QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Joshua William Klumper**
TITLE OF COURT:	Coroners Court
JURISDICTION:	SOUTHPORT
FILE NO(s):	2017/4180
DELIVERED ON:	7 March 2024
DELIVERED AT:	Brisbane
HEARING DATE(s):	12 July 2022; 25 October 2022; 26-27 April 2023; 17 May 2023
FINDINGS OF:	Stephanie Gallagher, Deputy State Coroner
CATCHWORDS:	Coroners: inquest, suicide, hanging, youth mental health, cannabis withdrawal, autism spectrum disorder (ASD),
REPRESENTATION:	
Counsel Assisting:	Mr J Crawfoot
Family:	Ms GE Devereaux and Ms L Soldi instructed by Caxton Legal
Nurses Horwood, Pettinger, Taylor, McAllister and Vandy:	Ms S Robb instructed by QNMU Law
Gold Coast Hospital And Health Service:	Ms MG Zerner instructed by Barry Nilsson Lawyers

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Circumstances of the Death

1. The deceased, Joshua William Klumper (Josh), was born on 17 November 1999 and died on 16 September 2017, aged 17 years. He had been living at an address on Macquarie Avenue, Molendinar, Qld with his grandmother (Ms Patricia Skjonnemand) and a cousin (Stephen). His mother, Ursula Wharton, lived at a separate address on the Gold Coast.

2. At the time of his death, Josh was working as an apprentice with Apex Painting.

3. On the morning of Tuesday, 5 September 2017, Josh presented to work as expected. During that day Josh's Manager (Ms Therese Ryan) did not observe any changes in his behaviour or attitude however, as she was finishing work, Josh informed her that he was not feeling well. Ms Ryan informed him that he could finish early but to let another colleague know when he was leaving. [1]

4. Josh returned to his grandmother's residence at about 4pm He was described by his grandmother as being "*upset*" and "*distressed*".[2] Josh asked his grandmother to pray for him which she did. He then left the house and drove away in his van.[3]

5. About 5 minutes after Josh had left, Stephen left the residence with a friend (Toby). Not long after leaving, Stephen received a phone call from Josh's mother informing him of a Facebook post by Josh and asking that they find him.[4] The Facebook post was dated 4 September 2017 at 23:13 (UTC +10 | 9:13am 5 September 2017 AEST).[5]

6. Stephen and Toby searched an area known as 'Ashmore Gate Station bushland'. When they arrived, they located Josh's vehicle. They searched the bushland and found Josh hanging from a tree, with a section of electrical cord used as a ligature. They disabled the ligature, commenced CPR, and called 'Triple 0'.[6] The Queensland Ambulance Service (QAS) electronic Ambulance Report Form (eARF) confirms that call was received at 5:02pm.

7. A QAS crew was dispatched at 5:04pm and arrived at the scene at 5:15pm.[7] QAS Paramedics took over attempts at resuscitation and were successful in achieving spontaneous return of circulation without the use of medication or defibrillator. On achieving return of circulation, paramedics intubated Josh and administered Fentanyl and Ketamine.

8. At 5:46pm, QAS Paramedics placed Josh in the ambulance and transported him to Gold Coast University Hospital (GCUH). Admission bloods did not test for the presence of alcohol or drugs.

9. A CT scan performed at 6:09pm on 5 September 2017 did not identify any acute intracranial pathology or cervical spine fracture.[8]

10. A second CT scan performed at 9:05am on 8 September 2017, when compared against the first scan, identified "*subtle*" loss of grey-white matter differentiation, with the possibility of early hypoxic ischaemic injury. At that time Josh was regarded as having a "*possible early hypoxic ischaemic injury*".

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[1] Exhibit B21 at p.1/21
[2] Exhibit B18 at p.6/6
[3] Exhibit B18 at p.6/6
[4] Exhibit B18 at p.6/6
[5] Exhibit I1
[6] Exhibit B17 at p.2/3
[7] Exhibit H1
[8] Exhibit C1.3 at p. 15/17

11. By 12 September 2017, the neurological findings were still regarded as "*equivocal*". A Consultant that reviewed the CT scan from 8 September 2017, considered Josh's "*CT and neurologic state portend[ed] a poor outcome*".[9]

12. At 9am on 14 September 2017, an MRI (brain and cervical spine) was performed. This imaging identified a "*diffuse hypoxic injury involving temporal, frontal and parietal white matter as well as basal ganglia*". The nature of the injury was such that Josh's recovery was "*limited at best to dependant cares*".[10]

13. A clinical decision was taken in consultation with family to extubate Josh. This occurred at 10:50pm on 15 September 2017. Josh's condition quickly deteriorated, and he was declared deceased at 1:02am on 16 September 2017.[11]

Autopsy

14. An external only autopsy was performed on 19 September 2017. The examination confirmed the presence of more than 70 slash scars to the extremities (left lower arm, anterior aspect left thigh, anterior aspect right thigh) that may be regarded as consistent with a history of self-harm.

15. The macroscopic pathology summary confirmed the presence of a hanging ligature mark which was consistent with the patient summary given to the Pathologist.

16. Cause of death was given as:

    1(a) Hanging

Coronial Investigation and Application for Inquest

17. The circumstances of Josh's death became the subject of a coronial investigation that was finalized by way of 20A findings that were delivered on 10 June 2021. It was the conclusion of Coroner McDougall that Josh's cause of death was hanging, no finding was made as to whether it was a suicide, although Josh's history of self-harm and suicide attempts were discussed in the findings.

18. By letter dated 19 July 2021[12], Ms Wharton, through her legal representatives (Caxton) made an application for the investigation into her son's death to be reopened and an inquest be held. Concerns were raised as to whether there had been missed opportunities for Josh to access treatment and care in the months before his death.

19. The concerns around missed opportunities, focus on a presentation to the GCUH Emergency Department (ED) on 2 September 2017 but also considered other historical aspects of Josh's treatment and care including whether a diagnosis of Autism Spectrum Disorder (ASD) placed Josh at greater risk. Consequently, concerns were raised as to whether Josh's death may have been preventable had his care and treatment been managed differently.

20. By decision dated 21 February 2022, the State Coroner granted the application for Inquest.

The Inquest

21. The inquest was heard by the Deputy State Coroner, Ms Stephanie Gallagher, over three days between Wednesday, 26 April 2023 and Thursday, 27 April 2023 and

[9] Exhibit C1.8 at p. 20/116
[10] Exhibit C1.8 at p. 9/116
[11] Exhibit C1.8 at p. 2/116
[12] Exhibit A5

concluding on Wednesday, 17 May 2023.

22. The issues for inquest were:

    a) The matters required by s.45(2) of the *Coroners Act 2003*, namely the identity of the deceased, when, where and how he died and what caused his death;

    b) Whether the decision to close Josh to the Child and Youth Mental Health Service in February 2017, was appropriate in the circumstances and made in accordance with relevant policies and procedures; and

    c) Whether the treatment and care provided to Josh on 2 September 2017 was appropriate in the circumstances.

23. By agreement with all the parties, the inquest heard evidence from 10 witnesses:

    a) Ms Ursula Wharton;
    b) Ms Patricia Skjonnemand;
    c) Ms Therese Ryan;
    d) Mr Jerem Clifford;
    e) Nurse Jessica Harwood;
    f) Nurse Kali Pettinger;
    g) Nurse Toni-Ann Taylor;
    h) Nurse Iain McAllister;
    i) Professor Justin Williams; and
    j) Dr Ness McVie.

Josh's Clinical and Social History

24. Records obtained during the coronial investigation identified that Josh had a long-standing, though irregular history with child and youth mental health services during the 10-year period prior to his death commencing when he was aged 7.[13]

25. Having regard to the scope of the issues for inquest, it is not intended to summarise that history in detail, however particular reference should be made to the circumstances of Josh's diagnosis with ASD, his engagement with Child and Youth Mental Health Services (CYMHS), and his history of self-harm and suicidal ideation.

26. Josh's first contact with CYMHS was on 14 August 2007 when a Client Intake Form was completed for Josh to access services with the Burleigh office.[14] He had been referred by his mother. A subsequent assessment on 20 August 2007[15] identified the basis of the referral as:

    "*7yo male referred by mother. Anger outbursts, defiant, difficulty managing behaviours, mood low, poor concentration, ↑ energy levels. Family hx of mental illness*".

27. As a result of that assessment, the following provisional diagnosis[16] was made:

    a) Moderate depressive episode;
    b) Attention Deficit Hyperactive Disorder (ADHD); and
    c) Oppositional Defiance Disorder (ODD).

28. The plan was for further assessment, discussions with Josh's school and parent-child

[13] Exhibit Folder 'C'
[14] Exhibit C1.5 at p.27/371
[15] Exhibit C1.5 at p.47/371
[16] Exhibit C1.5 at p.51/371

interaction therapy (PCIT).[17]

29. On 2 June 2008, a Client Intake Form was completed by CYMHS for Josh to transfer from the Burleigh office to the Southport office.[18] Suicide was not a risk factor. Transfer records between Burleigh and Southport indicate Josh received treatment from a Consultant Psychiatrist, participated in PCIT, received cognitive behavioural therapy (CBT) for anxiety, and engaged with a Speech Pathologist.[19]

30. During a counselling session on 21 August 2008, Ms Wharton was informed Dr Doug Shelton would complete an ASD assessment with Josh.[20]

31. Subsequent progress notes confirmed the assessment proceeded as planned however the coronial investigation, despite all steps being taken, was unable to obtain copies of any diagnostic tools used by Dr Shelton as part of that assessment. By statement dated 26 July 2022, Dr Shelton confirmed that Josh had met the criteria for the diagnosis.[21] Dr Shelton also confirmed he performed a direct, in-person assessment with Josh on 1 September 2008 consisting of:

    a) Autism Diagnostic Interview – Revised (ADIR); and
    b) Autism Diagnostic Observation Scales (ADOS).

32. On 25 August 2009, when Josh was aged 9 years he was documented as experiencing self-harm behaviours. Josh used a piece of plastic to scratch his arms.[22] Josh was interviewed by a Psychologist (Andrew Poznic) with Gold Coast, Youth and Mental Health Service at the Acute Care Treatment Team (Southport) and disclosed feeling "*silly*" for having cut himself.[23]

33. The report completed by Mr Poznic identified Josh had nil self-harm history until that time but described an occasion when he had threatened to kill himself by holding his breath. Josh denied any current plan or intent to self-harm or suicide.[24] The report confirmed Josh was not a client of CYMHS at that time and there was insufficient evidence to determine the date he exited, however on 27 August 2009, CYHMS sent a letter to one of Josh's family members, offering further assistance or support as required.[25]

34. On 12 February 2010, Josh re-presented to CYMHS in the context of suicidal ideation. A consumer intake form recorded "*escalating aggressive behaviour*" and Josh stating words to the effect that he 'wanted to go to heaven'.[26] When interviewed by a Psychologist, Josh confirmed that disclosure, but did not disclose any plan or intention to complete suicide. This was the first documented occasion of Josh disclosing suicidal ideation.

35. An assessment was offered and accepted by Josh's mother. That assessment was scheduled for 16 February 2010. The plan was to discuss Josh's case at the multi-disciplinary team (MDT) and consider the need for ongoing support or other appropriate service.[27]

[17] Exhibit C1.5 at p.51/371
[18] Exhibit C1.5 at p.30/371
[19] Exhibit C1.5 at p.34/371
[20] Exhibit C1.5 at p.97/371
[21] Exhibit B16
[22] Exhibit C1.5 at p.14/371 and 71/371
[23] Exhibit C1.5 at p.18/371
[24] Exhibit C1.5 at p.19/371
[25] Exhibit C1.5 at p.256/371
[26] Exhibit C1.6 at p.29/371
[27] Exhibit C1.6 at pp.33-60/97

36. Josh was again closed to CYMHS on 13 May 2010 due to a lack of engagement.[28]

37. Following Josh being closed to CYHMS there was a gap in his medical history between 2010 and 2014. In 2014, Josh engaged with the following providers:

    a) Medicine on Maple (GP Clinic) – Maleny;[29] and
    b) Nambour Hospital.[30]

38. Between 30 August 2014 and 18 December 2015, Josh presented to Medicine on Maple on a total of 15 occasions. Most of those presentations related to mental health concerns, including aggression, insomnia, attempts at suicide and suicidal ideation, and self-harm.

39. Josh's first documented suicide attempt occurred on Saturday, 25 April 2015, when he ingested a quantity of medications. Josh informed his GP that he "*woke up*" 12 hours after ingestion.[31] Josh was then aged 15 years. A plan was developed to urgently refer him to CYMHS, and a notification was made to, the then, Department of Child Safety.[32]

40. Josh was contacted by CYMHS the following day (28 April 2015) with an appointment made for 29 April 2015.[33] An initial assessment was completed on that date, although Josh was not admitted to the service. Whilst a decision was made to provide ongoing support via case management, this was postponed due to continued self-harm behaviours.[34]

41. On 4 May 2015 Josh attempted suicide. This was his second documented attempt. He was placed under an Emergency Examination Order (EEO) by attending QAS Paramedics and transported to Nambour Hospital. He was discharged home at 1:45pm on 5 May 2015.[35]

42. The following day (6 May 2015), Josh was admitted to Sunshine Coast CYMHS.[36] His discharge summary noted Josh had been experiencing stressors with criminal proceedings, conflict with peers and conflict with family members. Josh engaged in home visits, face-to-face sessions, and phone support with CYMHS.

43. On 22 May 2015, Josh attempted suicide. This was his third documented attempt.[37] Josh was again placed under an EEO and transported to the Nambour Hospital. A copy of the EEO identified that Josh was non-compliant with medication.

44. On 9 June 2015, Josh commenced treatment with Psychologist, Dr Johann Eloff. His engagement with Dr Eloff was on a private basis[38]. Between 24 June 2015 and 30 March 2016, Josh engaged in a further 11 sessions with Dr Eloff.

45. Josh was closed to Sunshine Coast CYMHS on 31 July 2015.[39] The basis for his being closed appears that he had settled, was compliant with his medication, had engaged with school, was engaging with Dr Eloff and there was reduction in his risk of harm to self, given Josh's compliance with the treatment plan.

46. On 30 September 2015, after Josh was closed to CYMHS; but whilst he was still

[28] Exhibit C1.6 at p.10/97 and Exhibit G1 at p.2/36
[29] Exhibit C2.1
[30] Exhibit C4.2
[31] Exhibit C2.1 at p.6/29
[32] Exhibit C2.1 at p.7/29
[33] Exhibit C2.1 at p.7/29
[34] Exhibit C4.3 at p.202-203/274
[35] Exhibit C4.3 at p.26/274
[36] Exhibit C4.3 at p.202/274
[37] Exhibit C4.3 at p.21/274
[38] Exhibit C3.1
[39] Exhibit C4.3 at p.202/274

engaged with Dr Eloff and Medicine on Maple, there was an instance of suicidal ideation with a plan to overdose using medication[40]. This incident occurred against the background of an alleged sexual assault against Josh. The assault and suicidal ideation were disclosed when Josh presented to his GP seeking STI testing because of the event.

47. Josh refused to self-present to the Hospital or consent to an ambulance to be called on his behalf, Josh's treating GP informed him that he was obliged to report his suicidal ideation to the Queensland Police Service. Josh then left the medical practice and the GP called QPS.

48. On 30 September 2015, QPS located Josh, placed him under an EEO and transported him to Nambour Hospital.[41] Josh was admitted then transferred to the Royal Brisbane and Womens Hospital (RBWH) on 2 October 2015 where he was admitted to the Adolescent Mental Health Unit (AMHU).[42]

49. On 19 October 2015, with the consent of Josh and his mother, he was discharged from RBWH[43] and his ITO transferred to the community to be managed.[44]

50. Between January and March 2016, Josh made additional presentations to the RBWH and Nambour Hospital, in relation to self-harm and suicidal ideation. These presentations did not result in admission. There was nothing in those presentations to indicate a deterioration in Josh's mental health from the preceding year.

51. In April 2016, Josh relocated from the Sunshine Coast and commenced living with his grandmother on the Gold Coast.[45]

52. On 20 June 2016, Josh presented to Dr Syed Taqvi at the Gold Coast Medical Centre.[46] Josh was unknown to that Practice.

53. Dr Taqvi generated a referral for Josh to Psychiatrist, Dr Paraneetharan Sivapathasundaram (Dr Siva).[47] Dr Taqvi's referral letter identified Josh had a history of consuming alcohol and marijuana, that was consistent with his social history when residing on the Sunshine Coast.

54. Whilst Josh did not further engage with Gold Coast Medical Centre, he presented to Dr Siva, in the company of his grandmother, at the Helix Health service on 18 July 2016. The basis of this presentation was ADHD and insomnia.[48]

55. A plan was developed to trial Josh on Concerta 36mg and Circadin 2mg to treat his ADHD.[49]

56. Josh presented to Dr Siva twice more on 28 July 2016 and 10 August 2016.[50] On the last occasion, Dr Siva prescribed him Ritalin (40mg) on a trial basis to treat his ADHD. It was reported that Josh was compliant with his other medications.

57. On 17 November 2016, Josh turned 17.

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[40] Exhibit C2.1 at p.12/29
[41] Exhibit C4.3 at p.208/274
[42] Exhibit C5.3 at p.46/183
[43] Exhibit C5.2 at p.11/18
[44] Exhibit C5.2 at p.13/18
[45] Exhibit C8.1 at p.4/22
[46] Exhibit C8.1 at p.18/22
[47] Exhibit C8.1 at p.18/22
[48] Exhibit C8.1 at p.17/22
[49] Exhibit C8.1 at p.17/22 and Exhibit B18 at p.1/5
[50] Exhibit C8.1 at p.16/22

58. On 27 November 2016, Josh voluntarily presented to Gold Coast University Hospital (GCUH) with his mother, in relation to suicidal ideation (no plan).[51] This was the first occasion Josh had presented to a public health service following his relocation to the Gold Coast. Progress notes from this presentation confirm Josh was not then engaged with CYMHS, but he was known to the service.

59. On presentation, Josh was triaged in the mental health area of the ED. After approximately 55 minutes, he became violent (breaking a glass) and was escorted from the Hospital by security. A call was then placed to Josh's mother who confirmed he had run away from her.

60. Ms Wharton then rang back 10 minutes later advising she had established contact with Josh, and he was verbalising suicidal ideation with a plan, he expressed wanting to hang himself with a rope.[52] Hospital staff then called 'Triple 0', notified them of the suicide risk and requested Josh be re-presented by QPS if he was located.

61. QPS located Josh at which time he was in an "*agitated and combative*" state.[53] Josh was then re-presented to the hospital on an involuntary basis (EEO). Josh refused to engage with treating staff. A review of the progress notes from this incident confirmed his treating team were aware of the Asperger's diagnosis.

62. Josh's mother and grandmother were actively engaged and assisted in providing relevant information to the treating team.[54] During this process, it was disclosed that Josh had separated from his girlfriend on the morning that he voluntarily presented. It was also disclosed that Josh had ceased engaging with Dr Siva and was no longer compliant with the medications prescribed to him.[55] It was also documented Josh "*is noted by his family to sabotage therapeutic alliances and not provide good enough attempts at trying prescribed medication*".[56]

63. At 3am on 28 November 2016, Josh began engaging with the treating team and an assessment was able to be completed. During this assessment Josh denied self-harm thoughts, planning or intent. He denied any recent drug use but declined to provide a urine sample. He was offered Olanzapine (5mg) and Lorazepam (1mg) to assist with his agitation. Josh accepted the medication.[57]

64. Progress notes indicate a considered approach was given to treating Josh, particularly the risks associated with placement in an Adult Mental Health ward, given his age. It was instead considered more appropriate to treat Josh in the ED and give him an opportunity to become calm before attempting any further assessment. Josh's mother was informed of this plan.[58]

65. Josh's mother ultimately agreed with the plan to allow the medications to take effect and calm Josh before any further assessment.

66. At about 6:48am on 28 November 2016, Josh was identified as being suitable for admission to the Adolescent and Young Adult (AYA) Unit at Robina.[59] At about 10pm that same day, Josh was transferred to AYA Robina. He was subject to an ITO.[60] Josh verbalised an intention to leave the unit, following which he was administered 25mg

[51] Exhibit C1.7 at p.1/103
[52] Exhibit C1.7 at p.1/103
[53] Exhibit C1.7 at p.3/103
[54] Exhibit C1.7 at p.4/103
[55] Exhibit C1.7 at p.5/103
[56] Exhibit C1.7 at p.5/103
[57] Exhibit C1.7 at p.12/103
[58] Exhibit C1.7 at p.13-14/103
[59] Exhibit C1.7 at p.15/103
[60] Exhibit C1.7 at p.16/103

Promethazine.[61]

67. Josh was reviewed at about 5:31pm on 29 November 2016. His level of engagement remained low however he requested that his treatment be transferred to CYMHS. He was informed there would need to be a change in his behaviour before a transfer could be facilitated.[62] The plan was to keep Josh admitted overnight and review again in the morning to determine his suitability for CYMHS.

68. During a review on the morning of 30 November 2016, Josh's condition and behaviour was improved. Josh expressed a goal to obtain the "*right medication*" and commence accessing leave.[63] He was not expressing any suicidal ideation. A plan was developed to allow Josh two 15-minute, supervised periods of leave that day to be reviewed that afternoon.

69. Following the success of that plan, it was agreed to allow Josh leave (20 minutes) three times per day, once (unescorted) in the company of a family member, and twice (escorted) on the grounds of the unit.[64] Josh's continued treatment at AYA Robina was for ADHD, ASD and ODD.[65]

70. On 1 December 2016, there was a decline in Josh's mental health and at 10am he absconded from the AYA Unit.[66] QPS were notified and an Authority to Return to Authorised Mental Health Service was approved. Josh's mother was informed of the incident by Josh's Consultant Psychiatrist. She expressed a view that Josh should be 'heavily sedated' to prevent him from having "*meltdowns*".[67]

71. Ms Wharton was informed that Josh was already on high doses of sedatives and anti-psychotic medication, and that they carried an increased risk of side-effects. Ms Wharton reiterated her preference for heavy sedation.[68]

72. At or about 4:27pm, Ms Wharton contacted the Consultant Psychiatrist and informed him she had established contact with Josh. She requested that QPS not be involved and offered to monitor and supervise Josh overnight.[69] This plan was agreed to on the proviso that Josh return to be reviewed at 9am the next morning. Ms Wharton was encouraged to call QAS or QPS if there was any deterioration.

73. Ms Wharton and Josh re-presented to AYA that afternoon and the Authority to Return was cancelled. He appeared settled and in good mood when he appeared.[70]

74. On 2 December 2016, Josh presented again. He was observed to be "*brighter*" and "*calmer*" compared to his admission period. He disclosed not being able to cope with being "*locked up*". Whilst Ms Wharton maintained a view Josh required "*high doses of medication*", Josh himself expressed a preference for community-based treatment.[71]

75. Consultant Psychiatrist, Dr Amoi Deshmukh, described Josh's presentation[72] in the following terms:

"*In totality, Joshua is a 17-year-old male with initial presentation consistent with acute*

[61] Exhibit C1.7 at p.16/103
[62] Exhibit C1.7 at p.18/103
[63] Exhibit C1.7 at p.20/103
[64] Exhibit C1.7 at p.20/103
[65] Exhibit C1.7 at p.34/103
[66] Exhibit C1.7 at p.35/103
[67] Exhibit C1.7 at p.47/103
[68] Exhibit C7 – Gold Coast University Hospital – CIMHA at T1.47
[69] Exhibit C7 – Gold Coast University Hospital – CIMHA at T1.47
[70] Exhibit C7 – Gold Coast University Hospital – CIMHA at T1.48
[71] Exhibit C1.7 at p.49/103
[72] Exhibit C1.7 at p.50/103

cannabis withdrawal and stress reaction on background of relationship break-up. Developmental history indicates diagnosis of Autism, ADHD and features of oppositional defiant disorder. PTSD symptomatology appears to be sub-threshold at this point but will need further ongoing elaboration and management. Restrictive treatment in PICU setting resulted in worsening of aggression. Importantly, Collaborative work helped improved therapeutic alliance."

76. A plan was developed for Josh to be discharged home and be supplied with one-months-worth of medication and discharged to the Continuing Care Team (CCT) to follow up within 7 days. Josh was encouraged to refrain from drug use.[73]

77. Josh's risk was assessed as follows:

"***Self harm*** *- low acute risk, medium to high chronic risk in view of history, poor impulse control and drug use. harm to others - low. risk increases exponentially whilst intoxicated.* ***Vulnerable***
- medium - easily influenced by negative peer group"[74]

78. At or about 3:46pm that day, a representative from CYMHS phoned Josh's mother to facilitate the 7-day follow up appointment. That call was unanswered however a message was left for her to make contact. Attempts to contact Josh directly on his mobile phone identified that number was no longer in service.[75]

79. On 6 December 2016, contact was established with Ms Wharton. She disclosed Josh was residing with his grandmother at Molendinar and that she had not seen him since he was discharged on 2 December 2016.[76] A call was then placed to Josh's grandmother who advised that Josh was being compliant with medications but had stayed out overnight on one occasion with friends. The grandmother also provided the following collateral information:

"*Has full house of 8 family members staying including Josh, 2 other grandchildren from other daughter, and another daughter and her 3 young children. Advised having large house and can accommodate all the family. Reported everyone generally gets along reasonably well though was incident last night involving daughter expressing concern of Josh returning to house with clothes smelling of cannabis*"[77]

80. A plan was made for a home visit on 7 December 2016 at the Molendinar address where Josh resided with his grandmother.[78]

81. At or about 4pm on 7 December 2016 a Social Worker (Kevin Gilbert) with CYMHS completed a home visit with Josh. Josh was future focussed although his mood was low. He denied active suicidal ideation although acknowledged it as a risk.[79] Nil acute concerns were reported or detected during this visit. Josh's risk profile was identified as:

"*Denied thoughts of self-harm whilst acknowledging has occurred in the past. Others: Low: Denied thoughts to harm others. Chronic Med risk of self-harm owing to history of poor frustration/impulse control*"[80]

82. A plan was developed to continue with medication and outpatient support. Josh was also referred to an employment agency to assist him with his employment goals, which

[73] Exhibit C1.7 at p.51/103
[74] Exhibit C1.7 at p.51/103
[75] Exhibit C1.7 at p.56/103
[76] Exhibit C1.7 at p.57/103
[77] Exhibit C1.7 at p.58/103
[78] Exhibit C1.7 at p.58/103
[79] Exhibit C1.7 at p.61/103
[80] Exhibit C1.7 at p.62/103

he had discussed during the home visit. It was also planned to have the Multi-Disciplinary Team (MDT) review Josh again after 7 days.

83. On 9 December 2016, Mr Gilbert completed a Risk Screening Tool. His risk of suicide was classed as 'low'. Josh disclosed that he was 'using cannabis regularly' and was also using Lysergic Acid (Acid) approximately 3-times per month.[81]

84. On 10 January 2017, Josh was seen by Consultant Psychiatrist, Dr Shilpa Aggarwal when he presented to CYMHS.[82] Josh disclosed having ceased his medication about 2 weeks prior. Josh's demeanour was described as: "*dismissive [and] agitated*" and he left the session[83]. A plan was developed with Josh's mother and grandmother to continue monitoring him for worsening symptoms after he self-ceased medication.

85. A follow-up phone call with was made to Josh's grandmother that afternoon. No immediate concerns were raised although it was acknowledged there had been a decline in Josh's mood. She discussed whether it would be appropriate to attempt to have Josh re-engage with Dr Siva, and it was agreed this may be a better option for Josh and would also be discussed at the MDT.[84]

86. On 12 January 2017, the MDT convened and discussed Josh's case. It proceeded on the basis that Josh was due to see Dr Siva the next day (13 January 2017).

87. On 13 January 2017, Josh presented as planned to Dr Siva.[85] Josh's mother was also present at the consultation. She expressed the view that she was happy for Josh to remain in the community. Josh disclosed he was still consuming cannabis although his intake had decreased.[86] There was discussion of 'restarting' Josh on Concerta 36mg however it was established that he was not taking any of his prescribed medications and was 'not keen to take medication'.[87]

88. Dr Siva issued a prescription for Concerta (36mg) and Ritalin (40mg). The Ritalin was prescribed on a trial basis.[88]

89. Dr Siva also generated a referral to Headspace for "*functional recovery*".[89]

90. Josh had no further contact with Dr Siva after this date.

91. On 13 January 2017, after the consultation, Josh's grandmother rang CYMHS and informed them of the prescription for Concerta. She also informed them there appeared to be a therapeutic alliance developing between Josh and Dr Siva but was unable to say whether Josh would attend any further appointments, though she was aware of the referral to Headspace. The CYMHS progress note recorded:

    "*We discussed whether there is a role for CYMHS at this time in view of Joshua's poor co- operation at last week's medical review with Dr Shilpa (Consultant) when he presented with poor frustration tolerance and stormed out of the review soon after it started. Gran spoke about how Joshua just gets frustrated and needs time to calm down coming across unwilling or unable to appreciate that in order for the service to support Joshua and offer him treatment it is important that he engages, so that his mental state and any other issues he may be struggling with can be assessed to decide how best the service can support him. As before Gran attributed Joshua's unpredictable and*

[81] Exhibit C1.7 at p.63/103
[82] Exhibit C1.7 at p.66/103
[83] Exhibit C1.7 at p.66/103
[84] Exhibit C1.7 at p.67/103
[85] Exhibit C8.1 at p.15/22
[86] Exhibit C8.1 at p.15/22
[87] Exhibit C8.1 at p.15/22
[88] Exhibit C8.1 at p.16/22
[89] Exhibit C8.1 at p.16/22

potentially volatile behaviour being due to the lack of progress in his life being of the opinion this is why he gets angry and frustrated when anyone talks to him about his situation"[90]

92. On 16 January 2017, Josh's grandmother rang CYMHS and spoke with Kevin Gilbert. She did not identify any immediate concerns but considered there may be a benefit to Josh receiving a community visit that day. She disclosed events from the weekend that may have contributed to Josh experiencing a low mood. Those events were associated with Josh feeling a sense of rejection associated with a former girlfriend and another female friend.[91] Josh's grandmother also disclosed being unsure if Josh was complying with his Concerta medication.[92]

93. On 19 January 2017, the MDT convened to discuss Josh case[93]. The following progress note was made:

"*Presented at MDT for discussion Joshua does not want to engage with CYMHS Has been recently seen by private psychiatrist Dr Siva who has refereed to Headspace. Confirm this with Dr Siva and advise family of discharge from CYMHS due to disengagement. Nandini Sethi (Psychologist) to follow up with above*".

94. On 20 January 2017, Dr Sethi made a telephone call to Dr Siva, to confirm the referral to Headspace. A message was left for a call back.[94]

95. On 24 January 2017, Dr Sethi contacted Josh's grandmother.[95] His grandmother confirmed the Headspace referral had been made but was unable to confirm if contact had been established. Josh's grandmother said she would attempt to speak with Josh about his preference for engaging with either CYMHS or Headspace and would contact CYMHS again.

96. On 1 February 2017 Josh's grandmother rang CYMHS and spoke with Dr Sethi, informing her it was Josh's decision to engage with Headspace. She was told on that basis Josh would likely be closed to CYMHS. Josh's grandmother told Psychologist Sethi she was "*happy*" with this plan and was aware Josh could be referred to CYMHS at any time in the future.[96]

97. On 2 February 2017, the MDT convened again to discuss Josh's case:

"*Discussed at CC with MDT-Joshua will be continuing to see Dr Siva privately he has been referred to and accepted a Headspace referral.*"[97]

98. The plan was to close Josh to CYMHS.[98]

99. On 6 February 2017, Josh voluntarily presented to Headspace. Previous attempts to establish contact (18 January 2017, 27 January 2017, and 3 February 2017) had been unsuccessful. The basis of Josh's presentation was for: "*vocational rehabilitation and social reintegration*".

100. Josh was seen by Occupational Therapist, Jerem Clifford. During his presentation Josh self- disclosed illicit substance use. He was described as "*difficult to engage, bordering*

[90] Exhibit C1.7 at p.73/103
[91] Exhibit C1.7 at p.75/103
[92] Exhibit C1.7 at p.75/103
[93] Exhibit C1.7 at p.75/103 and Exhibit B7
[94] Exhibit C1.7 at p.76/103
[95] Exhibit C1.7 at p.76/103
[96] Exhibit C1.7 at p.77/103
[97] Exhibit C1.7 at p.77/103
[98] Exhibit C1.7 at p.78/103

on hostile at times". Self-harm and suicide were identified as risks. Josh disclosed having "*intent [to commit suicide*" and a plan, although he would not disclose that plan to Mr Clifford. Josh informed Mr Clifford that he had self-ceased his Concerta medication about 1 week prior and was refusing to present to Dr Siva again stating: "*he is shit*".[99]

101. Mr Clifford assessed Josh as being at "*chronic moderate to high risk of self-harm and suicide*".[100] The plan was to refer Josh to the Vocational and Education Coordinator (VEC) and provide feedback to Dr Siva about the presentation.

102. Mr Clifford gave evidence at the inquest and acknowledged that his recollection of events was affected by the passing of time. Nonetheless it was his understanding that Dr Siva would maintain clinical governance of Josh.

103. On 13 February 2017, Josh presented to the VEC, Ms Naomi Bond. He confirmed he was seeking employment but did not understand why Headspace would be assisting him in that venture. When Ms Bond explained the services that were on offer, Josh informed her that he did not need any further assistance and was capable of securing employment without assistance from Headspace. He was offered the opportunity to engage with other service areas within Headspace but declined.[101]

104. On 15 February 2017, Josh entered a Job Plan with Centrelink.[102] On the same date he participated in an interview with Job Centre Australia (JCA) seeking work as an apprentice mechanic or labourer's assistant.[103] He did not disclose any health issues that might affect him however, he signed an authority giving permission to JCA to disclose his health conditions ("*Anxiety / Depression*") with future employers.

105. On 26 July 2017, Josh entered a training contract to become an apprentice painter / decorator with Apex Painting and Decorating. This apprenticeship was secured by ACE Apprenticeships Centre.[104] Whilst it was not disclosed in the training contract, drug testing was to be undergone by apprentices.

106. On 15 August 2017 a case note recorded Josh as having failed a drug test on that date.[105]

107. On 25 August 2017, Josh presented to Dr Benvinda Xabregas. Josh was in company with two male work colleagues and gave verbal consent to their being present at the consultation. The reason for the presentation was Josh's use of cannabis. Josh informed Dr Xabregas there was a strict "*no drugs policy at work*" and that he was 'dependent' on smoking 'weed' when he finished work each day.[106]

108. Josh disclosed being a 'heavy user' of the drug in conjunction with diazepam 'without significant sedation'. Josh's colleagues expressed concerns for the impact on Josh's wellbeing with his continued use of cannabis and his 'capacity to maintain work'.[107] Josh discussed the importance of being able to continue working.

109. A treatment plan was developed for Dr Xabregas to monitor Josh during his withdrawal period and commence him on a short-term course of diazepam (5-8 days maximum) to assist with acute withdrawal symptoms.[108]

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[99] Exhibit C7.1 at p.6/103
[100] Exhibit C7.1 at p.6/103
[101] Exhibit C7.1 at p.7/103
[102] Exhibit F4
[103] Exhibit F4.1 and Exhibit F7
[104] Exhibit F1
[105] Exhibit F7
[106] Exhibit B23 at paragraphs 18-20
[107] Exhibit B23 at paragraphs 21-22
[108] Exhibit B23 at paragraph 28 and Exhibit C10.1 at pp.1-2

110. At 9:10pm on 2 September 2017, Josh self-presented to GCUH with his grandmother.[109]

111. His presentation on this occasion formed a significant part of the oral evidence at the inquest and was an issue for inquest.

112. He disclosed detoxing from cannabis, had been prescribed diazepam but was struggling with "*crazy*" thoughts and would feel depressed. This was documented by Nurse Jessica Horwood as a direct quotation from Josh.[110] Nurse Horwood triaged Josh as Category 2, meaning he would be seen within 30 minutes. After triage Josh was taken to the resuscitation area of the ED to be further assessed by a member of the Acute Care Team (ACT).[111]

113. Nurse Horwood gave evidence at the inquest in relation to her interactions with Josh on that occasion. Her evidence at inquest was uncontroversial and consistent with her statement.

114. Josh was next seen by RN Kali Pettinger who conducted a full primary assessment of him. She concluded Josh was physically stable and did not require immediate medical intervention. Josh disclosed experiencing 'racing thoughts' in the preceding 5 days due to ADHD and having ceased consuming cannabis at the beginning of the week.[112]

115. Josh disclosed that his job required him to submit for drug testing and that he needed to cease cannabis use to maintain his job. Josh disclosed having seen a GP (Dr Xabregas) and being prescribed diazepam however 'it was not' helping.[113]

116. RN Pettinger also gave evidence at the inquest in relation to her interactions with Josh on that occasion. Her evidence at inquest was uncontroversial and consistent with her statement.

117. At 9:28pm, RN Toni-Ann Taylor escorted Josh and his grandmother to the Mental Health Pod, a secure area within the Emergency Department. It was acknowledged at the inquest that one of the features of the Pod was the secure door which could only be operated by security personnel to allow passage in and out.

118. RN Taylor's gave evidence at the inquest that Josh appeared 'elevated' and 'restless', was pacing and not wanting to engage and declined medication that she had offered to assist him to settle.[114] RN Taylor also confirmed that he was at all times a voluntary patient, and based on the triage and assessments, was not in need of acute medical care. Nurse Taylor also gave evidence that an aspect of Josh's presentation was that he was experiencing withdrawal from cannabis use which as causing him to feel agitated.

119. At about 11pm on 2 January 2017 Josh was seen by RN Iain McAllister.[115]

120. RN McAllister's interactions with Josh were the subject of a detailed and contemporaneous progress note entered within 4 hours of Josh's presentation.[116] The inquest had the benefit of the notes, RN McAllister' statement,[117] and his oral evidence at the inquest.

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[109] Exhibit C1.7 at p.82/103 and Exhibit B1
[110] Exhibit B2 at paragraph 8 and Exhibit B1 at p.3/25
[111] Exhibit B6 at paragraph 10
[112] Exhibit B6 at paragraph 10
[113] Exhibit B6 at paragraph 10
[114] Exhibit B7 at paragraph 6 and Exhibit B1 at p.5/25
[115] Exhibit B4 and B4.1
[116] Exhibit B4 at pp.12-13/20 entered at 1:43am on 3 September 2017
[117] Exhibit B4

121. RN McAllister gave evidence at the inquest of having 30-years-experience as a mental health nurse. He gave evidence of having trained in relation to ASD which he clarified as a neurodevelopmental disorder, not a mental health disorder. His gave evidence of experience with Axis 1 diagnosis (schizophrenia, bi-polar and depression) and demonstrated insight into how neurodivergence might be a relevant consideration with a presenting consumer, acknowledging "*people will see and experience the world differently*".

122. RN McAllister gave evidence of a previous occasion when he had interacted with Josh in a clinical setting in 2016. He said that prior presentations would be relevant to any immediate assessment.

123. RN McAllister gave evidence that at the outset of interactions with Josh on 2 September 2017, Josh was "*hostile*". RN McAllister gave evidence of attempting to de-escalate the situation and asking direct questions of Josh to understand why he was presenting and obtain a narrative from him. RN McAllister was aware of Josh's prescription for diazepam (by Dr Xabregas).

124. RN McAllister attempted to enlist Josh's grandmother in the assessment process because Josh was becoming adversarial.

125. Based on his interactions with Josh, it was RN McAllister's assessment that Josh was experiencing acute withdrawal from having ceased cannabis. He acknowledged Josh had requested Xanax but in relation to Josh's presentation, considered it was not clinically indicated, as it was shorter acting drug and contributed to "*boom/bust*" therapeutic support that is, Josh may obtain short-term temporary relief but given the period over which cannabis withdrawal may occur (up to 2 weeks)[118], this was not an appropriate long-term plan.

126. RN McAllister gave further evidence that in any event he was not able to prescribe Josh with Xanax, as only a doctor could prescribe the drug. RN McAllister gave evidence of explaining these limitations to Josh and his grandmother. In cross-examination by Ms Robb, RN McAllister gave evidence that whilst Josh was being specific about the medication he was seeking, RN McAllister endeavoured to manage Josh's expectations by informing him that there were other choices available to him.

127. RN McAllister's progress note details how the interview process with Josh deteriorated:

> "*Joshua was asked to remember that he could not reasonably expect a total evaluation and breakthrough with his life long struggle with emotional regulation at the ED in a brief crisis interview. He was advised that what he appeared to be describing was acute MJA withdrawal symptoms which could be expected to last for 2 weeks. He was reminded that by his own admission he was reasonably stable and moving ahead with his life until 5 days ago when he was required to abruptly discontinue MJA which he had been using for 5yrs. He was provided with a synopsis of the kinds of symptoms that acute withdrawal from MJA might entail*"
>
> "*Joshua strongly and angrily refuted that he was withdrawing from MJA. He described that last year he had been smoking and injecting ICE regularly although seemingly stopped this without undue issue. He attempted to explain that MJA is a lesser order of drug and therefore not likely to have withdrawal symptoms. Psychoeducation was attempted although he was not open to this discussion*"

128. As the interview deteriorated Josh demanded to leave the Pod. RN McAllister gave oral evidence that Josh was "*kicking and shouldering*" the secure door into the Pod. In

[118] Exhibit B4.1 at p.12/20

circumstances where Josh was a voluntary patient he could leave. In fact, as a voluntary patient he could not be compelled to stay.

129. RN McAllister gave oral evidence that his interview with Josh ran between 15 and 20 minutes.

130. In circumstances where Josh was presenting in relation to cannabis withdrawal, not suicidal ideation, there was no basis to commence him on a Suicide Prevention Pathway.[119]

131. This was the last occasion Josh had contact with the GCUH. The events of 2 September 2017 became the subject of a concerns raised by Josh's aunt on 3 September 2017.[120] Negative comments were made about 'the clinician's manner' which was understood to be a reference to RN McAllister.

132. On 4 September 2017, RN Albie Newton established contact with Josh's grandmother to discuss his recent presentation.[121] There were no disclosures of Josh experiencing any self-harm or suicidal ideation. Ms Skjonnemand did not disclose concerns of deterioration in Josh's condition. She did disclose Josh was with his boss who was taking him to see a GP.[122] The plan was to discuss Josh's case with CYMHS and consider whether he should undergo psychiatric review. It was also planned to consider liaising with AODS and Josh's employer.

133. That day Josh re-presented to Southport Metro Medical Centre. On this occasion he was seen by Dr Sahar Firouzinezhad.[123] Josh presented seeking a prescription for Valium to assist with weaning himself off cannabis. Josh was in company with a co-worker and a support person. Josh was given advice to contact AODS however he declined on the basis that they would 'not [be able] to do anything.[124]

134. Dr Firouzinezhad did not prescribe Valium to Josh and no further plan was developed with him.

135. A review of Josh's Pharmaceutical Benefits Scheme (PBS) schedule identifies that he did obtain a prescription for diazepam from a different medical practitioner on 4 September 2017.

136. Josh had no further contact with any medical practitioner or health service.

Other Evidence

137. By report dated 21 June 2019, Dr Ness McVie has given an expert opinion about the treatment and care received by Josh, with reference to the totality of his clinical records[125]. At the time of preparing that report there was a gap in the medical records. Additional investigation material was obtained and provided to Dr McVie. She gave an addendum report dated 8 April 2023.[126]

138. The inquest also heard evidence from Professor Justin Williams who provided a statement dated 2 December 2022.[127] His evidence was specifically targeted at the decision-making regarding closing Josh to CYMHS in February 2017 and whether that

[119] Exhibit G1 at p.21/36
[120] Exhibit C1.7 at p.94/103
[121] Exhibit C1.7 at p.97/103
[122] Exhibit C1.7 at p.97/103
[123] Exhibit C10.1 at p.2/2
[124] Exhibit C10.1 at p.2/2
[125] Exhibit D1
[126] Exhibit D2
[127] Exhibit B22

decision-making was consistent with the policies and procedures concerning youth mental health, the transition of care between providers, and the transition between youth and adult service providers.

139. Professor Williams evidence in relation to compliance with those policies and procedures, and other guidelines, was uncontested at the inquest.

140. In cross-examination by legal representatives for Josh's family, Professor Williams was questioned in relation to Josh's ASD diagnosis and the extent to which that may have been a factor in his presentation on 2 September 2017.

141. Commencing in 1988, Professor Williams had over 30-years clinical experience as a medical practitioner and with specialisation in Psychiatry from 1992. He has published extensively about autism.

142. In oral evidence, he described ASD as "*a very broad church*". Having the benefit of reviewing Josh's clinical records, and in the absence of seeing the basis on which Dr Shelton had formed the diagnosis of ASD, Professor Williams was unable to comment on how Josh's ASD may have affected him on 2 September 2017.

143. Professor Williams commented that the features of ASD for any person can be very individualised. He also commented that it is not straightforward to either confirm or refute a prior diagnosis of ASD however he further commented that Josh's diagnosis was based on a single clinical opinion and there was no evidence of any peer review.

144. In oral evidence Professor Williams also commented that on reviewing Josh's clinical records he was unable to identify any repetitive features or stereotypes to suggest ASD. He also commented a person may show features of ASD at age 9 but not present with those features at age 17.

145. In relation to the decision to close Josh to CYMHS in February 2017, Professor Williams commented that individual rights needed to be respected and that consent was an essential requirement for treatment. In his statement, Professor Williams gave evidence that Josh was refusing to engage with CYMHS and there was evidence he was under the care of Dr Siva at the time and there was a willingness for Josh to engage with Headspace.

146. In oral evidence Professor Williams commented that "*as a rule*" if a consumer is being managed in the private sector, there is no concurrent management within the public system. Professor Williams said in evidence that it was not clinically advisable to manage a patient concurrently in the private and public sectors He also commented that there are "*insufficient resources*" to duplicate care.

147. Dr McVie recognised that the involvement of multiple agencies in Josh's care had resulted in minor inconsistencies in his record. Dr McVie also acknowledged there were gaps in the record, where it was not possible to determine whether any care had been received by Josh.[128]

148. Dr McVie also acknowledged Josh's poor history of compliance with medication.[129]

149. Dr McVie had regard to the presentation on 2 September 2017.[130] In her oral evidence, Dr McVie also relevantly commented that during Joshua's presentation to the ED at the Gold Coast University Hospital on 2 September 2017, he presented on a background of cannabis withdrawal, but there was not anything in that presentation indicating any mental health condition or any feature of ASD. She agreed that adolescents with ASD do represent a

[128] Exhibit D1 at p.3
[129] Exhibit D1 at p.11
[130] Exhibit D1 at p.7

group with higher-than-average suicide rates,[131] however Dr McVie was unable to identify any clinical assessments that had supported that diagnosis in Josh's case.[132] However, in relation to Josh's overall treatment and care, Dr McVie opined:

"*Considering the complexity of the case, the lack of engagement with services and Josh's tendency to dictate his own management, I would consider the assessments and treatment provided were appropriate*"[133]

150. With specific reference to the events on 2 September 2017, Dr McVie opined:

"*Again, based on Joshua's history and on the descriptions of his presentation, his care and treatment provided on 2 September seemed appropriate and showed consideration of problems that had developed on previous encounters with the ED and involuntary admissions.*"[134]

151. In summary, Dr McVie concluded:

"*I would consider this to be a complex case with chronic moderate to high risk of suicide which may have responded more positively if, in the early stages, the family, mental health services and the school had been able to work cohesively in 2007 and 2008 to set limits and contain his behaviour at that time. The records suggest this never happened. The lack of negative consequences for his childhood behaviours may have contributed to his later presentations*"[135]

Root Cause Analysis

152. On 19 January 2018, a Root Cause Analysis (RCA) was completed by the GCHHS in relation to the care and treatment Josh had received since 2008. In that regard the RCA was broader than the issues for inquest, however it concluded there were opportunities for improvement in Josh's case.

153. As Josh was older than 16, the RCA concluded there was a greater need for teams to have made direct contact with Josh, rather than relying on the collateral information provided by his grandmother and other family members.[136]

154. The RCA also concluded there was a tendency by the MDT to make decisions based around a single issue or incident, rather than placing a focus on the consumers goals and plans and their progress towards those goals.[137]

155. The RCA made several recommendations, and an implementation plan was developed in response to those recommendations.[138]

Conclusion

156. The evidence before the inquest was that Josh was a 17-year-old youth with a complex history of contact with public and private service providers.

157. Whilst a diagnosis of Autism Spectrum Disorder (ASD) was made in 2008 when Josh was aged 8 years, there was no record of any assessment tools, or any other clinical

[131] Exhibit D1 at p.18
[132] Exhibit D1 at p.19
[133] Exhibit D1 at p.19
[134] Exhibit D1 p.20
[135] Exhibit D1 p.21
[136] Exhibit G1 at p.17/36
[137] Exhibit G1 at p.18/36
[138] Exhibit G1.1

basis, to support the diagnosis. There was no evidence of any peer review of that diagnosis, or any other subsequent review to confirm it. I do however accept the submission of his mother that it was a documented diagnosis.

158. It was the evidence of both Dr McVie and Professor Williams, both of whom had Josh's clinical records, that there were no repetitive features or stereotypes to suggest ASD in Josh. Whilst it was acknowledged by Dr McVie that as a general proposition, adolescents with ASD do represent a group with higher-than-average suicide rates, there was insufficient evidence from which any expert could determine whether Josh me the diagnostic criteria of ASD on 2 or 5 September 2017.

159. However, there was sufficient evidence that Josh had a history or substance use, including cannabis, for which he was attempting to cease due to concerns it may jeopardise his employment as an apprentice painter. In that regard he had evidence that he was seeking pharmacological support to assist with his withdrawal symptoms.

160. This became the basis of presentations to Dr Xabregas on 25 August 2017, the GCUH ED on 2 September 2017, and his presentation to Dr Firouzinezhad on 4 September 2017. On considering those presentations, Josh was, to adopt the phrase of Dr McVie, attempting to 'dictate' the terms of his own management by seeking pharmacological relief only and refusing other treatment pathways.

161. Josh's agitated behaviour on 2 September 2017, was a product of his cannabis withdrawal combined with a frustration of his unmet demands for medications. His treatment that day was responsive to the signs and symptoms he displayed.

162. Whilst Josh was experiencing psychological stressors, there is no evidence he was seriously psychiatrically unwell on 2 or 5 September 2017.

163. Notwithstanding Josh's reluctance to engage with medical practitioners, nurses, and other allied workers other than in a 'transactional' manner, attempts to engage with Josh continued up until 4 September 2017 with a view to developing a coordinated plan between his employer, AODS, and CYMHS including a potential psychiatric review.

164. Attempts were still being made to develop appropriate treatment pathways for Josh up to the time of the hanging event.

165. Turning to the first issue for inquest and findings required under s45 of the *Coroners Act 2003*:

a) The deceased is Joshua William Klumper;

b) As to how he died, Josh had a complex and entrenched mental health history with features of self-harm and suicidal ideation and attempts at suicide. Sometime between 4pm and 5pm on 5 September 2017, against a background of cannabis withdrawal and stressors related to potential loss of employment due to his cannabis use, Josh constructed a ligature that he used to hang himself with in the Ashmore Gate Station bushland near Molendinar. Josh intended to hang himself, and he intended to die as a result. Josh was found hanging by a family member and a friend. Attempts at resuscitation by the finders and Paramedics with the Queensland Ambulance Service were successful in resuscitating Josh and achieving spontaneous return of circulation, however as a consequence of the hanging, Josh sustained a hypoxic ischaemic injury that evolved and worsened over a 10-day period. After being resuscitated, Josh received treatment and care at the Gold Coast University Hospital, however the nature of the injury was such that his recovery was "*limited at best to dependant cares*". Against that prognosis, an informed clinical decision was taken in consultation with Josh's family to extubate him. This occurred at 10:50pm on 15 September 2017. Josh's condition quickly deteriorated, and he was declared deceased at 1:02am on 16 September

2017.

c) He died on 16 September 2017;

d) He died at the Gold Coast University Hospital; and

e) His death was caused by hanging.

166. Josh's death is a suicide.

167. Turning to the second issue for inquest, whether the decision to close Josh to the Child and Youth Mental Health Service in February 2017, was appropriate in the circumstances and made in accordance with relevant policies and procedures. I accept the evidence of Professor Williams and Dr McVie and find that the decision to close Josh was appropriate in the circumstances.

168. There was reliable information before the multi-disciplinary team, (that provided by his grandmother) that Josh was engaged with a private provider (Dr Siva) and had accepted a referral to Headspace. (I note the evidence that, on referral by Dr Siva, Josh saw Headspace on 6 February 2017 and 21 February 2017). The decision to close Josh at that time did not preclude him from re-engaging at any time but, any ongoing treatment required his consent.

169. In circumstances where Josh was engaging, on a private basis, with Dr Siva and Headspace, any attempts by CYMHS to continue providing treatment to Josh would have led to unnecessary duplication in his care.

170. I accept the submission of the family that "Professor Williams identified that no formal 'Transfer of Care plan' was developed by CYMHS before his file was closed; he pointed out that the 'plan' was not one established by CYMHS, but rather by Joshua (according to Ms Skjonnemand). There was no contact with Dr Siva, nor with Headspace, before the file was closed. Professor Williams stated that, if Headspace required any collateral information beyond Dr Siva's referral, 'it was open for Headspace to contact CYMHS for additional information' – and he confirmed in oral evidence that he would have expected Joshua or Ms Skjonnemand to have informed Headspace of CYMHS' prior involvement. Best practice might have seen such a plan be established, and direct contact occur (including so Headspace were aware of CYMHS' capacity to provide information). However, notwithstanding no plan was developed or provided to his private carers, the closure was appropriate.

171. Turning to the third and final issue for inquest, whether the treatment and care provided to Josh on 2 September 2017 was appropriate in the circumstances. The evidence in relation to his treatment and care on this occasion turns heavily on the evidence of RN Iain McAllister.

172. RN McAllister had approximately 30 years-experience as a nurse specialising in mental health care. His evidence was detailed, consistent and credible and demonstrated a genuine and compassionate clinical care for Josh's wellbeing. RN McAllister demonstrated appropriate clinical judgement in considering Josh's request for specific medication, the risks associated with that medication in the context of his cannabis withdrawal and made attempts to communicate that to Josh whilst also seeking to develop alternative pathways for him.

173. RN McAllister was mindful of the heightened state Josh had presented in, the physical space in which he was attempting to engage with him and made appropriate efforts to de-escalate Josh so they could have an informed and considered interaction.

174. I note the submission of the family that "Ms Skjonnemand thought that Mr McAllister's tone and demeanour was "not very compassionate" because "he wasn't giving us any solution to what Josh needed".

175. I had the written evidence of RN McAllister and the benefit of observing his demeanor in the witness box. The evidence before me does not suggest to me any likely issue with his clinical manner on 2 September 2017, as was suggested by Ms Skjonnemand. RN McAllister's detailed contemporaneous notes, clinical decision making and demeanor, before me, suggest that it is improbable that RN McAllister's professional conduct was other than appropriate. The care afforded Josh on 2 September 2017 was also appropriate.

176. I note the submissions made on behalf of the family that "inadequate care and emphasis was placed upon Joshua's Autism Spectrum Disorder ('ASD') diagnosis by those who treated him" that such a diagnosis and care should form the basis of any comment I may make under s.46 of the *Coroners Act 2003*.

177. In response to such submission, I adopt the submissions made on behalf of the GCHHS, premised on the opinions of psychiatrists I accepted as experts, as follows:

Dr McVie relevantly said in her evidence that despite Joshua having previously being diagnosed with ASD, there were no repetitive features or stereotypes to suggest ASD in Joshua, such that this impacted the decision of CYMHS to close his care and his treatment at the ED at Gold Coast University Hospital on 2 September 2017.

Professor Williams said in his oral evidence that ASD was "a very broad church" and that a patient's ASD were very individualised and might result in issues with communication, social reciprocation, ability to make friends and maintain relationships. He accepted that whilst the CYMHS records contained reference to Joshua's initial ASD diagnosis, CYMHS did not have cause to reconsider this diagnosis, given the CYMHS notes were dominated by substance misuse and withdrawal. Accordingly, even if Joshua had an ASD diagnosis, it may or may not have been pertinent to his mental health issues.

Even after Joshua's attendance at the ED of Gold Coast University Hospital on 2 September 2017 and before the events of 5 September 2017, Joshua's case was discussed at the CYMHS Access Team MDT on 4 and 5 September 2017 and further contact made with Joshua's grandmother regarding proposed follow up.

Following Joshua's death, GCHHS commissioned a Root Cause Analysis (RCA). This review was completed on 19 January 2018 and did not identify any root causes or contributory factors in relation to his death but did identify opportunities for improvement, including an additional recommendation in response to the interview of Joshua's family. The RCA recommendations included:

(a) MHSS consider a project to review the literature regarding compassion in healthcare, and use this to review and inform an action plan to further address this issue;
(b) The community CYMHS team/s introduce a process for direct engagement for consumers aged 16 years and older, in addition to contact with the consumer's next of kin;
(c) The community CYMHS team/s review their processes to ensure ongoing proactive response to difficult to engage consumers;
(d) The role of the Clinical Team Coordinator be clarified as part of the HHS "Code Black – Personal or Facility Threat" Procedure;
(e) Development and implementation of refresher training for the Acute Care Team focussed on advanced crisis assessment and intervention skills with some reference to age specific cohorts and for consumers with developmental conditions (e.g. ASD, autism etc);

(f) Future environmental reviews of the ED to take into account strategies to address concerns identified; high stimulus area for prolonged periods for consumers with sensory overload.

GCHHS has sought to implement each of these recommendations with updates provided on 26 August 2019 and 4 July 2022.

Given the RCA, steps taken by GCHHS since Josh's death and the evidence before the inquest, I find that there is no appropriate comments or recommendations to be made pursuant to section 46 of the *Coroners Act 2003*.

Findings required by s. 45

Identity of the deceased – Joshua William Klumper

How he died – Josh had a complex and entrenched mental health history with features of self-harm and suicidal ideation and attempts at suicide. Sometime between 4pm and 5pm on 5 September 2017, against a background of cannabis withdrawal and stressors related to potential loss of employment due to his cannabis use, Josh constructed a ligature that he used to hang himself with in the Ashmore Gate Station bushland near Molendinar. Josh intended to hang himself, and he intended to die as a result. Josh was found hanging by a family member and a friend. Attempts at resuscitation by the finders and Paramedics with the Queensland Ambulance Service were successful in resuscitating Josh and achieving spontaneous return of circulation, however as a consequence of the hanging, Josh sustained a hypoxic ischaemic injury that evolved and worsened over a 10-day period. After being resuscitated, Josh received treatment and care at the Gold Coast University Hospital, however the nature of the injury was such that his recovery was "*limited at best to dependant cares*". Against that prognosis, an informed clinical decision was taken in consultation with Josh's family to extubate him, and he died shortly after.

Place of death – Gold Coast University Hospital SOUTHPORT QLD 4215 AUSTRALIA

Date of death – 16/09/2017

Cause of death – 1(a) Hanging

Comments and recommendations – Nil

I close the inquest.

Stephanie Gallagher
Deputy State Coroner
BRISBANE