IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: **COR 2016 4391**

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)

Section 67 of the Coroners Act 2008

Findings of:	**MR JOHN OLLE, CORONER**
Deceased:	**SOPHIE MARGERY NICHOLAS**
Date of birth:	**23 MAY 1989**
Date of death:	**15 SEPTEMBER 2016**
Cause of death:	**INJURIES SUSTAINED IN MOTOR VEHICLE INCIDENT (PEDESTRIAN)**
Place of death:	**SLADEN STREET CRANBOURNE VICTORIA 3977**

HIS HONOUR:

BACKGROUND

1. Sophie Margery Nicholas was born on 23 May 1989. She was 27 years old at the time of her death.

2. Sophie had admissions to private services prior to 2016 and had engagement with the crisis assessment and treatment teams (CATT) and private practitioners. According to Kerry Nicholas, Sophie's mother, Sophie started relying on alcohol in Japan in 2012 where she lived and worked with her then boyfriend. In 2014 after returning to Australia the relationship ended and Sophie told Kerry she was an alcoholic. Sophie was often aggressive, both verbal and physical in the context of alcohol intoxication from December 2015. Sophie self-reported low-level use of party drugs over 2015-2016 and increased high-risk behaviours and disinhibition associated with intoxication. Sophie always reported to clinicians and services that she had very supportive and helpful parents in spite of the intervention orders in place and that her family funded her private health insurance and supported her financially

3. In January 2016, Sophie had a polypharmacy overdose. She was admitted to Victoria Clinic for alcohol addiction and therapy programs for BPD in January 2016 (22 days with a precipitous discharge after concealment and use of alcohol), February 2016 (17 days and discharge as planned), and in March 2016 (28-day program completed). In March and April 2016 Kerry contacted Monash Health psychiatric triage service and requested CATT input, however Sophie refused to engage. In about April 2016 Sophie had a further three-week admission to Victoria Clinic. About one week after discharge she assaulted her stepfather while intoxicated.

4. At 4.37pm on 27 April 2016, Sophie presented to the Monash Health Medical Centre Clayton requesting treatment for her mental illness. Sophie was intoxicated with a blood alcohol level (BAL) of 0.231 g/100ml with lowered mood and suicidal thinking and asked the paramedics to kill her. Sophie left the ED prior to treatment at 7.16pm. ED had a discussion with CATT and asked Kerry, who had spoken with Sophie, to bring Sophie back to ED.[1] Sophie was found by her parents in their street, and she was transported to the Monash Health Medical Centre Clayton ED at 9.11pm by Ambulance Victoria/Victoria

[1] Monash Health medical records pages 32-35.

Police under section 351 of *Mental Health Act 2014* (Vic) with a BAL 0.266 g/100ml. At 12.02am on 28 April 2016, Sophie left the ED and Oakleigh Police were notified.

5. On 2 May 2016 Sophie was assessed and admitted as a compulsory patient to Monash Medical Centre psychiatric unit and subject to a Mental Health Act assessment order following assessment and transport by the PACER unit earlier that day.[2] Sophie attended court and was issued with an interim intervention order (IVO) restricting her access to her stepfather. Following the hearing Sophie stood in front of oncoming traffic, sat on the road, and stated, "this is the end."

6. Sophie's diagnosis was borderline personality disorder (BPD) which was formulated by private psychiatrist at the Melbourne Clinic during a previous private admission. Sophie also had longstanding alcohol dependency. Sophie was noted to have delusional thinking on admission, she remained in the unit for nine days while she awaited a private admission and her status was changed to voluntary on 3 May 2016. She settled, was compliant with treatment and medications and responded well to the inpatient environment, was hopeful for the future and wanted to engage in therapy after discharge.

7. The IVO meant Sophie could not reside with her parents who were willing to fund private rental and were working with Sophie to achieve this. Her problems were listed as homelessness, social isolation, alcohol dependency and ongoing risk of self-harm. Sophie had temporary residence in a boarding house at discharge.

8. On 25 May 2016 Kerry contacted Monash Health psychiatric triage to express her concerns about Sophie's mental state, explained the IVO and clarified if they were to engage with Sophie. It was explained attempts had been made to contact Sophie but were unsuccessful.

9. On 26 May 2016 Sophie attended the Monash Medical Centre Clayton ED with her stepfather requesting treatment for her mental health. She was assessed and made subject to an assessment order under the Mental Health Act and was specialled.[3] Sophie's presentation included suicidal thinking,[4] posturing, thought blocking, sexualized thinking, and abdominal pain, and she was investigated for a urinary tract infection.[5] On 27 May 2016 Sophie was admitted to Dandenong Hospital psychiatric unit and presented with erratic and bizarre

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[2] PACER – Police, Ambulance, and clinical early response (mental health) is a joint crisis response to people experiencing a behavioural disturbance in the community.

[3] Specialled refers to providing a staff member to usually remain within arm's length of a patient for as long as deemed necessary.

[4] Monash Health medical records page 30.

[5] Monash Health medical records page 29.

behaviours and paranoid delusions. Further assessment orders were made and then revoked on 29 May 2016.[6]

10. Monash Health inpatient multidisciplinary review on 6 June 2016 noted Sophie's improved mental state, engagement in the ward program, continued homelessness and that she benefited from prescribed medications and participation in the emotional regulation skills group with which she had good engagement. Sophie was discharged on 7 June 2016, with a referral to the Casey Community Mental Health Services (Casey CMHS) for case management and CATT follow-up. The diagnoses at discharge on 7 June 2016 were schizophreniform or substance (alcohol) induced psychosis, and brief reaction psychosis in BPD.

11. On 8 June 2016 CATT contacted Sophie and completed a home visit. She reported she was coping, was drinking alcohol and had plans to contact the public addiction service South Eastern Alcohol and Drugs (SECADA). CATT contacted Sophie on 9, 10, 12, 14, 15, and 16 June 2016 by face-to-face and telephone. Sophie repeated her intentions to engage with SECADA, and to see her general practitioner (GP). Casey CMHS psychiatric registrar assessed Sophie on 15 June 2016. Sophie explained her contact with private psychiatrist and that she had arranged contact with SECADA.[7] On 16 June 2016 the Casey CMHS multidisciplinary review recorded Sophie was not for case management with apparent closure of the referral.[8]

12. On the same day Sophie told CATT she only had three days of medications left and that her GP would not prescribe them. A CATT medical officer documented a call from a medical practitioner (query this was the inpatient prescriber) who noted Sophie's mental state had improved with olanzapine[9] however the clinical response could be either a response to a first episode psychosis or treated psychotic feature of BPD, that she should remain on olanzapine and wean it if her mental state remained stable. A GP[10] was contacted and was not comfortable prescribing olanzapine for an off-label use because Sophie did not have a primary diagnosis of schizophrenia. This meant Sophie would be paying the full cost for olanzapine, which according to the advice sought by CATT from the pharmacy, would be $35.00 per month (PBS scripts an attract a dispensing fee only for patients with the appropriate entitlements).[11] The Casey CMHS multidisciplinary review's plan of care was to

[6] Monash Health medical records pages 8 - 10.
[7] Monash Health medical records pages 111 – 115.
[8] Monash Health medical records page 124.
[9] Olanzapine a second-generation antipsychotic indicated in the treatment of schizophrenia and related disorders, and bipolar disorder.
[10] Monash Health medical records page 130, 150 – 151.
[11] Monash Health medical records page 149.

provide Sophie with case management to facilitate her engagement with a GP who would prescribe antipsychotic medicines without a primary diagnosis of schizophrenia.[12]

13. Kerry contacted Casey CMHS to establish whether Sophie had been offered case management and expressed her concerns that Sophie's mental state had deteriorated, that she felt unsafe in her current accommodation and that CATT had been unable to contact Sophie and had closed the referral.[13] On 27 June 2016 the CMHS team documented they had not been aware Sophie was being provided care by CATT at the time of the assessment on 15 June 2016 and their decision to not offer further care.[14]

14. On 1 July 2016 Sophie was allocated Casey CMHS a case manager. One of the clinical psychologists received a phone call from Sophie's private psychologist who had reviewed Sophie several times over the past year. The private psychologist noted Sophie's presentation had deteriorated with increased alcohol use, homelessness or at-risk of, that Sophie had BPD and required stabilisation of accommodation and her alcohol use, so she could engage in longer term psychotherapy.[15] The CMHS clinical psychologist left a message for Sophie to remind her of a scheduled appointment with her, which Sophie did not attend.

15. On 5 July 2016 Sophie's CMHS case manager spoke to her and on 7 July 2016 completed an assessment. Prior to the appointment Kerry had told the case manager that Sophie was having difficulties with co-tenants which Sophie confirmed, that she had been drinking alcohol onsite (against the house rules) and stated she had an appointment with the landlord later that day. Sophie was given details for crisis accommodation should the meeting end in eviction. She said she took the medication as prescribed. Sophie said she had no formal thought disorder but reported voices who said bad things and wanted to kill her; that she woke up suicidal every day but would not act because she did not want to distress her parents; was attending alcoholics anonymous (AA) but continued to drink alcohol. Sophie's case manager contacted NEAMI[16] who confirmed Sophie had an application for a residential peer recovery community (PRC) and requested a supporting letter which was completed.[17] The letter identified stable accommodation as a mainstay to her recovery, and that she was currently willing to engage in treatment.

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[12] Monash Health medical records page 125.
[13] Monash Health medical records page 124.
[14] Monash Health medical records page 124.
[15] Monash Health medical records page 127.
[16] One of several non-government organisations that processed referrals to mental health residential rehabilitation facilities. NEAMI is not an acronym.
[17] Monash Health medical records pages 133 – 134.

16. An interim intervention order was issued on 7 July 2016 restricting Sophie's access to Kerry.[18]

17. Sophie was admitted to Victoria Clinic in crisis on 17 July 2016 (10 days) with increased alcohol use (20 standard drinks daily) and cannabis/amphetamine use. Sophie's admission BAL was 0.284 g/100ml and medications were withheld until the BAL dropped below 0.05 g/100ml. Sophie engaged in the ward program including trying to improve her sleep which was an ongoing problem for her.

18. On 18 July 2016 Sophie contacted her CMHS case manager to let her know she had been admitted to Victoria Clinic and would not be attending the scheduled appointment. She informed her case manager that she was feeling suicidal and needed detox.

19. Sophie's father (who was living in Singapore) had a stroke while Sophie was an inpatient. Proximate to the decision to arrange discharge, Sophie returned from leave with a BAL 0.085 g/100ml and had a bottle of vodka with her. Consequently, Sophie was reviewed and discharged without medications to a boarding house in Hampton Park on 27 July 2016 with a follow-up appointment for one week.[19]

20. On 1 August 2016 the CMHS case manager contacted Sophie to check she was still in hospital. Sophie told her case manager she was discharged, back at a boarding house in Hampton Park, had been unsuccessful in her application to the PRC but was for future consideration. Sophie agreed to a review appointment with the case manager on 3 August 2016.[20]

21. On 3 August 2016 Sophie met with the case manager and confirmed she had been precipitously discharged from Victoria Clinic for drinking alcohol, that she still wanted to do the rehabilitation but would like a longer program, that she recognised she would be at risk of early discharge from a PRC if she continued to drink alcohol, and that she had credit card debt. The CMHS case manager provided her with details of financial counselling services and offered an appointment for Sophie to see the Casey CMHS consultant psychiatrist, but Sophie stated she was seeing her private psychiatrist that evening, that he did not agree Sophie had schizophrenia and had ceased her medications. The case manager discussed the complexity of having two psychiatrists and advised Sophie to commit to one, but Sophie was unsure whether to stay with public or private. Sophie's case manager also

[18] Monash Health medical records page 12.
[19] Victoria Clinic medical records dated 27 July 2016.
[20] Monash Health medical records page 129.

met with Kerry who expressed concern about Sophie's drinking and that she believed she enabled it by paying for Sophie's food, bills, rent etc. The medical records suggest both the case manager and Kerry believed alcohol was at the centre of Sophie's financial and mental state issues. Kerry was referred to Carer Support and an appointment scheduled with Sophie for two weeks.[21]

22. On 15 August 2016, Sophie's case manager contacted Kerry in response to a message left by Kerry in the preceding week. Kerry reported Sophie had tried to enter Malvern Private Rehabilitation but was refused because she did not have a supportive environment to return to. Kerry noted that if Sophie was accepted by NEAMI, Sophie would be able to complete the Malvern Private Rehabilitation program as she had completed it three times prior. On 16 August 2016, Sophie's case manager spoke with Sophie and on 17 August 2016 Sophie was finding things difficult and she was reminded of her scheduled appointment for the following day. On 17 August 2016 Sophie did not attend her scheduled face-to-face appointment and attempts were made to contact her and prompt collect of her medication script.

23. Sophie was admitted to Beleura Private Hospital on 18 August 2016 for inpatient detoxification and rehabilitation. According to Sophie she consumed alcohol for most of the intervening period. Sophie responded well to rehabilitation and was to be transferred to a long-term rehabilitation PRC at MIND Australia.

24. On 25 August 2016 the Casey CMHS multidisciplinary team review requested that Sophie's private psychiatrist be contacted to confirm his level of engagement with Sophie. Kerry was also contacted and reported Sophie was in Beleura Hospital completing a 28-day rehabilitation program, that NEAMI was involved and Sophie had been referred to MIND Australia for entry to the PRC in Armadale. Kerry was told that with this level of engagement Casey CMHS would close Sophie's file and Kerry was advised to recontact the service should there be future concerns and she was provided with the details for re-entry. On 28 August 2016, the Casey CMHS multidisciplinary review was completed and Sophie was for discharge to the care of her private psychiatrist. On 29 August 2016, Sophie's CMHS case manager left a message for Sophie to make contact to discuss her discharge.

[21] Monash Health medical records page 136.

THE PURPOSE OF A CORONIAL INVESTIGATION

25. Sophie's death constituted a '*reportable death*' under the *Coroners Act 2008* (Vic), as her death occurred in Victoria, and has resulted, directly or indirectly, from an accident or injury.[22]

26. The jurisdiction of the Coroners Court of Victoria is inquisitorial[23]. The purpose of a coronial investigation is independently to investigate a reportable death to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.

27. It is not the role of the coroner to lay or apportion blame, but to establish the facts.[24] It is not the coroner's role to determine criminal or civil liability arising from the death under investigation, or to determine disciplinary matters.

28. The "cause of death" refers to the medical cause of death, incorporating where possible, the mode or mechanism of death.

29. For coronial purposes, the circumstances in which death occurred refers to the context or background and surrounding circumstances of the death. Rather than being a consideration of all circumstances which might form part of a narrative culminating in the death, it is confined to those circumstances which are sufficiently proximate and causally relevant to the death.

30. The broader purpose of coronial investigations is to contribute to a reduction in the number of preventable deaths, both through the observations made in the investigation findings and by the making of recommendations by coroners. This is generally referred to as the 'prevention' role.

31. Coroners are also empowered:

    (a) to report to the Attorney-General on a death;

    (b) to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and

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[22] Section 4, definition of 'Reportable death', *Coroners Act 2008.*
[23] Section 89(4) *Coroners Act 2008.*
[24] *Keown v Khan* (1999) 1 VR 69.

(c) to make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice. These powers are the vehicles by which the prevention role may be advanced.

32. All coronial findings must be made based on proof of relevant facts on the balance of probabilities. In determining these matters, I am guided by the principles enunciated in *Briginshaw* v *Briginshaw*.[25] The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about individuals, unless the evidence provides a comfortable level of satisfaction that they caused or contributed to the death.

MATTERS IN WHICH THE CORONER MUST, IF POSSIBLE, MAKE A FINDING

Identity of the Deceased pursuant to section 67(1)(a) of the *Coroners Act 2008*

33. Sophie Margery Nicholas was identified by dental record comparison on 19 September 2016. Identity was not in issue and required no further investigation.

Medical cause of death pursuant to section 67(1)(b) of the *Coroners Act 2008*

34. On 16 September 2016, Dr Heinrich Bouwer, Forensic Pathologist at the Victorian Institute of Forensic Medicine, conducted an inspection on Sophie's body and provided written report dated 11 October 2016, concluding a reasonable cause of death to be "I(a) Injuries sustained in motor vehicle incident (pedestrian)". I accept his opinion in relation to the cause of death.

35. Toxicological analysis of post mortem specimens detected methylamphetamine[26] (~0.1 mg/L) and its metabolite amphetamine (0.03 mg/L) and diazepam[27] (~0.03 mg/L) and its metabolite nordiazepam (~0.06 mg/L).

36. Dr Bouwer noted that the post mortem computed tomography (CT) scan showed comminuted skull vault and base of skull fractures with pneumocranium. No significant injuries to the torso or limbs were identified.

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[25] (1938) 60 CLR 336.

[26] Methylamphetamine is a strong stimulant drug that acts like the neurotransmitter noradrenaline or the hormone adrenaline. It is often known as "speed" or "ice".

[27] Diazepam is a sedative drug of the benzodiazepines class.

Circumstances in which the death occurred pursuant to section 67(1)(c) of the *Coroners Act 2008*

37. On 8 September 2016 Sophie was offered a residence at the MIND Australia Armadale PRC. Contact was made with Kerry confirming she agreed to pay the rent until Sophie started to receive Centrelink payments. Sophie consumed alcohol in the ward and according to the rules of the admission, was discharged early, about one week prior to completion of the program and one day after she was offered a place in the PRC.[28] On 9 September 2016 Sophie was discharged from Beleura Private Hospital.

38. Sophie contacted Armádale PRC to tell them she was safe, was finding temporary accommodation through the Salvation Army at the Comfort Inn Princess Highway, Dandenong from 9 to 11 September 2016 until she could re-attempt the Beleura Private Hospital Program in 30 days. Sophie was informed she could reapply to the PRC after she completed the program (or equivalent consistent engagement with alcohol and drugs services) however there was no guarantee of a vacancy upon completion. Sophie expressed a desire to abstain from alcohol and that moving to Armadale PRC was a priority for her.[29] Sophie's CMHS case manager completed Sophie's discharge and sent copies of the discharge summary to Sophie and Kerry.

39. On 12 September 2016 at 6.37pm, Kerry was contacted by Quest apartments in Dandenong requesting someone collect Sophie because she was very intoxicated. Kerry could not convince Sophie to go to the Dandenong Hospital ED voluntarily and required assistance from on-site staff. Sophie was intoxicated and consumed the alcohol-based hand rub in the cubicle. She was moved to the waiting room after review by a doctor, because of her behaviour and risk of further ingestion of hand rub, to wait until the morning to see the social worker. Sophie left the waiting room and was to be re-triaged if she represented. Sophie was noted as discharged at about 2.45am on 13 September 2016.[30] Sophie later contacted Kerry at 3.00am and was verbally abusive.[31]

40. On 13 September 2016, a MIND Australia staff member spoke with Partners in Recovery (PIR) worker who appeared to have advocated for Sophie to enter the PRC. The MIND

[28] Beleura Private Hospital medical records.
[29] Beleura Private Hospital medical records and Coronial brief of evidence page 7.
[30] Monash Health medical records pages 19 - 20.
[31] Coronial brief of evidence page 7.

Australia staff member spoke with Sophie later in the day and reiterated the requirements before she could be admitted to the PRC. Sophie said her relapse was due to a low mood.[32]

41. Kerry met Sophie in Dandenong at 10.00am and gave her some personal items and left her at the Vodafone store to buy a new phone.[33] Sophie's activities are unknown until 7.20pm when she contacted friend who described her as crying, hysterical, that she was in so much emotional pain, felt empty and that she could not understand why people were happy.[34]

42. Rodney Williams stated that at approximately 7.30pm, he, Craig Williams and Bradley McGrath approached Sophie who was on the road side in Dandenong because she looked upset and distressed. Sophie told the men that she had been robbed, however when asked she could not remember any details. After driving around the streets, withdrawing cash from an ATM, charging her phone at Rodney's home between 11.30pm and midnight, Craig (who did not provide a statement) and Bradley drove Sophie to find accommodation, including an offer to pay for a motel room but she wanted to remain with the two men. They parked at Lysterfield Lake in Rowville and talked all night, returned to Rodney Williams's home at 9.30am on 14 September 2016.

43. Rodney stated that Sophie was unwell but she wanted to spend the day with Craig and Bradley during which they took her to Centrelink, the Salvation Army and WAYSS[35] and visited a cousin. In the evening, they went to a deserted building in Cranbourne, lit a fire and talked. Sophie chose to remain in the building, refusing several alternative offers of help from the men and the men then returned home at between 11.00pm and 11.30pm.[36] Sophie did not have her phone or her jacket with her at the time of her death and had been wearing Bradley's jacket.[37].

44. At approximately 1.30am on 15 September 2016, Sophie was walking in an easterly direction along the service road adjacent to Sladen Street, Cranbourne, just before Fairbairn Road. At the same time a 2011 Hino FD 1024 tray truck was travelling at approximately 80 km/h in the same direction as Sophie.

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[32] MIND Australia attempted to contact Sophie on 25 October 2016 about a vacancy in the PRC and were made aware of her death on 25 November 2016.
[33] Coronial brief of evidence pages 54 – 58.
[34] Coronial brief of evidence pages 50 – 52.
[35] The WAYSS core purpose is to assist individuals who are homeless or at risk of homelessness to improve their life circumstances by providing access to stable accommodation.
[36] Coronial brief of evidence page 33-35.
[37] Rodney Williams and Bradley McGrath give two accounts of why Sophie did not have her phone with her. Coronial brief of evidence pages 33 – 34 and 41 – 42.

45. According to the driver of the truck, he had slowed to approximately 60km/h, when he was about 20 metres from Sophie, she ran straight out in front of the truck. The driver swerved to the right in an attempt to avoid her, but Sophie continued to run in front of the truck, and they collided. The driver stopped the truck to assist Sophie and called Emergency Services. Police and Ambulance Paramedics arrived shortly afterwards and Sophie was declared deceased at the scene.

46. Sladen Street Cranbourne, between Monahans Road and Fairbairn Road is a sealed bitumen road. It is a four-lane road divided by a grass median strip. There is provision for two lanes of traffic in each direction. There are two additional turning lanes just before the Fairbairn Road, a bicycle lane and a service lane. Sladen Street is a highway as defined by the *Road Safety Act 1986* (Vic). At the time of the collision the surface of the road was wet, the weather was fine, traffic was light, the street lights were on, but the visibility was good.

Department of Health and Human Services

47. The Department of Health and Human Services (DHHS) was asked to provide information specific to services available to people who are experiencing a crisis and have a diagnosis of BPD and/or comorbidities and who are not therapeutically engaged in ongoing treatment and are presenting frequently to services.

48. Secretary Kym Peake acknowledged the provision of services to this cohort of people is complex and that services are dispersed across both public and private mental health, general health, and primary care settings.[38]

49. Ms Peake outlined specialist targeted initiatives including the psychiatric assessment and planning units[39], mental health and Police initiative[40], the Hospital Outreach Post-suicide(al) Engagement initiative[41], and the Expanding Post Discharge Support Initiative[42] and that some mental health services have innovative solutions which are proving to be very effective, however no detail of these solutions provided.[43]

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[38] Statement of DHHS Secretary Ms Kym Peake, dated 1 December 2017.

[39] Psychiatric assessment and planning unit (PAPU) exist in some hospitals and/or are collocated with emergency departments. PAPUs provide short-stay care as an alternative to admission to a hospital.

[40] Mental health and Police initiatives are a dual service response in the community for the assessment of people with significant psychological and behavioural disturbance and is according to Ms Peake, provided statewide.

[41] Hospital Outreach Post-suicide (al) Engagement (HOPE) initiative provides follow-up to people who present to emergency departments with a suicide attempt. They provide one to one support to people who do not meet the threshold for admission to a mental health service. The service can be provided for up to three months. At the time of writing, HOPE initiatives were at Peninsula Health, Alfred Health, St Vincent's Health, Barwon Health, Eastern Health and Albury Wodonga Health.

[42] Expanding Post Discharge Support Initiative provides targeted post discharge peer support to consumers during the initial weeks following an inpatient admission where there was an identified risk if suicide. It is unknown where this is available.

[43] Statement of DHHS Secretary Ms Kym Peake, dated 1 December 2017, page 3.

50. Ms Peake acknowledged the complexities of people with a BPD, "The nature of the disorder tends to result in diminishing social supports and protective factors, often resulting in poor physical health, unemployment, financial distress and homelessness."[44] In addition, Ms Peake recognised people with a BPD are easily alienated in conventional mental health treatment settings, that trust is essential, the establishment of which requires high levels of skill and commitment, which is not regularly achievable without dedicated resources.[45]

51. Ms Peake believed the emergency responses for people with a BPD in crisis should be the same as anyone presenting in crisis, however particular emphasis should be placed on early identification, assessment and assertive post discharge follow-up. The gaps DHHS identified in delivering the best possible services to people with a BPD include misunderstanding and stigma, limited dedicated funding and specialist workforce, high demand for community mental health treatment, disconnection between mental health and other service systems, and technology that identifies people who present frequently that are not registered in the current Statewide systems, although DHHS is considering the development of guidelines to improve this. DHHS outlined that the Forensic Clinical Specialist Initiative[46] may result in capacity building to support the sector to engage with people with a BPD, although how was not explained.

52. Ms Peake acknowledged the suicide rate in people with a BPD was unacceptably high and that funding to Spectrum, the Statewide specialist BPD service has been increased to support BPD non-specialist Area Mental Health Services across the state. Ms Peake suggested better integration between mental health and other service systems is required, especially with substance services and notes the Drug Rehabilitation Plan has this emphasis.

Spectrum

53. Spectrum Associate Professor Dr Sathya Rao provided details of Spectrum as the publicly funded state-wide specialist service for people with severe or borderline personality disorders who receive services in adult and child and adolescent Area Mental Health Services and secondary advice to private psychiatrists, and one-off assessments as referred by GPs. Dr Rao stated Spectrum patients usually have clinical complexities and high risk of self-harm/harm to others and listed a range of services provided by Spectrum. These include

[44] Statement of DHHS Secretary Ms Kym Peake, dated 1 December 2017, page 2.
[45] Statement of DHHS Secretary Ms Kym Peake, dated 1 December 2017 page 2.
[46] Forensic Clinical Specialist Initiative embeds forensic clinicians in Area Mental Health Services.

education, Carer and Consumer support services and a 10-week brief intervention group that can be implemented by "resource-constrained" Area Mental Health Services.[47]

54. Dr Rao stated that people with BPD and comorbidities (as was the case with Sophie) do not receive appropriate treatment because of the comorbidities. Dr Rao also stated that people in this cohort can access emergency departments and CATT when in crisis but that the care provided in these settings is general and not well suited to complex presentations.

55. Dr Rao noted there is no legislative framework to enforce the treatment for people who make apparently poor decisions when in crisis and stated there are gaps in the Mental Health Act.[48] Dr Rao believed the elements of the current service systems do not complement each other and outlined an ideal continuum of care would be treatment for BPD and comorbidities at the one site and suggested possible pilot programs.

56. Dr Rao noted the conundrum that Spectrum is funded to treat public patients however many patients with a BPD are engaged with/referred to private providers. Dr Rao identified the training for ED staff and effective psychotherapeutic treatments for BPD in the public sector as lacking. A clinical concern for Spectrum is the misdiagnosis of BPD when a patient presents with psychotic features and is treated accordingly.[49]

57. In response to a request to identify opportunities to improve the services to people with BPD and comorbidities, Dr Rao identified three an adherence to the 2012 National Health and Medical Research Council (NHMRC) Clinical Practice Guidelines for the Management of Borderline Personality Disorder, 2) an opportunity to develop men-specific services for the treatment of BPD, 3) every Area Mental Health Service develop enforceable evidence-based guidelines for the management and treatment of people with a BPD, and 4) develop a one-stop accessible public-funded complex care service to manage patients who have complex psychiatric disorders with multiple comorbidities and psychosocial disabilities.

58. Dr Rao also included audit information using data from the Court's Victorian Suicide Register (VSR). This data included deaths where the evidence of a formal diagnosis of BPD was not established. The accompanying report from the Coroners Prevention Unit (CPU)[50] only includes deaths with evidence of a formally diagnosed BPD for the years 2009 – 2015, including details of service contacts.

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[47] Statement of Associate Professor Sathya Rao, Spectrum, dated 20 February 2018 page 2.
[48] Statement of Associate Professor Sathya Rao, Spectrum, dated 20 February 2018 page 3.
[49] Statement of Associate Professor Sathya Rao, Spectrum, dated 20 February 2018 page 3.
[50] Coroners Prevention Unit Advice April 2019 - Basic profile of people who had a diagnosis of borderline personality disorder and suicided, Victoria 2009 – 2015.

Discussion

59. Sophie's admissions to mental health units was usually in the context of crises, with other admission to private facilities for substance detoxification and treatment for dependency also often associated with crises. The programs offered by health services appear to have been evidence-based within the scope of the service type, however on reflection most are unlikely to meet the national guidelines for BPD suggested by Dr Rao.[51] Not all people require or respond to the approach set out in the guidelines, which by their nature are unenforceable. The choice of individual clients to engage with a private practitioner and service whose approach and methods result in improvement in mental state and function should be acknowledged.

60. The PRC admission letters and medical records suggest Sophie had insight into her inability to recover unless she was intensively supported, and she relied on clinicians to stay motivated and to prevent her isolation from alcohol use, her behaviours and the emotional dysregulation associated with the BPD.[52] Sophie self-reported her goals as learning to decrease her overwhelming anxieties including social anxiety, increase her self-confidence, learning to express herself and repairing her relationships with her family.

61. There is some suggestion Sophie usually agreed in the presence of mental health services that alcohol use was causative to her deteriorated mental state, and when with an addiction service and/or private practitioner that her mental state required treatment to enable her to be successful in no longer using substances. Sophie made commitments to engage with public drug and alcohol services but there is no evidence she did so on any ongoing basis. Because Sophie had private health insurance and financial support from her parents she was able to manage the private/public services, and over the longer-term moved between the two with no real clinical oversight or boundaries, with frequent changes in possible diagnoses, treatments and goals and no consequence of her frequent failure to engage in a therapeutically meaningful way.

62. There is also evidence that Sophie's anxieties increased before any transfer of care from a place where she felt safe, usually a private hospital, which resulted in a repeated behaviour of initiating alcohol use which often resulted in precipitous discharge. Sophie breached the admission rules and agreements she had signed as part of the admission, however there appeared to be little if any flexibility in identifying her increased risk periods, to intervene

[51] National Health and Medical Research Council, 2012. Clinical Practice Guideline for the Management of Borderline Personality Disorder. Melbourne: National Health and Medical Research Council.
[52] Monash Health medical records pages 104 and 124 - 125.

early and to respond to incidents in a collaborative way. Such discharges usually resulted in a letter to Sophie's GP, subsequent increased alcohol use, deterioration in mental state and presentations in crisis and little collaborative communication across the public/private sectors. There were documented plans to contact the private services by public mental health services or evidence of progress in engaging Sophie in public services, however Sophie would frequently arrange an admission to a private hospital prior or during the establishment of a public service treatment plan, and she would then be reasonably discharged from the public service. There was no evidence private practitioners or services who were aware of Sophie's vulnerabilities post-discharge made any attempts to notify public mental health services or at times, Kerry.

63. Sophie responded well to most inpatient environments with structure (which she recognised as beneficial for her) however they could not in the long run be considered effective in having addressed her substance dependency or BPD.

64. Services usually engaged with Kerry who continued to try to support Sophie, often responding to requests from services and community members to in some way respond to a need they had identified. Kerry repeatedly expressed her concern for Sophie and the lack of coordination of and between services.

65. Services that provide the care for a person with BPD who is in crisis and/or in long-term therapy, and/or addiction services, are not coordinated and often have conflicted evidence-based models for care which is acknowledged by Dr Rao and DHHS. To keep a person safe until they have the boundaries in place to enable them to engage with a therapist with the potential for it to be therapeutic is problematic, and the circumstances often investigated by Coroners.

66. As noted by Dr Rao, people in such circumstances are unlikely to meet the requirements for compulsory treatment under the Mental Health Act once an immediate crisis subsides and they usually want to leave as soon as possible. They are also unlikely to meet the requirements for the use of the *Substance Dependence Treatment Act 2010* (Vic) because they have a mental illness.

67. The promoted model for providing care to a person with a BPD is for community-based programs. Bed-based services in the short-term increase a sense of safety for the person (required for the engagement in meaningful therapy) but are also believed to increase dependency. This can result at the time of discharge in an overriding sense of abandonment

and escalated anxiety and subsequent emotional dysregulation proximate to, during and following transition of care. This can increase further if the person is not engaged in a therapeutic relationship in the community and/or is unsupported by a network of family, friends, and community-based supports as noted by Dr Rao and DHHS, which they have often shattered through their behaviours and crises. Further complicating the situation is that if a person has private health insurance and experiences repeated crises, has addictions and behaviours that are chaotic and high risk, they can often have multiple admissions and day program enrolments that do not appear to sustain post-discharge recovery in this group.

68. There is no doubt the evidence supports that once engaged in a meaningful and supported therapeutic relationship, people with a BPD do recover and most often recover to a full remission. The length of programs offered to people with a BPD ranges from a few months to many years. Engagement in such therapy cannot be forced and requires commitment by the person. This level of engagement is more likely to occur when they feel safe, have supports in place, and have boundaries set that assist in containing their overwhelming anxieties.

Conclusion

69. Not all people with a diagnosis of BPD live a chaotic crisis-driven life with the added complexity of addiction. For those who are experiencing an extended period of crisis, such as Sophie Nicholas, their presentation is chaotic, and they are often in the period between referral and engagement to a new therapist or services, or in a period of disengagement and reengagement with an established therapist, but most are not engaged in any therapeutic and meaningful way in treatment preceding death.

70. The result is that people with BPD, an addiction and often an eating disorder who have a chaotic lifestyle, limited supports, and multiple crises come into frequent contact with EDs, hospitals (following medical admissions post suicide and self-harm acts such as overdose, cutting, substances, poor physical health etc., acute psychiatric units, private hospitals, CATT, private psychologists and psychiatrists, addiction services (both acute, detoxification and residential rehabilitation), Victoria Police and Ambulance Victoria.

71. The Victorian Suicide Registry data 2009 – 2015 identified a cohort of 5.9% (n=242) of all suicide deceased Victorians, who had a diagnosed BPD and who had increased occurrence of comorbidities. There is practically no marked difference between male and female in the cohort, but when compared with all suicide deceased, the difference is notable. The BPD

cohort were on average seven years younger with peak frequency of death in age groups 25 – 34 and 35 – 44 years, however 13.2% (n=32) were aged between 18 – 24 years, 5% higher when compared with the all diagnosed cohort.[53]

72. The CPU report indicates that the BPD cohort have greater contact with health services in the six weeks prior to death and that the contact is more likely to be with a service designed to respond to high clinical acuity and by association, need, such as emergency departments (27.7%), CATT (17.4%), mental health practitioners (44.2%) and psychiatrists (54.1%).[54]

73. Each of these environments and services is appropriate for elements of acute care but they also present problems in management. People who present in crises and are chaotic with high risk behaviours can and do disrupt environments, affect other patients and service users, and most often require a large share of a finite resource.

74. According to Dr Rao, Spectrum's involvement is restricted to public patients and he notes that many people with a BPD engage with the private sector. According to the CPU, this is supported by the higher proportion of the BPD cohort than the cohort of all-diagnosed, engaging with both public and private services. Of note is the much higher proportion of contacts with private psychologists other than health services and that this is replicated in the all diagnosed cohort, although at lower numbers. This likely reflects the specialist nature of clinical psychologists and current Commonwealth funding structures.[55] Both the BPD cohort and all diagnosed cohort had greater contact with public drug and alcohol services when compared to private services although all at low levels. The BPD cohort was more likely to have higher contact with public drug and alcohol services (5% higher).

75. General practitioners are classified as a private primary care service. Across the BPD cohort and the all diagnosed group, about 60% of the cohorts consulted with a general practitioner within six weeks of their death.

76. Health services have service focus and differ dependent on their purpose, role and funding model and in respect to Sophie, each service worked within its service delivery model. The ED's focused on settling an immediate crisis and providing immediate physical health and

[53] Coroners Prevention Unit Advice April 2019 - Basic profile of people who had a diagnosis of borderline personality disorder and suicided, Victoria 2009 – 2015.

[54] Coroners Prevention Unit Advice April 2019 - Basic profile of people who had a diagnosis of borderline personality disorder and suicided, Victoria 2009 – 2015.

[55] Access to Allied Psychological Services (ATAPS) program enables a range of health, social welfare and other professionals to refer consumers who have been diagnosed with a mild to moderate mental disorder to a mental health professional for short-term focused psychological services.
Better Access - Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule initiative ('Better Access'), you will be able to receive a Medicare rebate on more than the standard number of sessions for services provided by your doctor, psychiatrist or psychologist.

usually a psychiatric assessment. In a public non-psychiatric bed in a hospital, the focus of care was on the management of medical issues with involvements by the psychiatric consultation liaison services and/or addiction services. In the private hospitals the focus was often on treatment stabilising in a less clinically acute environment, on ward treatment specific programs and in the community, referral to the private psychologist with the evidence-based engagement and treatment with longer-term psychotherapies.

77. In the acute psychiatric unit, a place of very high clinical acuity and associated risks, it is not a place where people can be assumed to feel safe. It is unlikely with bed pressures that a person with a BPD who has settled after a crisis, will retain a bed for any length of time. These people are more likely to be discharged through early discharge management programs and CATT support and many are lost to follow-up.

FINDINGS

78. Having investigated the death of Sophie Margery Nicholas and having considered all of the available evidence, I am satisfied that no further investigation is required.

79. On the basis of the available evidence, I am satisfied to the requisite standard that Sophie Margery Nicholas intentionally ended her own life.

80. I make the following findings, pursuant to section 67(1) of the *Coroners Act 2008*:

(a) that the identity of the deceased was Sophie Margery Nicholas, born 23 May 1989;

(b) that Sophie Margery Nicholas died on 15 September 2016, at Sladen Street, Cranbourne, Victoria from injuries sustained in a motor vehicle incident; and

(c) that the death occurred in the circumstances described in the paragraphs above.

COMMENTS

81. Pursuant to section 67(3) of the *Coroners Act 2008*, I make the following comments connected with the death:

82. BPD treatment is a specialist field and promoted as such by practitioners and Spectrum. However, the specialist BPD services do not routinely provide care to patients who are in acute crises with escalated risks, instead more often having developed safety plans advising people to attend a hospital ED and/or contact the psychiatric triage or CATT, when risks have escalated and when these people are at their most vulnerable.

83. No service or practitioner contributed directly to Sophie's death. They worked within their remit with reasonable practice and changing any one service response in isolation is unlikely to have prevented Sophie's death. A rethink of the model for keeping people safe who are in this situation is needed and it cannot be done by BPD specialist services such as Spectrum in isolation from the emergency services. The healthcare community has neither the resources, skills, legislation, service coordination or leadership to date, to effect a change in the current piecemeal system. This system is not meeting the needs of people with BPD who have addictions and are in a cycle of crises with overt high-risk behaviours that impact on them, their families and the community. Access to safe and affordable housing was noted by

several practitioners to be the required foundation for recovery for a person with a BPD with comorbidities and chaotic and risk-taking behaviours.

84. There are no easily identifiable recommendations that have the potential to change the health service system to the extent required. This is acknowledged by the Department of Health and Human Services and Spectrum who confirm that the experience of service for Sophie and Kerry was not unusual and that there is no straight forward solution.

85. I convey my sincerest sympathy to Sophie's family and friends.

86. Pursuant to section 73(1) of the *Coroners Act 2008,* I order that this Finding be published on the internet.

87. I direct that a copy of this finding be provided to the following:

(a) Sophie's family, senior next of kin;

(b) Investigating Member, Victoria Police;

(c) The Office of the Chief Psychiatrist;

(d) Spectrum;

(e) Department of Health and Human Services; and

(f) Interested Parties.

Signature:

MR JOHN OLLE
CORONER
Date: 7 October 2019

Coroners Prevention Unit Advice

Date: 16 April 2019

Re: Basic profile of people who had a diagnosis of borderline personality disorder (BPD) and suicided, Victoria 2009-2015.

Case: COR 2016 4391 – Sophie NICHOLAS

Summary

(a) Between 2009 and 2015 approximately 5.9% of Victorians who died by suicide had a diagnosed BPD.

(b) Comparing between the cohort of suicide deceased who had diagnosed BPD (the 'BPD cohort'), and all Victorian suicides of people with diagnosed mental illnesses (the 'all diagnosed cohort'), the following distinctive features were identified:

  (i) The BPD cohort were on average seven years younger and included a higher proportion of females.

  (ii) Drug-involved poisoning was a more prevalent suicide method in the BPD cohort than in the all diagnosed cohort.

  (iii) There was a substantially greater prevalence of comorbid substance use disorders and neurotic, stress-related, somatoform disorders among the BPD cohort.

  (iv) Proximal to death, the BPD cohort had higher levels of engagement with psychiatrists, emergency department staff and CATT for mental health related issues; as well as a higher proportion of deceased having been admitted for inpatient mental health treatment.

(c) The data suggests that treatment strategies for people with diagnosed BPD might need to accommodate their multiple co-morbid mental health diagnoses and the multiple services with which they come into contact for mental health related issues.

1. Background

Coroner Olle is investigating the death of Sophie Nicholas, who was aged 27 years when she died by suicide on 25 September 2016. In the period leading up to her death she had contact with a large range of health services in the context of her diagnosed BPD.

Coroner Olle requested that the general case investigations staff in the Coroners Prevention Unit (CPU) prepare the following background material regarding suicide among people with BPD, to provide context for his death investigation:

- Annual suicide frequency
- Basic demographic profile of deceased by sex and age group
- Suicide methods used
- Profile of diagnosed mental ill health
- Profile of deceased contact with health services for mental health related treatment in the period proximal to death.

2. Method

This section describes how the CPU used its Victorian Suicide Register (VSR) to compile data to address Coroner Olle's request.

2.1 Data source

The VSR is a database of all suspected and Coroner-determined suicides investigated by Victorian Coroners between 1 January 2000 and the present.

The VSR includes in its core dataset the age and sex of the deceased, suicide method, location of fatal incident, location of usual residence, and date of death report. The core dataset is coded when the death is first reported and added to the VSR, and revised as the Coroner's investigation progresses and more information becomes available. Presently the core dataset is coded for every Victorian suicide reported between 1 January 2000 and the present.

The VSR additionally contains an enhanced dataset encompassing place of birth, relationship status and employment status; history of physical and mental ill health (mental illness is classified using the ICD-10 categories for mental and behavioural disorders); identified interpersonal and contextual stressors; and contacts with health and other services in the period leading up to death. The enhanced dataset is coded from full review of coronial records, which includes the police report of death to the coroner, autopsy and toxicology reports and coronial brief. As at the date of completing this advice, the VSR holds an enhanced dataset for every Victorian suicide between 2009 and 2015, with 2016 coding commenced.

Much information of relevance to Coroner Olle's request is coded only as part of the enhanced dataset. Therefore the time frame for data analysis in this study was restricted to suicides occurring between 2009 and 2015.

2.2 Inclusion criteria

The inclusion criteria for a relevant suicide in this study were that (a) the death was reported to a Victorian Coroner between 1 January 2009 and 31 December 2015; (b) the death occurred in Victoria; and (c) there was unambiguous evidence a clinician had given the deceased a BPD diagnosis.

2.3 Case identification

In the ICD-10 classification of mental and behavioural disorders, BPD is grouped under disorders of adult personality and behaviour. This category includes other types of personality disorders (for example paranoid, schizoid, dissocial personality disorders) as well as impulse disorders (for example pathological gambling), gender identity disorders, and disorders of sexual preference.

On 29 March 2019 the CPU searched the VSR for all Victorian suicides occurring between 1 January 2009 and 31 December 2015 where the deceased was coded as having a diagnosed disorder of adult personality and behaviour. The VSR free text information describing the mental health history of each deceased was reviewed for evidence of confirmed BPD diagnosis. Strict criteria were applied:

- If the deceased was described as having borderline personality "traits" or "features", or a clinical presentation "suggestive of" borderline personality disorder, this was not considered sufficient evidence of diagnosis and the death was excluded.
- If the deceased was described as having a personality disorder but the disorder was not further specified, the death was excluded.
- If the deceased was described as having a "cluster B" personality disorder without borderline being specified, the death was excluded.[56]

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[56] Cluster B personality disorders are a category of mental health disorders in the Diagnostic and Statistical Manual of Mental Disorders (an alternative classification system to the ICD-10). Cluster B personality disorders include antisocial, borderline, histrionic and narcissistic personality disorders, which is why a non-specific "cluster B" diagnosis was not deemed sufficiently specific to meet the inclusion criteria here.

2.4 Analysis

For each relevant deceased, the following data was extracted and analysed using descriptive statistics (frequencies and proportions):

- Sex
- Age group
- Year of death
- Suicide method
- Diagnosed mental illnesses
- Evidence of contact with health services (psychiatrist, psychologist, mental health practitioner, general practitioner, emergency department, CATT, drug and alcohol service) for mental health treatment within six weeks of death.[57]

Separately, the CPU extracted and analysed the above-described data for all Victorian suicides that occurred during the study period where the deceased had any diagnosed mental illness. The purpose of this was to use all Victorian suicides of people with mental health diagnoses as a comparator group, to identify what (if anything) was distinctive about the BPD cohort.

2.5 Limitations

BPD is known to be a poorly diagnosed and treated mental illness.[58] Clinicians' use of ambiguous language – for example, referring to borderline "traits" and "features" and "presentation suggestive of cluster B disorder" and similar, rather than articulating a diagnosis – further compromises accurate identification of people who have diagnosed BPD. Therefore, it is reasonable to suspect the cohort of deaths reported in this study does not include all those who suffered from BPD (and also includes some people who did not actually have BPD).

3. Suicides of people with BPD diagnosis, Victoria 2009-2015

There were 4133 Victorian suicides reported to the Coroners Court of Victoria (CCOV) between 1 January 2009 and 31 December 2015. Among these, 2240 deceased had a mental illness diagnosis, including 304 deceased who were coded specifically as having diagnosed disorders of adult personality and behaviour.

From review of the VSR mental health free text notes, 242 of the 304 deceased with diagnosed disorders of adult personality and behaviour were established to have a BPD diagnosis. The remaining 62 deaths were of people who had other diagnosed disorders of adult personality and behaviour (the most prevalent were schizotypal, antisocial and narcissistic personality disorders, and mixed personality disorders); and/or for whom the evidence of BPD diagnosis was ambiguous (referring only to "traits" or "features" or so on).

For convenience, the 242 deceased who had confirmed BPD diagnoses are referred to as the 'BPD cohort'. The comparison group of all 2240 suicide deceased who had diagnosed mental illnesses, is referred to as the 'all diagnosed cohort'.

3.1 Annual frequency

Table 1: Annual frequency of suicides in BPD cohort, all diagnosed cohort, and all Victoria, suicides, 2009-2015. (% shows the frequency expressed as a proportion of all Victorian suicides for the year.)

Year	BPD	All diagnosed	All Victorian

[57] The VSR contains two sets of coded data on health service contacts for mental health treatment: contact within six weeks of death, and contact between six weeks and 12 months before death. Coroner Olle was specifically interested in the period immediately preceding death, so only the data for health service contacts within six weeks of death was extracted.

[58] See for example National Health and Medical Research Council, *Clinical Practice Guideline for the Management of Borderline Personality Disorder*, Melbourne: National Health and Medical Research Council, 2012; Paris J, "Why Psychiatrists Are Reluctant to Diagnose Borderline Personality Disorder", *Psychiatry*, January 2007, pp.35-39; Day N, Hunt A, Cortis-Jones L, Grenyer B, "Clinician attitudes towards borderline personality disorder: A 15-year comparison", Personality *and Mental Health*, 12(4), 2018, pp.309-320.

	N	%	N	%	N	%
2009	46	7.8	340	57.5	591	100.0
2010	32	6.0	286	53.3	537	100.0
2011	33	6.0	285	52.0	548	100.0
2012	37	6.2	304	50.9	597	100.0
2013	33	5.5	300	50.3	597	100.0
2014	26	4.2	335	53.6	625	100.0
2015	35	5.5	390	61.1	638	100.0
Total	**242**	**5.9**	**2240**	**54.2**	**4133**	**100.0**

Table 1 shows the annual frequency of suicides in the BPD cohort and all diagnosed cohort, as well as all Victorian suicides, for the period 2009-2015. The annual frequency of BPD suicides remained relatively steady across the period, and accounted for on average 5.9% of all Victorian suicides each year.

3.2 Sex

Table 2 shows the overall frequency and proportion of suicides in the BPD cohort and all diagnosed cohort by deceased sex. There are marked differences between the two cohorts; females comprise 53.3% of deceased in the BPD cohort but account for only 31.0% of suicide deceased in the all diagnosed cohort.

Table 2: Frequency and proportion by sex of BPD suicides and all Victorian suicides, 2009-2015.

Sex	BPD		All diagnosed	
	N	%	N	%
Male	113	46.7	1545	69.0
Female	129	53.3	695	31.0
Total	**242**	**100.0**	**2240**	**100.0**

3.3 Age group

Table 3 shows the overall frequency and proportion of suicides in the BPD and all diagnosed cohorts, by deceased age group. The peak frequency for the BPD cohort was in the age groups 25 to 34 and 35 to 44; whereas for the all diagnosed cohort the peak frequency was in the age groups 35 to 44 and 45 to 54.

Table 3: Frequency and proportion by age group of suicides in BPD cohort and all diagnosed cohort, 2009-2015.

Age group	BPD		All diagnosed	
	N	%	N	%
Under 18 years	7	2.9	52	2.3
18 to 24 years	32	13.2	184	8.2
25 to 34 years	71	29.3	419	18.7
35 to 44 years	70	28.9	482	21.5
45 to 54 years	39	16.1	512	22.9
55 to 64 years	17	7.0	325	14.5
65 to 74 years	4	1.7	146	6.5
75 to 84 years	2	0.8	81	3.6
85 years and over	0	0.0	39	1.7
Total	**242**	**100.0**	**2240**	**100.0**

The difference in age distribution between the two cohorts of suicides is further illustrated with reference to average ages. For the BPD cohort the average age at death was 37.5 years (38.1 years for men, 36.9 years for women). Among the all diagnosed cohort, the average age at death was 45.0 years (44.9 years for men, 45.2 years for women).

3.4 Suicide method

Table 4 shows the overall frequency and proportion by suicide method for the BPD cohort and the all diagnosed cohort. For clarity, only the eight most frequent suicide methods were listed individually in the table; all other less prevalent methods were aggregated.

The most notable difference found was that a greater proportion of the BPD cohort used poisoning by drugs as the suicide method.

Table 4: Frequency and proportion by method of suicides in BPD cohort and all diagnosed cohort, 2009-2015.

Suicide method	BPD		All diagnosed	
	N	%	N	%
Hanging	110	45.5	1027	45.8
Poisoning - drug	69	28.5	396	17.7
Engine exhaust gassing	10	4.1	29	1.3
Rail	19	7.9	147	6.6
Firearm	2	0.8	99	4.4
Jump from height	8	3.3	142	6.3
Inert gas inhalation	6	2.5	73	3.3
Sharp object	3	1.2	60	2.7
All other methods	15	6.2	267	11.9
Total	242	100.0	2240	100.0

3.5 Diagnosed mental illness

Table 5 shows the frequency and proportion of deceased in the BPD cohort and all diagnosed cohort, who were diagnosed with each of the categories of mental illness specified in the ICD-10.

Table 5: Frequency and proportion of suicides in BPD cohort and all diagnosed cohort, where the deceased had diagnosed mental illness in each ICD-10 ctategory, 2009-2015.

Diagnosed mental illness	BPD		All diagnosed	
	N	%	N	%
Disorders of adult personality and behaviour	242	100.0	304	13.6
Organic mental disorders	1	0.4	46	2.1
Disorders due to psychoactive substance use	86	35.5	446	19.9
Schizophrenia, schizotypal, delusional disorders	41	16.9	303	13.5
Mood disorders	180	74.4	1774	79.2
Neurotic, stress-related, somatoform disorders	109	45.0	753	33.6
Physiological / physical associated syndromes	12	5.0	81	3.6
Mental retardation	1	0.4	5	0.2
Disorders of psychological development	3	1.2	28	1.3
Disorders with childhood/adolescent onset	12	5.0	75	3.3
Unspecified mental disorder	1	0.4	14	0.6

The most noteworthy differences were that a greater proportion of the BPD cohort than the all diagnosed cohort had diagnosed disorders due to psychoactive substance use (35.5% versus 19.9%) and neurotic, stress-related and somatoform disorders (45.0% compared to 33.6%).

To explore these findings further, the CPU summed how many mental illness diagnoses were present among each of the cohorts and divided this by the number of deceased in the cohort to calculate the average number of mental illness diagnoses per deceased in each cohort. Deceased in the BPD cohort had an average 2.8 diagnosed mental illnesses; this compared to an average of 1.7 diagnosed mental illnesses per deceased in the all diagnosed cohort.

3.6 Proximal contact with health services for mental health related treatment

Table 6 shows the frequency and proportion of deceased in the BPD cohort and all diagnosed cohort, who had contact with health services for mental health related treatment within six weeks of death.

Overall, 86.6% of deceased in the BPD cohort had contact with a health service for mental health related treatment in the six weeks leading up to death; this compared to 69.7% of deceased in the all diagnosed cohort. This disparity was reflected clearly in the figures regarding contacts with specific health services, with a substantially greater proportion of the BPD cohort having contact with psychiatrists (54.1% versus 32.9%), mental health practitioners (44.2% versus 25.0%), emergency departments (27.7% versus 13.1%) and CATT (17.4% versus 9.4%).

Table 6: Frequency and proportion of suicides in BPD cohort and all diagnosed cohort, where deceased had health service contacts for mental health treatment within six weeks of death, 2009-2015.

Health service	BPD		All diagnosed	
	N	%	N	%
Any contact proximal to death	**210**	**86.8**	**1562**	**69.7**
Psychiatrist	131	54.1	736	32.9
Psychologist	44	18.2	295	13.2
Mental health practitioner	107	44.2	559	25.0
General practitioner	94	38.8	960	42.9
Emergency department	67	27.7	294	13.1
CATT	42	17.4	210	9.4
Drug and alcohol service	19	7.9	76	3.4
No contact proximal to death	**32**	**13.2**	**678**	**30.3**
Total	**242**	**100.0**	**2240**	**100.0**

To explore the findings from table 6 in more detail, the data was re-compiled to examine the number of different types of health services with whom the deceased had contact in the six weeks preceding death for mental health related issues.

The re-compiled data, shown in table 7, indicated that most deceased in the BPD cohort (61.2%) had contact with at least two different health services for mental health related issues in the six weeks preceding suicide, and a substantial minority (36.4%) had contact with at least three different health services. By comparison, among the all diagnosed cohort most deceased (61.0%) had contact with none or only one type of health service.

Table 7: Number of health service types with which deceased had contact in six weeks prior to death, BPD suicides and all Victorian suicides, 2009-2015.

Number of different health service types contacted	BPD		All diagnosed	
	N	%	N	%
None	32	13.2	678	30.3
One	62	25.6	688	30.7
Two	60	24.8	436	19.5
Three	46	19.0	245	10.9
Four	27	11.2	134	6.0
Five or more	15	6.2	59	2.6
Total	**242**	**100.0**	2240	**100.0**

Further analysis was conducted on a sub-set of the data presented in table 6, to explore the involvement of public and private health services in the proximal mental health treatment. For suicide deaths occurring between 2009 and 2013, the VSR contains a dataset specifying whether any service accessed within six weeks of death (psychiatrist, psychologist, mental health practitioner, general practitioner, emergency department, CATT, drug and alcohol service) was public or private. Coding of these variables was ceased for deaths occurring from 2014 onwards for efficiency reasons.

Table 8a shows the frequency and proportion of deceased in the BPD cohort for the period 2009-2013, who had contact with public and private health services for mental health treatment. Table 8b shows the same data for the all diagnosed cohort. Notable findings included that a higher proportion of the BPD cohort than the all diagnosed cohort engaged both private and public specialist health services (psychiatrists, psychologists, mental health practitioners) for mental health treatment in the six weeks preceding suicide.

Table 8a: Frequency and proportion of suicides in BPD cohort, where deceased had contact with public and private health services for mental health treatment within six weeks of death, 2009-2013.

Health service	Public		Private	
	N	%	N	%
Any contact proximal to death	**136**	**75.1**	**149**	**82.3**
Psychiatrist	111	61.3	71	39.2
Psychologist	21	11.6	62	34.3
Mental health practitioner	102	56.4	32	17.7
General practitioner	1	0.6	112	61.9
Emergency department	82	45.3	2	1.1
CATT	51	28.2	4	2.2
Drug and alcohol service	21	11.6	12	6.6
No contact proximal to death	**45**	**24.9**	**32**	**17.7**
Total	**181**	**100.0**	**181**	**100.0**

Table 8b: Frequency and proportion of suicides in all diagnosed cohort, where deceased had contact with public and private health services for mental health treatment within six weeks of death, 2009-2013.

Health service	Public		Private	
	N	%	N	%
Any contact proximal to death	733	48.4	1234	81.5
Psychiatrist	498	32.9	433	28.6
Psychologist	73	4.8	317	20.9
Mental health practitioner	492	32.5	157	10.4
General practitioner	17	1.1	1050	69.3
Emergency department	374	24.7	11	0.7
CATT	246	16.2	12	0.8
Drug and alcohol service	82	5.4	47	3.1
No contact proximal to death	782	51.6	281	18.5
Total	1515	100.0	1515	100.0

3.7 Proximal inpatient admission to mental health services

Table 9 shows the frequency and proportion of deceased in the BPD cohort and all diagnosed cohort, who were admitted as an inpatient to a mental health service within six weeks of death. The proportion of deceased in the BPD cohort who had inpatient admissions (29.3%) was substantially higher than the proportion in the all diagnosed cohort (14.9%).

Table 9: Frequency and proportion of suicides in BPD cohort and all diagnosed cohort, where deceased was admitted as an inpatient to a mental health service within six weeks of death, 2009-2015.

Inpatient admission	BPD		All diagnosed	
	N	%	N	%
Admission proximal to death	71	29.3	333	14.9
Voluntary patient	56	23.1	260	11.6
Compulsory patient	27	11.2	100	4.5
No admission proximal to death	171	70.7	1907	85.1
Total	242	100.0	2240	100.0

4. Implications for prevention

The findings suggest that successful treatment strategies for people with diagnosed BPD might need to consider and accommodate their multiple co-morbid mental health diagnoses and the multiple services with which they come into contact for mental health related issues. These themes are explored in greater detail in the accompanying mental health case investigator advice.