CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of TE
Hearing date:	30 January – 1 February 2023; 8 May 2023; and 14 – 15 June 2023
Date of findings:	11 September 2023
Place of findings:	NSW Coroners Court Lidcombe
Findings of:	Magistrate Elizabeth Ryan, Deputy State Coroner
Catchwords:	CORONIAL LAW – death as result of fall from height – deceased person suffering from borderline personality disorder - was it appropriate for person to be discharged from Royal North Shore Hospital – was care provided by psychologist appropriate.
File number:	2020/00231668
Representation:	Counsel Assisting the Inquest: D Ward of Senior Counsel and James Herrington of the NSW Crown Solicitor's Office i/b the NSW Crown Solicitor. The Commissioner, NSW Police: G Johnson of Counsel i/b Office of General Counsel, New South Wales Police Force. Northern Sydney Local Health District: P Rooney ib Makinson d'Apice Lawyers. Elizabeth Neal: D Dinnen of Counsel i/b DLA Piper. Dr Christopher Sulaksono: S Barnes of Counsel i/b Avant. Dr Kathryn Drew: B Epstein of Counsel i/b Meridian Lawyers.

Non publication orders	Non-publication orders made on 30 January 2023 prohibit the publication of certain evidence as well as various persons' personal information, have been made. The orders can be obtained on application to the Coroners Court registry. Pursuant to section 75 of the *Coroners Act 2009* (NSW) I direct that there be no publication of any matter (including the publication of any photograph or pictorial representation) that identifies the deceased person (anonymised as TE) and the deceased persons' relatives as that term is defined in section 75(3).
Findings	**Identity** The person who died is TE. **Date of death**: TE died on 7 August 2020. **Place of death**: TE died in the area below The Gap Bluff, Watson's Bay NSW **Cause of death:** TE died as a result of multiple blunt force injuries. A significant contributing condition was pregabalin toxicity. **Manner of death:** TE's death was the result of a fall from a height, carried out with the intention of taking her own life.
Recommendation	N/A

Section 81(1) of the *Coroners Act 2009* (NSW) [the Act] requires that when an inquest is held, the Coroner must record in writing his or her findings as to various aspects of the death.

These are the findings of an inquest into the death of TE.

Contents

Introduction

1. On the morning of 7 August 2020, TE aged 26 years took her life at The Gap Bluff at Watson's Bay, Sydney.

2. TE struggled with the complex mental health condition of borderline personality disorder. Chronic suicidality is a prominent feature of this condition, and sadly this was the case with TE.

3. TE was born on 27 October 1993, the second daughter of NP and AE. Her parents separated in her early childhood, and TE and her older sister continued to live with their mother. For many years TE had only sporadic contact with her father, but they reconnected a few years prior to her death and then saw each other regularly.

4. In the year 2018 TE commenced work as a purchaser at a construction materials company, where she was highly regarded. She continued in this work up until her death.

5. When she was about twenty years of age TE started to show signs of anxiety. Her mother was distressed to hear her say that she intended to take her own life in the next five or six years. TE was not willing to talk any further with her mother about this.

6. In November 2017 TE commenced therapy with registered psychologist Ms Elizabeth Neal. For reasons which were examined at the inquest, this therapeutic relationship became fraught with difficulties, and by September 2018 TE was receiving therapy from clinical psychologist Ms Courtney Smith. In February 2020 this relationship too came to an end.

7. Early on the morning of 6 August 2020 TE left home and travelled to The Gap, a well known area of Sydney's eastern coastline. She climbed over the fence at the cliff edge of The Gap Bluff, then rang emergency services to say that she intended to take her own life.

8. Police officers were quickly on the scene, and there followed many hours of attempts to persuade TE not to jump. Eventually a police officer was able to restrain her, and she was taken to Royal North Shore Hospital for assessment. However, she was discharged that evening.

9. Early the next morning TE returned to the cliffs of The Gap Bluff. This time, despite many hours of patient negotiation, police officers were not able to save her. Throughout the morning TE had been ingesting large amounts of prescribed medication and she was becoming noticeably drowsy and weak. At around midday she managed to roll her body over the cliff edge, and she fell to her death.

10. TE's mother and her sister attended each day of the inquest, and TE's father was also present by means of AVL. They cared deeply about TE, and the evidence at the inquest must have been immensely painful for them.

11. At the close of the evidence NP spoke lovingly of her daughter, of her reflectiveness, her intelligence, and her love of animals. She told the court that it was an honour to have been TE's mother, and that she and A missed her every day.

The issues at the inquest

12. There was no dispute as to the cause of TE's death. Forensic pathologist Dr Dianne Little concluded that TE had died from multiple blunt force injuries. As a result of the fall, she had suffered unsurviveable head and abdominal injuries, and numerous fractures.

13. Dr Little found that a significant contributing condition to TE's death was pregabalin toxicity. This medication is prescribed for nerve pain. It was present in TE's blood at a level within the reported toxic range. Dr Little considered that its effects of dizziness, confusion and somnolence could explain TE's appearance of drowsiness, noted by police on both days at The Gap Bluff.

14. The inquest examined the following issues:

    - The complexities involved in TE's mental health presentation
    - Whether the police response to TE's attendance at The Gap Bluff on 6 and 7 August 2020 was appropriate
    - The nature and adequacy of care provided by the Royal North Shore Hospital, and in particular, whether it was appropriate to discharge TE on 6 August 2020
    - The nature and adequacy of psychological care provided by psychologist Elizabeth Neal
    - Whether any recommendations are necessary or desirable pursuant to s 82 of the Act.

15. The evidence included statements and records from involved police officers, members of TE's family, clinicians from Royal North Shore Hospital and from private psychology practices. Some of these individuals also gave oral evidence at the inquest.

16. The court was further assisted with reports and oral evidence from the following medical experts:

    - Dr Katie Seidler, clinical and forensic psychologist.
    - Associate Professor Sathya Rao, consultant psychiatrist; Executive Clinical Director of Spectrum, the Personality Disorder Service for Victoria; Vice President of the Australian Borderline Personality Disorder Foundation.

- Associate Professor Danny Sullivan, consultant forensic psychiatrist and former Executive Director of Clinical Services at the Victorian Institute of Forensic Mental Health.

- Professor Matthew Large, senior staff specialist at The Prince of Wales Hospital, and Clinical Director of the Eastern Suburbs Mental Health Service.

17. Turning now to the issues examined at the inquest, there is no controversy regarding the second-named issue, which is the police response at The Gap Bluff. I will address this issue before turning to the other issues.

The police response to TE's attendance at The Gap Bluff on 6 and 7 August 2020

18. On 6 and 7 August 2020 many police officers from general and specialist units were present with TE at The Gap Bluff. They tried very hard to save her life.

19. There can be no criticism of their conduct, and TE's death was in no way attributable to their actions. On the contrary, they are deserving of praise for their patience, dedication, and courage over those many hours. Senior Constable Ben Wright and Sergeant Michael Hood, in particular, risked their own personal safety at the edge of the cliff to try to save TE.

20. I wish to acknowledge the police officers who were involved with TE on 6 and 7 August 2020, the strenuous efforts they made to keep her safe, and the emotional toll which the tragic outcome must have taken on them.

The complexities involved in TE's mental health presentation.

21. The court heard evidence about the severity and complexity of TE's mental health condition. This evidence provides essential context to the task of evaluating the care she received from those who sought to help her

What is borderline personality disorder?

22. TE suffered the complex mental health condition of borderline personality disorder [BPD], and to a very severe degree.

23. The court heard expert information about this disorder from Dr Sathya Rao. Dr Rao is an acknowledged expert in the management of BPD, and he is strongly involved in the development of services to better manage it. He provided a report and gave oral evidence at the inquest.

24. Dr Rao has extensive experience treating patients like TE, whose personality disorder severely impacted almost every aspect of her day to day living. As with

many of Dr Rao's patients, the greatest impairment was to TE's interactions with her family and her therapists.

25. BPD is also known as 'Emotionally Unstable Personality Disorder'. Dr Rao explained that the Diagnostic and Statistical Manual of Mental Disorders [the DSM-5] defines it as *'a pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning by early adulthood, and present in a variety of contexts'.*

26. Having reviewed the medical evidence, Dr Rao was of the opinion that TE had many of the features listed in the DSM-5 as characteristic of patients with BPD. TE's behaviour displayed:

    - a longstanding pattern of unstable and hyper reactive emotions
    - frequent episodes of suicidal ideations and attempts
    - unstable interpersonal relationships
    - severe fear of abandonment and rejection
    - anger outbursts and impulsivity
    - chronic self-loathing
    - repeatedly feeling unworthy, unlikeable, undesirable, and hopeless
    - longstanding psychological distress and psychic pain.

27. Dr Rao considered that TE suffered from BPD to a very severe degree. He noted above all her tendency to form intense attachments, her extreme sensitivity to abandonment, and her *'excessive tendency to perceive rejection/invalidation'.*

28. In addition, Dr Rao noted that TE was probably dependent on benzodiazepines, excessive use of which may have severely disturbed her emotions and behaviour on 6 and 7 August 2020.

29. Dr Katie Seidler also has extensive experience working with people who suffer BPD. Dr Seidler assisted the inquest with two expert reports in which she reviewed the therapeutic treatment TE received from two psychologists, Ms Elizabeth Neal and Ms Courtney Smith. Dr Seidler also gave oral evidence at the inquest.

30. Based on her review of the materials, Dr Seidler agreed that the most appropriate diagnosis for TE was BPD. She described this condition as:

    ' ... an incredibly difficult condition to treat and typically requires a high level of motivation and engagement from the client, in addition to long term, highly structured and clearly boundaried treatment …'

31. In the first of her two expert reports Dr Seidler explained why '*clearly boundaried treatment'* is needed for many BPD clients:

    '.. The primary challenge in treating someone with BPD is the ongoing therapy-interfering behaviours, which may include boundary crossing, self-destructive behaviour, distorting the therapeutic relationship, emotional manipulation, high

levels of emotional neediness, excessive reassurance seeking, anger, aggression and resistance …'

32. Dr Rao concurred, commenting in his report that it was *'an intrinsic part of the disorder'* for patients with BPD to have difficulties adhering to boundaries in their interpersonal relationships, and that this *'often gets played out in therapeutic relationships with clinicians'.*

33. Dr Seidler eloquently described the dilemma which the symptoms of BPD create for those who seek therapeutic help for it:

    ' …their intense fear of abandonment and rejection often leads them to engage in a range of very difficult behaviours that can ultimately bring about the thing they fear the most, which is the breakdown of a significant relationship'.

34. As will be seen, these behaviours were very much present in TE's interactions with her psychologists. To her immense distress, they precipitated the breakdown of her therapeutic relationships with both Ms Neal and Ms Smith.

TE's mental health history

35. When she was about twenty years old TE started to show signs of anxiety, and to voice an intention to end her life.

36. As will be described, in late 2017 TE, of her own initiative, commenced seeing psychologist Ms Neal and later, Ms Smith. She also had brief hospital admissions in 2019 after making threats to take her own life.

37. As the year 2020 progressed, TE's behaviour became increasingly disordered and distressed. There were numerous crisis interventions by police and ambulance in response to her suicidal ideation and threats.

38. On 30 June 2020, TE took a highly lethal overdose of prescription medication, and she was taken in an unconscious state to Concord Repatriation General Hospital. There she received treatment in the Intensive Care Unit, then remained in the hospital's mental health unit until 3 July 2020. Significantly, when TE was reviewed prior to her discharge, her treating team recorded the following:

    '*Her increasing expressions of distress and actively suicidal behaviours over the past two years appear to have been precipitated following engagement in and subsequent termination of therapy by private psychologists. She described this to have been a very traumatic experience for her, and has struggled to cope with subsequent feelings of betrayal, abandonment and devaluation'.*

39. Of significance to later events, on many occasions TE expressed to her treating team that acute mental health admissions had not been helpful for her in the past, describing these as '*traumatic', 'confining'* and *'punitive'*. TE's very negative response to hospital admission was one of the reasons why her treatment team decided against a longer admission:

'In this context, admission would likely worsen her relationship to medical and psychiatric services, making her less likely to engage with treatment or self-present if needed in the future'.

40. TE was therefore discharged on 3 July 2020 into the care of the Ryde Community Mental Health Team. Unfortunately, she did not engage with their clinicians or their services either.

41. This brief outline gives some indication of the complexity and severity of TE's condition, highlighting on the one hand her very high levels of distress and on the other, her unwillingness and perhaps inability to work with those who may have been able to help her.

42. It also provides context to the two key issues examined at the inquest. These were the appropriateness of the decision to discharge TE from Royal North Shore Hospital on 6 August 2020, and the nature and adequacy of care provided by TE's psychologist Ms Elizabeth Neal.

43. I will now turn to the events which took place when TE was taken to Royal North Shore Hospital [RNSH], and the care which was provided to her there.

The decision to discharge TE on 6 August 2020

TE's attendance at Royal North Shore Hospital

44. There is little dispute as to the following facts.

45. Once police had managed to physically restrain TE and bring her away from the cliff edge, she was taken by ambulance to the Emergency Department [the ED] of RNSH. She arrived there shortly after 1.00pm.

46. During the ambulance trip TE told the accompanying police officers: *'I don't know why you guys are doing this, as soon as I get out of hospital I'm going to go back there and jump anyway. I won't tell anyone'.*

47. Two police officers completed a section 22 form under the *Mental Health Act 2007,* which they gave to hospital staff. In this form they recounted that over a period of six hours at The Gap Bluff TE had consumed medication while making threats to jump over the cliff, that she had been forcibly restrained from jumping, and that she had stated to police that she intended to return to The Gap *'the second I leave hospital'*.

48. The police narrative concluded*: 'Police believe threat of suicide to be valid and to be taken very seriously'.*

49. During the time that she was in the ED TE was difficult for medical and nursing staff to manage. She was hostile, argumentative, and at times angry. She was also insistent on being discharged.

The psychiatric assessment of TE

50. At about 4.00pm that afternoon TE's mother learned that her daughter was at the hospital. She arrived shortly afterwards, to hear that TE did not want to see her. Police officers spoke with NP, urging her to insist that TE be admitted.

51. At hospital NP also spoke with a member of staff, who was most likely Registered Nurse Justin Newton. RN Newton was and is the Mental Health Clinical Nurse Consultant at RNSH's ED. NP asked him to do all he could to keep her daughter in hospital.

52. The progress notes prepared by CNC Newton reflect that NP expressed strong concern about TE and her own ability to manage her daughter's risk, asking that she be admitted to hospital *'even if for just one night'.*

53. At about 5.00pm NP had to return home to feed TE's dog.

54. Dr Christopher Sulaksono commenced his shift as psychiatric registrar at about that time. In this role he was responsible for the entire hospital, including its ED. He had phone access to Dr Kathryn Drew, who was the on call psychiatric consultant and Clinical Director of the North Shore Ryde Mental Health Service.

55. When Dr Sulaksono's shift commenced, TE was considered to be too drowsy to be assessed immediately, so Dr Sulaksono deferred his review until sometime after 6.00pm.

56. Dr Sulaksono prepared progress notes following his assessment of TE. He documented that TE had a previous diagnosis of BPD and *'multiple risky behaviours/suicide attempt'*. He noted her '*chronic abandonment sensitivity, personality vulnerabilities, poor distress tolerance'* and *'emotional dysregulation that predisposes her to chronic high risk'.*

57. Nevertheless, Dr Sulaksono did not consider that TE displayed any symptoms or signs of acute mental illness. Furthermore, when he questioned her about her current intentions, she told him she was not suicidal, had *'no active plan'*, and would engage with community care services. He noted that TE had given permission for hospital staff to speak with her family.

58. It seems likely that Dr Sulaksono had a phone conversation with NP while she was at home feeding TE's dog. Dr Sulaksono's notes record that TE's family *'supports her discharge and is confident of maintaining safety hygiene at home'.* I note that NP disputes having said this to any member of hospital staff, and I will return to this discrepancy later in these findings.

59. Additionally, in a statement which Dr Sulaksono provided for the inquest he said NP had informed him that TE's behaviour had changed only in the past three days. Dr Sulaksono stated that this information '*supports the notion of crisis rather than the presence of mental illness which would be prolonged and longer than three days'*.

60. Based on his assessment of TE, Dr Sulaksono thought that a hospital admission might be beneficial, because it would allow more time to review her state of mind and to develop a discharge plan based on more collaboration with her family. But he was left in no doubt that TE would not agree to his preferred option, which was a voluntary admission. TE was adamant that she wanted to be released.

61. Dr Sulaksono then considered the possibility of an involuntary admission under the *Mental Health Act 2007,* but he concluded that the grounds did not exist. At the inquest, he explained his reasons for this conclusion.

62. Dr Sulaksono readily agreed that TE's risk for suicide was high, and that she displayed traits of BPD. He was of course aware of the events at The Gap Bluff that day, although he did not appear to have known that police had had to forcibly remove her from the cliff edge. Nevertheless, he agreed in his evidence that TE had placed herself in a situation of very high personal risk.

63. However, TE had assured him that she had no present plan to take her own life. Dr Sulaksono was also aware that involuntary admission was often unhelpful for patients with BPD. He noted in respect of TE that '*acute inpatient admission can potentially do more harm than good'*, and that if admitted against her will it was likely she would need to be chemically restrained, with resultant trauma.

64. These features persuaded him that '*discharge with community support is consistent with patient's wishes and is the least restrictive form of care'*. Dr Sulaksono telephoned on call consultant Dr Drew and discussed his plan for TE's care.

65. In this telephone conversation Dr Drew agreed that an involuntary admission would not be in TE's best interests. At the inquest she explained that although this might have provided the opportunity to form a more comprehensive discharge plan, TE would most likely have had to be chemically sedated, a removal of her agency which would have distressed her greatly. This in turn would have reduced the likelihood that she would engage with therapeutic help in the future.

66. Dr Drew also told the inquest that the most effective treatment for patients with BPD was not care within an acute setting, but a long term form of therapy known as Dialectical Behaviour Therapy. This is only available within a community setting. This further persuaded her that an involuntary admission of TE was not appropriate.

67. Following this discussion, Dr Sulaksono documented a Treatment Plan as follows:

    'MSA lifted. Once medically cleared, can be discharged to the care of her mother. Follow up phone call by Ryde [Acute Care Team]'.

68. Dr Sulaksono then rang a contact within the Ryde Acute Care Team and asked that a team member make contact with TE, the next day if possible.

69. At some time between 7.00pm and 7.30pm NP received a phone call from TE, asking her to collect her as she was to be discharged home. NP returned to the

hospital, to find TE waiting outside the front entrance. According to NP, TE was adamant that her mother stay in the car and not go inside the hospital. She was agitated on the drive home, and went to bed without discussion.

70. The next morning NP told TE that she would stay at home with her, but TE insisted that she go to work. NP agreed, promising to come home at lunch time. But when she returned soon after midday, TE was not there.

71. NP rang 000, and received the terrible news from police that her daughter had died.

TE's assessment at RNSH: the expert evidence

72. TE's tragic death so soon after her discharge from hospital naturally raises the question whether it was appropriate for hospital staff to have discharged her from their care.

73. From the outset it must be acknowledged that the decision faced by Dr Sulaksono and Dr Drew was an extremely challenging one. This was emphasised by Dr Rao, Dr Large and Dr Sullivan, who gave expert evidence in conclave at the inquest.

74. On the one hand, TE suffered a serious personality disorder which was associated with chronic suicidality and was in her case complicated by substance misuse. She had been prevented from carrying out a highly lethal suicide attempt, and she had threatened to repeat the attempt as soon as she could. Furthermore, she was without the protection which might be afforded by community mental health treatment.

75. On the other hand, TE was emphatic that she did not wish to remain in hospital, and she insisted that previous admissions had not benefited her. There was good reason to expect that keeping her in hospital against her will would be traumatising for her.

76. The challenge which Dr Sulaksono and Dr Drew faced that evening was aptly summarised by Dr Sullivan in his report:

'For clinicians, these scenarios provide impossible contradictions and are very difficult to resolve'.

77. At the inquest Dr Rao and Dr Large concurred. I readily accept that this was a very difficult decision for those treating TE.

78. Nevertheless, the three expert witnesses did not agree that there was no clinical basis to involuntarily detain TE that night. I now examine their reasons.

79. First, the conclave disagreed with Dr Sulaksono's assessment that TE's actions at The Gap Bluff that day did not constitute a suicide attempt. Dr Sulaksono told the court that if he had thought they did, he would have been more ready to conclude that TE required an admission, even an involuntary one. In his opinion, however,

since she had not actually jumped from the cliff, the episode was one of suicidal ideation or suicide threat.

80. The conclave witnesses did not endorse this characterisation of TE's actions. In their unanimous opinion, the episode was a suicide attempt of the utmost seriousness, combining medication overdose with imminent physical harm. Dr Large added that given the potential lethality of TE's actions, whether they amounted to suicidal ideation, or an attempt, should not have affected the treatment decision.

81. Secondly, Dr Sulaksono's reliance on cross-sectional data in assessing TE's risk was the subject of comment by the expert witnesses. Dr Sulaksono was aware that TE had told police officers she intended to return to The Gap Bluff once she was released from hospital. But when he had asked TE what her present intention was, she had replied that she had no intention of killing herself.

82. In a similar vein, although Dr Sulaksono had not been aware of TE's June 2020 admission at Concord Hospital, which had been precipitated by a medication overdose, he did not think this would have altered his decision against an involuntary admission. The historical context, he said, was less relevant than TE's current presentation and intentions.

83. This also was his response to the information that when TE was discharged from Concord Hospital, she had disengaged from the community mental health services to which the hospital had referred her. Dr Sulaksono agreed that this indicated a possibility that she would not engage this time as well. However, this was not relevant to her risk for suicide, he said. Rather it would indicate a need for the Treatment Plan to include that TE's family be involved in encouraging her to work with community carers.

84. Dr Sulaksono's focus upon the circumstances of TE's *current* presentation was noted by the expert witnesses. Cross-sectional data of this kind was, they agreed, relevant to the assessment of a person's risk. But on the other hand, as observed by Dr Sullivan in his report:

    ' … there was information suggesting serious and sustained suicidal ideation, a predisposing condition associated with suicidal ideation, and increased risk of completed suicide … there were few protective factors which could be identified, and she was not linked to a treating clinician or service effectively.'

85. In a similar vein, Dr Rao noted:

    'The risk assessment appears to have relied heavily on cross sectional evaluation of risk, not taking into consideration the suicide attempt she had made earlier in the day with clear intent and plans.'

86. Dr Rao also queried Dr Sulaksono's conclusion, relevant to TE's level of risk, that she showed '*no indication of acute mental illness',* despite clinical practice guidelines which identify BPD as a mental illness.

87. These features led Dr Rao to opine that Dr Sulaksono's risk assessment:

' … did not demonstrate a sophisticated understanding of the difference between acute and chronic risk for suicide in people with BPD, and appropriate management strategies for risk mitigation'

88. As will be seen, underlying the above comment is Dr Rao's opinion that people who suffer severe BPD require a management plan which incorporates strategies both for acute and ongoing care. Commenting that such patients periodically suffer episodes of suicide crisis, he considered it was very likely that they would require brief periods of admission, even on an involuntary basis, to manage their risk at such times.

89. Additionally, Dr Rao was of the view that in deciding to discharge TE, Dr Sulaksono did not sufficiently consider what the impacts over the next several hours were likely to be for her. She had consumed large amounts of medication throughout the day, with consequent impairment of her cognitive ability and capacity to problem solve. There was a case, he said, for keeping her in hospital while these effects abated.

90. Dr Large agreed, commenting that in TE's case,

' … the presence of a concurrent overdose of benzodiazepines, particularly of diazepam that has a long half-life, complicated the discharge decision'.

91. For the above reasons, and contrary to the opinions of Dr Sulaksono and Dr Drew, the expert psychiatrists were of the view that there was a basis to involuntarily detain TE under the *Mental Health Act 2007*. Furthermore, it would have been both *'possible and reasonable'* to do so, to gain some control over her behaviour, to allow the medications she had taken to metabolise, and to develop a more effective treatment plan.

92. As a further matter, it did not escape the attention of Dr Rao and Dr Sullivan that NP was likely suffering a heavy burden of carer fatigue. They concurred that it would have been appropriate to consider her capacity to care for TE over the next 24 hours.

93. Dr Rao, Dr Large and Dr Sullivan are highly qualified and experienced in the assessment and management of people who suffer severe personality disorders. I accept their unanimous opinion that the circumstances of TE's presentation that evening did provide a basis for involuntary detention, contrary to the conclusion reached by Dr Sulaksono in consultation with Dr Drew.

94. I accept further their opinion that a period of involuntary detention would have provided an opportunity to develop a more comprehensive treatment plan for TE.

95. However, the conclusions I have reached need to be qualified with two related points.

96. First, the challenging nature of the decision which Dr Sulaksono faced that evening, and the finely balanced nature of its competing considerations, was fully acknowledged by the conclave witnesses. None of them suggested that Dr Sulaksono's ultimate decision to discharge TE was outside the boundaries of acceptable practice. I accept this opinion.

97. Secondly, none of the expert witnesses considered it likely that an involuntary detention that evening would have altered the tragic outcome for TE. In the words of Dr Sullivan, a hospital admission may only have delayed TE's completed suicide:

' .. in light of her resistance to treatment, the intractability of her distress, and the therapy-defeating behaviours she manifested which are a feature of BPD'.

98. For these reasons, I accept the closing submission of Counsel Assisting that it would not be appropriate to find that the decision of Dr Sulaksono and Dr Drew to discharge TE that night fell below standards of acceptable practice.

Interactions with NP

99. One further matter concerning TE's discharge from the RNSH needs to be considered.

100. I have mentioned a factual dispute arising out of the evidence of Dr Sulaksono and NP, concerning their interactions that evening.

101. Dr Sulaksono told the court that at some point between 5.00pm and 6.30pm he had a telephone discussion, first with NP and then with TE's sister. In his statement and oral evidence, Dr Sulaksono said that when he had such discussions with family, he would ordinarily provide advice about how to keep their person safe, should they be discharged home. He said NP had told him that she would be able to monitor TE and supervise her medications.

102. Dr Sulaksono did not make a direct record of his conversation with NP. However, it can be inferred from the content of his progress notes that he did speak with her that evening. In those notes he recorded that NP was '*protective, activated, and wants her daughter discharged into her care'.* NP was also '*confident of maintaining safety hygiene at home'*.

103. This account is at odds with that of NP. In her statement and in her evidence at the inquest she denied having told Dr Sulaksono or any hospital staff member that she wanted TE to be discharged into her care that night. Her evidence on this point receives some support in the progress notes of RN Justin Newton, which are referred to at paragraph 52 above. NP also stated that she had not received any advice as to the steps she should take to keep TE safe.

104. Further complicating the picture, at the inquest Dr Sulaksono told the court that his discussion with NP and A, referred to in paragraph 101 above, had taken place *prior to* his assessment of TE. It was, he said, in the nature of an advice to her family of what the possible options might be for her, and what was needed if she

was to be discharged home. He said that his subsequent decision to discharge TE would have been communicated to NP by another member of staff.

105. The hospital records support the conclusion that once it had been decided that TE was to be discharged, it was not Dr Sulaksono who communicated this decision to NP. This person was most likely the After Hours Nursing Unit Manager, RN Mohammed Saleem Sivalingam.

106. It appears that the manner in which the discharge decision was communicated to NP was less than ideal. NP clearly did not feel that she had been involved in discussions about how she should care for TE, nor what kind of treatment in the community was contemplated for TE and how her family might support this.

107. Each of the expert psychiatric witnesses were of the view that the advice to TE's family that she was to be discharged ought to have been given by the most senior clinician involved in that decision. They acknowledged, however, that this would not always be possible in a public hospital, particularly during after hours shifts.

108. I will now turn to the remaining issue, namely the adequacy of care provided by psychologist Ms Neal.

The therapeutic care and treatment provided by Elizabeth Neal

TE's engagement with Ms Neal

109. Registered psychologist Elizabeth Neal provided psychological services to TE from November 2017 to February 2019. Ms Neal was a sole practitioner who operated her practice from rooms in her home. Until she commenced work with TE her practice had largely been in couples therapy, with most clients referred to her by their General Practitioner.

110. TE, however, had located Ms Neal from an internet search, and she did not want her new therapist to discuss her presentation or treatment with any clinicians with whom she had previously been involved.

111. It is important to note from the outset that while Ms Neal was a patient and compassionate therapist, her training and experience did not equip her to provide the therapeutic support which a complex client like TE needed. This is a fact which Ms Neal herself came to realise.

112. At the inquest Dr Katie Seidler explained that as a registered psychologist working mainly in couples therapy, Ms Neal was unlikely to have had exposure to patients with BPD. Due to the complexity of this mental illness, it is more commonly treated by a clinical psychologist. This is because of the higher level of study, training and experience a psychologist must undertake in order to qualify as a clinical psychologist.

113. In their early sessions Ms Neal established that TE experienced feelings of anxiety, depression, and stress with social and work relationships. Ms Neal told the court that her treatment plan for TE was to assist her in dealing with these relationship challenges, and to understand the multiple perspectives present in a situation.

114. TE met with Ms Neal for therapy on average at least once per week, but by mid-June 2018 TE had become very demanding. She deluged Ms Neal with texts and emails at all hours of the day, detailing her feelings of intense anxiety and her demands for reassurance. She reacted with intense anger and distress, as well as threats of suicide, if her pleas for more consultations with Ms Neal were declined.

115. Ms Neal told the court that despite her attempts, TE was not interested in engaging in any processes of reflection on her behaviour. Nor would she make contact with the additional supports which Ms Neal recommended to her, such as Headspace and group therapy sessions.

116. Eventually Ms Neal came to see that while TE wanted the help of therapy, she was unable or unwilling to do the work needed to help address her difficulties.

117. At about this time Ms Neal also began to understand that TE was displaying traits of BPD. She noted her sensitivity to rejection, her inability to regulate intense anger, and the way she sought reassurance by making unreasonable demands on others.

118. Ms Neal discussed her therapeutic approach with peers in a meeting group. Following this she made it a condition that TE obtain the concurrent support of other therapists. In September 2018 TE commenced sessions with clinical psychologist Courtney Smith.

119. Increasingly feeling out of her depth and understanding that she could not provide the therapeutic support TE needed, Ms Neal decided that she must bring their professional relationship to a close. In December 2018 she tried to prepare TE for a suspension of their therapy while she (Ms Neal) entered a period of maternity leave.

120. Ms Neal sought the advice of a more senior psychologist on how to approach this withdrawal in a way which would cause the least pain for TE, but this was to no avail. TE reacted with aggression, bewilderment, and distress at her therapist's perceived abandonment of her. The intensity of these feelings persisted right up to the day she died.

121. Ms Neal's final session with TE took place on 6 June 2019. However, for many months afterwards TE continued to contact Ms Neal, describing her feelings of abandonment and worthlessness, and pleading with her to resume their therapy.

TE's engagement with Courtney Smith

122. TE commenced therapeutic sessions with psychologist Courtney Smith on 15 September 2018. Until February 2019 when Ms Neal commenced maternity leave, TE's sessions with Ms Smith overlapped with those of Ms Neal.

123. Courtney Smith is a clinical psychologist, and at that time she operated within a multi-clinician private practice. She was able to recognise at an early stage that TE had BPD. In contrast with Ms Neal, she swiftly set firm boundaries around TE's behaviour and communication with her.

124. TE's relationship with Ms Smith came to an end with Ms Smith's recognition that the private psychology practice within which she worked could not meet TE's acute mental health needs. These included escalating suicidal ideation, and an increase in the kind of behaviour with which Ms Neal had become familiar, namely frantic demands for more contact followed by suicide threats when these were not met.

125. Because of this, Ms Smith made it a condition of her continuing therapy that TE receive the concurrent support of other specialist services. These included psychiatric intervention, drug and alcohol counselling, and a program of Dialectical Behaviour Therapy. TE was unwilling to do so, interpreting these conditions as a sign that Ms Smith wanted to abandon her relationship with her.

126. On 19 February 2020 Ms Smith informed TE that she and her practice could not adequately address her needs, and that TE must seek support from other sources. Ms Smith offered to make these referrals for TE, and formally transferred her care to the Ryde Community Mental Health Team.

127. I can state at this point that on the basis of the evidence at the inquest, in particular that of Dr Seidler, I am able to find that the psychological treatment which Ms Smith provided to TE was entirely appropriate, and well within the standards of acceptable practice. Dr Seidler commented that Ms Smith had the training and experience to appreciate the complexity of TE's condition and the need to place clear boundaries around TE's interactions with her.

128. Dr Seidler noted with approval the following additional features of Ms Smith's therapeutic work with TE:

- she used evidence-based psychological treatments
- she regularly assessed TE's risk for suicide and her substance use
- she attempted (albeit unsuccessfully) to engage TE with other services such as drug and alcohol counselling, psychiatric overview, and community mental health.

129. Dr Seidler also found Ms Smith's record-keeping to have been of a good standard, with detailed and appropriate note-taking. Overall, she found Ms Smith's treatment in relation to TE to have been '*generally of a good standard'*.

Evidence of Dr Seidler regarding Ms Neal's psychological care

130. I have outlined, and I accept, the expert opinion of Dr Seidler that Ms Smith's assessment, treatment and management of TE was appropriate.

131. Dr Seidler was asked for her opinion as to the adequacy and appropriateness of the psychological care which Ms Neal provided to TE.

132. Dr Seidler readily acknowledged that Ms Neal was a patient and caring therapist. She was not critical that it took several months for Ms Neal to identify that TE had BPD. Ms Neal's failure to appreciate this at an earlier stage was *'… a function of her training and the lack of breadth of her clinical experience at the time',* rather than malpractice or misconduct on her part.

133. Dr Seidler also considered it appropriate that Ms Neal eventually decided to disengage from treating TE, when she recognised that her skills and experience were:

> ' … *insufficient to meet Ms [E's] needs and address the level, extent and type of her pathology'.*

134. However, Dr Seidler identified two areas of Ms Neal's approach which caused her concern.

135. The first was an inability to set appropriate boundaries to her therapeutic relationship with TE. Dr Seidler cited Ms Neal's willingness to allow TE to communicate with her in between sessions, her practice of disclosing personal information to TE, and an episode where she shared with her some photos of herself while on holiday.

136. Dr Seidler noted Ms Neal's rationale for such practices, being the desire to build trust and rapport with TE and to reassure her that she was willing to go *'above and beyond'* for her. Nevertheless, in Dr Seidler's opinion there were serious risks associated with these practices, in particular with clients with personality disorders. They allowed the client:

> *' … to personalise the relationship and distort and breach boundaries, as well as placing undue responsibility on the therapist for energising the change process rather than this being with the client'.*

137. Dr Rao shared this opinion, stating that:

> *' … holding boundaries and setting limits are important parts of the early stages of treatment for both the clinician and the person with BPD.'*

138. Dr Seidler acknowledged that Ms Neal lacked experience with the kinds of thinking that are common with people suffering BPD, and hence may not have appreciated the risks of using such practices with TE. Nevertheless, she said, all psychologists are expected to recognise the signs that a client is abusing their boundaries.

139. At the inquest Ms Neal acknowledged that in hindsight some of her approaches had been inappropriate, and were open to be misinterpreted by TE as an offer of friendship. She had also not realised at the time that self disclosure practices were not recommended for clients with BPD.

140. The second deficiency identified by Dr Seidler was Ms Neal's failure to maintain appropriate records in relation to her work with TE. Dr Seidler had examined Ms Neal's files, and reported as follows:

'There are no notes at all for some sessions, the session notes for the majority of sessions contained in the file are brief, there is little to no reference to risk, clinical assessment, therapeutic strategies or Ms Neal's concerns about the utility of treatment.'

141. In short, Ms Neal's clinical record of her work with TE was '*woefully inadequate in relation to professional guidelines and standards'.* Her notes were so sparse that it had been impossible for Dr Seidler to identify what therapeutic work Ms Neal had actually carried out with TE.

142. Nor was Dr Seidler satisfied with Ms Neal's explanation for her scanty records, namely that she had felt able to rely on her memory of what was discussed in her sessions with TE. Dr Seidler was sceptical of the proposition that without notes a therapist could recall what a client had disclosed, what interventions had been attempted, and what homework tasks had been set. In addition, a psychologist needed to keep adequate notes in order to guide their reflection on which strategies had been effective for a client over time, and which had not.

143. In her supplementary report Ms Seidler concluded:

'*It is my view that in reference to section 6 of the Australian Psychological Society's Ethical Guidelines for Record Keeping (in relation to Records Content), Ms Neal's records would be deemed insufficient and failing to meet the necessary professional standard.'*

Submissions regarding Ms Neal

144. At the close of the evidence, submissions were made on behalf of Ms Neal that the evidence did not support the making of any adverse findings in relation to her.

145. Those representing Ms Neal urged that her conduct as a psychologist had no bearing on the manner and circumstances of TE's death; and that therefore it was '*not open to the Court to make any adverse findings, referrals or recommendations'* regarding it.

146. I do not accept that the circumstances of Ms Neal's therapeutic relationship with TE had no relevance to the manner of her death. The evidence strongly supports that the termination of this relationship, and TE's perception of this event as abandonment, impacted very significantly on her state of mind throughout 2019 and 2020.

147. The severity of this impact is evidenced, among other things, in TE's many communications with Ms Smith over this period, as well as Ms Smith's notes of their sessions. The enduring nature of the impact is also evidenced in progress notes from Concord Hospital dated 30 June 2020, referring to TE's *'actively suicidal behaviours'* as having been '*precipitated following engagement in and subsequent termination of therapy by private psychologists'*.

148. It is clear that TE's experience of her relationship with Ms Neal and the termination of it was a contributing factor to her suicide, and therefore relevant to the manner and circumstances of her death.

149. It is therefore open to the Court to comment upon Ms Neal's deficiencies in setting appropriate boundaries upon her therapeutic relationship with TE, and more seriously, in failing to keep adequate records in relation to her work with TE.

150. This is not to say that Ms Neal is to blame for TE's death. Despite being critical of certain aspects of Ms Neal's practice, Dr Seidler was unequivocal that Ms Neal was not responsible for TE's decision to end her life.

151. I accept this opinion. Neither Ms Neal nor Ms Smith was responsible for the way in which TE experienced the termination of her relationship with each of them. Nor were they responsible for the desperately sad actions she took, partly in response to that experience.

Conclusion regarding the treatment provided by Ms Neal

152. As I have noted, Dr Seidler was mildly critical of Ms Neal's belated recognition that she had not set clear boundaries on TE's communications and interactions with her. I accept that criticism of Ms Neal in this regard must be tempered by an acknowledgement of her lack of training and experience with clients who suffer personality disorders.

153. With regard to the deficiencies in Ms Neal's record keeping however, Dr Seidler was unequivocal. Her opinion provides the basis for a finding that Ms Neal's record keeping in relation to her work with TE was inadequate.

154. In closing submissions, Counsel Assisting proposed that on the basis of this evidence, it would be open to the Court to exercise its power to make a referral or recommendation regarding Ms Neal's conduct.

155. On behalf of Ms Neal, however, it was urged that this power did not arise, as (it was submitted) the quality of her record keeping had no impact on the psychological treatment she provided to TE. It was further submitted that any concerns the Court might have about the records kept for Ms Neal's *other* clients must be beyond the scope of this inquest.

156. There is, however, no need for me to address these submissions on behalf of Ms Neal. This is because I have decided that the appropriate course of action is

to proceed in accordance with section 151A(2) of the *Health Practitioner Regulations National Law (NSW).*

157. This section enables a coroner to provide a transcript of the evidence heard in coronial proceedings to the Executive Officer of the Council for the relevant health profession, where the coroner has:

'... reasonable grounds to believe the evidence given … may indicate a complaint could be made about a person who is … registered in a health profession'.

158. An exercise of this power requires only that a coroner has reasonable grounds to believe that evidence given may indicate that a complaint could be made. The expert opinion of Dr Seidler, referred to in paragraphs 131-143 above, provides ample grounds for me to believe that evidence given in this inquest may indicate a complaint could be made about Ms Neal in respect of the adequacy of her record keeping.

159. The threshold for the exercise of this power therefore does not require me to engage with the arguments made at paragraphs 24 to 27 of the submissions on behalf of Ms Neal.

160. I will therefore refer Ms Neal's evidence, and a copy of these findings, to the Executive Officer of the Psychology Council of NSW.

Dr Rao's evidence re appropriate BPD treatment

161. In their evidence both Dr Rao and Dr Large observed that the Treatment Plan which accompanied TE's discharge on the evening of 6 August 2020 was not a comprehensive one.

162. Consistent with the focus of the Coroners Court upon enabling improvements to public health, the inquest sought Dr Rao's expert opinion as to the clinical care and treatment which would appropriately be provided to patients like TE who suffer severe BPD.

163. In his report and evidence Dr Rao described a best practice treatment model for patients like TE, assuming, as he noted, *'a willingness on the part of the patient to engage in treatment'.*

164. For Dr Rao, the challenging decision which Dr Sulaksono faced on the evening of 6 August 2020 underlined the need for BPD patients to have in place both a Treatment Plan and a crisis management plan.

165. Dr Rao explained that for patients like TE, ongoing and chronic suicidality is a prominent feature of their unwellness. Mortality rates among people suffering BPD are significant, and they are likely to have recurrent episodes of acute crisis. A period of involuntary detention may be needed to keep them alive, despite the personal distress and loss of agency that this would likely involve for them.

166. For this reason, a Treatment Plan formed between the patient, family, and treatment team when the patient is *not* in crisis was necessary. It would include as an essential element, the steps needed to keep the patient safe during episodes of acute suicidality.

167. As for the ongoing care which TE needed, in Dr Rao's opinion she required a clinician who was highly experienced in the psychotherapies that are specific to BPD. The clinician also needed to be supported by a multidisciplinary team of clinicians, who would work with a single treatment plan and crisis plan.

168. Importantly her clinician would need to be closely supervised by a senior colleague. This is due to the emotional fatigue which clinicians working with such patients tend to experience. In TE's case, the need for such a measure is clearly demonstrated in the response which both Ms Neal and Ms Smith received from TE when they attempted to set boundaries on her communications and behaviour. TE's reaction of intense anger, hurt and a sense of rejection ultimately led to the termination of both relationships.

169. As for the essential elements of an effective treatment plan for BPD, Dr Rao identified the following:

- treatments that were specific to personality disorders, such as Dialectical Behaviour Therapy
- Crisis intervention to help keep the patient alive during suicide crises
- Care to help them improve physical health and wellbeing
- Help to improve jobs and relationships
- Education and support for families and carers.

170. Dr Rao commented that this treatment model was best supplied through a specialist personality disorder service. This service would support and supervise the staff of the public mental health service at which, ideally, patients like TE would be treated.

171. Dr Rao and Dr Large both told the Court that notwithstanding the significant challenges in providing care for patients with personality disorders, remission was possible and relapse rates were low for those patients who persisted with treatment.

172. The inquest heard some evidence, albeit limited, about the availability within the Northern Sydney Local Health District [NSLHD] of health care for patients suffering BPD. This evidence was provided by Ms Sheila Nicholson, Service Director, North Shore Ryde Mental Health Service. At the Court's request, further material on this subject was provided on behalf of NSLHD.

173. In brief:

- the North Shore Ryde Mental Health Service conducts Brief Intervention Clinics for people with BPD. These offer up to four sessions for patients referred by the Acute Care Team. From this program clients are able to be

referred to other therapy teams, who may be able to offer a course in Dialectal Behaviour Therapy

- courses in Dialectal Behaviour Therapy operate from community mental centres in North Shore and Ryde. Ms Nicholson advised that each course is able to take 12-15 people, for a course running for up to 14 months. Such courses are also offered by certain private clinics within the area

- clients within North Shore and Ryde receive case management and/or therapy for BPD from services within the NSLHD

- certain police stations within the area operate the PACER program, whereby mental health clinicians attend mental health-related situations alongside police officers. One of the aims is to relieve pressure at hospital EDs from such presentations.

174. It is beyond the scope of this inquest to investigate whether therapy and case management services within the NSLHD are able to meet the needs of those within the LHD who suffer personality disorders. Suffice to say that in the opinion of Dr Rao:

'Unfortunately, access is extremely limited for the kind of care described above in most jurisdictions of Australia'.

175. It would be naïve to suppose that securing better treatment for BPD patients is an easy matter. There is a limited budget for public health, and a long journey to recovery for those who are able to engage with the treatment they need.

176. As this inquest reveals however, there is a heavy cost for individuals who suffer BPD and their families, as well as those who treat them, and those who are called out to assist them in an emergency situation. Counsel Assisting is surely right to submit that there is a need for more information about the personal and the community costs of this disorder, and better education and training for health professionals to treat it.

Conclusion

177. TE's final days were immensely sad, and her early death has brought enduring pain for her family who love her and miss her deeply.

178. There is an emotional toll on the police officers who attempted to save her on 6 and 7 August 2020, and the clinicians who tried to care for her.

179. I hope that in time the many people who cared about TE will find a measure of peace and comfort.

180. I wish to thank the excellent assistance provided to me throughout this inquest by the Assisting team, and my appreciation to the Officer in Charge Detective Sergeant Scrivens for her conduct of the coronial investigation.

Findings pursuant to section 81 of the Act

181. As a result of considering all of the documentary evidence and the oral evidence heard at the inquest, I am able to confirm that the death occurred and make the following findings in relation to it.

Identity
The person who died is TE.

Date of death:
TE died on 7 August 2020.

Place of death:
TE died in the area below The Gap Bluff, Watson's Bay NSW

Cause of death:
TE died as a result of multiple blunt force injuries. A significant contributing condition was pregabalin toxicity.

Manner of death:
TE's death was the result of a fall from a height, carried out with the intention of taking her own life.

182. I close this inquest.

Magistrate E Ryan
Deputy State Coroner
Lidcombe
11 September 2023