QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of AB**
TITLE OF COURT:	Coroners Court
JURISDICTION:	BRISBANE
FILE NO(s):	2021/3940
DELIVERED ON:	10 October 2025
DELIVERED AT:	Brisbane
HEARING DATES:	22 July 2024 Written submissions 5 November 2024 - 13 January 2025
FINDINGS OF:	Deputy State Coroner Gallagher
CATCHWORDS:	Coroners: inquest, mental health, hanging, suicide, LGBTIQA+, domestic and family violence, self-harm, emergency examination authority, recommendation for assessment, borderline personality disorder, dialectical behaviour therapy, mental health care plan.

REPRESENTATION:

Counsel Assisting:	J Pietzner-Hagan

AB's Family:	B Stringer, instructed by K Coles, Caxton Legal Centre
Metro North Hospital and Health Service:	D Callaghan, instructed by J Young, Metro North Hospital and Health Service
ORDERS:	1. Non-Publication order 2021/3940 made 13 February 2024.

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Introduction

[1] AB was aged 31 when he died sometime between 28 August 2021 and 29 August 2021. He is remembered by his family as a son, brother, uncle, and grandson. His death is a tragedy and has had a profound impact on those who knew and loved him.

[2] Through her family statement, AB's sister described AB's many achievements, performing in the art of dance, and noted that: *'his talent and dedication shone brightly in every performance*.' She recalled AB's *'gift for brightening the days of those around him made him exceptionally special. His infections fun-loving nature made him a joy to be around.'* [1]

[3] AB's sister also described the deep loss and pain endured by their family upon losing AB through suicide:

> AB's *'absence is more than a physical absence; it's a void in our hearts and a gap in our family structure that can never be filled. We carry him with us always, his spirit woven into the fabric of our lives, a painful yet enduring reminder of the life we once shared.'* [2]
>
> *'As we reflect on his life and the impact of his death, we are reminded of the importance of addressing mental health with compassion and understanding. Suicide leaves behind not only deep sorrow but also countless unanswered questions and what-ifs. Our hope is that his story will shed awareness on the complexities of mental health struggles and encourage greater awareness and support for those who may be silently battling similar challenges.'* [3]

[4] AB's family participated in the coronial inquest with strength, dignity, and in the hope that any findings and recommendations will bring changes which may save the lives of other people with similar mental health concerns and vulnerabilities as AB.[4]

[1] Family Statement, 1.
[2] Family Statement, 2.
[3] Family Statement, 3.
[4] Submissions on behalf of the family at [2].

Coronial jurisdiction

[5] In accordance with s 8(3)(b) of the *Coroners Act* 2003 (Qld) (the Act), AB's death was a reportable death.[5] For such deaths, pursuant to s 28(1) of the Act an inquest may be held where a coroner is satisfied it is in the public interest to hold an inquest.[6]

Coronial investigation

[6] AB's death was reported to the coroner by a Form 1 completed by Queensland Police Service (QPS) officers. Subsequently, medical records, witness statements and expert reports were obtained. An expert report from Consultant Psychiatrist, Dr Jill Reddan was commissioned by the court.

Autopsy results

[7] On 30 August 2021, Dr Nadine Forde, Forensic Pathologist, conducted an external examination and full CT scan of the body. Samples of blood and urine were collected for toxicological analysis. Dr Forde was assisted in her examination by the contents of the Police Form 1.[7] During the examination, Dr Forde observed the following scars, some of which she believed may be consistent with prior self-harm:

a. Central abdomen: 15mm vertical linear scar;
b. Left anterior and posterior forearm: multiple vertical and horizontal linear scars measuring up to 150mm in length. On the posterolateral aspect are a 40mm linear scar and a 70 x 40mm T shaped scar which are purple and have adjacent small round scars consistent with suture marks;
c. Right anterior forearm: 30mm and 40mm pink horizontal linear scars;
d. Right posterior forearm: 30mm linear scar;
e. Left lateral thigh: three horizontal linear scars measuring from 60 to 90mm;
f. Left lateral leg: 60mm oblique linear scar;
g. Right anterolateral thigh: at least five multidirectional scars measuring from 70 to 80mm;
h. Right anterior leg: 15mm linear scar; and
i. Right lateral leg: several linear scars, the most apparent measuring 45mm and 55mm.[8]

[8] Dr Forde described the injury to the neck as an abraded furrow which passed across the larynx and concluded that the abrasion was consistent with having been caused by the woven belt present with the body.

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[5] Violent or otherwise unnatural.
[6] See also, s 28(2) *The Coroners Act* 2003 (Qld) and The State Coroners Guidelines, Chapter 7.
[7] Dr Forde issued a Form 30. The cause of death was listed as 1(a) Hanging. Exhibit A2.
[8] Exhibit A3, 2.

[9] A small bruise near the eye and a couple of minor superficial injuries on the lower limbs were noted. No other significant injuries were observed. The CT scan showed no obvious internal trauma or discernible natural disease.[9]

[10] Toxicological analysis of a post-mortem sample of femoral blood revealed the presence of:

a. Alcohol 212 mg/100mL (equivalent to 0.212%);
b. Diazepam 0.21 mg/L;
c. Nordiazepam 0.19 mg/L;
d. Sertaline 0.10 mg/L;
e. Desmethyl Sertraline 0.4 mg/L; and
f. Ibuprofen 3 mg/L.[10]

[11] Dr Forde opined that the levels of the benzodiazepine diazepam and its metabolite, the antidepressant sertraline and its metabolite and the anti-inflammatory ibuprofen were at non-toxic levels.[11]

[12] Examination of a urine sample identified alcohol at a concentration of 271 mg/100mL.

[13] Dr Forde opined that the cause of death was: *1(a) Hanging*.[12]

[9] Exhibit A3, 5.
[10] Exhibit A4.
[11] Exhibit A3, 5.
[12] Exhibit A3, 5.

Inquest

[14] On 13 February 2024, a Pre-Inquest Conference (PIC) was convened. Written submissions were received in respect of the proposed issues for inquest and witness list.

[15] The Inquest was held in Brisbane on Monday 22 July 2024. The brief of evidence was tendered without objection at the commencement of proceedings. Following the Inquest, written submissions were received between 5 November 2024 and 13 January 2025.

[16] In accordance with section 45(5) of the Act, a coroner must not include in findings, statements that a person is or may be guilty of an offence or may be civilly liable for something. The focus of the coronial jurisdiction is on determining what happened, not on ascribing guilt, attributing blame to any person or party, or apportioning liability. The relevant standard of proof is that of the balance of probabilities, with reference to the *Briginshaw*[13] standard. The more significant the issue for determination, the clearer and more persuasive the evidence must be for a coroner to be sufficiently satisfied on the balance of probabilities that an issue has been proven.

[17] In adjudicating the significance of the evidence before the court, the impact of hindsight bias and affected bias must also be considered:

> *Hindsight bias is the tendency after the event to assume that events are more predictable or foreseeable than they really were. What is clear in hindsight is rarely as clear before the fact…It is an obvious point, but one that nonetheless bears repeating, particularly when coroners are considering assigning blame or making adverse comments that may damage a person's reputation…*
> *…*
> *Coroners should attempt first to understand the circumstances as they appeared at the relevant time to the people who were there.*
> *…*
> *Hindsight, of course, is a very useful tool for learning lessons from an unfortunate event. It is not useful for understanding how the involved people comprehended the situation as it developed. This distinction needs to be understood and rigorously applied.*[14]

[18] I am satisfied that there is sufficient evidence to make the findings required by section 45 of the Act.

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[13] *Briginshaw v Briginshaw* (1938) 60 CLR 336.
[14] The Australasian Coroners Manual. Hugh Dillon and Marie Hadley, Federation Press, 2015, 10.

Issues for inquest

[19] Following consultation with the family and others granted leave to appear, the issues for inquest were settled as:

1. The findings 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; and

2. Consideration of the circumstances leading up to the death including:

    a. AB's co-occurring substance use disorder and other mental health disorder/s including any personality disorder/s.

    b. Was there appropriate treatment for mental health consumers, within the public health or community systems, such as those suffering the mental health condition/s with which AB was diagnosed?

    c. Was AB an appropriate candidate for such treatment?

    d. Was such treatment offered to AB?

    e. Absent AB's consent, could AB be compelled, over the period of contact he had with mental health services to undergo such treatment?

    f. In all the circumstances, was the treatment afforded AB, for the mental health condition/s diagnosed, appropriate?

    g. Whether there was any failure to provide appropriate care that caused or hastened the death.

    h. Whether any aspect of the care actually provided, caused or hastened the death.

3. Whether any changes to procedures or policies could reduce the likelihood of death occurring in similar circumstances or otherwise contribute to public health and safety or the administration of justice.

Witnesses called

[20] During the Inquest, oral evidence was taken from the following witnesses:

a. Dr James Allen – General Practitioner;

b. Dr Kathryn Turner – Psychiatrist, Executive Director of Metro North Mental Health (MNMH); and

c. Dr Jill Reddan – Consultant Psychiatrist.

Evidence and findings on issues

[21] On 28 August 2021, AB was last seen alive, by his ex-partner XY, who recalled that they were together between 6:30pm and 8:00pm and had planned to spend time with XY's family on Sunday.

[22] On 29 August 2021, about 1:00pm, AB was found deceased, in his unit, by XY, who resided in the same unit complex. XY told QPS officers that AB would often leave his unit door unlocked to allow XY to visit. They had been separated for about three months, following incidents of Domestic and Family Violence (DFV). XY entered AB's unit through the unlocked door and observed AB in the bathroom / laundry area, sitting against the open door with a brown leather belt around his neck. The belt was attached to the door handle. AB's left leg was tucked in towards his groin, with his right leg extended. His right hand was positioned on the floor beside him with his fingers spread apart and his left hand was grasping his crotch area. AB was clothed in a blue singlet, grey track suit pants, and no shoes. QPS officers noted the body was cold to touch and in a severe state of rigor mortis. There were no obvious wounds other than the ligature mark around the neck and what appeared to be old cut marks on the left forearm.[15]

[23] QPS officers did not observe any obvious signs of disturbance at the unit. The television was on, showing a stand-by screen, no lights were on. QPS officers observed the bathroom towel hanger was broken and considered that AB may have attempted to use this as a hanging point, prior to using the door handle. Police formed the view that AB had hung himself.[16]

[24] AB's brother identified AB's body.[17] XY advised QPS officers that AB had been drinking a lot recently and would self-harm[18] when he drank. XY stated that AB drank at least a 750mL bottle of wine the night prior and ¾ of a bottle of wine and took at least two Valium tablets.[19] At the time of his death, AB had a documented history of depression, anxiety, and a substance use disorder (alcohol). There was also mention of borderline personality disorder (BPD) and a childhood experience of attention deficit hyperactivity disorder (ADHD).[20] AB was considered to

[15] Exhibit A1, 11.
[16] Exhibit A1, 11.
[17] Exhibit A1, 12.
[18] *Self-harm refers to a person intentionally causing pain or damage to their own body. This behaviour may be motivated as a way of expressing or controlling distressing feelings or thoughts. Self-harm and suicide are distinct and separate acts although some people who self-harm are at an increased risk of suicide.* See https://www.abs.gov.au/statistics/health/mental-health/national-study-mental-health-and-wellbeing/latest-release#self-harm.
[19] Exhibit A1, 12.
[20] Exhibit C1, 27.

have had a co-occurring substance use disorder (alcohol misuse) and other mental health disorder. QPS officers located numerous prescribed medications in AB's apartment including Sertraline, Norgesic, Quetiapine, Diazepam, Cephalex, Restavit, and Tenofovir Disoproxil Fumarate / Emtricitabine.

[25] In the months preceding his death, AB was subject to an Emergency Examination Authority (EEA) under the *Public Health Act* 2005 (Qld)[21], on several occasions.

[26] On 27 March 2021, AB had his first contact with MNMH when he was transported to the Royal Brisbane and Women's Hospital (RBWH) Emergency Department (ED) by the Queensland Ambulance Service (QAS) subject to an EEA. AB absconded from the ED in the early hours of 27 March 2021 and an authority to return was issued. AB was located and returned to the ED by the QAS.[22] AB presented with a lacerated left forearm after he intentionally cut himself with a knife. He was reviewed by the Psychiatric Registrar. AB self-reported the injury as a coping mechanism to seek relief. He denied suicidal intent and reported he had had an argument with his partner and drank about two litres of wine. He had held one relationship for ten years and described himself as the *'drama queen in the relationship*.'[23] AB was admitted for surgical repair of the wound. At the time, it was noted that AB had a history of depression and anxiety, with prior entries in the Consumer Integrated Mental Health and Addiction (CIMHA) application for intentional overdose in 2011.[24] Collateral information was obtained from AB's mother who described AB's mental health as "shocking."[25] Upon review of his mental state, AB was considered to have had capacity to consent to treatment and as such there were no grounds for an involuntary mental health admission.

[27] AB was referred to the Consultation Liaison Psychiatry Service (CLPS)[26] (for review on 28 March 2021) for mental health support during his admission. He was also referred to the Acute Care Team (ACT) for follow up in the community in respect of a medication review and a General Practitioner (GP) referral for Dialectical Behaviour Therapy (DBT). Through the coronial investigation, AB's family questioned why DBT was suggested in the absence of AB having a confirmed BPD diagnosis at this time.

[28] On 28 March 2021, AB was reviewed by the Psychiatric Registrar and requested discharge, despite his surgery being postponed. The Psychiatric Registrar assessed AB as having a chronically elevated level of risk due to an underlying personality structure and alcohol use

[21] See sections 157A to 157F.
[22] Exhibit C7, 40-44.
[23] Exhibit C10, 2.
[24] Exhibit C10, 1.
[25] Exhibit C10, 1.
[26] A specialised team who provide consultation and support within the general hospital setting.

however, AB was considered to have had capacity to decide to leave.[27] The Psychiatric Registrar referred AB to the ACT for follow up in the community. This was the first entry in the medical file to suggest BPD as a diagnosed condition.

[29] On the evening of 29 March 2021**,** AB was discharged from the RBWH, following surgical repair of his wound.[28] While a psychiatry review was attempted prior to discharge, AB was asleep and was not woken. The plan was for referral to the ACT for follow up in the community within seven days.[29]

[30] On 30 March 2021, the ACT attempted to contact AB however the listed number was for his mother. The ACT social worker also spoke to AB's sister, who told the social worker that she thought AB self-discharged, returned to his apartment with alcohol and started drinking again. AB's sister also said that AB was missing, no one could contact him, and he had made threats of self-harm.[30] The ACT attempted to contact AB by telephone but were unable to reach him.[31]

[31] On 1 April 2021, the ACT contacted AB by telephone and a clinician review was scheduled for 7 April 2021.[32] AB attended the review and was seen by a social worker.[33] He was encouraged to engage with Biala. AB planned to attend his GP for a Mental Health Care Plan (MHCP). AB denied any ongoing thoughts of self-harm and identified harmful alcohol use as a precipitating factor. He was motivated to engage with the Alcohol and Other Drugs Service (AODS) for support to reduce his alcohol intake.[34] The social worker determined that the assistance of the ACT was no longer required, and information would be sent to AB's GP. AB's case would be discussed at a Multidisciplinary Team Review (MDTR) with a view to closing his file.[35]

[32] On 8 April 2021, around 12:46am, AB was transported to the RBWH ED by QAS with suicidal ideation and deliberate self-harm (DSH) (superficial laceration to the right thigh and left arm) in the context of intoxication (BAC 0.232). AB absconded prior to his medical review at 1:00am however, he was located and returned to the RBWH by QPS officers under an EEA.[36] The EEA was extended so that AB could be assessed in the Psychiatric Emergency Centre (PEC). Prior to the presentation, AB had phoned a drug rehabilitation facility seeking admission and was told that would not occur. This upset AB and increased his suicidal ideation.[37] Collateral information was obtained

[27] Exhibit C10, 7.
[28] Exhibit C12, 6.
[29] Exhibit C10, 4.
[30] Exhibit C10, 8.
[31] Exhibit C10, 9-10.
[32] Exhibit C10, 11.
[33] Exhibit C10, 12-13.
[34] Exhibit C12, 6.
[35] Exhibit C10, 12-13.
[36] Exhibit C10, 18.
[37] Exhibit C7, 36.

from his mother, sister and partner and information was shared regarding referral pathways for treatment in the community. AB's sister told the clinician that AB was very manipulative and would tell a different story to go home. AB's sister requested that she be included in the discussion for a possible mental health plan.[38]

[33] On 8 April 2021, at 1:19pm, AB was assessed by the Psychiatric Registrar who noted AB's history of intentional overdose (consuming 75 x 10mg Phenergan tablets in 2011), and two previous presentations to ED with DSH, an intentional overdose (consuming 60 x 25mg Quetiapine tablets in 2019) whilst intoxicated, a presentation under an EEA for aggression towards family and DSH in 2020, and the recent presentation under an EEA with DSH while intoxicated, and that AB had absconded during that presentation. Upon assessment AB did not display symptoms of a psychotic illness or pervasive mood disorder and had capacity to consent to treatment, he did not meet the criteria for use of the *Mental Health Act 2016* (Qld) (the Mental Health Act) and admission would likely cause iatrogenic harm.[39]

[34] The Psychiatric Registrar's impression was that AB experienced DSH while intoxicated, on a background of undiagnosed BPD, alcohol misuse disorder and possible ADHD, in the setting of psychological stressors and perceived rejection.[40] The Psychiatric Registrar explained the diagnosis of BPD and the chronic elevated risk of further self-harm and possibly death with these ongoing behaviours. DBT as a treatment for BPD was discussed, as was the long wait list for public access however, it was also discussed that DBT could be accessed with a psychologist and under a MHCP. The Psychiatric Registrar spoke with AB's partner, mother, and sister.[41] AB was provided with a copy of the assessment and follow up plan and was discharged, for collection by his partner. AB was told to attend Biala the following day and see his GP for a referral for Footprints DBT and a psychologist.[42]

[35] On 9 April 2021, the ACT contacted AB for follow up. AB reported that he had an appointment with his GP on Monday 12 April 2021 to seek a Footprints referral for DBT and an appointment with Biala on 13 April 2021.[43]

[36] On 9 April 2021, AB contacted the Biala AODS requesting outpatient detox services. AB had not had prior engagement with the service and stated that he got the pamphlet from the RBWH. He was informed that he would be reviewed daily and would be required to consent to a blood alcohol reading on arrival. He indicated an interest in counselling.[44]

[38] Exhibit C10, p18.
[39] Exhibit C10, 23.
[40] Exhibit C10, 23.
[41] Exhibit C10, 21-22.
[42] Exhibit C10, 24.
[43] Exhibit C10, 1.
[44] Exhibit C3, 1.

[37] On 12 April 2021, the ACT MDTR closed AB's case. Information was sent to his GP.[45] The Bowen Hills Medical Centre had no record of a consultation for AB on 12 April 2021.

[38] On 14 April 2021, AB commenced detox at Biala.[46] AB reported drinking from the age of 16 and problematic drinking from the age of 23 when he worked on a cruise ship and there was heavy drinking. He reported smoking ten cigarettes a day, smoking cannabis since age 18 (about once a week), and occasional MDMA or coke use (once a year) when out partying.[47] AB attended Biala daily from 15-18 April 2021.[48]

[39] On 21 April 2021, AB participated in a detox completion review. AB reported having consumed one large glass of alcohol the night prior, to make him sleepy. On assessment, the Nurse Practitioner, considered the alcohol withdrawal was completed, and gave AB a script for Naltrexone (50mg) for management of cravings. AB was directed to take half a tablet for the first four days and then one tablet daily. A total of 30 tablets and one repeat script was provided.[49] AB was referred for education and counselling on the third floor of the Biala clinic.[50]

[40] On 26 April 2021, AB relapsed and presented to the RBWH ED around 2:37pm under an EEA,[51] threatening self-harm while intoxicated. Upon assessment, AB was not considered to have displayed symptoms of a psychotic illness or pervasive mood disorder. Collateral information was obtained from AB's mother who thought AB was doing well as an outpatient at Biala. It was noted during this presentation that AB had been arguing with his partner and family. He threatened himself with knives and threatened to jump off the balcony.[52] On assessment he reported feeling better and denied thoughts of self-harm and was focussed on attending work the next day.

[41] AB was reviewed by the Drug and Alcohol Brief Intervention Team and reported using alcohol on three of the prior seven days. He was monitored while in the PEC and once sober, he was discharged, with a referral to the MNMH-RBWH ACT for follow up in the community.[53]

[42] On 27 April 2021, about 11:50am, AB missed a call from the ACT.

[43] On 28 April 2021, AB missed two further calls from the ACT. The ACT contacted AB's mother who said she would ask AB to contact them to make an appointment or to decline their services.[54] AB missed a counselling appointment at Biala and was followed up by telephone by

[45] Exhibit C10, 27.
[46] Exhibit C13, 1.
[47] Exhibit C3, 13.
[48] Exhibit C3, 25 -29.
[49] Exhibit C3, 46.
[50] Exhibit C3, 43 and 48.
[51] Exhibit C7, 26.
[52] Exhibit C10, 34.
[53] Exhibit C12, 6.
[54] Exhibit C10, 35-36.

a social worker. A message was left for AB to return the call if he would like a counselling appointment.'[55]

[44] On 29 April 2021, an unannounced home visit was undertaken by the ACT. AB was not home; however, collateral information was obtained from AB's partner, XY and a request was made for AB to make contact. AB was reportedly not pleased by the home visit and contacted the ACT the following day reporting that he was upset by people attending his home when he was not present. AB declined further engagement with the ACT and his partner and GP were so advised. AB's referral to the ACT was closed on 30 April 2021. [56]

[45] On 30 April 2021, AB attended the Bowen Hills Medical Centre and was seen by Dr Shihui Lai. AB disclosed that when he drank too much alcohol he became depressed. He reported having two bottles of wine per night since earlier that month following presentation to the RBWH. He said that three times a week he was having at least one litre of wine. He self-reported taking Sertraline 100mg daily for anxiety for the past three years and Quetiapine PRN for sleep, usually one to two intermittently at night. AB confirmed he had never had counselling. Dr Lai told AB it may be BPD and that DBT may be helpful. AB described feeling sleepier on Naltrexone (that was prescribed post detox at Biala). AB stated that he relapsed into alcohol use on day five of the outpatient detox program. Dr Lai considered that AB's diagnosis was anxiety/depression and alcohol overuse. AB's Sertraline was increased to 150mg daily and it was suggested that he continue counselling with Biala or attend an Alcoholics Anonymous (AA) meeting. A MHCP was noted for *'next time – to ref to psychologist in the community.'*[57]

[46] On 16 May 2021, AB presented to the RBWH ED, with a five-centimetre laceration to the right lateral calf. AB was medically reviewed and disclosed that the injury occurred while intoxicated. AB was not seen by mental health practitioners and was discharged.[58]

[47] On 11 June 2021, AB was transported to the RBWH ED by QPS, under an EEA, where he was reviewed medically. AB presented with a deliberate laceration to his right forearm (DSH), caused by a broken wine glass following an argument with his partner. AB absconded prior to being medically reviewed.[59] AB was located and returned to the ED, subject to an Authority to Transport Absent Person (ATAP).[60] AB was assessed in the ED by the Medical Registrar who noted AB was intoxicated the night prior, had previously been to Biala and involved with mental health services at MNHHS. Despite this, he was finding it difficult to abstain from alcohol. AB reported that he had follow-up in the

[55] Exhibit C3, 51.
[56] Exhibit C13, 2. Exhibit C12, 6.
[57] Exhibit C14, 6.
[58] Exhibit C7, 23-24. Exhibit C12, 6 – 7.
[59] Exhibit C7, 21.
[60] Authorises a patient to be returned by a health practitioner, ambulance officer or, if necessary to ensure the safe transportation / return of a patient, a police officer.

community with his GP next week and the Registrar formed the impression that AB's presentation was an episode of DSH in the context of intoxication and acute stressors. AB was medically cleared, not suicidal and not currently at risk of further self-harm. It was noted that AB had a new DVO against his partner so could not return home, but he had a safe place to stay with his mother. AB was cleared for discharge into his sister's care.[61] AB's GP records do not show an appointment occurred between 14 and 20 June 2021.[62]

[48] On 16 June 2021, a Police Protection Order (PPO) was made naming AB as the respondent and XY as the aggrieved. The PPO contained two conditions including that the respondent must be of good behaviour towards the aggrieved, and not commit acts of domestic violence against the aggrieved, and the respondent must not approach the aggrieved when the aggrieved is at any place. The order was in force to and including, 15 June 2026.[63]

[49] On 21 June 2021, AB was charged with a contravention of the order and was to appear in the Brisbane Magistrates Court on 30 August 2021.

[50] On 23 June 2021, an application to vary the terms of the order was lodged at the Brisbane Magistrates Court. The application to vary was subsequently struck out on 1 September 2021.[64]

[51] On 1 July 2021, a social worker noted: *'Attempted to make contact on several occasions. No reply received. Client yet to present to Level 3 Counselling at Biala. Is linked in with ACT. No assessment made.'*[65] As a result of AB's lack of engagement, his referral with MNMH – AODS was ended on 1 July 2021.[66]

[52] On 2 July 2021, AB participated in a telephone consultation with GP, Dr James Allen who recalled:

> a. *'He* [AB] *disclosed a past history of ADHD. He* [AB] *expressed interest in obtaining his records from the Qld Centre for Learning and Behaviour Disorders with a view to commencing treatment for ADHD. A request for medical records to the Centre was created and emailed to* [AB] *to sign and return for actioning.*
> b. *He disclosed that he was currently on sertraline and quetiapine, which had been commenced by his GP, Dr Nesse, in Regents Park.*
> c. [AB] *was not seeing a psychologist or psychiatrist but during previous admissions to the RBWH and Logan*

[61] Exhibit C7, 18.
[62] Exhibit C14, 6-7. Exhibit 10-11.
[63] Exhibit D2.
[64] Exhibit D4.
[65] Exhibit C3, 52.
[66] Exhibit C13, 1. Exhibit C12, 6.

Hospital he had been told that he had a diagnosis of BPD.[67]

d. [AB] *disclosed he was going through a break-up and was currently living alone.'*

[53] Dr Allen referred AB via the Primary Health Network Brisbane Mind pathway, to the Queensland Council for LGBTI Health, formerly known as the Queensland AIDS Council, for additional counselling and support. AB agreed to contact 1300MHCALL, the Qld Health Mental Health Access Line that day to ensure that he was in their system for support, to check where he was on the RBWH waitlist for DBT, and to ensure that he knew how to access ongoing support and care from the public mental health system. Dr Allen emailed AB the preparatory homework that he routinely provided for patients wishing to complete a mental health care plan to enable access to rebated visits to a counsellor or psychologist under the Medicare system. A note was made on AB's file of complex post-traumatic stress disorder (cPTSD) on this visit. An additional file note relating to a suicide attempt with ingestion of medication in the past requiring attendance at Logan Hospital was also made during the same consultation.[68]

[54] On 7 July 2021, a Temporary Protection Order (TPO) was made, suspending the PPO of 16 June 2021. The Order contained conditions that the respondent must be of good behaviour towards the aggrieved, and not commit acts of domestic violence against the aggrieved and must not approach the aggrieved when the aggrieved was at a place except: Hummingbird, Albion on Saturdays, and Family Nightclub on Sundays.

[55] On 12 July 2021, AB attended the Bowen Hills Medical Centre and was seen by Dr Bianca Maiden. He disclosed that he was also attending at Stonewall Medical Centre and on Pre-exposure Prophylaxis (PrEP). AB requested a new script for Sertraline (150mg), Quetiapine (25mg) and PrEP The medical notes recorded that AB had a referral to a psychologist and was booking an appointment in the next few weeks. Prescriptions for Sertraline (100mg and 50mg), and Quetia (25mg) tablets were provided.[69]

[56] On 14 July 2021, AB presented to the RBWH ED via QAS due to self-harm (two deep lacerations to his left forearm). AB was medically reviewed, and it was noted that he had been drinking, became disassociated and self-harmed. AB did not report ongoing distress or mental health concerns and declined Drug and Alcohol Brief Intervention Team (DABIT) and PEC review. He was discharged home after his lacerations were sutured.[70]

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[67] Exhibit B1, 1 – 2.
[68] Exhibit B1, 2.
[69] Exhibit C14, 7.
[70] Exhibit C12, 6 -7, Exhibit C7, 13-15.

[57] On 25 July 2021, AB was transported to the RBWH ED under an EEA due to self-harm while intoxicated. QAS officers enacted an EEA noting that AB had inflicted large, deep lacerations to both forearms and was expressing a desire to die.[71] A Recommendation for Assessment (RA)[72] was made by the ED Consultant and AB was admitted to the RBWH as he was an absconding risk. AB was managed in Wattlebrae because he had been a close contact of a COVID-19 case.

[58] On 26 July 2021, AB was reviewed by a mental health clinical nurse consultant by video conference. There was no current indication for mental health admission and AB did not meet the criteria for the RA to be continued as he was engaging with assessment and ongoing follow-up.[73] A Registrar declined to place AB on a Treatment Authority (TA)[74] under the Mental Health Act as he was engaging voluntarily. During the admission, AB disclosed that he had separated from his partner of 10 years approximately three to four weeks prior resulting in his relocation to Bowen Hills. He indicated that he wanted to return home to his dog and was experiencing financial stress due to the separation and move, as well as 14-day quarantine requirements as he was unable to attend his hairdressing apprenticeship and identified limited support outside of his family. It was in this context and acute alcohol intoxication that he cut his wrists with suicidal intent.[75] AB was at ongoing risk of self-harm due to ongoing stressors and alcohol dependence without appropriate engagement with alcohol and drug counselling. He declined re-referral to the AODS, however, agreed to ongoing support by the ACT for support and linkage with a psychologist in the community. As AB was engaging with the Community Liaison Team (CLT) and agreeing to ongoing care by the team, he was not considered to meet the criteria for ongoing use of the Mental Health Act and the RA was ceased.[76]

[59] When AB was seen by the Orthopaedic team, he was reportedly frustrated that he had not had his operation yet and, when advised of the plan for intravenous antibiotics with the operation on 30 July 2021 he advised he did not want to remain in hospital for antibiotics, as it was detrimental to his mental health. AB elected to discharge against medical advice and was provided with information on the signs and symptoms of infection and a plan was made for him to receive the antibiotics orally at home, and to return for outpatient surgery.[77]

[71] Exhibit C4, 1-2.
[72] Allows a person to be assessed by an authorised doctor to decide whether a Treatment Authority is required to authorise involuntary treatment and care of the person, or whether there is a less restrictive way.
[73] Exhibit C10, 56.
[74] A Treatment Authority is a lawful authority under the Mental Health Act that allows for the provision of treatment and care to a person with a mental illness, who does not have capacity to consent to treatment.
[75] Exhibit C12, 7.
[76] Exhibit C13, 2. Exhibit C12, 7.
[77] Exhibit C12, 7.

[60] A video of the damage AB caused to his arm was provided by his family. An apparent suicide note was also provided by his sister to staff at the RBWH.[78]

[61] Following this presentation, an incident report[79] was completed by the RBWH noting that AB was admitted as an inpatient with self-inflicted lacerations to both arms while intoxicated. He had been assessed on video link, late morning on 26 July 2021. The documented plan was written into the CIMHA application, and a printed note was handed to Ward 6C staff. The note stipulated the mental health plan was for a further mental health review on 27 July 2021. AB's sister contacted the Registered Nurse (RN) on Ward 6C and communicated her concerns about AB's potential discharge to the mental health team. AB was discharged to the community without any communication with the afterhours mental health team. The nurse unit manager for Ward 6C indicated that AB had requested discharge and was allowed to do so as the mental health team had removed his RA the day before.[80]

[62] On 27 July 2021, about 10:30am, the ACT[81] contacted AB via telephone. During this contact, AB described the hospital environment as depressing and horrible which prompted his self-discharge the day prior. He identified concerns that his history of ADHD may be impacting on his mental health. AB was informed of the concerns expressed for his safety by his family. AB acknowledged that people would be concerned for him, however, he reportedly denied that he would be at risk of self-harm currently.[82]

[63] On 27 July 2021 at 2:08pm, AB contacted the Bowen Hills Medical Centre seeking a Seroquel script. Dr Lai declined to issue the script without an in-person review.[83]

[64] On the evening of 27 July 2021, AB was transported to the RBWH Emergency and Trauma Centre by QAS under an EEA in the context of intoxication. He had reportedly drunk 1.5L of wine and was being aggressive to his ex-partner.[84] AB presented with self-inflicted lacerations to his arms[85] and was readmitted and referred to the Consultation Liaison Service for mental health review. On review, he reported further stressor of a pending court hearing due to a Domestic Violence Order. AB was advised by Dr Rothwell that the RA under the Mental Health Act would be extended for further assessment as this was his third presentation to services in the context of ongoing psychosocial stressors and alcohol dependence. While AB's risk was not considered to be acute, the multiple presentations in the setting of ongoing psychosocial stressors that had not resolved, and his

[78] Exhibit C10, 61 - 63.
[79] Incident ID: 3567609.
[80] Ibid.
[81] Exhibit C10, 64.
[82] Exhibit C10, 64.
[83] Exhibit C12, 8.
[84] Exhibit C12, 7.
[85] Exhibit C10, 64.

presentation, complicated by ongoing alcohol dependency was impeding his problem-solving capacity. The extension of the RA allowed for better assessment of AB and supportive discharge planning. [86]

[65] AB was commenced on diazepam for alcohol withdrawal and was advised he was not able to discharge without further review by the mental health service. His management plan included the allocation of a nurse special and referral to both Social Work and the Hospital Alcohol and Drugs Service for review. AB was supported by the Hospital Alcohol and Drug Service and made plans to reengage with the MNMH – Alcohol and Drug Service for counselling in the community.[87] AB's RA was extended again on 28 July 2021.

[66] On 29 July 2021, AB was reviewed by the Consultation Liaison Service who noted that AB reported feeling improvement with the commencement of diazepam and abstinence from alcohol whilst in the medical ward. He denied feeling depressed or anxious and was not dysregulated when discussing his upcoming court hearing. He had been in contact with his workplace and arranged to return on light duties and had been notified that his quarantine period had been backdated resulting in release that evening. He denied any ongoing suicidal ideation and his risks were considered to be chronically elevated in the context of alcohol intoxication. He did not meet the criteria for ongoing use of the Mental Health Act. The RA was ceased on 29 July 2021, when it was determined AB was not at imminent risk of self-harm. AB was discharged from the Consultation Liaison Service with face-to-face review to be provided by the ACT on discharge from the medical ward.'[88]

[67] AB's sister was contacted on 29 July 2021 to obtained collateral information and was advised of the proposed plan, including, short-term follow-up with the ACT.[89]

[68] Following this presentation, an incident report was completed by the RBWH.[90] The report noted that while there was no actual harm to AB at that time, the delay in requesting mental health advice, noting AB's presenting, risks could have resulted in potential harm.[91]

[69] On 30 July 2021, AB underwent surgery, having agreed to remain in hospital for that purpose. He was discharged from the RBWH on 31 July 2021.[92]

[70] On 2 August 2021, AB was contacted by the MNMH-RBWH ACT. AB denied ongoing suicidal or self-harm ideation. He denied substance

[86] Exhibit C12, 7.
[87] Exhibit C13, 2 - 3.
[88] Exhibit C13, 3.
[89] Exhibit C10, 80.
[90] Incident ID: 3577742.
[91] Ibid.
[92] Exhibit C12, 8.

use. AB requested to engage with the ACT for support and a face-to-face review was arranged for 9 August 2021. During this contact, AB expressed a need for support around his substance use and was encouraged to continue with his plan to re-engage with Biala. AB agreed to further contact with the MNMH-RBWH ACT.[93]

[71] On 4 August 2021, Dr Agbuya had a telephone consult with AB. AB stated he had moved to Bowen Hills, had ongoing counselling with a new psychologist and ongoing psychiatrist review from the hospital. AB expressed a desire to stop alcohol and asked for Diazepam. Dr Agbuya issued a 25-tablet script to assist in alcohol cessation. Other scripts were for Seroquel 25mg (60 per script), Mometasone and Doxycycline. AB was advised to follow up and get his scripts from his new GP.

[72] On 5 August 2021, AB was contacted via telephone and confirmed the face-to-face review as scheduled however he requested a facetime call. During this contact AB stated that he no longer wanted to engage with Biala but had been looking to attend AA. He reported having not consumed alcohol for two days and that he had arranged an appointment to discuss ADHD medication.

[73] On 6 August 2021, AB attended Stonewall Medical Centre in person however, Dr Allen was working remotely and providing telehealth appointments that day. Dr Allen recalled that they spoke on the phone and agreed on a schedule to meet again in person on 10 August 2021. AB indicated that he wished to seek assistance for BPD and ADHD following another admission to hospital for self-harm. Reportedly, AB had not consumed alcohol for three days. Dr Allen noted that voluntary admission to a private psychiatric facility was not an option at that time because AB did not have private health insurance and it was unaffordable for him. Dr Allen emailed AB contacts for potential support options with the Queensland Council for LGBTI Health, where he had been previously referred. Dr Allen also provided contact details for Communify (a community centre in New Farm) and Lena Lundell (a mental health social worker in Windsor), so that AB would have some options to consider in order to decide what he felt might be most suitable for him.[94]

[74] On 9 August 2021, the ACT attempted a facetime call to AB at the scheduled time however he could not be contacted.

[75] On 10 August 2021, the ACT contacted AB who advised he missed the appointment as he was called into work. AB denied thoughts of self-harm. He declined referral to MNMH Alcohol and Drug Service (ADS) and further contact with MNMH-RBWH. Because AB declined further contact, his information was sent to his GP, his family were contacted to advise that he had declined follow up and his care was ended with

[93] Exhibit C12, 7.
[94] Exhibit B1, 2.

MNMH-RBWH on 12 August 2021.[95] There was no further contact between MNMH and AB.[96]

[76] On 10 August 2021, AB attended Stonewall Medical Centre in person. Dr Allen recalled that they discussed AB's potential diagnosis of cPTSD and self-harm. Dr Allen noted a previous suicide attempt with an ingestion of quetiapine without ongoing physical sequelae. Dr Allen worked on establishing ongoing rapport with AB and agreed upon the boundaries of working together. AB had Dr Allen's mobile number and, as was his usual process for patients at risk of suicide, Dr Allen outlined the scope of the service he could provide and the need to also seek assistance from services that were resourced to provide 24-hour care, when needed. They discussed AB's medication at length. AB mentioned that his other GP had been prescribing diazepam in addition to quetiapine and a Selective Serotonin Reuptake Inhibitor (SSRI). Dr Allen explained some of the significant risks of sedative medication and that AB could be at an increased risk given his previous suicide attempt and the use of alcohol. They also discussed tolerance, dependence, respiratory depression, death, and cerebral injury with long term morbidity. Dr Allen agreed that he could continue to prescribe Quetiapine to AB, so long as he agreed that Dr Allen would be the sole prescriber for all of AB's medications in the general practice setting. AB agreed to attend his weekly appointments, collect weekly staged supplies of his medications from a single pharmacy (Terry White Chemist at the Gasworks) and that while he continued to attend weekly appointments, Dr Allen would bulk bill all his consultations.[97]

[77] Dr Allen also assisted AB with his request for urgent continuation of PrEP. Dr Allen was of the view that he had established an effective therapeutic relationship with AB during their consultations.[98] He was aware of AB's domestic violence order and the need for him to find new accommodation. Dr Allen recalled that for AB to comply with the order, he would have been required to find new accommodation, which was particularly difficult at that time in Queensland, given the Covid-19 pandemic. To Dr Allen's knowledge, there was no emergency accommodation for men in relationships where domestic violence was present. The property manager for the building in which AB and his partner lived was aware of his situation and, in an attempt to assist, found AB new accommodation in the same building.

[78] Whilst Dr Allen recognised that AB might have been in breach of the domestic violence order, it was the only practical solution available to AB, but it left him chronically exposed to the possibility of being found to have breached the domestic violence order.[99] Dr Allen believed AB's situation was highly complex, as one of his primary supports was his ex-partner and despite significant interactions with the health care

[95] Exhibit C12, 8.
[96] Exhibit C13, 3.
[97] Exhibit B1, 2 -3.
[98] Exhibit B1, 3.
[99] Exhibit B1, 3.

system, minimal significant alternative supports could be identified and provided in a timely manner. There had been no provision of training to establish other healthy forms of distress tolerance and emotional regulation, so it was both understandable and highly likely that AB would turn to either his ex-partner or alcohol and/or other substances when his distress reached a significant level. This would either place him in legal jeopardy or escalating risk of suicide. Dr Allen was aware that an ongoing relationship of support between AB and his ex-partner continued in this context.[100]

[79] On 16 August 2021, AB attended Stonewall Medical Centre in person. The appointment was bulk billed and lasted a little over an hour. Dr Allen recalled that they discussed a range of issues around the experiences of guilt, shame and humiliation and the links between them and violent behaviour. They worked on tools to respond to uncomfortable emotions in more effective ways, with a focus on communication skills in interpersonal relationship. This was particularly important given that AB remained in legal peril while he lived in the same building, shared a vehicle, and maintained ongoing contact with his ex-partner. They continued to explore and monitor AB's risks and triggers, and AB told Dr Allen that he had chosen to no longer drink alcohol.[101]

[80] On 24 August 2021, AB cancelled his scheduled appointment with Dr Allen. Dr Allen telephoned AB to check his wellbeing due to his concern for AB's elevated level of risk. Dr Allen recalled that AB said he cancelled the appointment because he had developed symptoms of a respiratory tract infection. Dr Allen later learnt after AB's death that this was not the case and that he had been suffering the after effects of alcohol use the night prior. Given the symptoms AB reported, arrangements were made for a Covid-19 test and the necessary isolation pending the result, as per Covid-19 pandemic guidelines at the time. Dr Allen issued a medical certificate and provided a continuing supply of diazepam on a staged supply from his usual pharmacy. A Covid-19 test result was not forthcoming from AB in the following days. Dr Allen recalled that AB confirmed he would be attending his scheduled appointment the following week.[102] There was no further contact between AB and Dr Allen.

[81] On 3 September 2021, Dr Allen was advised by AB's sister that AB had passed away.[103]

Domestic and Family Violence Related Death

[82] As noted above, at the time of AB's death, he was recorded as the respondent in a Domestic and Family Violence Protection Order and his ex-partner XY was the aggrieved. The contravention charge was

[100] Exhibit B1, 3.
[101] Exhibit B1, 3-4.
[102] Exhibit B1, 4.
[103] Exhibit B1, 4.

listed for first mention on 30 August 2021, in the Brisbane Magistrates Court. As AB was deceased, the charge was dismissed.[104]

[83] Chapter 7 of the State Coroners Guidelines sets out the criteria used to define a domestic and family violence related death:

> *'Suicides of a victim or perpetrator of domestic and family violence in which there is a clear link between the suicide and history of domestic and family violence, such as an incident of violence within close proximity to the death.'*[105]

[84] Noting the above definition and the timeline of events set out above, I find that the history of domestic violence and the legal implications that followed may have contributed to the psychosocial stressors suffered by AB and contributed to his death. As such, AB's death may be considered a domestic and family violence related death.

Suicide

[85] Counsel assisting submitted and I accept that while the Coroners Act does not contain a prescribed definition of suicide, it would be appropriate for me to make such a finding in the circumstances.

[86] To do so, I must be satisfied that AB acted intentionally, knowing the probable consequence.[106] The capacity to form such intent is a threshold requirement for a finding of suicide.[107] Recognised circumstances which may deprive a person from having such capacity include mental disease, intellectual impairment, psychosis, extreme distress, intoxication under the influence of alcohol or drugs or infant immaturity.[108] In some circumstances, a death can have been an accident even though it appears to be intentional and in other rarer cases, there can be a suspicion of foul play. Accordingly, before a finding of suicide is made, the evidence supporting such a finding cannot be equivocal. A finding of suicide must be determined on the balance of probabilities, but its seriousness warrants the application of the upper spectrum of the *Briginshaw* scale, meaning that there must be clear evidence to support such a finding. Usually, the evidence supporting such a finding is circumstantial requiring inferences of fact to be drawn from those circumstances.

[87] On all the evidence before me, I find that it is more likely than not, AB's death was intentionally caused by him.

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[104] Exhibit D1.
[105] State Coroner's Guidelines, Chapter 7, page 28.
[106] *Clark v NZI Life Ltd* [1991] 2 Qd R 11.
[107] *Inquest into the death of Tyler Jordan Cassidy* [2011] Coroners Court of Victoria.
[108] *Suicide Reporting in the Coronial Jurisdiction*, Coronial Council of Victoria Consultation Paper, 23 April 2014.

Issue one

The findings required by s 45(2) of the Coroners Act.

[88] To prevent repetition, I will deal with the medical cause of death under this heading. In accordance with the evidence contained in the report of Dr Forde, I find the cause of AB's death was hanging.

Issue two

Consideration of the circumstances leading up to the death including:

AB's co-occurring substance use disorder and other mental health disorder/s including any personality disorder/s.

[89] Counsel assisting submitted and I accept the expert opinion of Consultant Psychiatrist, Dr Jill Reddan, in respect of AB's co-occurring substance use disorder and other mental health disorder/s including any personality disorder/s. [109]

[90] Counsel for AB's family accepted that AB had a substance use disorder, namely alcohol use disorder at the relevant time he was presenting to the MNHHS, and likely a personality disorder also.

[91] Counsel assisting submitted and I accept that in finding AB suffered an alcohol use disorder and personality disorder – on the borderline spectrum, that consideration of the most appropriate treatment would also acknowledge the difficulties in engaging mental health consumers within this cohort.

[92] As submitted by counsel for AB's family, Dr Reddan opined that while the working diagnosis of the MNHHS clinicians appeared to be BPD, that it was more likely that AB had mixed Personality Disorder, but the *pressing concern* [emphasis added] was his alcohol use disorder. Both conditions required active follow up.[110] Dr Reddan also outlined in her report that substance use disorders were very common in individuals with personality disorders but there is very little research to examine how alcohol use disorders and Personality Disorders interact in terms of outcome however, most psychiatrists would consider that a co-occurring personality disorder with a substance use disorder would suggest a poorer prognosis for an individual.[111]

[109] 22 July 2024, T 1-34, LL 2 – 4.
[110] Exhibit E1, 4.
[111] Exhibit E1, 6-7.

Was there appropriate treatment for mental health consumers, within the public health or community systems, such as those suffering the mental health condition/s with which AB was diagnosed?

[93] Counsel assisting submitted and I accept Dr Reddan's opinion that the appropriate treatment for those suffering the mental health conditions with which AB was diagnosed is primarily community based follow up and long-term care:

> *'There are very few psychiatric disorders that kind of get fixed in – in a very short period of time, and mostly what people need is long-term psychotherapy, as well as attention to the substance use disorder. The complicating factor is – is that, while people are still using substances, it's very difficult to do psychotherapy with them, but that's the mainstay of treatment of people with personality problems.'*[112]

[94] Dr Reddan identified DBT as an appropriate treatment for persons such as AB, however, Dr Reddan identified the difficulties in administering such treatment, particularly in respect of AB's alcohol use disorder:

> [CA] *'If you could speak to whether that is an appropriate treatment for personality disorders?*
>
> [Dr Reddan] *Yes, it is, particularly in the early stages of treatment – can be very helpful, because it can help people develop some skills to do with emotional ups and downs and with the inherent mood instability, but very often, they need more than that in the longer term, because so much of the pathology in – with people with personality disorders centres around their relationships with others. Dialectic behaviour therapy is helpful with that, but it doesn't address it in the deeper way that they often need. So very often, it's useful early on, and it can help people develop some skills, because often they have very poor skills, and they aren't resilient at dealing with life's vicissitudes, and they tend to create crises for themselves, but really, what they often need is a long-term therapeutic relationship.*[113]

[112] 22 July 2024, T 1-35, LL 1 – 6.
[113] 22 July 2024, T 1-35, LL 10 – 20.

[CA] *And would that be something that would perhaps come from a psychologist through talk therapy? -*

[Dr Reddan] *It could be. It could be a psychologist or a psychiatrist. They need to be, with this type of personality problem, pretty well trained, and they need supervision, and they need to be comfortable with seeing people long term, and they need to be comfortable with the sort of vicissitudes that the treatment process it's going to involve long term. But they can make considerable gains in long-term therapy.*

[CA] *So it's fair to say that the therapeutic relationship between the mental health consumer and the treatment provider is paramount? ---*

[Dr Reddan] *Oh, absolutely. It – it's a lot of the actual therapeutic process – is learning to sustain that relationship. But it's not like a relationship – anything like, really, that you have in the rest of life. It's one where the person – the therapist does not talk about themselves, does not share time with them outside the therapeutic framework. And particularly with people with significant borderline traits, they do need a very strict therapeutic framework with a lot of boundaries, because they really struggle with that. It's really hard for them. So in therapy, it's important that the chaos, often of their lives isn't reflected in the therapy, so the therapy needs to be very structured.*[114]

[CA] *So, in terms of your experience again…would it be fair to say that people with borderline personality disorder or personality disorder traits, it's quite difficult to provide treatment to them in the acute care setting? ---*

[Dr Reddan] *Yes. You're not – all you're doing in an acute care setting, in many ways, is dealing, perhaps, with a current crisis, although, very often, I think, the tendency of the person to, in a way, inadvertently create the crisis themselves can be ignored, and it doesn't address the longer-term restructuring, in a*

[114] 22 July 2024, T 1-35, LL 22 – 39.

way, of a personality that's needed. And one of the problems I think we have in our systems, both privately and publicly, is, to a certain extent, they're very much geared towards short-term cross-sectional-type treatments, whereas a person with this type of personality needs to be in a therapy where they see the same person all the time. I wouldn't underestimate how difficult this treatment can be, but in particular it's more difficult if there's substance use going on."[115]

[95] Dr Reddan gave evidence at the Inquest of the problematic effects of alcohol on persons such as AB who also have a personality disorder:

[Dr Reddan] *'And it's very common for individuals with borderline personalities to abuse substances, and I think I mention that somewhere in my report. And it's – that's a really big challenge because, again, it – it influences the emotional reactions of people.'*

[CA] *Could that also influence the, perhaps, lethality of a suicide attempt? ---*

[Dr Reddan] *Yes. Well, we know that alcohol abuse increases the risk of suicide in the general population, and – but substance use generally does. But alcohol, in particular, will, although methamphetamine does too.*[116]

[CA] *Is that perhaps due to a disinhibitive characteristic or something else? ---*

[Dr Reddan] *I think it's – that's part of it, but it's more than that. It's also the fact that it – it tends to entrench the pathological behaviours. Often, when people are using a lot of substances, they fail to benefit from maturing experiences in life, plus there's the effects on the brain. Often, people who are using substances find it difficult to learn new things and to learn new strategies, particularly when those previous ways of behaving have been very entrenched over a lifetime or over many years, anyway. And there's the biological effect. Alcohol is a central nervous*

[115] 22 July 2024, T 1-36, LL 23 – 35.
[116] 22 July 2024, T 1-35, LL 39 – 47.

system depressant – not just depresses the brain stem in terms of breathing and that, but it has an effect on mood. It's – and it's – it's really a – a terrible drug if people have mood instability. So is methamphetamine and the stimulants, generally.'[117]

[96] Counsel assisting submitted and I accept the opinion of Dr Reddan that while appropriate treatment may be available, there is a need to be more proactive as opposed to reactive patient led care. Long-term solutions cannot be found by treating people such as AB in emergency departments. Preferably, as opined by Dr Reddan, there would be an option for longer-term chronic treatment, rather than just reaction to crises.[118]

[97] Counsel assisting submitted and I accept that while the prescription medication provided to AB was appropriate and commonplace for the conditions diagnosed (albeit only a short-term option that would not address the underlying pathology), caution must be exercised in respect of prescription medications in the treatment of conditions such as those that AB had:

[CA] *'Are you of the view that they were appropriate prescriptions for the treatment – for the conditions as diagnosed? ---*

[Dr Reddan] *Very, very commonplace, so yes. Useful, and I wouldn't have said that they necessarily – there's no evidence that they were particularly, I think, implicated in what ultimately happened, that is, his suicide. But prescription – we need to be careful about prescription medication. First of all, it can be used to overdose. It wasn't in this particular case, but it can be. But it also is, again, a very short-term – it won't deal with the underlying pathology. It has a place, but it's not the whole place. One of the difficulties with some people with borderline personalities is they become preoccupied with the prescription of drugs. I don't think that's the case here with* [AB]*, but it can be, and you've got to be careful that you don't overdo the prescribing, and you've also got to be careful that you don't give the patient the idea that there's a drug to fix every*

[117] 22 July 2024, T 1-37, LL 1 – 11.
[118] 22 July 2024, T 1-39, LL 12 – 14.

> *passing emotional disturbance, because there isn't. And you've got to start being careful about interactions with drugs and side effects and all the usual things. It's not the mainstay of treatment.'*[119]

[98] The evidence at the Inquest was that patients with a diagnosis of BPD are dysregulated, highly emotional, occasionally impulsive and as such any treatment regimen required structure and formality and the addition of alcohol will cause a break down in structure and effectiveness of the treatment provided. Commitment and discipline are required from the patient.[120] It is not unreasonable to speculate that such commitment and discipline would have been incredibly difficult for AB in the context of an alcohol use disorder, very real issues of addiction, and where there is much more to be done to properly understand BPD.

Was AB an appropriate candidate for such treatment?

[99] Counsel assisting submitted and I accept that AB was an appropriate candidate for DBT, but AB would have also required treatment for management of his alcohol use disorder at the same time for the DBT to be effective.

[100] AB's family supported and endorsed the submission of counsel assisting in respect of this issue for inquest.[121]

[101] AB's suitability for DBT was supported by the expert opinion of Dr Reddan. Dr Reddan also appropriately acknowledged the challenge that AB would face in undertaking DBT in the context of his alcohol use disorder:

> *'And it was also important that he be able to commit to the DBT and practice the skills that are developed through DBT. And that's going to be awfully difficult in the context of an alcohol use disorder. Now, that doesn't mean you don't offer it, but it means that you might be thinking about the timing of the offering of it. The difficulty always is – is that – as I said before, structuring treatment in a lot of – assessment, even, around EDs really doesn't – is problematic. Now, I've given a lot of thought to how do we do it better, and I can't really come up with something better in my own mind. But what you need to do is to try to get some continuity of care early on. And so DBT would have been useful, but most services don't offer DBT over years. They're pretty short term.'*[122]

[119] 22 July 2024, T 1-41, LL 7 – 21.
[120] 22 July 2024, T 1-41, LL 32 – T 1-42, LL 1-6.
[121] Submissions on behalf of the family at [3].
[122] 22 July 2024, T 1-43, LL 35-45.

[102] It was further supported by the expert evidence of Dr Kathryn Turner, Executive Director, MNMH who compiled the root cause analysis (RCA) investigation and report following AB's death. At the Inquest, Dr Turner gave the following evidence:

> [CA] *'So in terms of the delivery of that type of therapy* [DBT]*, would it be fair to say that that's generally community-based treatment that is provided - - -? ---*
>
> [Dr Turner] *Yes. - - -*
>
> [CA] *As opposed to a treatment that is provided in an acute care setting in a mental health ward? ---*
>
> [Dr Turner] *Yeah, absolutely. So you can have dialectic sort of informed approaches on an inpatient unit, but dialectical behaviour therapy is a longer – you know, medium term therapy that's provided in the community.*
>
> [CA] *So where you said you can have those informed approaches, it may – is it – would it be fair to say that it may influence the decision, or the assessment of the individual, at that point, in crisis? ---*
>
> [Dr Turner] *No. And it wasn't, yeah, really referring to that. More if – sometimes inpatient units might have groups and things like that that can be informed by those sort of approaches, but – but generally speaking, when we're talking about DBT, we're talking about that sort of group and individual work that's long term that's based in the community. That's, you know, when – when it's – when it is available to people.*
>
> [CA] *And when we're talking about an alcohol use disorder, from your experience, is it generally community-based care or inpatient-based care that would be offered to a person with that type of disorder? ---*
>
> [Dr Turner] *So the longer-term care is in the community Some people, if they've got particular risks that would place them at risk from a community detoxification, may be admitted briefly to hospital for detoxification. Some*

people do get admitted to residential rehabilitation as well, but it's also available – both community detoxification, which [AB] *had, and also ongoing counselling within community drug and alcohol services as well.'*[123]

Was such treatment offered to AB?

[103] Counsel assisting submitted and I accept that AB was offered appropriate treatment by MNHHS (and his GP) for his diagnosed conditions.

[104] Counsel assisting submitted and I accept there are limitations regarding what is available within the public, as opposed to the private health system due to availability of beds and public funding and that the Inquest examined the issues with the benefit of hindsight.

[105] Counsel for MNHHS submitted and I accept that while Dr Reddan did comment on bed availability in the public system as a factor to be considered if admission was clinically warranted, her evidence was that such an admission was not clinically appropriate in AB's case.[124]

[CA] *'So in order to access that type of treatment, where would a mental health consumer generally go? ---*

[Dr Reddan] *Well, that – that often – it depends on the circumstances. Sometimes if they're, say, in employment and that – they would benefit from going to a psychologist who does that type of work privately or a psychiatrist who does it because of the need to front up for work. And it's very important that that be maintained. Or there are DBT courses, but most of them in the public sector are offered in a group format, and that's, again, not necessarily – would I be critical of that at all. But sometimes, they need longer-term treatment. Now, in the continuing care treatment setting in public mental health services, they generally don't take on a lot of people with personality problems because of resources at the moment and they certainly don't offer, generally speaking, the kind of long term care they need. That needs to be in*

[123] 22 July 2024, T 1-8, LL 28 – 47. T 1-9, LL 1 – 5.
[124] Exhibit E1, 5, 7. 22 July 2024, T1-46, L 21-24. Submissions on behalf of MNHHS at [7].

the private sector. So they might need to see a psychiatrist for 10 years or maybe five years but it often is that kind of time we're talking about."[125]

[106] The Inquest heard evidence from Dr Reddan that proactive rather than reactive management and patient led care may have benefited AB. This might have included very short-term hospital stays initiated by AB however, the issue of available beds in the public sector at any particular time could inhibit this administration of treatment and care:

> *'Now – and it would be about the hospital as a very short term space to perhaps give the patient, not only a sense of safety, but some room to distance themselves from immediate passing emotions. Now, the problem is going – is often, in the public sector, is having space available at any particular time. But this is more a proactive type of management, where the patient takes the lead. Now, it's not open ended. It's not open slather either. It can't be or the patient will never learn the skills necessary and they can't live in a hospital because they'll never improve if they do. But it can be a part of managing patients who are frequently presenting. And I've actually seen some patients do very well. What it requires, though, is everybody, in a way, to hold their nerve sometimes because sometimes when the patient presents, he might say well, no, not this time. So it's not whenever they want to come into hospital, they come into hospital. It's not like that. One place I worked, they used to call it a green card admission but that's – we've used different terms for the different places. But it can be useful as part – if this pattern goes on and on and on. If somebody like* [AB]*, wouldn't have offered that early on because this hadn't been an established pattern over many years. Well, there was a pattern of self-harming but not a pattern of presenting a lot. But it can be useful if that starts to develop."*[126]

[107] Ultimately however, if AB did not meet the criteria for involuntary treatment and care he could not be forced to stay as an inpatient and could choose to leave the hospital, as his history of care clearly demonstrates he did.

[108] AB's family submitted that he was not offered any treatment for his personality disorder and he was not referred to the continuing care team that may have provided him with appropriate case management to seek the treatment he desperately needed. Rather, AB was encouraged to attend his GP and request that he be referred to the Footprints program on 8 April 2021. This was not treatment that was

[125] 22 July 2024, T 1-44, LL 1 – 13.
[126] 22 July 2024, T 1-46, LL 7 – 26.

provided by either MNHHS mental health clinicians, or his GP. When AB attended the Bowen Hills Medical Centre on 30 April 2021, there was no mention of a referral to Footprints.[127] Submissions filed on behalf of MNHHS rejected the submissions of the family on this issue.[128]

[109] The records of MNHHS made clear the recommendation of MNHHS clinicians that AB undergo DBT but also state the long waiting list for such care and that DBT may have been more readily available via a GP and MHCP.

Absent AB's consent, could AB be compelled, over the period of contact he had with mental health services to undergo such treatment?

[110] Counsel assisting submitted and I accept that absent AB's consent over the period of contact he had with mental health services, he could not be compelled to undergo (involuntary) treatment under the Mental Health Act unless he satisfied the specified criteria.[129] Pursuant to the Mental Health Act, a person can receive treatment and care for their mental illness[130] under a TA when they do not have capacity to consent.[131] An authorised doctor[132] may make a TA where they are satisfied the treatment criteria[133] apply and there is no less restrictive way[134] for the person to receive treatment and care for their mental illness.[135]

[111] This is supported by the expert opinions of Dr Reddan and Dr Turner taken at the Inquest. It considered the conditions with which AB was diagnosed, the manner in which he would present in crisis, and how quickly he would resile from that point of crisis, meant that longer term, structured treatment in the community would have been of most benefit to him:

> [CA] *'And in terms of the possibility of admitting* [AB] *under the Mental Health Act, as an involuntary patient, could you speak to any challenges the clinicians encountered and why that may not have been an option for them? ---*
>
> [Dr Turner] *Well, I think it is, most of the, well, in all of the circumstances often the crisis would resolve and* [AB] *was accepting of that initial follow up with the acute care team or with the drug and*

[127] Submissions on behalf of the family at [59]-[61].
[128] Submissions on behalf of MNHHS at [12]-[17].
[129] Submissions of Counsel Assisting at [100]-[101]. Section 12(1) *Mental Health Act 2016* (Qld).
[130] *Mental Illness* is defined in Section 10 of the *Mental Health Act 2016* (Qld).
[131] Section 14(1) *Mental Health Act 2016* (Qld).
[132] Schedule 3 *Mental Health Act 2016* (Qld).
[133] Section 12(1) *Mental Health Act 2016* Qld).
[134] Section 13 *Mental Health Act 2016* (Qld).
[135] *Involuntary Patient* is defined in Section 11 (a)(iii) of the *Mental Health Act 2016* (Qld).

> *alcohol service, you know, throughout those presentations. So and here, you know, we have, when we're – so he appeared to have capacity to make choices at that time and was, you know, engaging with the assessment and with the plan for follow up. Therefore the Mental Health Act wouldn't have been appropriate in those circumstances. And, and at that time, you know, the most like – you know, probably the most appropriate care was to continue care into the community and that there would be limited benefit from an in-patient admission.'* [136]

[112] AB's family accepted the submission of counsel assisting in respect of this issue for inquest. They further submitted that despite the extended use of the Mental Health Act during presentations on 25 July and 27 July 2021, and the use of RAs, the family accepted that there was otherwise no basis for the ongoing use of the Mental Health Act once AB engaged with treatment at the relevant point in time.[137]

In all the circumstances, was the treatment afforded AB, for the mental health condition/s diagnosed, appropriate?

[113] Counsel assisting submitted and I accept that on the evidence, the treatment afforded AB, for his diagnosed mental health conditions was appropriate. However, as supported by the recommendations of the RCA and the evidence of Dr Turner and Dr Reddan taken at the Inquest, there are clear opportunities for improvement of service delivery to mental health consumers such as AB. Simple solutions such as ensuring AB was able to access the community-based programs he was referred to were overlooked.[138]

[114] AB's family adopted the submission of counsel assisting in respect of this issue for inquest. The family recognised that there were limitations on the care and treatment afforded to patients in the public health system for the mental health conditions suffered by AB.

[115] Counsel assisting and AB's family submitted, and I accept, that the evidence taken at the Inquest firmly supports the assertion that there are clear opportunities for improvement of service delivery to mental health consumers such as AB.

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[136] 22 July 2024, T 1-43, LL 5 – 15.
[137] Submissions on behalf of the family at [67].
[138] Recommendation 3 of the RCA Report. 22 July 2024, T 1-11, LL 36 – 47. T 1-12, LL 1 – 17. Submissions of Counsel Assisting at [102].

Whether there was any failure to provide appropriate care that caused or hastened the death.

[116] Counsel assisting submitted and I accept, that on the available evidence, there is no factual basis to find that there was any failure to provide appropriate care, that caused or hastened AB's death.[139]

Whether any aspect of the care actually provided, caused or hastened the death.

[117] Counsel assisting submitted and I accept, that on the available evidence, there is no basis to find that any aspect of the care actually provided, caused or hastened AB's death.[140]

Issue three

Whether any changes to procedures or policies could reduce the likelihood of death occurring in similar circumstances or otherwise contribute to public health and safety or the administration of justice.

[118] Counsel for MNHHS advised that MNHHS commenced the ASPIRES Pathway in June 2023. ASPIRES is a modification of the Zero Suicide Framework, designed to improve the way staff respond to, recognise, and support people who present with concerns about suicide and self-harm. It includes evidence-based approaches to engage consumers, families, and carers.[141]An evidence-based safety planning tool aligning with the ASPIRES framework was endorsed in September 2022 and used by both the ACT and the Psychiatric Emergency Centre (PEC). Between October 2023 and April 2024, 379 of these safety plans had been completed.[142] Rapid follow up in the community is supported by the ASPIRES pathway and booklets have been produced to provide better education and information about resources to patients, families, and carers, including processes such as Ryan's Rule.[143]

[119] At the time of submissions MNHHS had been successful in being allocated funding for the initial stages of implementing Project Air –a systems approach and stepped care approach for patients presenting with personality disorders in crisis situations.[144]

[120] MNHHS had undertaken a project to pull together information regarding NGOs and other resources in the community to which staff may recommend or refer patients, available online. A flyer and video were created to assist staff in navigating this resource.[145]

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[139] Submissions of Counsel Assisting at [103].
[140] Submissions of Counsel Assisting at [104].
[141] Submissions on behalf of MNHHS at [20]-[26].
[142] Exhibit B2, 2-3.
[143] Exhibit B2 at [29].
[144] Exhibit B2 at [30]-[33].
[145] Exhibit B2 at [34]-[39].

[121] MNHHS had established an Acute Presentations Committee with key clinical members, who reviewed patients who presented frequently to MNMH, to ensure that there was appropriate clinical and risk management, which could include acute management plans, creating alerts, stakeholder meetings or Complex Care Review Committee.[146]

[122] MNHHS also implemented discharge checklists to help ensure that all appropriate referrals and other requirements were in place prior to discharge.[147]

[123] AB's family welcomed and encouraged the work MNHHS was doing in the ASPIRE program and the attempts made to get the Project Air Model operational at MNHHS and the introduction of the nurse navigator position in PEC to identify patients presenting frequently and may need further support.[148]

Findings required by Section 45 *Coroners Act 2003* (Qld)

[124] I make the following findings:

Identity of the deceased: AB

How they died: AB used a belt to hang himself by tying one end of the belt around his neck and securing the other end of the belt to a door handle in the unit in which he resided.

Place of death: Panorama Apartments, Mayne Road, Bowen Hills, Qld, Australia, 4006.

Date of death: Sometime between 28 August 2021 and 29 August 2021.

Cause of death: 1(a) Hanging.[149]

[146] Exhibit B2 at [40]-[50].
[147] Exhibit B2 at [51]-[54].
[148] 22 July 2024, T1-13, L 40-44. Submissions filed on behalf of family at [69].
[149] Exhibit A2.

Comments and recommendations

Support for the LGBTIQ+ community in respect of mental health treatment and care and domestic and family violence supports

[126] The Qld Mental Health Commission (QMHC) publication entitled 'Every Life, The Queensland Suicide Prevention Plan 2019-2029' (phase one and two) that provides statistical guidance in respect of the prevalence of suicide in the community, particularly for certain vulnerable cohorts:

> 'Specific male groups, such as Aboriginal and Torres Strait Islander men, elderly men, men with mental illness, and men who have been marginalised, including gay and bisexual men, are at an elevated risk .'
>
> 'Suicide data for lesbian, gay, bisexual, transgender, gender diverse, intersex and queer (LGBTIQ+) communities is limited in Australia and no population-based studies have been published. The Australian Bureau of Statistics has referenced studies from 1991 through to the present that indicate a heightened risk of poor mental health that may lead to suicidal behaviour in LGBTIQ+ communities.
>
> This increased risk of poor mental health and suicidality among LGBTIQ+ people is not [emphasis added] attributable to sexuality, sex or gender identity, but rather due to experiences of discrimination and exclusion.'

Tracking data

[127] Counsel assisting submitted that it is appropriate to comment in respect of mental health services actively tracking data to better understand and support vulnerable members of the LGBTIQ+ community experiencing mental health crises and suicidal ideology. While I do not consider that any specific comment is required, the evidence taken at the Inquest from Dr Allen supported such tracking:

> 'In relation to the question of whether the rate of failed suicide is decreasing in this population, we don't have that data. It's not collected. And so really, we don't know where we're at, and if we don't measure things, we can't improve things. In terms of BPD and alcohol or other substance use, if we look at the report Rainbow Realities, which was released earlier this year – and that's a compilation of, I think, six surveys with a total of about 20,000 participants – 13.3 per cent of the LGBTI population had a low alcohol or other drugs risk. So everyone else is elevated. Eighty-three point seven per cent of young people reported self-harm, suicidal ideation or an attempt, and 53.5 per cent of people – of LGBTIQA+ adults reported suicidal ideation during the pandemic. So we're sort of already one or two rungs up the ladder when you're looking at diagnostic criteria. We're sort of – there's, I think, complexity around

accessing services if a high rate of sort of people in that community are going to be engaged in substance use. There's complexity around that being the sort of threshold that they need to step over before there's more treatment or support.'

[128] The Inquest took evidence from Dr Allen that Stonewall Medical Centre (the clinic at which he treated AB) was a speciality clinic with a primary focus on the LGBTIQA+ community: 'the ethos at the clinic is very supportive not only of that population but many marginalised populations who would seek care at the clinic.' As AB's GP, Dr Allen identified that AB was in a very difficult position following the breakdown of his long-term intimate relationship. He was aware that AB was named as the respondent in a DFV order and to comply with the DFV order he would have to find new accommodation, which was difficult at that time, particularly due to the COVID-19 pandemic. At that time, Dr Allen was not aware of many services that could be accessed to assist with accommodation and further noted: 'I guess it's complex in same-sex relationships where 100 per cent of the perpetrators are male, 100 per cent of the victims are male. So the gender lens doesn't always work, and even categorising it as that way is a gross oversimplification.' Dr Allen further stated that 'the only practical solution available to him [AB] was to be in breach of his DV order, and that left him chronically exposed to the possibility of being found to have breached that order.' Dr Allen attributed this in part to the lack of availability of emergency accommodation for gay men.

[129] Other than the comment above I make no further comment or recommendation.

I close the inquest.

S Gallagher
Deputy State Coroner

Schedule of Abbreviations

AA	Alcoholics Anonymous
ACT	Acute Care Team
ADHD	Attention Deficit Hyperactivity Disorder
ADS	Alcohol and Drug Service
AODS	Alcohol and Other Drugs Service
ATAP	Authority to Transport Absent Person
BAC	Blood Alcohol Content
BPD	Borderline Personality Disorder
CIMHA	Consumer Integrated Mental Health and Addiction
CLPS	Consultation Liaison Psychiatry Service
cPTSD	Complex Post Traumatic Stress Disorder
DABIT	Drug and Alcohol Brief Intervention Team
DBT	Dialectical Behaviour Therapy
DFV	Domestic and Family Violence
DSH	Deliberate Self Harm
EEA	Emergency Examination Authority
GP	General Practitioner
MDTR	Multidisciplinary Team Review
MHCP	Mental Health Care Plan
MNHHS	Metro North Hospital and Health Service
MNMH	Metro North Mental Health
PEC	Psychiatric Emergency Centre
PPO	Police Protection Order
PrEP	Pre-exposure Prophylaxis
QAS	Queensland Ambulance Service
QPS	Queensland Police Service

RA	Recommendation for Assessment
RBWH	Royal Brisbane and Women's Hospital
SSRI	Selective Serotonin Reuptake Inhibitor
TA	Treatment Authority
TPO	Temporary Protection Order