CORONER'S COURT OF THE AUSTRALIAN CAPITAL TERRITORY

Case Title:	**Inquest into the death of Joshua**
Citation:	**[2023] ACTCD 2**
Decision Date:	**10 February 2023**
Before:	Coroner Archer
Decision:	See [4].
Catchwords:	**CORONIAL LAW** – Mental health - death by suicide at an ANU residence – lack of co-ordinated mental health care between ACT Mental Health Service and ANU – disclosure of personal health information to family – review of ANU mental health strategy
Legislation Cited:	*Coroners Act 1997* (ACT) sections 13, 34A, 52 *Health Records (Privacy and Access) Act 1997* (ACT) *Mental Health Act 2015* (ACT) *Health Act 1993* section 47
Cases Cited:	*Inquest into the Death of Mark Jolliffe* [2015] ACTCD 2 *Inquest into the Death of Adrian Pitman* [2019] ACTCD 13 *Inquest into the Death of Kaitlin McGill* [2020] ACTCD 7 *John XXIII College v SMA* [2022] ACTCA 32
Texts Cited:	Australian National University (2016) *Mental Health Strategy*, Canberra. Canberra Hospital and Health Services Operation Procedure (2017) *Initial Management, Assessment and Intervention for People Vulnerable to Suicide* (No CHHS17/143) Canberra. Canberra Health Services Procedure (2021) *Sharing Information with Carers – MHJHADS Adult Inpatient Units*, Canberra. Orygen (2020) *Australian University Mental Health Framework Report*, Melbourne. Productivity Commissions (2020) *Mental Health Report* (No 95) Canberra. Western Australia Department of Health (2016) *Good Practice Guidelines for Engaging with Families and Carers in Adult Mental Health Services*.
Counsel Assisting:	Ms X King

CORONER ARCHER

Summary

On 16 August 2018 Joshua was found deceased in his room at a residential hall owned by the Australian National University ("ANU") in Canberra but operated on its behalf by another entity. Joshua's full name and the name of that facility (referred to as "the residential hall") are not reproduced in these reasons. Joshua was 18 years old at the time of his death. It was clear from the room in which he was found that he had taken his own life by hanging. The findings of an autopsy conducted the following day confirmed that fact, and that his death had occurred some days before his body was discovered.

Joshua's death has been the subject of a coronial investigation. No hearing was held.

Matters of public safety are found to have arisen.

The following recommendations are made:

1. It is recommended that the ANU publish, in October 2023, an update of its review of its Mental Health Strategy.

2. It is recommended that the ANU and operators responsible for the operation of residential halls at the ANU co-operate in the reviewing the University's Mental Health Strategy and be involved in the re-negotiation of the Memorandum of Understanding ("MOU").

3. It is recommended that ACT Mental Health Services ("ACTMHS") provide guidance to ACTMHS practitioners and to carers as to the circumstances that would justify the disclosure of personal health information pursuant to Principle 10 of the *Health Records (Privacy and Access) Act 1997* (ACT). That guidance would apply generally and not just to the disclosure of information about patients who are subject to mental health orders.

4. It is recommended that the Government consider these disclosure of information issues in future reviews of the *Mental Health Act 2015* (ACT).

5. It is recommended that the Memorandum of Understanding between the ANU and ACTMHS, which deals with co-operation between those agencies concerning students with mental health challenges, be re-visited and updated by both the ANU and ACTMHS, informed by Joshua's experiences and the findings in this inquest.

Jurisdiction

1. Joshua's death was reported to the Coroner by officers from the AFP who were called to the residential hall after his body was discovered. As the death fell within the terms of section 13(1)(a) of the *Coroners Act 1997* ("the Act") the Coroner was required to hold an inquest into the manner and cause of Joshua's death and make the findings required by section 52 of the Act. That section of the Act relevantly provides:

> **52 Coroner's findings**
>
> (1) A coroner holding an inquest must find, if possible—

(a) the identity of the deceased; and

(b) when and where the death happened; and

(c) the manner and cause of death; and

(d) in the case of the suspected death of a person—that the person has died.

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(4) The coroner, in the coroner's findings—

(a) must—

(i) state whether a matter of public safety is found to arise in connection with the inquest or inquiry; and

(ii) if a matter of public safety is found to arise—comment on the matter

Evidence

2. The findings that follow are based on material received by the Coroner during the inquest process. Documents from ACTMHS were produced to the Court upon request. Investigating police produced a lengthy report to the Coroner which included information from family, friends, and fellow students. The Court received an autopsy report from Professor Duflou dated 124 October 2018. Joshua's family sent letters to the Coroner detailing Joshua's background and the mental health difficulties he suffered from his adolescent years. They also addressed issues they confronted in providing support to Joshua after he moved to Canberra, particularly in the period after he had self-harmed on 27 May 2018.

3. Based on that material, I was satisfied, for the purposes of section 34A of the Act, that the manner and cause of Joshua's death were sufficiently disclosed and, therefore, a hearing was unnecessary. My decision not to conduct a hearing and the reasons for that decision were provided to a member of Joshua's immediate family in writing and disclosed to affected parties in the provisional findings process.

FORMAL FINDINGS – SECTION 52(1) OF THE ACT

4. I am not able to determine with certainty when Joshua died. The swipe card to his room was last used on 31 July 2018. There were no reported sightings of him after that time. Therefore, based on the autopsy conducted by Professor Duflou, I make the following formal findings:

> Joshua died between 31 July and 16 August 2018 at Canberra in the Australian Capital Territory. Joshua died of asphyxia when he intentionally took his own life by hanging.
>
> I also find that matters of public safety arise in connection with the inquest in respect of Joshua's death. These are identified below, and comment is made.

PUBLIC SAFETY ISSUES – SECTION 52(4) OF THE ACT

5. The public safety issues that arise in this inquest emerge from the responses of ACTMHS and the ANU to Joshua's mental health crisis, which manifested both before and after his act of self-harm on 27 May 2018.

6. On 9 September 2022, the findings proposed to be made in relation to these public safety issues were sent to the ANU and the ACTMHS for their response and comment. Both organisations responded. The ANU response included information sourced from the operators of the residential hall. I have treated those responses as part of the evidence in the inquest.

Part 1 - Joshua's Background and Mental Health - Chronology

7. The public safety issues that arise, must be placed in the context of Joshua's relationship with his family and his mental illness.

Life experience before ANU

8. Joshua was born in another State and lived in that State before coming to the ACT in 2017 to study at the ANU. In February 2017, Joshua signed an occupancy agreement with the residential hall.

9. Joshua exhibited depressive traits from his teenage years although no formal diagnosis of mental illness was made at the time. There was a history of depression in his father's family. He was often very withdrawn and angry. In correspondence with the Court, his mother expressed the view that Joshua may have been autistic (although not diagnosed). There also may have been hearing problems. When Joshua was fourteen, he witnessed the aftermath of a serious car accident involving his mother and her friend. Joshua's mother believes this traumatic incident was the beginning of Joshua's mental health decline.

10. Joshua found it difficult to make friends and he experienced bullying at school. Whilst at school, he consulted a counsellor once although his family were never told what the content of that consultation was or what plan for further counselling or treatment was to be. They, and his general practitioner, encouraged Joshua to accept further psychological help but he was resistant to that suggestion.

11. Joshua did well at school and was accepted into a field of study at the ANU.

Student Life at ANU

12. Joshua commenced study at the beginning of 2017. When he moved into the residential hall, he signed a lease agreement in his own name.

13. He lived a mostly solitary life and made few contacts within his peer group. He kept to himself in the residential hall. Those who did have contact with him thought he was "depressed". His family did their best to maintain contact with Joshua. However, for reasons unclear to them at the time, he was reluctant to engage with them and reluctant to accept either financial or emotional support.

14. Academically, his first year of study was reasonably successful. He travelled home to spend time with his family over Christmas. It was a time of conflict, and the family were distressed and frustrated at his refusal to engage constructively with his siblings and in family events. Within three days of returning to Canberra, Joshua contacted his family and told them that he had closed the account that had been used by the family to provide him financial support. He asked them not to contact him again. Thereafter, he was able

to obtain limited part time work and received a Centrelink allowance. From that time, direct contact with his family was almost non-existent.

15. His isolation became even more pronounced and his social contacts, even with people in the residential hall in which he lived, were limited. In May 2018 he changed his course of study. He was consuming alcohol. He was occasionally cutting himself (arms and legs) although he made no report of that activity to anyone.

16. He visited the ANU health clinic on 3 May 2018 for an influenza shot. His mental health did not arise during the consultation.

First Act of Self Harm

17. On 27 May 2018, an ambulance was called to the residential hall in which he lived. Attending paramedics were told that Joshua had stabbed himself with a large hunting knife. He was taken to the Canberra Hospital ("TCH") where the wound was medically treated, and his mental health assessed. He told the attending clinician that he had suffered "low mood" for several years but in a more pronounced way in the last few weeks. He reported that he stabbed himself out of desperation and not knowing what else to do. He said he had been cutting himself for several years. He reported to mental health clinicians that he had few friends and little contact with his family. He claimed to have consulted with a psychologist at the ANU at the start of 2018 for "general depression" but found that person's treatment suggestions unhelpful. He initially resisted attempts made by hospital staff to get contact details for his family.

18. Joshua was not found to satisfy conditions for a mental health order that would have compelled his admission. Nor did he want to be admitted to the mental health ward. Nonetheless, he agreed to stay at the hospital in a medical ward for treatment of the wound, further mental health assessment and to allow time for putting in place community-based supports.

19. His parents were contacted by treating staff and his mother provided a recent history of his behaviour and his lack of contact with his family. Concerned by what they heard, his parents eventually contacted a family friend and her husband (Nathan) who was a pastor. They lived in Canberra and Joshua had met them both. They went to the hospital and spoke to Joshua and were able to communicate details of Joshua's presentation to his family.

Discharge from TCH

20. Joshua was discharged from TCH on 29 May 2018. A Suicide Vulnerability Assessment Tool was completed and reviewed. The discharge summary read:

> *Impression*
> *Provisionally, depressive disorder with suicide attempt*
> *Moderate risk of further attempt in the future but denied current intent or plan*
> *He does not wish to remain in hospital and is not detainable under MHA*
> *He wishes discharge and for a family friend to pick him up*
> *He is quite isolated and this may be an aggravating factor. May have personality factors contributing to mood and social situation.*
> *Plan*
> *Message left with family friend*
> *Discharge home*
> *CAT referral and follow up, monitor risk*
> *To review for antidepressants. He was given a number for CAT*
> *Wayback psychology consent form completed and is for referral*

21. His parents were not told that Joshua was being discharged nor were they informed of the terms of the discharge plan.

22. Joshua was picked up by Nathan and he stayed with him and his wife for a night. Thereafter, Nathan contacted Joshua from time to time to check as to how he was going. Nathan's view, recorded in the ACTMHS notes, was that Joshua had no other contacts to whom he could talk or seek assistance. An examination of Joshua's phone after his death confirmed that he was in contact with very few people.

23. Nathan called ACTMHS on 30 May 2018 expressing his concerns about the follow up plan. He told ACTMHS that Joshua did not want to talk to his family and that he was concerned Joshua might not follow up with the Crisis Assessment and Treatment Team ("CATT").

24. Joshua called ACTMHS a few hours later. He provided information about himself and told the nurse that he did not have suicidal thoughts or urges to self-harm. He was encouraged to see his GP. A Suicide Vulnerability Assessment Tool was completed and "nil acute risks were identified".

25. His parents came to Canberra on 31 May 2018 to see Joshua and provide him support. They contacted ACTMHS and detailed their concerns about Joshua's vulnerabilities particularly the lack of supports that were in place in his life. They spoke to ACTMHS of Joshua's lack of candour and honesty about his life and the extent of his mental health challenges.

26. Nathan called ACTMHS on 1 June 2018 to check that Joshua would be followed up by the CATT. He told the psychologist he spoke to that Joshua had a tendency not to tell the whole truth to family and friends. He also told the psychologist that Joshua was refusing to see his parents.

27. Later in the day on 1 June 2018, Joshua was reviewed by the CATT at City Mental Health (having missed an appointment the day before due mostly to the unavailability of the CATT). It was recorded that Joshua was very vague in response to questions from the CATT members. The assessment included in the Suicide Vulnerability Assessment Tool was that he was 'very guarded':

> *RISK:*
>
> *Denied any current thoughts of suicide or self-harm, however was very vague and guarded in his responses. Was agreeable to engage with his GP and with a follow-up phone call from CATT on Saturday evening.*
>
> *Impression:*
>
> *18-year old male who is not known well to ACT mental health services. Presented to the City mental health for follow-up review with CATT. Joshua was exhibiting signs of being depressed due to flat affect and monosyllabic responses which may be being exacerbated by previous or? Current ICE use which may be causing psychotic features noted from the vague engagement? Thought blocking and being very guarded around this current situation. Joshua refused for a follow-up consultation with one of the CATT psychiatrists, however is interested in seeing this GP for his mental health management.*

28. The notes contain an alert – *"information about Joshua not to be released to parents*". The reference to ice use was probably in error. Joshua had used ice to numb the area of his stomach where he had stabbed himself. It is not clear whether Joshua was aware

that this error had found its way into his clinical records. It is not clear to what extent this mistake informed clinical decision making.

29. On 2 June 2018 Joshua's father called to confirm that Joshua had attended his appointment the day before. He was told that he had, and that the CATT would continue to provide support as needed. Later that day a psychologist with MHS rang Joshua. He reported that he was "alright". He said he was supported by family friends and that he would follow up with "the GP earlier in the week" for a mental health care plan. He said he was seeing the GP through the university. He asked whether he had to keep in contact with the CATT and asked if follow up with the GP was enough. He assured the clinician that he would contact the CATT or Lifeline "in the event that the thoughts worsened". A detailed written referral was made to the ANU's student medical service by facsimile message and the notes of the 1 June 2018 assessment were included.

30. On 3 June 2018 ACTMHS notes indicate that Nathan called informing ACTMHS that, in the face of his refusal to engage with them, Joshua's parents were returning home. He told MHS that he was seeing Joshua daily and that Joshua was aware of the confidentiality that he (Nathan) had to maintain "with the exception of potential harm".

31. On 4 June 2018 Joshua's father called the ACTMHS. The notes of the conversation indicate that his father expressed concern about Joshua's level of support and volunteered parental support if Josh needed it. The ACTMHS notes record that "limited details provided about the care given Josh does not want details disclosed to his parents".

32. On 5 June 2018, a call was made by ACTMHS to Joshua. He confirmed details of his present living arrangements. He said he hadn't contacted his GP yet but said he would do so that day. He denied any thoughts of self-harm or suicidal ideation. No acute risks were identified.

33. Later that day his father was called by ACTMHS after he had complained to management within ACTMHS about not being given information about Joshua's care. During that call he expressed frustration at the lack of information provided to the family despite Joshua only being 18 years old. It was explained to him that since Joshua was an adult and had requested no information be released to his family, there was only limited information that could be provided. His father was encouraged to contact the CATT if he had specific concerns. According to ACTMHS notes, similar conversations about not being able to be told about Joshua's care occurred on 11 June 2018,18 June 2018, 28 June 2018, and 12 July 2018. His parents claim that there were other occasions in which similar things were said.

34. It should be observed that when these calls were made, information about Joshua was provided by his parents. That information was recorded and, therefore, was available to inform clinical judgments made about Joshua's care.

35. On 8 June 2018 Joshua was called by an ACTMHS social worker. He reported his mood was "good". He said he had an appointment with his GP "next Wednesday" and he would discuss a Mental Health Care plan with his GP. He said he had friends he could talk to. The social worker indicated in her notes that it was "difficult to get honest answers and difficult to engage – pleasant to talk to but he reports everything is "good"".

36. On 14 June 2018, a call to Joshua by an ACTMHS nurse was not answered. Later the same day Nathan called saying he had seen Joshua "last Tuesday" (possibly 12 June 2018). He said that Joshua "responds well to the contact with him and his wife" and that they "will continue contact with him".

37. Joshua did not answer a call made by an ACTMHS social worker on 15 June 2018. He was successfully contacted by phone the following day. He said he "didn't get a chance to see his GP" but may be able to see the GP "in two weeks" qualifying this by saying "we will see". He had not contacted any psychologist to book an appointment but said he would follow this up. He said that he had support "from his friends" and "feels this is enough". He said he did not feel the need for further CATT involvement. The brief Mental Health Examination was recorded thus:

> *Brief MSE*
>
> *Polite, superficial engagement. Reported good mood and sounded flat. Logical and linear thought form, future focussed content. Sounded oriented and alert but not formally tested. Some insight and judgment.*

38. The recorded plan was to review the case with a view to closing the file.

39. On 18 June 2018, an ACTMHS psychologist spoke to Joshua's father at some length about Joshua and his history. As previously noted, he expressed frustration about the system in which "nil information" can be provided to them. He said the family felt more confident with Joshua "having CATT support".

40. Later that day an ACTMHS psychiatrist called ANU Health. It was confirmed that Joshua had seen a doctor at ANU Health on 6 June 2018. In fact, this was not so. A CATT report had been sent to ANU Health on 2 June 2018 asking for follow up. A message was left for the GP to contact the psychiatrist.

41. On 19 June 2018 "*Wayback*" accepted a referral for psycho-social support. That service is provided through Woden Community Services and is available to support people in the first few months following a suicide attempt.

42. On 21 June 2018, a clinical team within ACTMHS met to discuss the case. The consulting ACTMHS psychiatrist indicated he would contact ANU counselling to see if they would engage with Joshua. That day the GP returned the call indicating Joshua had only been seen once, and that was in March 2018.

43. On 25 June 2018 *Wayback* called ACTMHS to indicate that Joshua had declined support from their service. He had told them "he has enough supports in place". *Wayback* indicated that he was given their number and invited to contact *Wayback* if he changed his mind.

44. Following that call, the consulting ACTMHS psychiatrist called the head of the ANU's counselling service. The history of the case was outlined. Parental concerns were noted as were Joshua's limited social contacts. The head of counselling undertook to try to "follow up" and "provide feedback to the CATT".

45. On 26 June 2018 Joshua visited a GP at ANU Health. Joshua was described as answering "with one or two words". It was said that it was "not easy to assess mental state". The report that had been sent by CATT (see above [40]) had been reviewed prior to the consultation. The notes record that Joshua indicated that his "moods now stable with no TOSH". He indicated he was still depressed, he wanted to try "Rx" (prescription medicine). He was recorded as saying "he has seen counselling but did not find it useful". He told the doctor he lived in University accommodation and "has friends". He said that he had no drug and alcohol issues and asked for a note because he had missed weeks of study in semester 1. He was given a script for a month of Zoloft. He was to be reviewed in a month.

46. On 28 June 2018 Joshua's father called ACTMHS. The content of the call was to the effect set out at [33].

47. On the same day, the consulting ACTMHS psychiatrist spoke to "ANU counselling". The notes of the discussions of that day are headed "Not to be released". It was indicated in the notes that the counselling service had been in contact "with supports at Joshua's uni accommodation staff who are in regular contact with Joshua. They are not concerned about his mental state". The notes go on to record:

> *GP Aware*
> *ANU counselling aware*
> *Joshua declining CATT contact*
> *Plan*
> *CATT closure*

48. The corresponding notes were sought from ANU counselling by subpoena but not produced. The Court was informed that if the notes existed, they could not be found.

49. On 9 July 2018 Nathan called and provided an update on Joshua's circumstances. He said, "he meets Josh regularly" and that "he spends time with some other people", he (Joshua) was "cagy" with professionals, and he was quite happy "5-6 on a scale of 10". Nathan was told that the file was closed but that he (Nathan) was quite welcome to call CATT.

50. On 12 July 2018 Joshua's father called "seeking information re Joshua contact with mental health services". He was told by the nurse that "due to privacy and confidentiality laws" information could not be divulged to him without Joshua's consent. He was again told that he was welcome to register any issues or concerns "that he may have regarding Joshua requiring mental health attention". According to the notes, he was not told that the CATT file had been closed and that, therefore, ACTMHS were no longer monitoring his condition.

51. There are no further contacts recorded in the notes until 17 August 2018 when MHS were notified of Joshua's death by the office of the ACT Coroner.

Last Contacts with Nathan

52. When spoken to by police investigating on behalf of the coroner, Nathan outlined the contact he had with Joshua. Some of that contact is set out above. He told police that in his view, the act of self-harm in May 2018 was motivated by the stress Joshua was feeling in his studies. He saw him as lonely and frustrated. Nathan said Joshua was reluctant to engage with health professionals. Joshua had said to him that the single psychologist appointment at City Mental Health had not been very useful. Joshua had also said he had been told to see a GP but had refused. Nathan last saw him in late July 2018 at a bar in Civic. Joshua said he was doing well but that his study was "really hard". The last text message he had from Joshua was on 25 July 2018 which was to cancel a meeting they had planned. Shortly after, Nathan travelled interstate for work. When he returned to Canberra, he texted Joshua without receiving a response. Nathan was contacted by McDonalds who were expecting Joshua to begin work there. On 16 August 2018 Nathan contacted the residential hall and suggested they check Joshua's welfare. That suggestion eventually caused his body to be discovered in his room later that day.

Part 2 – Significant Features of his time at ANU

Life at the Residential Hall

53. Fellow students who lived in close proximity to Joshua at the residential hall were interviewed by investigating police. They indicated that they had little contact with him at any time but particularly in the period leading to his death. He was described as spending most of his time in his bedroom with the door shut. He played on-line games and would rarely engage in conversation. One fellow resident described him as depressed and said he often joked about self-harm. He was described as very poor. It was known by that person that Joshua was estranged from his family and that he, Joshua, was resentful of visits to his room by members of staff from the residential hall. Joshua had described these visits as an "invasion of privacy". They were not able to say when they last saw Joshua.

Pastoral care

54. Until his act of self-harm in May 2018 the interactions between Joshua and those responsible for the management of the residential hall generally appear to have been those necessary for the maintenance of his tenancy. According to the residential hall, there was no signs or evidence of any concerns during the first 12 months or so of his tenancy. On 12 January 2018 Joshua's mother called reception and asked that a welfare check be conducted on her son. That was done and Joshua stated that he was "OK" and that there was no need to check on him. On 13 March 2018 concerned friends asked for a welfare check to be conducted. That was done and Joshua reported that he was "OK". However, Joshua was angry about these checks being conducted and on 27 March 2018 he asked for a meeting with the Assistant Residential Life Manager (ARLM) to discuss why these checks were taking place as he regarded them as a breach of privacy. That meeting took place on 3 April 2018. The ALRM told Joshua that the welfare checks were justified by the contractual agreement that existed between them.

55. On 1 June 2018, after Joshua was released from TCH following the act of self-harm, the ALRM contacted Joshua to check on his welfare. An agreement was reached that they would meet every two weeks for the next 6 weeks starting on 7 June 2018. According to the residential hall, meetings took place on 21 June 2018, 3 July 2018, 12 July 2018, 13 July 2018 and 31 July 2018. Although no record was kept of what was discussed Joshua apparently indicated that he was doing "OK" and that he was receiving support from Nathan. The act of self-harm did not cause a formal consideration (at least to the extent of that being documented) of what Joshua's apparent vulnerability might require by way of structured intervention, liaison with mental health providers or increased or structured pastoral care.

ANU Counselling Services

56. Joshua's contact with counselling services at the ANU appear to have been limited. The only recorded consultation with Joshua took place on 8 March 2018. Joshua initiated that consultation. He reported feeling "down". The history given of his background suggested resentment towards his family. He reported being socially isolated. He reported no thoughts of self-harm although his depression was rated as "extremely severe". He was given a range of options including enquiring about a "mood management course" at the ANU or seek out courses on-line. He was offered the continuing involvement of the ANU counselling service and he agreed to re-book. He was referred to a general practitioner for the prescription of anti-depressants. No record was found of him consulting this service again. The contact between MHS and ANU Counselling that apparently occurred on 2 and 25 June 2018 did not result in the production of a record or a case plan.

Part 3 – Analysis of the ANU's Response to Joshua's Mental Health Crisis

57. The evidence does not suggest that the ANU responded to Joshua's mental health challenges in a co-ordinated way.

Student Mental Health - General Issues

58. The Productivity Commission in its 2020 *Mental Health* report[1] surveyed mental health amongst tertiary students. It concluded that there was evidence that tertiary students had poorer mental health than the general population. Where these rates stood in 2018 is difficult to say as there is no regular national data collection on the mental health of tertiary students in Australia that allows a point in time comparison.[2] The factors that were found to worsen mental health outcomes included the challenges that Joshua was facing:

    (a) Workloads and academic demands

    (b) Separation from families and support networks; and

    (c) Financial stress

59. The Commission found that many students do not seek out help for their mental health, with only a third of students with elevated levels of psychological distress having consulted a health professional regarding their stress,[3] often because of the stigma associated with seeking help.[4]

60. The *Higher Educational Framework 2015* and the *National Access to Services Benchmarks* include well-being and safety standards that all universities must provide including, relevantly, the development of a critical incident policy together with procedures that cover the immediate actions to be taken after such an incident and any follow up required.[5]

61. The ANU published its *Mental Health Strategy* in April 2016. Its strategy was self - described as a "graduated response to mental health, determined by need".[6] It has seven elements. Relevantly it provides:

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[1] Productivity Commission (2020) *Mental Health Report* (No 95) Canberra.
[2] Ibid Vol. 2, 262.
[3] Ibid Vol. 2, 267.
[4] Ibid Vol. 2, 268.
[5] Ibid Vol. 2, p 270. In 2020 *Orygen* released the *Australian University Mental Health Framework report.* The Foreword to that framework states its objectives:

> The Australian University Mental Health Framework (the framework) provides guidance for mentally healthy university settings that provide the best opportunities for students to thrive educationally and personally. The framework also includes guidance for the mental health sector to strengthen its engagement with universities to support student mental health and wellbeing.
>
> The Framework identified six thematic areas of best practice for the education sector which included the following:
>
> 4. The response to mental health and wellbeing is strengthened through collaboration and coordinated actions.

5. Students are able to access appropriate, effective, timely services and supports to meet their mental health and wellbeing needs.
6. Australian National University (2016) *Mental Health Strategy* Canberra, 2.

6. Accessible mental health services

To improve timely and coordinated access to relevant University mental health services and referral to community services for students with identified mental health needs, with a service focus on building strengths and recovery.

7. Crisis management

To ensure a well-communicated, coordinated, and timely campus response to mental health crises (situations of acute distress and imminent risk of harm to self or others), including the clarification of student role expectations and channels of emergency support.

62. The published document does not give specific content to these elements.

Application in Joshua's case

63. In Joshua's case, it is not clear how this strategy was given practical application. The self-harm event of 27 May 2018 caused the production, at the residential hall, of a "Student Critical Incident Report". However, that form was not being used as a case management tool. The form described the type of incident as "Student suicide attempt". It contained details of the event, emergency services response and welfare checks done in relation to affected roommates. The "Follow up post incident" section of the form did not contain any reference to ongoing support of Joshua by way of counselling or referral to mental health providers. As noted, ANU Counselling did not produce any documents evidencing contact with Joshua, knowledge of Joshua's act of self-harm or awareness of his well-being in the period after that self-harming event. There is a general absence of material suggesting that there was a co-ordinated attempt to identify Joshua's psychological stressors and to ensure that appropriate supports were in place. Given the seriousness of the act of self-harm this absence of documentation and a care plan is surprising.

64. The extent to which a response to Joshua's mental health crisis was delegated to the residential hall is discussed below.

65. The mental health challenges that Joshua was facing did not result in him being provided with an Education Access Plan ("EAP"). An EAP is a document that allows a student who is impacted by a disability, including a mental health condition, to receive reasonable adjustments to their study requirements. Information from the present day suggests EAP's are provided by a service at ANU called *Access and Inclusion* who have a team of Disability and Equity Advisors.

66. It appears then and now, that this service is based on self-referral. Subpoenaed material from ANU did not suggest Joshua was linked with that service. Those records also suggest he sought deferral of exams by letter dated 31 May 2018; noting he had been "hospitalized and ill for the first week of ANU exams". He produced a medical certificate dated 29 May 2018 from ACT Health saying he would be unfit "for work" because of a "medical condition". The date of the "accident" was given as 27 May 2018. He was deemed fit by ANU to undertake deferred examinations from 2 June 2018. However, no link was made between this notification and an act of self-harm.

Pastoral Care Provided by the Residential Hall

67. When Joshua went to live at the residential hall in 2017 and when he returned in 2018, he entered into an occupancy agreement. The agreement incorporated by reference the terms of the residential hall's *Handbook*. Neither the agreement nor the *Handbook* makes

clear the content of the obligations owed by the residential hall in respect of the pastoral care of students residing at the hall.

68. That said, in its dealings with Joshua before his act of self-harm, the residential hall explicitly asserted that its interventions by way of welfare checks were obligated by the contractual duty of care owed by the residential hall under the residency agreement. It saw itself as owing a duty of care to Joshua greater than him being simply an occupier of a room. For the purposes of this inquest, it is not intended to survey the legal duty of care owed to residents by residential halls at the ANU.[7] It is assumed that the Operating Agreement between the ANU which appointed the operator of the residential hall, required the operator to provide services, including student support management, pastoral care and work health and safety.

69. As has been observed in the above chronology of events, the residential hall did engage with Joshua both before and after the act of self-harm in May 2018. That engagement did include visits to his room (before that event) and regular meetings with him afterwards. Less clear is the extent to which relevant employees of the residential hall encouraged Joshua to access mental health support or facilitated such engagement. Certainly, no documents were produced that indicated the existence of a co-ordinated care or welfare plan or an assessment of on-going risk. The level of knowledge within the staff of the residential hall as to the extent of Joshua's engagement with such services seems to have been low. Assurances given by him that he was "OK" seem to have been accepted.

70. It is evident from the 2018 *Handbook,* that a number of employees were responsible for providing pastoral care to student residents, including Residential Advisors (RAs), Senior Residents (SRs), Community Coordinators (CCs), the Assistant Residential Life Manager (ALRM) and the Residential Life Manager (RLM). At the time those employees resided on site, and some were students in their later years of study.

71. It is unknown to what extent these employees were trained in dealing with mental illness. It is also unclear what expectations were held in relation to students providing this form of pastoral care for fellow students who may have been suffering mental health problems.

72. Taken as a whole, it is not clear that this level of engagement by the residential hall and ANU health providers was consistent with the ANU's stated mental health strategy. In particular, it could not be described as "well communicated" or "co-ordinated". There were no policy or procedure documents that have been drawn to the attention of the coroner that gave the ANU's Mental Health Strategy practical application either at the time of Joshua's death or subsequently.

73. Nor is there much sense of attempts being made by agencies within ANU (the residential hall, ANU Health, and ANU counselling) to engage, other than on a purely ad hoc basis, with ACTMHS.

Part 4 – Analysis of the ACTMHS response to Joshua's Mental Health Crisis

Confidentiality – Providing Information to Families

74. The facts as found, indicate that Joshua was at the time of his death, most probably suffering from a depressive illness or disorder and that it was untreated. Before and after his act of self-harm in May 2018, he resisted opportunities to engage with medical professionals who may have been able to assist him. Before that act of self-harm, he

[7] See generally *John XXIII College v SMA [2022] ACTCA 32* and the *Civil Law (Wrongs) Act 2002 (ACT)*.

also positively resisted attempts made by the staff at the residential hall in which he lived to make checks as to his welfare. Typically, of a young man with a depressive condition, he persistently misled mental health practitioners who sought to assess his mental health status by painting a false picture of social connection and "wellness". He answered inquiries about his well-being by saying he was "OK". Nathan was his only consistent social contact and his continued involvement provided re-assurance to others who were concerned as to his welfare.

75. In correspondence sent to the coroner his family have contended that they were effectively prevented from making a realistic assessment of Joshua's needs by the refusal of ACTMHS to provide them with information. This included not being told about the decision taken by ACTMHS to end their involvement in Joshua's case.

76. Joshua's parents are haunted by the feeling that, if they had known that he was effectively without professional engagement or support, they could have done more to intervene.

77. It is noted that they did not live in Canberra and Joshua had eschewed contact with them. They were in contact with Nathan and could and did receive information from him in respect of Joshua's general circumstances. They probably knew more about Joshua's circumstances than ACTMHS did. They did their best to impress upon ACTMHS that he was very isolated. Given his refusal to engage with his parents there was little they could do to help their son beyond arranging for Nathan to be a point of social contact. Even if they were told his file had been closed, and they came back to Canberra as a result, it was highly likely Joshua would not engage with them. They could have done no more than they did.

78. I make no finding that the refusal of ACTMHS to disclose information to Joshua's parents contributed to his death.

79. The right to privacy of a person receiving mental health services is legislated in the ACT under the *Health Records (Privacy and Access) Act 1997* ("the Health Records Act") and the *Mental Health Act 2015* ("the Mental Health Act"). Principle 10 (in schedule 1 of the Health Records Act) establishes the general rule that a patient's personal health information is confidential and is only disclosed to people who are authorised by the Health Records Act legislation to have it. The Mental Health Act makes clear (at section 6) that a person with a mental disorder or mental illness has the same rights and responsibilities as other members of the community. Relevantly, they can consent to or refuse treatment, care and support and they have a right to have their will and preferences considered in decisions made about their treatment, care, and support. Although under both Acts the role in care of relatives and carers is acknowledged, the terms of that acknowledgement are expressed in conditional terms and not in terms of competing rights enjoyed by family members to information about a family member who may suffer from a mental illness or disorder. Section 6J of the Mental Health Act, for example, states that services provided to a person with a mental disorder or illness should (with emphasis added):

> (x) *facilitate appropriate* involvement of close relatives, close friends and carers in treatment, care or support decisions in partnership with medical professionals;
>
> ……
>
> (xii) *promote inclusive practices* in treatment, care or support to engage families and carers in responding to a person's mental disorder or mental illness; and

80. The Health Records Act, particularly at Principle 10, does envisage that information about a person can, even in the absence of consent, be disclosed to members of a family but only in limited circumstances. Those circumstances relevantly include:

    (a) where disclosure is required or allowed under a Territory law; and

    (b) where the record keeper believes on reasonable grounds that the disclosure is necessary to prevent or lessen a serious and imminent risk to the life or physical, mental, or emotional health of the consumer or someone else.

81. In the absence of one or more of the justifications stated in the Privacy Principles to the Health Records Act, disclosure of information against the express wishes of a consumer is unlawful.

82. Joshua was not subject to any orders that limited his capacity to make decisions on his own behalf. Joshua could make decisions about the disclosure of information to his family. He expressly, and obviously forcefully, did not consent to that disclosure.

83. As noted, the terms of the Health Records Act permit disclosure necessary to prevent or lessen a serious and imminent risk to the life or physical, mental, or emotional health of the consumer or someone else. The ACTMHS notes in this case do not contain reference to this consideration when decisions were taken to refuse to provide information to Joshua's family.

84. The Court was not able to find any guidance that is provided to ACTMHS practitioners as to how this provision is to be implemented. I make no finding that this failure contributed to the cause of Joshua' death. Joshua may have been at an elevated risk of self-harm because of his history of depression and having committed an act of self-harm. The over the phone assessments after his release from TCH which are referred to above, did not suggest that there were *serious* and *imminent* risk to his life. Whether there were serious and imminent risks to his mental and emotional health is more difficult to say. However, there is no evidence reflected in the ACTMHS notes that this assessment set out in the Health Records Act was undertaken, even in the period immediately after Joshua's discharge from hospital and in the face of ongoing requests for information made by Joshua's parents.

85. As to the lack of transparent reference to this consideration in refusing Joshua's parents access to information, ACTMHS noted in its response to my provisional findings that various policy documents and training packages refer to the balancing issues required by Principle 10. Evidence was provided of mentoring processes that ensured that learnings were shared amongst staff. Note was made that the Suicide Vulnerability Assessment Tool (SVAT) was available and used by clinicians on 27 May 2018, 30 May 2018, and 1 June 2018.

86. The inflexibility of the legislative regime, or at least as it is interpreted, that restricts (in the absence of consent) the capacity of families to receive information about a member of their family who may have a mental illness or disorder has been the subject of previous recommendations made by other coroners in the context of persons who have been subject to orders such as psychiatric treatment orders: see *Inquest into the Death of Mark Jolliffe [2015] ACTCD 2; Inquest into the Death of Adrian Pitman [2019] ACTCD 13* and *Inquest into the Death of Kaitlin McGill [2020] ACTCD 7*.

87. The general effect of those recommendations was that the ACT Government should review relevant legislation to determine whether legislative reform was desirable in the context of information dissemination to families subject to PTO or similar orders. The Government response to the recommendations made in *McGill* was layered. The Government pointed to those parts of Principle J in the Mental Health Act supporting the

role played by carers and family in the care of those suffering a mental illness or disorder and the importance of facilitating communication with clinicians. It noted that the right of privacy enshrined in section 12 of the *Human Rights Act 2004* (ACT) could be subject to reasonable limitations. Finally, it was observed that the Mental Health Act was undergoing phased review and that the recommendations of the coroner "could be included as part of the review process" noting that the Government is due to conduct phase two and phase three of the review of the Mental Health Act.

88. The Mental Health Act has been subject to review after it came into effect on 1 March 2016. The timing and focus of future reviews are not known.

Case Management Processes within ACTMHS

89. The case planning processes in this case were not robust. After discharge from hospital (through the clinical rather than psychiatric path) a holistic care plan was not developed, and Joshua was not given clear advice about his treatment options and where and when they could have been sourced. To the knowledge of ACTMHS, he was avoiding engagement with his GP, but no care alternatives were explored. Information available to ACTMHS about his level of engagement with ANU counselling was limited.

90. Joshua's file was closed (in the sense of their being active case management) within about a month from an act of self- harm that had required hospitalisation for a number of days. He was known to be estranged from his family and reluctant to seek out mental health and other medical supports. Little was known of his social network other than the presence of Nathan. Nathan's future life plans, if they were known, were not recorded. The possibility of him being absent from the Territory was not considered when considering the closure of the ACTMHS file. Joshua was seen in person once by ACTMHS after discharge. No documented meetings occurred between ACTMHS clinicians and staff at the ANU and no attempt was made to organize meetings between Joshua, ACTMHS and ANU clinicians or staff or students at the residential hall. There does not seem to have been consultation with relevant areas of the ANU to ensure that psychological stressors such as academic and financial pressure were being addressed or at least being discussed with Joshua.

91. ACTMHS provides guidance to all ACTMHS staff on the initial management assessment and intervention for a person vulnerable to suicide in its procedure *Initial Management, Assessment and Intervention for People Vulnerable to Suicide* ("the Guide").[8] The Guide was issued on 11 July 2017 and was in place at the time of Joshua's death. I find that the procedure set out in that document was generally complied with in respect of most issues, including ongoing assessment of risk through the SVAT process. However, it is noted that in the absence of much reliable information being available to ACTMHS about Joshua's progress, it is difficult to determine how his suicide risk was determined and reviewed.

92. The paucity of information that was available to clinicians within ACTMHS underscored the need to ensure that there were adequate community supports in place. The issue in Joshua's case was the degree of "wrap around" support that was in put in place after his file was closed. A documented care plan was not provided to Joshua as the Guide requires. The Guide required that Joshua be "linked with ongoing treatment, information and formal support services prior to discharge from the service".

93. The Memorandum of Understanding ("the MOU") between ANU and Mental Health Justice Health and Alcohol and Drug Services, in place at the time of Joshua's act of

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[8] Canberra Hospital and Health Services Operation Procedure (2017) I*nitial Management, Assessment and Intervention for People Vulnerable to Suicide* (No CHHS17/143) Canberra.

self-harm, contemplated that this linking would be addressed in the context of a level of co-operation as between ACTMHS and the ANU. The contents of the MOU is discussed at [105] of my findings. Whilst the referral to ANU counselling was made, the "wrap around care" within the university was not as carefully co-ordinated as might appropriately have been the case.

Part 5 – The Provisional Findings Process

94. On 9 September 2022, my provisional findings were sent to the ANU and ACTMHS for comment. Both organisations responded and matters raised in their responses are addressed below.

95. The factual findings, analysis and recommendations set out in this judgment are virtually identical to those published to the parties in the provisional findings.

The ANU's Response to Provisional Findings

96. Responses were received from both the ANU and the residential hall.

ANU Response

(a) Mental Health Strategy

97. The response from the ANU - I find, correctly - asserted that there was evidence that agencies within the ANU and the residential hall provided support to Joshua after his act of self- harm. These interventions are noted in the chronology set out above.

98. It is acknowledged that new structures have recently been put in place that have the potential to make the ANU more responsive to students in a position of mental health crisis. A Head of Clinical Services has been created in a new *University Experience* Division. In 2022 that Division was expanded including the appointment of case managers and a nurse. A *Student Safety and Wellbeing T*eam was formed in 2021. In March 2022, a *Student Safety and Wellbeing Plan* was promulgated. It was updated in July 2022. These are positive developments. However, the Court was not provided with evidence of guides, policy documents or protocols that govern the practicalities of the relationship between clinical services (such as ANU counselling), areas within the ANU concerned with academic governance, and the residential halls in respect of assisting students (like Joshua) with mental health challenges. The *Student Safety and Wellbeing Plan* is directed primarily at issues surrounding sexual assault rather than being a detailed response to mental health issues in the student population.

99. In its response the ANU conceded that more work needed to be done:

> The university notes that it is important to recognise that Senior Residents are not expected to provide mental health support to students. In the event of an identified area of concern, the student is referred to experienced personnel in the case workers/counselling teams. In April 2022, the University Senior Management made a commitment to review the student residences (business operations, student pastoral care and academic integration) with the intent to further improve upon its training to staff, students and service providers, look at alternate pastoral and wellbeing programs, review the Senior Residents responsibilities and training and ensure consistency in services across all residence, along with better integration and coordination. This work is expected to take 18-24 months.

100. The ANU's response acknowledged that "under present day case management process …a greater level of wrap around support could have been afforded". The response does not in terms indicate what the different approaches in practice might be.

(b) Co-ordination between ANU and ACTMHS

101. The MOU between the ANU and Mental Health Justice Health and Alcohol and Drug Services was provided to the Coroner by ACTMHS in its response to the provisional findings. The stated objective of the MOU was to "formalise the collaborative relationship between the services". The document states that it is a "working document" and will be supplemented by specific protocol, procedures, and referral forms as relevant. As to clinical management it stated that "[b]oth parties are committed to developing a clinical management system that recognises the complementary role of each party'. The documents committed the parties to "consul[ting] with families, care givers and other stakeholders". ANU Counselling amongst other entities within the ANU is identified as a key stakeholder in this process of co-operation.

102. The ANU's response to the provisional findings did not acknowledge the existence of the MOU, although mention was made of the fact that the *Student Safety and Wellbeing Team* "is also establishing greater connections with local community services such as ACT Mental Health and the Canberra Rape Crisis Centre. The team has met with a number of partner organisations with a view to formalising relationships and this work is ongoing".

103. The ANU noted in its response that a "taskforce has been established by the University Council at its October 2022 meeting for the purpose of reviewing the University's Mental Health Strategy. The mandate of this taskforce is to review the operation of the Mental Health Strategy and to provide findings to Council to inform a new and/or amended Strategy". That indication is welcomed.

> 1. It is recommended that the ANU publish, in October 2023, an update of its review of its Mental Health Strategy.

Residential Hall Response

104. The residential hall provided a separate response to the ANU. Relevantly, it stated:

> In addition to the matters addressed by the University, [the residential hall] wishes to add that as an operator of a residential accommodation facility, it does not have visibility in relation to a number of aspects regarding a resident following their engagement with a counselling service or another mental health service provider. That is not a criticism of anyone in any way and is very understandable in many instances due to privacy and other considerations. Such is also probably an implicit acknowledgement by those others of the fact that [the residential hall] is an accommodation provider who, as part of its accommodation services, offers certain pastoral care and support services to residents, rather than it being a specialist provider of those services.
>
> However, the "one-way flow" or referral of information can on occasion create a seemingly disjointed engagement with a resident which, in the case of Joshua, resulted in [the residential hall's] "check-ins" and welfare-based engagements being perceived by him as intrusions into his privacy and a source of frustration for him. That was quite obviously contrary to the intended purpose of those engagements and is something which [the residential hall] would very much like to avoid and improve upon (and in the case of Joshua, very much regrets, as the intention and purpose of those engagements (and those of the persons involved in them)) was at all times to assist Joshua with his well-being and to improve the quality of his experience, not to cause him frustration).
>
> [The residential hall] would welcome the increased provision of appropriate information by others to it after an engagement with counselling or other relevant

service has occurred, as this may permit a more nuanced or tailored approach to be adopted in its engagements with a resident. However, that would, of course, be very case specific in terms of what information may be able to be conveyed to [the residential hall] and the matters which can, appropriately, be addressed or participated in by [the residential hall], bearing in mind the services which are able to be provided by it and the obligations which are owed by it to both the University and the resident.

105. The response highlights the lack of cohesion as between the residential hall, the ANU and ACTMHS which has been referred to above. It is obviously important that the residential halls be part of the review of the ANU's Mental Health Strategy that is referred to above and the re-negotiation of the MOU.

> 2. It is recommended that the ANU and those responsible for the operation of residential halls at the ANU co-operate in the review of the ANU's Mental Health Strategy and be involved in the re-negotiation of the MOU.

ACTMHS Response to Provisional Findings

106. A response dated 28 October 2022 was received from ACTMHS. It was authored by Ms Katie McKenzie, Executive Director of Mental health, Justice Health and Alcohol and Drugs Services. The response was directed principally at three issues:

(a) The release of information to families

107. In the provisional findings published to the ACTMHS the following recommendation was foreshadowed:

> I recommend that consideration should also be given by MHS to the provision of guidance to MHS practitioners and to carers as to the circumstances that would justify the disclosure of personal health information pursuant to Principle 10 of the Health Records Act.[9] That guidance would apply generally and not just to the disclosure of information about patients who are subject to mental health orders.

108. Ms Katie McKenzie provided this response

> I agree with that recommendation. The provision of such guidance is important in framing and setting expectations and boundaries regarding disclosure. Such would be beneficial in providing the best support and care for our clients.
>
> I also acknowledge that ongoing training on such is important, as is learning from past experience. It must be recognised that each client's circumstances are unique to that client. As such, there can be no fixed prescriptions as to what circumstances would meet the disclosure exemptions in Principle 10.
>
> I also agree with the recommendation at [85] that general advice regarding disclosure obligations and legislative restrictions be developed and readily accessible to family members, carers, and support people. As a starting point, I note the Canberra Health Services flyer 'Mental health information for family, friends, support people and carers', November 2020. …will be updated to contain more explicit guidance on sharing of information.

[9] Specific guidance is provided in respect of information sharing when patients are discharged from a Mental Health, Justice Health, Alcohol and Drug Services.

I confirm that the 'Canberra Health Services Procedure: Sharing Information with Carers- MHJHADS Adult Inpatient Units' (issued 27 April 2021) contains a section on pages 13 and 14 in relation to the nature of the relationship between staff and a Carer and types of information which can be shared with a Carer when a person withholds consent. ….. In addition to updating consumer information as described in paragraph 10, MHJHADS will review and expand Canberra Health Services Procedure: Sharing Information with Carers- MHJHADS Adult Inpatient Units, to cover all service areas, not only the adult inpatient units. We welcome any further guidance or recommendations around these planned improvements.

109. Those indications are noted.

> 3. It is recommended that ACTMHS provide guidance to ACTMHS practitioners and to carers as to the circumstances that would justify the disclosure of personal health information pursuant to Principle 10 of the Health Records Act. That guidance should apply generally and not just to the disclosure of information about patients who are subject to mental health orders.

> 4. It is recommended that the Government include these disclosure of information issues in future reviews of the Mental Health Act. [10]

(b) Collaborative partnerships with tertiary institutions

110. In respect of the collaborative partnership issue, the ACTMHS response noted the existence of the MOU. However, it went on to say:

> "Presently, there are no formal protocols or guidelines in place regarding collaboration between MHS and tertiary institutions however given the large number of students involved in crisis services, the Home Assessment and Acute Response Team (HAART) regularly liaise with ANU and ANU counselling and have effective working relationships."

111. Joshua's case highlights a shortfall in co-ordination between ACTMHS and the ANU. The MOU not only sets out aspirational standards in relation to the level of care provided to ANU students by the ANU and the ACTMHS, but it also addresses some practical goals in case management including information sharing and safe transfer of student care.

> 5. It is recommended that the MOU between the ANU and ACTMHS be re-visited and updated by both the ANU and ACTMHS informed by Joshua's experiences and the findings in this inquest.

(c) Case management practices in Joshua's case

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[10] See for example the Western Australia Department of Health (2016) *Good Practice Guidelines for Engaging with Families and Carers in Adult Mental Health Services*. It provides comprehensive advice to clinicians about information sharing with carers and families distilling the principles that are contained in legislation equivalent to our Mental Health Act and Health Records Act and setting out what expectations carers can have as to the release of information to them.

112. The ACTMHS response noted the contacts and referrals that are detailed above. It was asserted that given Joshua's unwillingness to engage and no objective indication of deterioration in his mental state that file closure was appropriate. As I have indicated that the issue was not so much whether file closure was indicated as whether appropriate "wrap around" care was in place through the ANU.

113. In the provisional findings it was asserted that Joshua's death did not result in an internal review. Nothing had been produced on subpoena to suggest such a review had been undertaken. It was brought to my attention in the response of ACTMHS that in fact his death had been the subject of a detailed "M & M internal case review". The outcome of that review was sent to the Court. The committee that undertook the review was a quality assurance committee for the purposes of the *Health Act 1993.* Therefore, the product of the review is not admissible in a coronial proceeding: section 47. It is my intention to raise with Government the desirability of such a legislative prohibition. That will be done outside the context of this inquest.

CONDOLENCES AND ACKNOWLEDGMENTS

114. To Joshua's parents and family, I convey my condolences. I apologise to them for inordinate and harmful delay that has occurred in the finalisation of this inquest. As I have observed in other cases, section 3BA of the Act requires inquests to be conducted in a way that recognises that the death of a person and an inquest into the person's death, has a significant impact on the person's family and friends. In this case, I acknowledge that the Court has not discharged that statutory obligation. Delay in the disposition of coronial inquests can add significantly to the trauma experienced by members of the deceased's family. The Court's communications with Joshua's family confirm that reality.

115. Finally, Nathan's support for Joshua was a selfless expression of his concern. He has felt Joshua's passing deeply. I have conveyed to him my belief that he did all that could be reasonably done to alleviate Joshua's distress and sense of isolation.

I certify that the preceding one hundred and fifteen [115] numbered paragraphs are a true copy of the Reasons for Decision of his Honour Coroner Archer.

Date: 10 February 2023