Inquest into the death of AB

FINDINGS

AB was born in 1998; he died on 2 September 2009, just before his 16th birthday. He is survived by his sister and his parents.

Ms. Ward, Counsel assisting went into some detail in her opening in relation to AB's background, as it was markedly different from most teenagers raised in the suburbs of Sydney's north shore. AB's parents adopted AB and his sister in 2000. At that time, AB was $6^{1/2}$ and his sister was 2 years old.

On their adoption, very little information was provided to AB's parents in respect of the background of the siblings. What was provided essentially comprised of one paragraph stating that their parents were deceased and that they previously had been in the care of their grandmother. Thereafter they were to learn that AB was home when an unknown male attacked his grandmother (his sole carer) with a machete and he had accompanied her to hospital where she ultimately died from her injuries. In all probability AB witnessed the attack. AB and his sister subsequently were taken into care and adopted by his parents.

After his grandmother's attack and prior to his adoption, AB was injured in a motor vehicle accident. As a result of the injuries he sustained in the accident AB required medical intervention in Australia. Ultimately he was left with loss of movement in his right ankle and his right leg 1.5cm shorter than his left.

Prior to the submissions by the various legal representatives, AB's mother was invited to provide insights into AB "the boy" so I could grasp the person who was obviously so loved and cherished by those around him. She availed herself of the opportunity and I for one was glad she did. AB was described as mischievous, loyal and outgoing to friends, reserved with adults and a perfectionist with an artistic streak. He obviously took his role of protector of his sister very seriously and was much loved by his family.

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

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

A number of issues arose during the course of the inquest in relation to the surrounding circumstances leading up to AB's death. In particular the provision of health care he received in the period late July to 2 September 2009. These include:

1. Was it appropriate to prescribe Lexapro / Esipram to AB?
2. What were the known risks associated with taking an SSRI antidepressant such as Lexapro to adolescents as at August 2009?

3. As at 2009 what guidelines were in place regarding warning patients about the associated risks of taking Lexapro?
4. Was AB warned of the risks associated with taking Lexapro?
5. Were there any confidentiality issues with respect to Dr. Marrett advising AB'smother about her consultations with AB?
6. Was AB's mother warned of the risks associated with taking Lexapro?
7. Was AB's mother advised to carefully monitor AB for the possible emergence of suicidal thoughts in the initial period of treatment with Lexapro?
8. Did Dr Marrett ensure adequate monitoring of AB for any adverse reactions to the Lexapro during his first weeks of treatment?
9. Should AB have been referred to a psychiatrist or an adolescent psychiatrist?
10. Was the standard of care provided to AB by Claire McKenzie appropriate?
11. Did AB take his own life on 2 September 2009?

I will deal with each of the issues in turn.

Was it appropriate to Prescribe Lexapro to AB?

Lexapro is the registered trademark of the drug known as Escitalopram oxalate produced by Lundbeck. It is used to treat depression and belongs to a group of medicines called selective serotonin reuptake inhibitors (SSRIs).

Esipram is the generic version of Lexapro, it is also produced by Lundbeck. They are therefore one and the same drug but distributed under different names.

The evidence is clear that AB was provided with a starter pack of Lexapro by Dr. Marrett on 8 August 2009, which contained 7, 10mg tablets of Lexapro (enough for

one week), and thereafter was provided with a prescription for Lexapro on his return to Dr. Marrett on 19 August 2011[1] one week later.

The evidence from Dr. Deborah Pelser, who is the manager of scientific affairs of Lundbeck Australia can be summarised as follows:

1. Both Lexapro and Esipram are registered with the Therapeutic Goods Administration for use in persons over the age of 18 years;
2. Neither Lexapro nor Esipram are registered with the Therapeutic Goods Administration for use in persons under the age of 18 years;
3. Accordingly, neither drug can be marketed for use in persons under the age of 18 years;
4. The lack of registration of either Lexapro or Esipram for use in people under the age of 18 years does not prevent doctors from being able to prescribe them to patients who are 18 years if it is clinically indicated. This practice is know as “off label prescribing”;
5. There are no SSRI’s currently registered for use in patients under the age of 18 years;
6. Lundbeck only provides starter packs to practitioners for Lexapro and not for Esipram;
7. The starter pack for Lexapro ordinarily contains the Consumer Marketing Information (CMI) for Lexapro;
8. When a pharmacist dispenses either Lexapro or Esipram on prescription the package does not contain the relevant CMI for the drug.

It is uncontroversial that Dr Marrett had three appointments with AB between 8 August 2009 and 19 August 2009. All the appointments took place without his mum

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[1] Exhibit 5 in the proceedings. The prescription dated 19/08/09 was signed by Dr Marrett and contained 5 repeats.

being in attendance (as she remained in the waiting room). The first appointment was on 8 August 2009 ("the initial appointment"). The initial appointment did not occur in a vacuum. Both AB's mother and Alex Whyburn, psychologist had contacted Dr Marrett prior to the initial appointment in relation to the behaviours exhibited by AB and their specific concerns.

The second occurred on 11 August 2009. It was at this appointment that Dr. Marrett diagnosed AB with "depression" according to her contemporaneous notes and a "moderate to severe depressive episode" or a "major depressive episode" according to her oral evidence. Her contemporaneous notes of the consultation indicate that they "*discussed need to see a counsellor in view of his poor family relationship; finally agreed to see Claire McKenzie who works with Sue Du Plessis; but not interested in family therapy; a K10-scored 28; admitted to feeling depressed and suicidal at times; agreeable to try lexapro*"[2].

In cross-examination Dr. Marrett indicated that her diagnosis of a "moderate to severe depressive episode" was based on the following clinical observations of AB:

1. his score of 28 on the K10;
2. that he had thought about suicide (expressed suicidal ideation);
3. he was suffering from low self esteem.

Accordingly she formed the view that AB's treatment required a two-pronged approach namely a prescription of an antidepressant together with attendance on a psychologist.

The court appointed expert, Professor Newman AM, Professor of Development Psychiatry and Professor of Child and Adolescent Psychiatry in her report dated 8

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[2] Exhibit 2 page 66

June 2011[3] in effect concurred with Dr. Marrett's diagnosis of depression. She stated in her report that:

"*In terms of depressive disorder, I am of the view that AB exhibited signs consistent with a depressive episode evolving over several months prior to his death. Specifically his increasing irritability then followed by withdrawal and isolation and repeat of treatment are likely indicative of depression. His suicidal ideation and report of "feeling bad" are noted in the clinical records. Depression in young people is known to be associated with irritability and oppositional behaviour and may then progress to symptoms more typical of melancholia such as anergia withdrawal and flattening of the affective response…"*[4]

Furthermore, Professor Newman was of the view that the management plan formulated for AB namely to commence a trial of antidepressants and to have psychological support and treatment was "*in accordance with standard treatment*"[5].

What were the known risks associated with taking an SSRI antidepressant such as Lexapro to adolescents as at August 2009?

As at August 2009 the literature available to Dr. Marrett in relation to prescribing SSRI antidepressant medication to adolescents included:

a) Publication of Australian Government, Department of Health and Ageing, Therapeutic Goods Administration – Adverse Drug Reactions Advisory Committee dated 15 October 2004, "Use of SSRI antidepressants in children and adolescents"[6]; and

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3 Exhibit 2 tab 22

4 Ibid at page 317D;

5 Ibid at page 317I;

6 Exhibit 10 in the proceedings;

b) Guidelines produced by the Royal Australian College of General Practitioners in March 2005 titled, "Clinical guidance on the use of antidepressant medications in children and adolescents"[7];

As at 2009, namely the time when AB was prescribed Lexapro, it was recognised that there was some evidence available to indicate an increased risk of suicidality associated with the use of SSRI antidepressants such as Lexapro. The Adverse Drug Reactions Advisory Committee bulletin dated 15 October 2004 stated:

"Assessment of the published and unpublished data available for SSRI use in children and adolescents indicates that there is evidence of an increased risk of suicidality, including suicidal ideation, suicide attempts and self-harm events, associated with each of the SSRI's".

Similarly, the Royal Australian College of General Practitioners' guidelines produced in March 2005 state:

"A recent re-analysis by the FDA of adverse events reported in trials of antidepressants in children and adolescents concluded that the risk of treatment-emergent suicidal thinking or behaviour was increased in patients on active drug (up to 4%) compared to those taking placebo".

As at August 2009 what guidelines were in place regarding warning patients about the associated risks of taking Lexapro?

As at August 2009, when AB was dispensed and then formally prescribed Lexapro/ Esipram the Royal College of Australian General Practitioners' guidelines supported and endorsed the contents of the Australian Adverse Drug Reactions Advisory Committee's revised statement of 15 October 2004 which was:

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7 exhibit 11 in the proceedings;

"1. Any SSRI use in adolescents with major Depressive Disorder (MDD) should be undertaken only within the context of comprehensive management of the patient. Such management should include careful monitoring for the emergence of suicidal ideation and behaviour;

2. The choice of SSRI for adolescents should be made taking into account the recent evaluation of clinical trial data and product information. Note that the current Australian Product information for SSRIs recommends against their use in children and adolescents and that no antidepressant currently has an indication for the treatment of depression in children and adolescents.

3. *Adolescents who are currently being treated for MDD with an SSRI…"*

The guidelines continue:

"When children and adolescents are commenced on an SSRI, we recommend:

- *Starting with a low dose and building up gradually,*
- *Warning parents and patients about potential activation symptoms, including the possible emergence of suicidal thoughts early in treatment;*
- *Careful monitoring in the early weeks for the emergence of behavioural activation, with the prescriber being available for contact;*
- *Consultation, wherever possible, with a child and adolescent psychiatrist or developmental paediatrician in the case of a non-response or significant deterioration. This may be done by telephone or teleconferencing (where available) if review in person is impractical;*
- *…"*

Was AB warned about the risks associated with taking Lexapro?

It was the evidence of Dr. Marrett that despite AB being booked for a 15 minute consultation on 11 August 2009 she spent almost an hour with him. I accept that during that appointment she:

1. reviewed the ulcer on his right ankle;
2. administered the K10 diagnostic tool;
3. had a discussion with AB during which he revealed to her that he had thought about suicide (suicidal ideation) but had no plan (accordingly no intent);
4. spoke with him with respect to the fact that she felt he is suffering from depression and would be assisted by the taking of an antidepressant;
5. provided him with a starter pack of Lexapro;
6. advised him to take half a tablet to start with in the morning and wrote the dosage on the starter pack;
7. had a short discussion with mum in the waiting room that she was giving AB an anti-depressant.

It is not clear what warnings, if any, Dr Marrett gave AB about the potential side effects of Lexapro. Her evidence in relation to this aspect of the appointment can be summarised as follows:

1. she usually advises patients when prescribing an antidepressant that it can take three to six weeks for it to kick in fully but some people can feel better within a week;

2. you may feel worse before you feel better, the first week can be the worst;

3. usually there is an autofill document that she goes through with the patient, and she hoped that she had gone through them with AB with respect of the side effects namely, increased agitation, nausea, may not sleep well and increased suicidal ideation. She didn't print these notes.

4. She does not specifically recall going through these issues with AB in the appointment but hoped she did.

Mr. McGee, Counsel for Dr. Marrett submitted that it has been 2 years since the appointment and that nothing can be drawn from Dr. Marrett's lack of recollection of the specific warnings about the side effects of Lexapro to AB.

I do not agree. Dr Marrett was someone who took notes of consultations and follow up phone calls. She took notes of the conversations she had with AB's mum regarding her concern about AB and the behaviours he had been exhibiting in the period leading up to and during the period. Accordingly, if she had have gone through the "autofill document" which sets out the potential side effects of Lexapro it would have been recorded somewhere in her notes. Furthermore, in my view Dr Marrett should have been able to recall if she had warned AB about the risks associated with the medication given the following:

1. he was a young adolescent male who had already expressed some suicidal ideation to her;

2. that as he was having communication issues with his parents it follows that they may not be in a position to judge whether or not his suicidal ideation had increased;

3. the Royal Australian College of General Practioners' Guidelines issued in 2005 although not mandatory did recommend that patients be warned of the possible emergence of suicidal thoughts or increased suicidal thoughts;

4. that as AB died so soon after the appointment (less than 25 days later) she would have turned her mind to what occurred at the appointments and whether or not she did follow best practice and in fact warned AB about the possible side effects of the medication she had prescribed.

Accordingly, I am satisfied on balance that Dr. Marrett did not warn AB of the risks associated with taking Lexapro. Furthermore, I find that she did not advise him that he may suffer from increased thoughts about suicide and what he should do in the event that he does.

Were there any confidentiality issues with respect to Dr Marrett advising AB's mother about her consultations with AB?

AB at the time of his appointments with Dr. Marrett was 15 years old. He attended on her without the presence of his mum. All concerned (namely mum and Dr. Marrett) were of the view that this was the best course as one of the major concerns regarding AB's behaviour at this time was that he was not talking to his parents (a behaviour I note is not uncommon with teenagers). Despite this, there is no evidence from Dr. Marrett that AB indicated that he wanted his consultations to remain confidential and that he did not want her discussing his issues with his mother.

Accordingly, the issue of confidentiality does not arise in this case.

Was AB's mum warned about the risks associated with taking Lexapro?

On 11 August 2009, Dr. Marrett provided AB with a starter pack of Lexapro. Her evidence was that she was acutely aware that AB's mum would not be happy with her decision to start AB on antidepressant medication so she took the time to attend on AB's mother in the waiting room to advise her that she had given AB the starter pack of Lexapro and her reasons for making such a decision.

Her primary focus was to explain that AB was suffering from depression, needed the medication and had agreed to see Claire McKenzie, a psychologist. Dr. Marrett conceded that her conversation with AB's mum was brief and that she did not:

1. go through the risks or side effects of Lexapro with AB's mother;

2. advise AB's mother that AB had expressed some suicidal ideation; and

3. that the medication could take three to six weeks to kick in; and

4. that she should closely monitor AB whilst commencing the medication.

The evidence of AB's mother corroborated the evidence of Dr. Marrett.

Accordingly, I am satisfied on balance that Dr. Marrett did not adequately warn either AB or his mother of the range of possible side effects of Lexapro in particular the need to be alert to increases in agitation and suicidal ideation. Moreover, there was no discussion of what steps should be taken by either AB or his mum should AB display or suffer from any of the side effects.

Was AB's mother advised to carefully monitor AB for the possible emergence of suicidal thoughts in the initial period of treatment with Lexapro?

Despite the guidelines published by the Royal Australian College of General Practitioners in 2005 that recommend that practitioners on prescribing medication such as Lexapro:

*"***** Warning parents and patients about potential activation symptoms, including the possible emergence of suicidal thoughts early in treatment,*

****** Careful monitoring in the early weeks for the emergence of behavioural activation, with the prescriber being available for contact…"*

It is clear that Dr. Marrett did not do so in this case.

Did Dr Marrett ensure adequate monitoring of AB for any adverse reactions to the Lexapro during his first weeks of treatment?

After providing AB with a starter pack on 11 August 2009, Dr. Marrett reviewed AB one week later on 19 August 2009. Professor Newman was of the view that the review one week after the commencement of the medication was adequate.

It was at the 19 August 2009 appointment that Dr Marrett provided AB with a script (together with 5 repeats) for Lexapro and advised him that the plan was to review him after 6 visits to the psychologist[8]. Essentially Dr. Marrett's evidence in regard to monitoring of AB on the medication can be summarised as follows:

1. AB's mum was engaged and concerned about AB's mental health and that she had no doubt that AB's mother would call her if any concerns had arisen;

[8] Exhibit 2 at page 55

2. That AB had commenced to see and had agreed to continue to see Claire McKenzie, psychologist and she was of the view that Ms. McKenzie would keep an eye out for any adverse reactions to the medication.

I note however that:

Firstly, Dr. Marrett in no way informed AB's mother of the risks associated with taking Lexapro, that AB had already admitted to her that he was feeling depressed and suicidal at times, and that the medication itself may be associated with an increased risk of the emergence of such thoughts;

Secondly she had no conversations with Claire McKenzie regarding AB's care. I acknowledge that she forwarded a "mental health care plan"[9] which in effect constituted a referral however the information contained in that document was incomplete. It made no reference to the fact that she had prescribed AB Lexapro (I give no credence to Dr. Marrett's explanation that she had yet to prescribe it and only provided him with a starter pack. In my view it had been dispensed and therefore prescribed), and there was a lack of detail regarding the suicidal ideation expressed by AB to her (in fact it was ambiguous and Ms. McKenzie had interpreted it as no current suicidal ideation).

Thirdly, when specifically questioned by Counsel Assisting regarding the lack of reference to the provision of Lexapro in the mental health care plan, Dr. Marrett responded that she had no doubt that AB's mother would have advised Ms. McKenzie. I note that Ms. McKenzie had been informed but though her colleague Alex Whyburn who had spoken with AB's mother.

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[9] Exhibit 2 page 267

Dr. Marrett made assumptions when it came to the supervision and monitoring of AB. AB's mother was and is an exceptional mother; she was engaged, proactive and concerned. Despite the lack of communication on the part of Dr. Marrett, AB's mother sought out and obtained the CMI in relation to Esipram from her pharmacist some time after it was prescribed and familiarised herself with the risks involved (and upon doing so decided to take some time off work to keep an eye on AB). So Dr. Marrett's assumptions were clearly correct however, the lack of communication in my view prevented AB's mum from:

1. having the knowledge that AB had in fact "admitted to feeling depressed and suicidal at times" prior to his starting on Lexapro;

2. what signs to specifically look out for as a potential adverse reaction (increased agitation which can be associated with difficulty sleeping according to Professor Newman); and

3. what to do and how urgently to deal with any signs of an adverse reaction.

Should AB have been referred to an adolescent psychiatrist?

It was Dr. Marrett's evidence that she "would have loved to have referred AB to an adolescent psychiatrist" but did not for the following reasons:

1. AB's mum had requested a referral to a psychologist;

2. AB had indicated he would only see an older female;

3. It is exceptionally difficult to get into a child psychiatrist that practices within their locality.

There is no doubt that Dr. Marrett in her appointment with AB on 11 August 2009, had established enough of a rapport with her patient that AB had expressed willingness to embrace her treatment plan namely antidepressant medication together with talk therapy.

Professor Newman suggested AB's case could have been referred to a child and adolescent psychiatrist but ultimately made no criticism of the lack of referral.

However, this is a case where communication or lack there of is a central issue. Dr. Marrett did not attempt to see if an adolescent psychiatrist was available for AB, she did not discuss the difference in treatment provided by a psychologist as opposed to a psychiatrist with AB's mother in essence denying AB's mother of an ability to have the opinion or resource available to her. This court understands the time pressures that general practitioners have to operate in and that we are forced in the circumstances of an inquest to focus on matters with the benefit of hindsight. In my view the option of a review by an adolescent psychiatrist should at least have been raised.

Was the standard of care provided to AB by Claire McKenzie appropriate?

Claire McKenzie is a registered psychologist and not a clinical psychologist. As such she is not and was not at the time of treating AB able to diagnose him in relation to depression or otherwise. As a psychologist, and not a medical practitioner she was not responsible for recommending, assessing the appropriateness of, prescribing or monitoring AB in relation to antidepressant drug therapy.

Ms. McKenzie had 3 appointments with AB prior to his death. From both her contemporaneous notes and evidence before the inquest she seemed to be able to

engage AB in his therapy and to have made progress with him. She canvassed the issue of whether or not he felt suicidal at the first session and reviewed how he was feeling (improved or otherwise) at the other sessions.

In my view, Ms. McKenzie's treatment of AB was professional and appropriate at all times.

Did AB take his own life on 2 September 2009?

It is generally accepted that a coroner should apply the *Briginshaw standard*[10] before making a finding of suicide.

In *Neat Holdings Pty Ltd v Karajan Holdings Pty Ltd*[11], Mason CJ, Brennan, Deane and Gaudron JJ reviewed the authorities to provide a clear statement of the *Briginshaw* principle:

"The ordinary standard of proof required of a party who bears the onus in civil litigation in this country is proof on the balance of probabilities. That remains so even where the matter to be proved involves criminal conduct or fraud. On the other hand, the strength of the evidence necessary to establish a fact or facts on the balance of probabilities may vary according to the nature of what it is sought to prove. Thus, authoritative statements have often been made to the effect that clear or cogent or strict proof is necessary 'where so serious a matter as fraud is to be found'. Statements to that effect should not, however, be understood as directed to the standard of proof. Rather, they should be understood as merely reflecting a conventional perception that members of our society do not ordinarily engage in fraudulent or criminal conduct and a judicial approach that a court should not lightly make a finding that, on the

10 Briginshaw v. Briginshaw (1938) 60 CLR 336

11 (1992) 110 ALR 449

balance of probabilities, a party to civil litigation has been guilty of such conduct."

The following matters, in evidence need to be considered:

1. AB's mother had reported to Ms. McKenzie in her phone call at about 6.30pm that AB had "had a good day". They had repaired a chair together;

2. On the night of 2 September 2009, AB had left the family home to go for another walk (having walked the dog earlier before);

3. He was not seen alive again by any of his family members;

4. AB's mother was adamant that prior to this walk:

    a. That she did <u>not</u> notice any indicia that AB had been drinking (namely slurred speech, staggering gait (over and above his usual difficulties) nor did she smell alcohol on his breath);

    b. That AB was wearing thongs, that if he was well intoxicated on leaving the family home he would not have made it up the steep driveway;

5. That the CCTV footage from the railway station records AB throwing away a bottle and walking along the platform and waving to somebody;

6. The Post Mortem reveals that AB had consumed alcohol but as a result of a contamination of the analysis by the stomach contents we are unable to say with any certainty how much alcohol AB had consumed prior to being hit by the train;

7. It was the evidence of Professor Starmer that adolescents suffer the effects of a blood alcohol reading of 0.05g/mL - 0.08g/100mL , and those effects can result in loss of inhibition and reckless behaviour; It is not possible to

> make a finding as to the amount of alcohol in AB's system as at the time of his death. The blood samples taken from the stomach cavity were unreliable due to likely contamination. Furthermore, the urine sample does not permit me to make a finding in the absence of accurate evidence as to when AB commenced drinking, what he drank and how much. However, it is clear that the very fact that AB had consumed any alcohol was unusual for him and the very high reading in the urine sample, coupled with the CCTV footage suggest a level of alcohol consumption that would have had a disinhibiting effect in this young man.

We will never know what AB was thinking or was intending moments before his death. However, I am not satisfied to the *Briginshaw standard* that he in fact sought to take his own life.

CONCLUSION

AB died in tragic circumstances. He was clearly a talented, enthusiastic and empathetic young man who was much loved by his family. Unfortunately this inquest has focused on the last days of AB's life which were marred by the mental health issues he was suffering from at the time but I understand and accept that this was out of the ordinary for AB and he was a boy who had overcome so much, was particularly resilient and had a zest for life and trying new things.

I have made certain findings in relation to AB's medical care during the period late July to 2 September 2009 and subsequent death. Essentially, those findings can be summarised as a lack of communication from Dr. Marrett with respect to the associated risks of Lexapro and what steps should be taken to minimise those risks to AB's mother and AB.

I do not suggest that if Dr. Marrett had in fact followed best practice and fully informed AB's mother of the associated risks of Lexapro and how and what to monitor AB for that he would not have died but in not communicating effectively Dr. Marrett did not provide AB's parents with information that may have permitted them to act differently, including his closer monitoring.

Accordingly I now turn to the findings I am required to make pursuant to section 81 of the Coroners Act 2009.

I find that AB died on 2 September 2009 directly from multiple blunt force injuries as a result of being hit by a train. As to whether his death was self inflicted I make an open finding.

Pursuant to section 82 of the Coroners Act 2009 I make the following recommendations arising out of the death and subsequent inquest into the death of AB:

During the course of the hearing I had the benefit of evidence from Professor Newman who, amongst other things, was a member of the Expert Working Committee briefed by the National Health and Medical Research Council to update guidelines on the treatment of depression in children and adolescents. The resulting Beyond Blue, Clinical Practice Guidelines - Depression in adolescents and young adults, published in February 2011 comprehensively addresses many of the issues that arose in AB's case.

In light of the existence of that document I have formed the view that it is important that clinicians involved in the diagnosis and treatment of adolescents with mental

illness should be advised or reminded of the useful information contained within the Guidelines.

At my request, there have been preliminary discussions between the Crown Solicitor's Office and various bodies who may be able to assist in promoting the existence of the guidelines to relevant clinicians. The organisations who have so far responded to the inquiries of the Crown Solicitor's Office have broadly supported the need for publicity attached to the Beyond Blue Guidelines and I am grateful and encouraged that they have been able to respond so quickly to inquiries made at my request.

I note that the guidelines are available on line and can therefore be accessed free of charge by any clinician and indeed, concerned parents and caregivers. This should limit the cost of implementing the recommendations that follow.

1. That the Australian Medical Association, Royal Australian College of General Practitioners, Royal Australian and New Zealand College of Psychiatrists, the Australian Psychological Society and the Counsellors and Psychotherapists Association of NSW use their best endeavours to publicise the availability of the Beyond Blue Clinical Practice Guidelines -Depression in adolescents and young adults published in February 2011, to their members.
2. That such publicity should specifically highlight the recommendations and good practice points set out in the guidelines at Part C as to assessment, management (including the use of SSRI medications where clinically indicated), warning and monitoring of symptom severity and adverse effects and the need for communication with adolescents and parents and/or caregivers.
3. That a copy of my findings be forwarded to the above organisations along with these recommendations;

4. That a copy of my findings be forwarded to the Pharmaceutical Society of Australia suggesting that they use their best endeavours to publicise the availability of the Beyond Blue Clinical Practice Guidelines -Depression in adolescents and young adults published in February 2011, to their members and ask them to bring it to the attention of parents care givers when it is clear that a prescription is being filled for antidepressant medication.

22 July 2011

Magistrate Sharon Freund

Deputy State Coroner