[12] Ibid at page 4.
[13] Ibid
[14] Exhibit 2 Tab 3 at paragraph 8.

those days. He reported his mood to be good for the last few weeks. Energy levels good. Denied any suicidal intentions or thoughts of self harm".[15]

The records also indicate that Adam denied any auditory hallucinations and had no evidence of any psychotic symptoms. I note however, the ambulance records record that the overdose was in relation to a '*suicide attempt'.*[16] Adam discharged the following day.

On 10 September 2009, Adam was brought into the Emergency Department by Ambulance after taking an overdose of Clonidine tablets. The ambulance records indicate that the overdose was taken as part of a suicide attempt[17]. However, the Mental Health Review document that was completed on that same date, by Dr Nagesh, psychiatric registrar, stated that Adam *"denied any suicidal ideations or thoughts of self harm at the moment"*. It also recorded that "*Adam denied any hallucinations and had no evidence again of any psychotic symptoms and he had last seen Dr Phipps in the community today*"[18].

On 11 September 2009, Dr Phipps received a phone call from Mrs Hayward who advised him that Adam had taken an overdose of blood pressure medication the previous night and had presented to the Emergency Department of Liverpool Hospital and had been sent home after being assessed[19]. Dr Phipps' notes indicate that he then spoke to Adam who was '*voicing ideas of intention to suicide'* saying' *"I'm going to do it eventually, I don't trust myself"*[20].

A Mental Health Review was conducted on 11 September 2009, by Dr Nagish and discussed with Dr Pai, the plan was recorded as:

1. *To be discharged home*
2. *Follow up by COMHET*
3. *Needs to be medically stabilised before discharge*

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[15] Exhibit 4 – Medical Records – Liverpool Hospital recorded in Emergency Department Notes.
[16] Exhibit 4.
[17] Exhibit 4
[18] Exhibit 4 – Mental Health Review Assessment Sheet for 10.09.09.
[19] Exhibit 2 Report of Dr Michael Giuffrida dated 9.12.13 at page 4.
[20] Ibid

4. *Continue current medication.*[21]

There was a COMHET visit that evening by Ms Marine GUTIERREZ where it was noted that Adam repeated his chronic suicidal ideation. Adam told the attending nurses that *"when suicidal thoughts come they are intrusive and strong to the extent that he could not possibly control it"*[22]. He also reported that this time was '*different*' as the suicidal thoughts just come out of the blue'[23].

On 15 September 2009 he was accepted into the GROW residential drug and alcohol rehabilitation program which was a non-government residential drug and alcohol rehabilitation service. This program was tailored for people with dual mental health and drug and alcohol diagnosis. Unfortunately, after an incident involving an allegation of Adam throwing a chair at a window because of a dispute relating to his friendship with a female called Monique, Adam was asked to leave the program on 11 October 2009.

Thereafter, on 12 October 2009, Adam again attended Liverpool Hospital after taking another overdose. Adam was admitted to PECC and a mental health review was completed by Clinical Nurse Consultant ("**CNC**") Helmut Obmann who recorded:

"has been in GROW rehab until yesterday got to know another resident – Monique – budding relationship, had an argument with Monique yesterday (was jealous because he thought she was looking at other blokes) got angry threw a table smashing a window). Eviction from GROW, got home and took an OD of Olanzapine and Fluoxeine. Did not tell anyone, mother checked on him in am found him semi conscious"[24].

It was also recorded that "he was not psychotic, denies current suicidal thoughts, wants to go home, orientated to person place time"[25].

After obtaining Adam's history CNC Obmann conducted an assessment of his current risk of suicide. He noted that whilst Adam had a significant past history or

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[21] Exhibit 4 under Document NSW Health – Mental Health Review page 2 under Section "Action Plan Following Review" dated 11.09.09

[22] Exhibit 2 Report of Dr Guiffrida dated 9.12.13 at page 4.

[23] Ibid.

[24] Exhibit 2, Tab 10, paragraph 14;

[25] Ibid at paragraph 15;

risk, he did not have any recent thoughts, plans or symptoms indicating an active risk of suicide. On this basis he assessed Adam's risk of suicide as 'low'.

Adam was kept overnight and seen by Dr Sujaya Sringeri, Staff Specialist Psychiatrist on Tuesday 13 October 2009 at PECC. During that review Adam denied any suicidal or homicidal ideations. It was recorded also that he had no perceptual abnormality. Adam was discharged that same day with a plan for follow up with COMHET and his GP.

According to the evidence of Mrs Hayward, she and her husband picked Adam up from the hospital and returned him to their house. She noted that whilst Adam was in the car he was very agitated and had indicated that he felt the hospital was not taking him seriously and would not take any notice of him.

Dr Phipps' evidence was that he phoned Adam at home on the Tuesday and Adam stated he had his children with him, and wished to see Dr Phipps on the 20 October 2009 as he would have his children with him till the 19 October 2009. Dr Phipps agreed to this plan.

On 14 October 2009, Adam re-presented to Liverpool Hospital with Suicidal Ideation. The triage document stated:

"*Discharged from hospital yesterday following OD, now feels he wants to do the same. Plans to take Zyprexia and Prozac, (Diagnosed with Depression and Schizophrenia. Pt quietly spoken good eye contact, nervous*"[26].

Adam's mental health review conducted during the course of this presentation recorded his suicide risk as *'medium'.*[27]

On 15th October 2009, a family meeting was conducted at Liverpool Hospital. In attendance was Dr Phipps, Dr Dipti Harne, Registrar, and Adam's parents. It was at this meeting that Adam's treating doctors attempted to explain to Adam's parents his treatment plan namely to continue the psychotherapy and for his medication to be administered weekly. It was also to work towards re admission to the drug and alcohol rehabilitation service at GROW or to provide a trial of dialectical behaviour

[26] Exhibit 4 Medical Records – Liverpool Hospital under 25th Admission.
[27] Ibid.

therapy, although Dr Phipps expressed concerns as to Adams ability to engage with the required level of homework.

On 16th October 2009, Adam was reviewed again by Dr Sringeri who recorded that:

"Adam reported that he has been having low mood and not confident about the safety'. Reported constant low mood and worsened – triggered by an incident at GROW." [28]

The Plan was recorded as:

"continue Olanzapine – stop Fluoxetine and commence Duloxiline 60mg mane from tomorrow. He also recorded PECC only admission as the plan was to avoid lengthy and unhelpful admissions of patients with personality disorders, and those who present frequently with deliberate self harm or have self harm ideas"[29].

Adam was discharged from PECC on the 19th October 2009.

On that date he was again seen by Dr Sringeri. He noted that Adam had denied having any self harm ideas. The plan was for him to be discharged that day with a review by COMHET in one week and to continue the same medications.

According to Mrs Hayward, she attended the PECC unit on 19 October 2009 and had a meeting with one of the Doctors and Dr Phipps. It is not entirely clear what time this meeting occurred as the hospital records indicate that Adam was brought back to hospital by Ambulance at 4.55pm hours after another attempted suicide.

It was at this meeting that Mrs Hayward indicates that she and her husband voiced their concerns that they weren't getting anywhere and Adam needed help desperately. Her evidence was that Dr Phipps stated that in his opinion keeping Adam in hospital was of no benefit to Adam. She indicated that Adam left the room very upset and annoyed but returned a short time later and confronted her husband, Gordon and said, *"if you let me out, the first opportunity I get, I am going to commit suicide'.* Accordingly it was agreed to keep Adam overnight and reassess him the next day.

On 20 October 2009, Adam was assessed by CNC Mark Short whose notes of that assessment record:

[28] Exhibit 2, Tab 14 paragraph 16;
[29] Ibid.

"this 33 year old male was discharged from PECC. He states he thought he was ok however once home he felt he could not bear living. Had been in GROW and developed a 1 month relationship. He observed her talking to another male and became angry – smashing a window. This resulted in her ending the relationship and he was evicted from GROW. He states he wanted to die however he became too ill and called the Ambulance. He does describe ambivalence at that time however now regrets not dying and has ongoing ideation. He describes feeling inadequate rather than obsessed about the relationship. He presents as having not adjusted to the joint losses – GROW and girlfriend' Requesting Admission" [30] .

On 21 October 2009, Adam was reviewed by Dr Bryne and Dr Phipps. In Dr Byrne's statement she notes that:

"Adam reported feeling much brighter. He was future orientated and optimistic. There was no evidence of low mood or psychotic symptoms. He described becoming pre occupied with thoughts to overdose at times. The use of distraction techniques, which he found useful in the past was encouraged. He talked of how his abstinence from drug use had left a hole in his life as his daily routine had revolved around procuring and using drugs. He denied having relapsed to abusing illicit drugs or alcohol since leaving GROW and having the intention to return to GROW when his 3 months stand down was over"[31].

In her report dated 21 October 2009 Dr Byrne stated that

"today he describes experiencing periods of low mood and hopelessness in the context of feelings of loss and disappointment over the relationship. He was disappointed to have had no contact letters from the woman since he left GROW and he feels he has scared her off by his behaviour. He feels lonely at home alone and becomes preoccupied with thoughts of overdosing. At other times when occupied or in company he feels better and his mood is euthymic" [32]

Adam was discharged on that date.

On 22 October 2009, Adam contacts Trang Le from COMHET and states, that he is feeling suicidal and plans to take an overdose, not feeling safe at home and was not able to guarantee his safety would like to go to Hospital'. He was brought to the hospital by his worker from New Horizon's Ms Tamar Adamson.

Adam was assessed by CNC Obmann from PECC who records the following:

[30] Exhibit 2 Tab 11 at para 8;
[31] Exhibit 2, Tab 4, paragraph 29;
[32] Exhibit 2 Tab 7

"returned to hospital due to increased suicidal thoughts, worried that he is now considering 'hanging himself' an idea that apparently is new for him – unable to guarantee safety when at home but feels safe in hospital"[33]

Furthermore he assessed Adam's risk of suicide as *'medium'* given his history of self harm

Following that review Adam was discharged from the medical ward and accompanied home by a New Horizons support worker.

That same afternoon Adam is assessed by Dr Byrne and Phipps in Emergency Department. Dr Byrne's notes record that:

"*Adam discussed waking early 5am with low mood and suicidal thinking since discharged yesterday following OD. She also notes 'unable to identify clear triggers to current thoughts but ongoing distress over GROW / female no contact & loneliness. Also contacted parents this morning mother attending Dr's appointments today and he felt parents busy and not time for him – felt unable to go home. Stated couldn't go to my parent for support so came here. Early in interview questioned my intentions to admit him to PECC and stated what do I have to do to get admitted if I go home I will just overdose to get admitted.*

Explained our feeling that admitting over past number days have not assisted his managing his distress and that he would still have to go home eventually and manage alone. Unable to identify why he wanted admission / PECC. Clearly acknowledged it could not keep him safe as he came and went / smoked outside'. Eventually Adam requested to phone parents to pick him up and Andrew had phone conversation with parents explaining situation.

Adam able to reflect that he wanted to spend time at parents but that if he remained negative and marose it would only increase their distress and anxiety and make them more reluctant to have him around still intends to return to GROW in 3 months. On discharge he was more positive and agreed to attempt to use strategies to distract from distress – spending time with parents. He intends to attend appointment on Wednesday with Andrew and is keen for Andrew to meet with him and parents also next week to (indeciperhable) ways of offering support". [34]

His mother, Mrs Hayward stated that she received a call from Adam advising that they were not going to keep him overnight. Mrs Hayward asked to speak to the Doctors and spoke to Dr Phipps. She said she strongly expressed her fear and concerns that if Adam wasn't admitted he would go home and suicide. She said she

[33] Exhibit 2 Tab 10, paragraph 19;

[34] Exhibit 4 – under Progress Notes for 22.10.09 completed by Dr Byrne.

became extremely upset that she was not being taken seriously and handed the phone to her husband. Gordon collected Adam from hospital and after dinner took him back to his unit.

On Friday 23 October 2009, his mother picked Adam up at 9am and brought him back to her house for the day. According to her the whole day Adam was extremely depressed and spoke of overdose and even mentioned trying to 'hang himself'. Adam asked to be taken home early about 3pm which his parents did.

Again on Saturday 24 October 2009, Adam was picked up from his unit and taken for a ride to Quaker's Hill and after doing this he asked his parents to take him home early to his unit which they again did.

I note that on this date a COMHET visit was not conducted due to other priority workloads that day.

On 25 October 2009, Mrs Hayward tried to contact Adam by phone without success. A visit was also conducted that day by COMHET who rang Adam's doorbell but there was no response. A calling card was left in an envelope in his letterbox to let him know that they had visited.

As we all know Adam was found deceased in his apartment on 26 October 2009.

A coroner's function is to attempt to answer five questions namely, who died? When did he or she die? Where did he or she die? What was the cause of death? And finally, what was the manner of death? The cause of death is the immediate physical cause. The manner of death refers to a way a person dies, including the surrounding circumstances. A coroner may also make recommendations concerning public health or safety issues arising out of the death in question.

In relation to Adam's death there is no issue in relation to the identity, date, place or direct cause of his death. The sole issues to be determined by this inquest are in relation to the manner of Adam's death arising out of the surrounding circumstances, namely:

1. Was the principal diagnosis of Adam correct namely that he suffered from Borderline Personality Disorder as opposed to schizophrenia?

2. Was the care and treatment of Adam appropriate and in particular should he have been discharged from Liverpool Hospital on 13, 19, 21 & 22 October 2009? And

3. Did Adam take his own life?

I will deal with each of these issues in turn.

Was the principal diagnosis of Adam correct namely that he suffered from Borderline Personality Disorder as opposed to schizophrenia?

This Inquest obtained two expert reports from Dr Michael Guiffrida, consultant psychiatrist in relation to the care and treatment received by Adam up until the time of death from Liverpool Hospital[35].

In relation to Adam's primary diagnosis, Dr Guiffrida's findings can be summarised as follows:

i. Adam's original diagnosis of Schizophrenia was treated accordingly with a depot injectable antipsychotic and case managed for that in the community;

ii. Adam suffered from a very long standing poly substance abuse problem and probable dependence on a number of substances including over the counter remedies containing codeine for which he was ultimately put on the methadone maintenance program. Adam also used amphetamines and cannabis together with apparently illicitly obtained benzodiazepines;

iii. He did not disagree with the diagnosis of an Emotionally Unstable Character Disorder Borderline type, although that did not eliminate the diagnosis of schizophrenia as the two may co-exist. He did believe that Adam's emotional instability was more likely a symptom and function of his underlying continuing schizophrenic illness;

iv. He noted that in Adam's subsequent medical records after 2006 that the diagnosis of schizophrenia disappeared and was replaced with the

[35] Exhibit 2 Tab 18-19 respectively.

personality disorder. He did not believe that such a diagnosis simply goes into remission not to ever reappear;

A report was also prepared by Dr Matthew Large, psychiatrist [36] in response to the reports by Dr Guiffrida. His evidence can be summarised follows:

a) Adam's neuropsychological assessment which found substantial deficits in his verbal memory are more typical of alcohol related brain impairments than of schizophrenia – in his view schizophrenia typically causes more generalised deficits and frontal lobe impairment;

b) He agreed with the diagnosis of poly substance abuse / dependence;

c) He also agreed with the diagnosis of Borderline Personality Disorder. Ada had a pervasive pattern of instability in interpersonal relationships and mood, and his clinical presentation was dominated by central features of Borderline Personality Disorder including impulsiveness in several areas of his life, affective instability, intense angry feelings and recurrent self-harm;

d) He did not agree that Adam exhibited signs of schizophrenia after 2006. He believed Adam way prone to psychosis due to ongoing substance use and his personality disorder. He remained on antipsychotic medication appropriate to his vulnerability after 2006;

Both Dr Guiffrida and Dr Large accepted the description of borderline personality disorder as outlined in the NICE Guidline on Treatment and Management the National Clinical Practice Guideline published by the British Psychological Society and The Royal College of Psychiatrists which described

" a consistent pattern of functioning and behaviour characterised by instability and reflecting a disturbed psychological self-organisation.. and included striking fluctuations from periods of confidence to times of absolute despair, markedly unstable self-image, rapid changes in mood, with fears of abandonment and rejection, and a strong tendency towards suicidal thinking and self harm. Transient psychotic symptoms, including brief delusions and hallucinations, may also be present."[37]

[36] Exhibit 2 Tab 19
[37] Exhibit 9.

I had the benefit of hearing the evidence of both experts at the same time in the witness box We could therefore have a full and frank discussion of the evidence that was presented to the inquest and how it ultimately effected their respective conclusions. Ultimately, Dr Guiffrida agreed in evidence that the reported delusions and hallucinations could result from drug induced psychosis and that such symptoms may also appear in persons suffering from borderline personality disorder.

Moreover, Adam's treating psychiatrists namely, Doctors Byrne and Cross, who are both experienced clinicians and who both treated Adam over extended periods did not agree with this initial diagnosis of schizophrenia.

Accordingly, on the balance of probabilities, I am satisfied the diagnosis of a borderline personality disorder was appropriate.

Was the care and treatment of Adam appropriate and in particular should he have been discharged from Liverpool Hospital on 13, 19, 21 & 22 October 2009?

I agree with the submission made by my Advocate Assisting, Mr Kelly, that in looking at the care and treatment provided to Adam by Liverpool Hospital and associated health agencies, that it be considered as whole and the focus not simply be placed upon the final week of Adam's tragically short life.

Both independent experts in this case, namely Dr Guiffrida and Dr Large, acknowledged that Adam received very good care and treatment and that he was not neglected. It was clear to me, from the evidence provided, particularly by Dr Phipps and Dr Cross, that they clearly cared about him and would have taken all necessary steps to avoid the outcome that ultimately occurred that weekend of 24 October 2009 if it could have been predicted. It is the very unpredictability of the behaviour and/or actions of those with Adam's diagnoses that makes treatment so difficult.

Having accepted that the diagnosis of borderline personality disorder was accurate, I accept that the treatment guidelines for such a patient as Adam is as set out in the NICE guidelines (and Paris and Krawitz articles referred to by Dr Phipps) which endorses the expert consensus view that impatient stays ought to be brief and focused on crisis management, with no evidence that long term hospitalisation is an effective treatment for this condition. Treatment for this condition is focused principally on psychological interventions including the use of cognitive behavioural therapy, amongst others, but inclusive of humanistic and integrative psychotherapies.

When Adam was discharged on 22 October 2009 he had ceased expressing suicidal thoughts or ideation. The evidence of both Dr Byrne and Dr Phipps was clear that they would have most likely have "admitted" Adam if he was still expressing such thoughts. I accept the evidence that the treatment plan was not to allow admission but to minimise it and this was an appropriate plan for the reasons set out above.

Accordingly I am satisfied on the balance of probabilities that the care and treatment was appropriate in the circumstances.

Did Adam take his own life?

It is generally accepted that a coroner should apply the *Briginshaw*[38] standard before making a finding of suicide.

In *Neat Holdings Pty Ltd v Karajan Holdings Pty Ltd*[39], Mason CJ, Brennan, Deane and Gaudron JJ reviewed the authorities to provide a clear statement of the Briginshaw principle:

"The ordinary standard of proof required of a party who bears the onus in civil litigation in this country is proof on the balance of probabilities. That remains so even where the matter to be proved involves criminal conduct or fraud. On the other hand, the strength of the evidence necessary to establish a fact or facts on the

[38] Briginshaw v. Briginshaw (1938) 60 CLR 336
[39] (1992) 110 ALR 449

balance of probabilities may vary according to the nature of what it is sought to prove. Thus, authoritative statements have often been made to the effect that clear or cogent or strict proof is necessary 'where so serious a matter as fraud is to be found'. Statements to that effect should not, however, be understood as directed to the standard of proof. Rather, they should be understood as merely reflecting a conventional perception that members of our society do not ordinarily engage in fraudulent or criminal conduct and a judicial approach that a court should not lightly make a finding that, on the balance of probabilities, a party to civil litigation has been guilty of such conduct."[40]

There is clearly no issue that Adam took the drugs that ultimately claimed his life nor that he was expressing suicidal thoughts as recently as the week prior to his death. There is no evidence that the overdose which led to his death was an attempt to get "high" or was a reckless act not caring as to whether it would result in his death or a deliberate attempt at suicide. Adam had taken a number of overdoses in the past and survived on those prior occasions. Some of those occasions he advised treating medical staff that the overdose was not an attempt at suicide[41]. In the absence of clear evidence of an intention at the time to take his own life, and given evidence of prior overdoses without suicidal intent, I am not satisfied to the requisite standard as set out in *Briginshaw*, that Adam took his life.

Conclusion

This was a very sad case. Adam was a young man with four young children when he died. It was evident from the evidence before this inquest that he had many lovely qualities and attributes and had a good relationship with all his treating doctors who were clearly moved by his death.

His parents Betty and Gordon Hayward, never gave up on their son despite his complex mental health history and sought advocate for him even after his death.

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[40] Ibid at

[41] Exhibit 2 Report of Dr Guiffrida dated 9.12.13 on page 2. Refers to Chronic and Complex Care Plan Meeting which states, 'consumer states doesn't want to change. Enjoys drinking and the effect he gets from overdosing'. See also Mental Health Assessment conducted on 14.08.09 re section titled "History of Presenting Problem" where it was recorded that Mr Hayward denied any suicidal intentions after presenting due to overdose.

The experts in this case agreed that a patient like Adam is very difficult to manage as risk of suicide was always ever present. Despite the complexity of his condition the files pertaining to the treatment of Adam reveal that his treatment was caring, committed and dedicated and ultimately was well coordinated and comprehensive.

I now turn to the formal findings I am required to make pursuant to s81 of the Coroners Act 2009

I find that Adam Hayward died between 24th and 26th October 2009 at Unit 52, 10 Woodward Crescent, Millar from Multi drug toxicity as a result of misadventure.

For the reasons set out in these findings I decline to make any recommendations.

9 May 2014

Magistrate Sharon Freund
Deputy State Coroner