QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Dylan James Bell**
TITLE OF COURT:	Coroners Court
JURISDICTION:	BRISBANE
FILE NO(s):	2022/4917
DELIVERED ON:	4 December 2025
DELIVERED AT:	BRISBANE
HEARING DATE(s):	23, 24 and 25 July 2025
FINDINGS OF:	Melinda Zerner, Coroner
CATCHWORDS:	**Coroners: Inquest; Drug Induced Psychosis; Safety Planning; Self-harm; Suicidal and Homicidal Ideations.**

REPRESENTATION:

Counsel Assisting:	Ms C McKeon (in- house Counsel Assisting)
Bell Family:	J Liddle (Counsel) instructed by Caxton Legal Centre
Redland Hospital:	D Atkinson KC (Counsel) instructed by Metro South Hospital and Health Service

Contents

Introduction

[1] Mr Dylan James Bell ("Dylan"[1]) was born on 27 March 1994 and died on 28 September 2022 at 24 Pioneer Road, Sheldon. He was 28 years old.

[2] Dylan worked part time as a disability support worker and lived with his girlfriend in a cabin (granny flat) on his parents' property. He has been described by his family as a kind, compassionate, respectful, sensitive, and empathetic person. He engaged in community events, being there for people in need and advocating for social justice issues.

[3] On Tuesday 27 September 2022, Dylan was transported by the Queensland Ambulance Service ("QAS") to the Redland Hospital under an Emergency Examination Authority ("EEA") for a mental health assessment, following a period of odd behaviour observed by Dylan's parents and his girlfriend.

[4] Dylan's parents had not previously observed Dylan acting the way he was, and he had not previously had a presentation to a hospital for mental health concerns. It was believed his behaviour may have potentially been linked to some drugs Dylan had reportedly taken.

[5] Dylan was assessed by medical and mental health clinicians in the Redland Hospital Emergency Department ("ED"), and following assessment, he was discharged home to the care of his mother.

[6] On his arrival home, Dylan stayed in his bedroom in the family home. The following day, he refused breakfast but was provided some medication at 11am.

[7] At about 2.30pm, Dylan's mother went to Dylan's bedroom. The door was locked. Dylan's father searched for the key. It took a while to find the right one and when he entered the room he observed Dylan hanging from a hook by a leather belt.

[8] The QAS attended the scene. Dylan was cold to touch and had no signs of life. He was declared deceased at 2.40pm.

[9] The Forensic Pathologist determined Dylan had injuries consistent with hanging and that there was no evidence of any other injuries or natural disease that could have caused or contributed to his death. She found the cause of his death was 'Hanging'.

[10] Dylan's mother and girlfriend raised concerns about the care Dylan received in the Redland ED on the evening of 27 September 2022.

[11] At the outset, I express my condolences to Dylan's family and friends for their loss.

[1] Mr Bell's family requested that he be referred to as Dylan throughout the Inquest. I have adopted this approach in my findings.

The Role of a Coroner

[12] On or around 22 February 2024, the State Coroner transferred Dylan's file to me. I sought additional evidence, including engaging a Consultant Psychiatrist, Dr Fajumi, to provide an expert medical opinion.

[13] On or around 9 October 2024, I determined pursuant to s 28(1) of the *Coroners Act 2003* ("Coroners Act"), it was in the public interest to hold an Inquest into Dylan's death. There was a delay in convening the Inquest due to my availability and the availability of witnesses to give evidence at the Inquest.

[14] The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability. The investigation is about attempting to find the root cause of the incident that precipitated Dylan's death and to consider whether appropriate remedial steps have been taken.

[15] I am not able to make adverse findings against, or comments about individuals, unless the evidence provides a comfortable level of satisfaction that they caused or contributed to Dylan's death.

[16] I am prohibited by s45(5) and s46(3) of the Coroners Act, respectively from including in the findings or comments 'any statement that a person is or may be' guilty of a criminal offence or civilly liable for something.

[17] As required by s45(2) of the Coroners Act, I am required, if possible, to make findings as to:

a. who the deceased person is; and

b. how the person died; and

c. when the person died; and

d. where the person died; and

e. what caused the person to die (the medical cause of death).

[18] All findings are made to the civil standard of proof. That is, the evidence presented must show that a particular version of events is more probable than not.

[19] In the circumstances of this case, the findings of who, when, where and what caused Dylan to die are not contentious. How Dylan died includes 'by what means and in what circumstances'[2] he died. It is the focus of my findings.

[2] *Regina v Her Majesty's Coroner for the Western District of Somerset (Respondent) and another (Appellant) ex pate Middleton (FC) (Respondent* [2004] UKHO 10, [35]

[20] Section 46(1) of the Coroners Act empowers coroners to comment, whenever appropriate, on anything connected with the death that relates to public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in the future. I have made one recommendation at the conclusion of my findings.

[21] Section 48 of the Coroners Act provides referral powers to another agency such as a disciplinary body. I have determined no referrals are required in this case.

Coronial Issues and the Inquest

[22] The Inquest was held over three days from 23 to 25 July 2025.

[23] At the Pre-Inquest Conference ("PIC") it was agreed that in addition to the findings required by s 45(2) of the Coroners Act, the following issues would be explored:

a. the adequacy of the mental health assessments of Dylan conducted by Redland Hospital on 27 September 2022, including whether the collateral information obtained was sufficient in the context of Dylan's presentation;

b. the appropriateness of the management of Dylan in the Emergency Department (ED) of the Redland Hospital on 27 September 2022 following both self-harm attempts by him within the Department;

c. the adequacy of the discharge plan put in place for Dylan by the Redland Hospital including whether it sufficiently addressed his risk of harming himself or others and sufficiently involving his family;

d. whether during Dylan's admission to the Redland Hospital on 27 September 2022 there were any missed opportunities to recognise and respond to an acute deterioration in his mental health; and

e. whether any preventative changes to procedures or policies could reduce the likelihood of deaths occurring in similar circumstances or otherwise contribute to public health and safety or the administration of justice.
("the Coronial Issues")

[24] The Coronial Issues defined the scope of the Inquest, and as such I can only rely on evidence that is relevant to, and logically probative of, matters within the scope of the coronial inquiry.

[25] The Brief of Evidence ("BOE") was tendered at the commencement of the Inquest. Six witnesses were called to give oral evidence. They included:

a. Ms Pauliina Hirvella (Mental Health Social Worker);

b. Dr Yiyao (Peter) Tu (evening shift Psychiatric Registrar);

c. Dr Gemma Hayman (day shift Psychiatric Registrar);

d. Dr Priyanka Halangoda (on-call Consultant Psychiatrist);

e. Dr Balaji Motamarri (Director Medical Services, Metro South Addiction and Mental Health); and

f. Dr Tolulope Fajumi (Expert, Consultant Psychiatrist).[3]

[26] Dylan's mother and girlfriend were not called to give evidence at the Inquest. No party objected to this course.

[27] I thank Counsel Assisting, and the parties' legal representatives for their assistance during the Inquest and for their written submissions following the hearing, the last of which I received on 31 October 2025.

Chronology of Events from the Clinical Records

[28] Prior to Dylan's presentation to the Redland Hospital ED on 27 September 2022, Dylan had no recorded medical history of a psychosis or psychotic symptoms, and had not had any previous mental health presentations to a hospital or ED.

[29] On 24 September 2022, the QAS attended on Dylan. In the electronic Ambulance Report Form ("eARF"), the paramedic noted Dylan's girlfriend, and parents reported he had been behaving strangely with episodes of disassociation, and irrational/ uncharacteristic behaviour. Dylan was confused and could not understand why his thoughts were so dark as he had not had any suicidal ideation for a long time. It was thought he may have had a psychosis related to Lysergic Acid Diethylamide (LSD) use.

[30] When reviewed by the paramedics, Dylan denied suicidal ideation, thoughts of self-harm or harm to others. He also denied any persistent delusions or hallucinations. His thought form and content were all rational and he was appropriate in conversation. He was reported to have displayed good insight into his mental health. He agreed to stay at home with his girlfriend, to contact the MH hotline phone number, and to seek a GP appointment to obtain a mental health care plan with referral to a psychologist. The paramedics consulted the mental health clinician who spoke with Dylan's girlfriend, and it was agreed to leave Dylan in the care of his family.

[31] Later that night, Dylan presented to the Redland Hospital (ED) with a suspected allergic reaction to a tick bite. He reported feeling tightness in his throat and was observed to be well but unkempt. He had self-administered his epi-pen. He was monitored for four hours and then discharged.[4]

[3] Ex. F1- Report of Dr Tolulope Fajumi; F1.1- F7- Attachments to Report of Dr Fajumi; F2- Request for Supplementary Report; F3- Email response from Dr Fajumi; T3-10 – T3-47 at pp. 3-47.
[4] Ex C2.15,16

[32] On 26 September 2022, Dylan's mother contacted the Logan Central Adult Community Mental Health Service because Dylan was having suicidal ideations and paranoid behaviours which had commenced on the previous Friday.[5] According to the records,

a. Dylan was reported to be paranoid and telling his family they had to get off their acreage property because the spirits did not want them there. He was referring to spirits of First Nations peoples. He also did not want his family to get in their car. He was scared and did not want to sleep in his granny flat so had been sleeping in his parents' house. He was agitated and down on himself.[6]

b. Dylan described his mind had been racing with thoughts and presented as preoccupied, confused and not present. He needed his family to repeat questions before he could respond. His mother had given him some Valium and health supplements. QAS were called on Friday night and attended Saturday morning. They did not think an Emergency Department presentation was necessary. Dylan's mother advised he was reasonably settled when QAS attended but became worse in the afternoon. Dylan had used Cannabis in the past, but his mother was unsure of the use of any other drugs. Dylan agreed to seek help but was not able to see a GP until 6 October 2024. There was a plan for telephone triage to occur the following morning.[7]

[33] On 27 September 2022 at 8.58am, a telephone triage call was made by the Logan Central Adult Community Mental Health Service but there was no answer. A message was left. A note was made to attempt contact again the following day.[8]

[34] At 10.14 am, Dylan's mother returned the call from the Community Mental Health Service. She observed that Dylan was getting worse over time. He had become more paranoid and was acting more strangely and out of character. He had just run off down to the back yard. Dylan's mother said Dylan would refuse to speak with the Mental Health Service on the phone or present to the ED voluntarily. Dylan's mother agreed for the call to be transferred to the QAS to request they attend to assess Dylan.

[35] The clinician then checked on the 'viewer' (Qld Health record) to confirm that Dylan had arrived at the Redland Hospital ED under an EEA at 12.19pm.[9]

[5] Ex C3.1
[6] Ex C3.1
[7] Ex C3.1
[8] Ex C3.2
[9] Ex C3.3

[36] According to the QAS eARF, the treating paramedic recorded,

> *Oe, pt has had previous QAS interaction, for abnormal behaviour after use of 'acid'. Pt was left in care of family, pt states since Saturday he has been feeling worse in his mental state.* ***Pt feel unsafe in self. Pt states he has suicidal thought, multiple negative voices at times and the overwhelming feeling of depression****. Pt has thoughts, no means or method.* (emphasis added)

[37] Under the heading 'Criteria for being transported' in the EEA, the paramedic records,

> *Pt unable to maintain eye contact*
> *Pt unable to maintain complex conversation*
> *Pt unable to sit still*
> *Pt states to have had 'acid' within the past 3 days, which has declined his mental state.*
> *Family on scene worried about pts mental state*
> *QPS on scene first, unable to gain great detail from pt due to pt withdrawing from QPS*[10]

[38] Under the heading, 'Describe the reasons you believe...the person is at immediate risk of serious harm', the paramedic recorded, "*Pt has stated to QAS that he has suicidal thoughts. Pt states he feels unsafe within himself. Pt has thoughts but no means or method*".[11]

[39] The paramedic also recorded under 'reasons for risk', "*Pt states to have used acid within the last few days which has caused a mental decline, resulting in increased suicidal thoughts*".[12]

[40] At 1.30pm, Dylan was assessed by a Resident Medical Officer in the ED. He recorded,

> *Had come in today because he is concerned that he is psychotic*
> *Finds that he is having thought that he can't control*
> *Voices are telling him to hurt people to save them from hell –* ***has twice in the last few days strangled his partner*** *in response to this, thinking that he needed to save her*
> *Has also been having thoughts that* ***he needs to kill his parent to save them*** *– no particular thoughts about how he would do this*
> ***As a consequence of this he has been having thoughts of suicide – feels that he is a danger to others****, reports that he has a vague plan of overdosing*
> *Tried to strangle himself with a blanket a few days ago, not able to give me details re whether it was via hanging or whether he lost consciousness*

[10] Ex C2.57
[11] Ex C2.57
[12] Ex C2.57

Denies thought insertion/broadcast/withdrawal

Does not feel like the voices control him or that they are doing things to him[13] (emphasis added)

[41] Under the heading MSE, Mental State Examination, the RMO recorded,

MSE:
A- 28M appears stated age, dressed in shorts with no t-shirt or shoes, dirty nails, multiple scabs and grazes over body, scratch marks on back, and area of redness over anterior neck, unkempt beard and hair, poor personal hygiene, fair dentition.
B- quite guarded, limited rapport but appropriate engagement, quite agitated throughout review, picking at nail and teeth, fidgeting with hands
S- limited spontaneous speech, normal rate and rhythm, hypotonic at times
M- mood quite low

A- very labile, ranging from dysphoric to sobbing to anxious
Tf – no overtly delusional content, discussing content of AH regarding needing to kill people to save them from hell, some SI
P- ***appears to be responding to/distracted by internal stimuli at times***
B- not formally assessed, alert and oriented
I+J – appears to have limited insight into AH, but impaired judgement as evidence by the fact that he had been action on the AH[14] (emphasis added)

[42] Dylan was physically assessed, and pathology testing was undertaken. He was medically cleared and referred for psychiatric review.

[43] At or around 3.45pm[15], Dylan was assessed by a Mental Health Social Worker, Ms Hirvella and a Psychiatric Registrar, Dr Hayman. Ms Hirvella recorded,

Pt reports that his mental health has not been good since he took acid on the weekend (also smokes weed everyday). He reports that he feels that ***he is dangerous, a danger to himself and others****,* ***has thoughts of suicide and homicide – has tried to strangle his partner of two years twice due to voices telling him to save people from him, has no history of feeling this way before****, and thinks that he cannot work now because of his mental health. IEMR MO notes indicate that pt was concerned that he was psychotic, that he was hearing voices telling him to save others from hell –* ***and strangled his partner because of this. He also reported that he is having thoughts to kill his parents to save them, and vague plans to overdose****. Prior to review pat was seen interacting with the nurse with nil issues, on approach and on review, pt was fidgety and unsettled, shaking*

[13] Ex C2.12
[14] Ex C2.12
[15] Ms Hirvella's shift commenced at 3pm. Prior to reviewing Dylan, she reviewed the ED records, and the CIMHA notes made by the clinicians from the Logan Central Adult Community MHS. The medication prescribed by Dr Hayman was given at 3.52pm, the preliminary review of Dylan likely occurred shortly prior to this.

his arms around, scrunching up his face, talking with a pinched voice, appeared to be affected by substances. Pt was charted ABDM and plan to review when settled.

Plan
Dr Hayman charted ABDM [Acute Behavioural Disturbance Medications] *meds*
Re-review when olanzapine takes effect[16] (emphasis added)

[44] Dr Hayman did not make a clinical note.

[45] At 3.52pm, Dylan was administered 5mg Diazepam and 5mg Olanzapine.[17]

[46] At 3.53pm, a Registered Nurse ("RN") handed over Dylan's care to a RN on the evening shift. She noted security had advised that Dylan was attempting to 'strangulate self with hands'.[18]

[47] At 4.05pm, a RN advised security to closely monitor Dylan to ensure he did not use the intravenous ("IV") line to attempt strangulation.

[48] At 4.36pm, Dylan's mother was sitting with him in the Interview Room.

[49] Ms Hirvella went back to see Dylan after he was administered the medication. She recorded a clinical entry which was part of her previous entry. The note was signed off at 6.10pm but edits were made to the entry up until 10.20pm:

1730 second review
Pt clam and compliant. Attended to UDS – positive for THC, benzos. Blood sample sent, requested by ED doctor. Pt reported that he feels ashamed of his actions, thinks he is not a good person, doesn't know what he wants from MH assessment. Asked pt several time how we can offer support and pt reported he needed an admission. ***Mum reported that pt has been acting strangely for the past few weeks and she wondered if he had been using substances****. He reports that* ***he did hurt his gf on the weekend and that she is ok****, but that they are both very sensitive and he would be very ashamed about his actions.*

R3 *Background ~~Background~~*[19]
Yesterday open to MH Call after mum called concerned about SI and paranoid behaviour, racing thoughts, confusion
Nil formal MH dx
Prescribed an A/D
Hx cannabis use daily, acid every now and then

R3 *Assessment~~Assessment~~*[20]

[16] Ex C2.8
[17] Ex C2.26
[18] Ex C2.11
[19] Ex C2.6 - Entry amended at 8.33pm
[20] Ex C2.6 - Entry amended at 8.33pm

MSE
*28 yo male, very slim, average height, appearing of stated age, dark hair dishevelled long on the top and sticking up, short back and sides, poor self care, wearing clothes appropriate to the weather but no shoes, scab on one knee, pt was willing to engage but was agitated, rapport difficult to establish, intense eye contact maintained, grimacing at times, some psychomotor agitation evident, Nil FTD, conversation logical and sequential, discussed thoughts of harm to self and others, nil perceptual disturbance evident – not responding to unseen stimuli, mood/affect - agitated, speech -**R4** minimal, slow to answer at times, soft normal rate, tone and volume[21] **R3** orientated to PPT, vague, ?paranoia ?delusions about needing to hurt family to save them from himself, ~~orientation not formally assessed but appeared orientated to PPT, paranoia…Delusions…elicted~~* [illegible][22]*, poor judgement ator and insight limited*

Impression: suicidal and homicidal ideation on background of mental and behavoiural disturbance due to polysubstance use (pt requires treatment for same).
Risks: Risk of misadventure when under the influence of substances and emotionally dysregulated. Mitigated by harm minimisation, safety planning, AODS support.

Plan

17:30 Second review
*Discussed presenting symptoms **R5**and recommendations for MH support[23] with pt and mum. Discussed plan to refer to ACT for follow up of ms & risk, for further review.*
D/W consult psych on call…, who recommended olanzapine to take home (2 x 5mg)
*Meanwhile, ED nurse came to advise writer that **pt had tied belt around his neck and tightened until he was bright red**, **then attempted again somehow after the belt removed**. Risk status has changed – elevated **R5** ~~forte[24]~~ harm to self.*
P/c to Dr…who requested psych reg to review
H/o to psych reg…, who will kindly review with thanks

*Await pscyh reg recommendations **R1**[25]*

*Per psych reg: for d/c to ACT for assertive follow up, Zero suicide, medical review, offer brief therapies clinic and AODS P/c to mum re R2 plan, happy with the plan. Will pick up script for medication and will hold and dispense **R1**[26] P/c to mum re plan*

[21] Ex C2.6 - Entry amended at 9.59pm
[22] Ex C2.6 - Entry amended at 8.33pm
[23] Ex C2.6 - Entry amended at 10.20pm
[24] Ex C2.6 - Entry amended at 10.20pm
[25] Ex C2.6 - Entry amended at 6.55pm
[26] Ex C2.6 - Entry amended at 6.55pm

R2[27] *P/c to mum re Plan, happy with the plan. Will pick up script for medication and will hold and dispense*
~~*P/c to mum re plan*~~

R2[28]
Plan
TOC to ACT (Emphasis added)

[50] At 5.43pm, a RN recorded, "*found patient his belt wrapped around his neck he was bright red in the face, red marks on neck intervened pt alert and apologised belongings removed*". A medical assessment was requested, Dylan's airway was patent, and he was talking normally.[29]

[51] At 5.50pm, a RN recorded, "*pt found a few minutes later with his shirt wrapped around his neck*".[30]

[52] At 7.33pm (when the clinical entry was commenced), Dr Tu, the Registrar, documented Dylan's history and observations made by other clinicians. The clinical entry was closed off at 8.55pm.[31] Dr Tu recorded,

Situation:
28 M BIBQAS on EEA due to acute suicidal ideation with plan due to recent psychosocial stressors.
Allegedly strangled partner 2x in recent weeks in context of drug induced psychosis

Background:
Demographics
28M currently living in family home
2-year relationship with partner Emma
Working part time as disability support worker for clients with both physical and mental health needs

PPsychHx
Anxiety
Depression
ADHD
ASD (?)
DSH

PMHx
Anaphylaxis to tick bites
Urology concerns

[27] Ex C2.6 - Entry amended at 6.58pm
[28] Ex C2.6 - Entry amended at 6.55pm
[29] Ex C2.10
[30] Ex C2.9
[31] Ex C2.3

Substance Hx
Heavy THC abuse – daily, 6-8 cones, increasing
Monthly recreational hallucinogenics – mushrooms, acid
Recreational EtoH – history of binging

Summary of Review – detailed history as per previous assessments by ED psych reg and ED MH Clinician
Dylan euthymic in affect on approach despite having just attempted to strangulate self twice whilst in ED
When asked how he was feeling now bluntly stated, "I've snapped out of it now"
States there was due to emotional distress and ambivalent when asked re. suicidal intent "I don't have it in me to do it again"

History revisited as per ED RMO Note:
….has twice in the last few days strangled his partner in response this, thinking that he needed to save her…

Teary when discussing and did not wish to elaborate on psychotic content in great details
Reports nil ongoing thoughts but continues to feel that he is a danger to himself and others given his recent actions
Reports ongoing AH telling him to harm himself but has been trying to resist
When asked to describe the voices states, 'just like my own voice'

When asked re. previous DSH harm attempts, reports usually hits self when emotionally distressed but has been escalating in light of recent events.
States was "just unable to go through with it" when probing into reported attempted strangulation with blanket at home'.
"People supporting me"
However immediately became teary and distressed as he feels he hurt Emma who is "the best thing in his life" and she is understandably terrified.
-topic of criminal charges was not broached in ED setting
Denies ever having done anything violent towards others in past

Long-standing suicidal ideation but never this bad
Felt a bit better after taking partner's Seroquel which she usually takes for sleep/anxiety
Vague ongoing suicide plans but accepting of safety planning
-hopefully things will settle with Emma but suggested avoid confronting her in acute period and let things settle
-feels he will be unable to return to work
-will be at home with family, mother will supervise medications

Continued to remain hesitant surrounding discharge despite initially accepting of ACT with AODS input.
Reiterated limitations of inpatient admission
When asked when he felt 'hospital would be better place', eventually disclosed he was 'scared'. On clarification, was due to fear of facing consequences for his actions, doing something similar again and

harming himself. *Responded well to validation of concerns but once again reiterated that inpatient admission would not mitigate any of recent stressors and would need to confront them in a safe and supported environment with family and interim ACT support.* (emphasis added)

MSE
28 M appearing of stated age. Casually dressed. Dishevelled in appearance. Multiple scratches at varying stages of healing. Bloodshot eyes

Superficially settled and engaged throughout review. Generally vague and perplexed on engagement.
Psychomotor agitation evident, with constant fidgeting and picking at skins and nails, significantly worse when discussing distressing topics.
Soft, monotonous speech with limited spontaneous.
Reports mood as low. Labile affect, congruent with conversation.
Nil FTD. Logical and coherent throughout conversation. Nil overt psychotic content voided but rather recounting previous psychotic experiences. Ongoing SI without clear intent or plan.
Described ongoing auditory hallucinations which appear to be more in keeping with negative self-talk on clarification.
Insight and judgment likely chronically limited given personality constructs. Limited insight into impact of substances on presentation
Cognition grossly intact

Risks
Self Harm – moderate/high
Suicide – moderate
Violence – low/moderate
Vulnerability – low/moderate
AWOL/Non-compliance – low

Impression
28M presenting with situational crisis after committing acts of violence against partner whilst acutely intoxicated/experiencing recurrent drug-induced psychosis in the context of heavy poly-substance abuse. Cross-sectionally, although Dylan continues to express fears that may repeat these actions and, he does not present as acutely psychotic. Rather his reports of psychotic experiences are recounts of interpretations of his recent episodes of drug-induced psychosis which have since resolved.
Despite his recent experiences, Dylan demonstrates a lack of insight into the impact his heavy substance abuse on current presentations. He continues to abuse marijuana daily and evidently acutely intoxicated on presentation to ED. However, he was agreeable that his substance use had become problematic in his life and in (sic) accepting of assistance in reducing/ceasing.

Risk Formulation

Given Dylan's cluster B personality vulnerabilities and history of deliberate self-harm, Dylan presents at a chronically elevated risk of harm to self, fluctuating with times of emotional distress.
He currently presents at an acutely elevated risk of harm to self. However given nature of the circumstances and as behaviours in ED have demonstrated, this risk would not be appropriately mitigated through inpatient admission.
His risk of harm to self is appropriately minimised through assertive follow-up by the ACT.

As recent behaviours have demonstrated, Dylan is capable of acts of violence whilst under influence of illicit substances. However, this risk will continue to fluctuate given his ongoing polysubstance abuse and also can not be appropriately mitigated through inpatient admission.

DDx: Situation crisis, accentuation of personality traits, drug-induced psychosis (resolved)

Plan
Discharge from MH perspective with ACT follow-up
-for consideration of ZS Protocol
-for consideration of Allied Health Brief Therapy Clinic
GP referral for GP MHCP + Form 291 for possible assessment of ASD traits
Seroquel 25 mg x 7
-script provided to ED to give to mother
Mother to monitor medications whilst at home
ACT to facilitate referral to AODS

[53] The script for the Seroquel (Quetiapine) was for a seven day supply of tablets and was completed by Dr Tu at 6.40pm.[32] This suggests Dylan was reviewed by Dr Tu at least prior to 6.40pm.

[54] The Registrar, Dr Tu had a conversation with the on-call Psychiatric Consultant, Dr Halangoda about his assessment. There is no clinical record of this conversation.

[55] The 'Discharge Documentation' was completed at 8.35pm. I make the presumption that Dylan was discharged at or around this time.

[56] On 28 September 2022, Dylan was discussed at the MDTR (Multidisciplinary Team Review) at the Bayside Adult Community Mental Health Service. The plan was to telephone Dylan to carry out a Mental State Examination (MSE), assess his risk, discuss a safety plan, determine his needs and to offer Dylan a face to face appointment. An attempt was made to call Dylan, a message was left, and an SMS was sent with an invitation to contact the service.

[32] Ex C2.80

[57] On 29 September 2022, a further attempt was made to contact Dylan. The service was advised by Dylan's girlfriend that Dylan had taken his own life.

Recollections of Mother and Girlfriend

Mother

[58] On **1 December 2022**[33], following Dylan's death, Dylan's mother provided a lengthy email outlining her recollection of events.

[59] Dylan's mother first observed Dylan exhibiting strange behaviours on 22 September 2022. He was tree hugging, singing at a very loud volume and jumping backwards while looking up at the sky.[34]

[60] Later that night, Dylan's girlfriend contacted his parents. She was worried he was having a psychotic like episode and reported Dylan wanted to take his life and that he had attempted to harm her. This was very unusual as Dylan had not previously attempted to hurt anyone and was particularly protective of his girlfriend.[35]

[61] On 23 September 2022, Dylan's mother rang triple zero on the advice of Lifeline. There were no ambulance units available to come immediately. She was put through to a mental health nurse that was linked to the QAS who rang back three times. By the third phone call, Dylan was more settled, and they agreed they could wait for an ambulance to arrive the following morning.[36]

[62] As outlined above, on 24 September 2022, Dylan was assessed by the QAS because of concerns his mother and girlfriend had concerning his strange behaviours.

[63] On 25 September 2022, Dylan continued acting strangely. He was frightened to get in a car, saying 'no, we can't get in the car, we will all be killed'. He was upset and hard to console. After lunch he said, 'we have to get out of here, we are all going to die'. 'The ancestral spirits aren't happy with us being here on their land'. She stated,

> *We are worried about Dylan as he has never been like this before, thinking we just have to wait out until the drug gets out of his system and wondering how to help him or if he is developing something like schizophrenia*.[37]

[33] I provide some weight to the evidence of Dylan's mother given the contemporaneous nature of the email.
[34] Ex B1.1
[35] Ex B1.1
[36] Ex B1.1
[37] Ex B1.2

[64] On Monday 26 September 2022, Dylan's mother tried to get an appointment with his GP but could not. As referred to above she reached out to their local community mental health service.

[65] On 27 September 2022, Dylan's behaviours escalated. He took off with a tennis ball and his girlfriend was shouting as he was trying to choke himself with it. Dylan's father and girlfriend chased after him. His pants became loose in the struggle, and he stripped them off. She stated,

> *Steve (Dylan's father) tackles him further down in our front yard and holds him tight saying to Dylan, its okay, its okay. Dylan is frightened and confused and I am on the phone dialling 000 for the ambulance. Instead multiple police arrive and this further spokes Dylan's anxiety…*[38]

[66] The body warn camera footage from the Police's attendance on Dylan was obtained and has been reviewed. Dylan was sitting relatively calmly in a chair but was making various strange movements.[39]

Girlfriend

[67] Emma provided a detailed statement of her recollection of events on 8 February 2023.

[68] Emma first became concerned about Dylan on 20 September 2022. He was erratic in his behaviour and his movements and saying a number of things that did not make any sense. He spoke about connecting to spirits and was hugging tress on the property. There was then an incident at a local quarry where his behaviour continued to be erratic, and he gripped Emma firmly around her neck. Dylan was able to recognise what he had done and was extremely apologetic. [40]

[69] On 23 September 2022, Dylan was again acting strange. He told Emma and his parents he had taken LSD. Emma was not convinced because she did not think Dylan had access to LSD that day.[41]

[70] That night, Dylan again attempted to strangle her. She pushed him off. He was again distressed, and apologetic. He told her 'we both need to die' and that there was a problem with them being on the property as he had done something terrible which made the spirit mad at him. She called Dylan's parents to help.[42]

[71] Emma outlines ongoing strange behaviour of Dylan over 24, 25 and 26 September 2022.[43]

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[38] Ex B1.3
[39] Ex E1
[40] Ex B1.1
[41]EX B2.3
[42] Ex B2.3 [I note Dylan's mother says this occurred on 22 September 2022, I accept it happened and I do not consider anything turns on the inconsistency in dates].
[43] Ex B2.3.3-5

[72] On 27 September 2022, Dylan was displaying a lot of erratic behaviour such as pacing and swinging his body up and down in a bowing movement at extreme speeds. He told her he needed to do this until he was told by the 'spirit' that he could stop or that he'd done it enough. He developed other ticks and rituals such as needing to jerk his neck to 'remove negative thoughts or voices', making himself vomit to 'remove dark energies and bring in the light' and touching people and dogs to 'heal them and give them light energy'. She stated,

> *Later in the morning, Dylan's thoughts and feelings about hurting me were getting too overwhelming for him and he was fearful that he would act on his intrusive feelings of harming me. He tried to choke himself with a tennis ball and I called out to his mum for help. Dylan took off crying and yelling at me to stay away. He lost his pants as he struggled to run away naked towards the front of the property where the road is. I didn't follow him because I was concerned that my involvement would cause him further distress, so I yelled to his mum to call 000 while his dad chased him and tackled him to the ground. I stayed away from Dylan while his parents waited on their veranda with him for emergency services to arrive.*[44]

[73] Emma decided not to go up to the hospital but was in regular contact with Dylan's mother. She received a text at 8.15pm from Dylan's mother in which she advised Dylan was home but a bit drowsy. Dylan did not want to sleep with Emma and would not make eye contact with her. He denied her request for a hug, said he was sorry and left to sleep in the spare bedroom.[45]

[74] Emma referred to Dylan experiencing earlier symptoms and odd behaviour in the weeks prior. I acknowledge and accept that this information was not available to any health professional, and it seems it was only after reflecting on Dylan's passing that she had recalled the behaviours. I accept the primary trigger for Emma's concerns regarding Dylan, were the events of 20 September 2022.

Factual Circumstances for Determination

[75] From the evidence provided at the Inquest, in consultation with the parties I suggested there were five primary factual issues concerning the care Dylan received at the Redland Hospital ED which would assist me to make the necessary finding as to 'how' Dylan died. I suggested to the parties that they address the issues in their written submissions but that they were not beholden to the issues I had identified.

[76] The issues are:

a. the appropriateness of the assessment of Dylan, including the obtaining of collateral information by Ms Hirvella and Dr Tu;

b. the appropriateness of the diagnosis made by Dr Tu;

c. whether Dylan should have been discharged from the ED, or held for a

[44] Ex B2.5
[45] Ex B2.6

period of observation, either in the ED or via an admission to the mental health ward;

d. if it is submitted Dylan should not have been held for a period of observation, the appropriateness of the safety planning in writing or otherwise, and the steps put in place to implement the safety planning by Ms Hirvella, Dr Tu and Dr Halangoda; and

e. whether there were any interventions that would have changed the outcome for Dylan.

[77] The parties generally addressed the issues in their written submissions.

The appropriateness of the assessment of Dylan, including the obtaining of collateral information from Ms Hirvella and Dr Tu

[78] For the reasons detailed below I find:

a. the preliminary assessment by Ms Hirvella and Dr Hayman was appropriate.

b. the documentation by Ms Hirvella of the collateral information she obtained from Dylan's mother was unsatisfactory.

c. the collateral information obtained by Ms Hirvella from Dylan's mother was likely deficient.

d. at the very least, Dr Tu should have asked Ms Hirvella to contact Emma to discuss the proposed discharge plan and what safety precautions were in place for Emma.

e. in the presenting circumstances, Dr Tu should have spoken to Dylan's mother herself regarding his assessment of Dylan, and the proposed discharge of Dylan.

f. there was a deficiency in Ms Hirvella's second assessment of Dylan in relation to the onset of his symptoms in the context of his drug use and presenting symptoms.

g. Ms Hirvella took appropriate action once she had determined Dylan's risk profile had changed because of his attempts of self-harm in the ED.

h. there was a deficit in Dr Tu's assessment of Dylan. There was no detailed exploration by Dr Tu as to the behavioural disturbances Dylan had experienced in correlation with Dylan's drug use prior to his admission to the ED at Redland Hospital.

First Assessment by Ms Hirvella

[79] Ms Hirvella has a Masters in Social Work and had worked in the ED at the Hospital for more than four years.[46] She was tasked with undertaking a 'rapid assessment', and explained the reason it was called a rapid assessment was because it was undertaken in the ED setting. It was not to be rushed and would take on average about two and a half hours.[47]

[80] Ms Hirvella had reviewed Dylan's ED and CIMHA (Consumer Integrated Mental Health and Addiction) records before she assessed him.[48]

[81] Because of Dylan's initial presentation, there were two assessments carried out by Ms Hirvella. The first was undertaken with Dr Hayman at or around 3.45pm. It was very brief.

[82] Counsel Assisting has set out the facts concerning the first assessment, I adopt those:

a. Upon attendance on Dylan, Ms Hirvella and Dr Hayman attested to observing Dylan displaying indicia consistent with potential intoxication.[49] Having taken a history from Dylan that he was a daily cannabis user, and had used acid over the weekend,[50] Ms Hirvella's impression was that Dylan was intoxicated on cannabis upon presentation.[51]

b. Ms Hirvella advised the Court in oral evidence that she observed Dylan had psychomotor agitation, was grimacing with his face, and his eyes were not clear and bright. She stated she viewed this presentation as a drug-based intoxication, as opposed to one due to alcohol.[52]

c. Dr Hayman stated that Dylan was observed to be displaying psychomotor agitation by way of unsettled movements, inability to get comfortable, shaking his limbs, scrunching his face, using a different tone of voice, and pulling his hair.[53]

d. Dr Hayman stated in oral evidence that the level of agitation she observed could be caused by intoxication, but it could:

> *be caused by other things as well, and that's why we get collateral from other information sources, and that's why I ordered a urine drug screen to con – or deny or confirm if there were substances - - -*

[46] T1-8 lines 6 and 15
[47] R1-8, lines 41 and 44
[48] T-11.1-9
[49] Ex. B3- Statement of Pauliina Hirvella at [4]; T1-12 at line 6 and T1-61 at lines 11-14; Ex. B9- Statement of Dr Gemma Hayman at [16].
[50] T1-42 at line 41.
[51] T1-44 at lines 4-5.
[52] T1-12 at lines 8-23.
[53] Ex. B9- Statement of Dr Gemma Hayman at [16].

Sure?--- - - - um – impacting.[54]

e. Given her observations, Dr Hayman assessed Dylan was not appropriate for a health assessment at that time.[55]

f. As a result, Dr Hayman:

   i. completed a pathology order for a urine drug screen to confirm or exclude intoxication as being part of Dylan's presentation;[56] and

   ii. charted Acute Behavioural Disturbance Medications (ABDM) to treat Dylan to reduce his agitation/distress, namely 5mg Olanzapine [and 10mg of Valium].[57]

g. Having formed the view that Dylan was displaying indicia consistent with possible intoxication, the review was discontinued.

h. The plan put in place at the point of discontinuance was for Ms Hirvella to return to review Dylan in 90 minutes to assess whether he had settled, his symptoms of intoxication had resolved, and whether the urine drug screen results were returned. If he had settled and his symptoms of intoxication had resolved, his assessment was to be completed with a view to achieving a comprehensive clinical impression of his presentation.[58]

[83] Dr Hayman did not take a history. She advised she briefly saw Dylan and determined he was not suitable for mental health assessment and that he needed treatment for his agitation and distress.[59]

[84] Dr Fajumi agreed it was appropriate to have prescribed Dylan Olanzapine and Diazepam in the circumstances.[60] The medications were administered at 3.52pm.

[85] The urine drug screen was taken at 5.20pm. It was positive for Benzodiazepines and Cannabinoids. The level of each drug is not recorded.[61]

[86] I find the preliminary assessment by Ms Hirvella and Dr Hayman was appropriate.

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[54] T2-6 at lines 35-40.
[55] Ex. B9 - Statement of Dr Gemma Hayman at [16].
[56] Ex. B9- Statement of Dr Gemma Hayman at [12]; T2 -6 at lines 37-38.
[57] Ex. B3 - Statement of Pauliina Hirvella at [4]; T2-2 at lines 29-31; Ex C2- Logan & Redland Hospital Records at p. 8; Ex C3- MSMHS- CIMHA at p. 10; Ex. B9- Statement of Dr Gemma Hayman at [20].
[58] Ex B3- Statement of Pauliina Hirvella at [4]; T1-12 at lines 34-44.
[59] T2-7, line1
[60] T3-34, line 48
[61] Ex C2 p22

Collateral

[87] Ms Hirvella obtained collateral information from Dylan's mother and undertook a further review of Dylan at or around 5.30pm.

[88] Counsel Assisting has outlined the collateral obtained by Ms Hirvella. I adopt the summary:

a. Ms Hirvella advised the Court in oral evidence that the collateral was obtained from Dylan's mother at around 5:30pm, and before the second assessment was conducted.[62] Ms Hirvella estimated this conversation lasted for potentially 20 minutes.[63]

b. Of the conversation that was had between Dylan's mother and Ms Hirvella at around 5:30pm, Ms Hirvella advised the Court that the following notes were what she documented about the exchange between them, and the collateral obtained:

> *"Mum reported that pt has been acting strangely for the past few weeks and she wondered if he had been using substances".*[64]

c. In oral evidence, Ms Hirvella stated she could recall the following further details about the exchange:

> *I recall speaking to mum just outside of the interview room, and I remember her talking about him behaving very strangely around trees, and just erratic behaviour. I can't really recall – I mean, I can recall a long conversation with mum. I can't recall the detail, apart from I know that she was talking about him around the trees and things like that. I know there was more. I just can't – and I – when I read her statement, I remember a couple of those things but not all of those, no….*[65]

d. Of her in-person conversation with Ms Hirvella, Dylan's mother stated:

> *"*[Dylan] *told me that a certain antipsychotic seemed to help him so I said I would let* [Ms Hirvella] *know, which I did. I then talked to* [Ms Hirvella] *who said she would talk to Dylan after talking to me. I told her I think this started with Dylan taking something, I let her know that Dylan had an ADHD diagnosis and was most likely on the autism spectrum, (his brother has level 3 autism). She told me she had* 'one of those' *at home also…I told her he was having what seemed like delusions and paranoia and gave the examples. I said I was also worried for him as he was doing strange body movements at times. I then left Dylan to talk to her".*[66]

[62] T1-14 at lines 44-45; T1-15 at lines 1-5.
[63] T1-62 at lines 29-30.
[64] T1-20 at lines 40-46 and T1-52 at lines 1-12; Ex C3 MSMHS- CIMHA at p. 6.
[65] T1-20 at line 49- T-21 at line 6 and lines 21-23.
[66] Ex B1- Bell, Gabrielle at p. 3.

e. In a subsequent statement, Dylan's mother clarified the examples given to Ms Hirvella were:

> *"a. Dylan jumping backwards while looking up at the sky, hugging a tree and singing at a very loud volume.*
> *b. Dylan refusing to be in the car with us saying 'no, we can't get in the car, we will all be killed'*
> *c. Dylan staring into the trees and bushland towards the neighbouring block saying 'we have to get out of here, we are all going to die. The ancestral spirits aren't happy with us being on their land'".*[67]

[89] Understandably, given the passage of time, Ms Hirvella could not recall the entire contents of the estimated 20 minute conversation. Her clinical record regarding the 'collateral' information she obtained is bereft to say the least.

[90] Despite Dylan's mother not being called for cross examination, I cannot see any reason why I would not accept her evidence of the first conversation she had with Ms Hirvella.

[91] As to the extent of collateral information to be gathered, Dr Fajumi said,

> *The first thing I would say, is that I'd probably like to explore further about what the mum means by 'acting strangely'. That would be the first thing, just a bit more detail about exactly what she means. Um – I'd want to know whether she was worried about his safety, worried about his own safety. I mean – I mean, my understanding is they were living together. And it says there, she wondered if he had been using substances. So I'd want to know what substances did she think he was using, did she have any idea how often. Um – I'd want to know if she was aware when he started – when he started using substances. So what I'm trying to gather, by asking Mum that, is okay – so Dylan was, you know, in his mid-20s. for example, was the mum aware that he'd been using substances since he was 18, and if he had, why was it now that he was – he was starting to act strangely, try to get some kind of picture as to why this was happening now, why not, you know, last year. So now, why is this happening the last few weeks, and what concerns did she have about him. And was there anything else that she thought might be causing his behaviour, anything else. Other than the drugs, was there anything else that she had had concerns about.*[68]

[92] I acknowledge Ms Hirvella did document that Dylan took acid on the weekend (also smokes weed everyday), and that she had discussed with Dylan's mother the need for Dylan to obtain support for his alcohol and drug use.[69] There is though no evidence Dylan's drug use was appropriately interrogated to the level suggested by Dr Fajumi, including what had caused or was causing Dylan's acute intoxication on his presentation to the ED.

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[67] Ex. B8- Bell, Gabrielle at [11].
[68] T3-12, lines 37-49; T3-13, lines 1-3
[69] T1-25, lines 21-26

[93] Ms Hirvella had read the entry of the RMO and had documented in her note prior to meeting with Dylan's mother that Dylan had 'strangled his partner' because of hearing voices to save others from hell, and that he was 'having thoughts to kill his parents to save them'. I accept Ms Hirvella cannot now recall the conversation with Dylan's mother but there is otherwise no evidence of any interrogation of these behaviours, including means, frequency, and precipitating events in the immediate period leading up to his admission to the ED during her interview with Dylan's mother.

[94] Dr Fajumi thought given Dylan had harmed Emma prior to Dylan's presentation to the ED and on the basis, he was returning home to Emma, she needed to be contacted to assess how she felt about that.[70] Emma was not contacted.

[95] Dr Tu relied on the collateral information obtained by Ms Hirvella. Dr Halangoda relied on the information from Dr Tu and Ms Hirvella. Neither spoke directly with Dylan's mother or Emma.

[96] Counsel Assisting set out the evidence concerning Dr Tu's recollection of the collateral information, which was reported to him by Ms Hirvella, I adopt the summary:

a. Of the nature of the collateral information, he was provided by Ms Hirvella, Dr Tu stated that the collateral handover described Dylan as a highly sensitive individual with long-standing cluster B personality vulnerabilities. This was evidenced in a long history described by his mother of emotional instability, limited coping of internal mechanisms, intense relationship dynamics and a long standing history of deliberate self-harm during periods of distress. He stated this was reflected during his prior review. He said he was also informed that Dylan's mother reportedly expressed her own suspicions and concerns surrounding his recent substance misuse but was uncertain of which substances.[71] In oral evidence he further advised:

> *So to the best of my recollection,* [Ms Hirvella] *did approach me in person to discuss the collateral that she had already obtained. It's described – she reported mother – Dylan's mother had described Dylan to be a very pleasant young man but tendency to be quite emotional at times, can be very, very sensitive. History of getting quite upset and having – you know, emotionally labile during periods of distress. I remember there was a discussion that both Dylan and his partner were – the relationship was quite intense at times, and both could be quite emotionally charged. She described Dylan, I do believe that it was a somewhat limited and somewhat, sometimes, maladaptive coping strategies, turning to substances in times of acute distress to self-soothe. And that was the main, I guess, the main picture that was painted of Dylan. A very pleasant, sensitive young man, who was – who had presented with evident homicidal and suicidal ideation to the Emergency Department…*[72]

[70] T3-27, line 48
[71] Ex. B4- Statement of Dr Tu at [8]-[9].
[72] T1-71 at lines 21-33.

…the handover indicated that in the past few days there were, more acutely, was – there was some unusual behaviours. He was acting in strange, unusual ways, and there was – that would have in keeping with Dylan. The specifics of it I don't recall at this point in time.

Okay?---But there was definitely clear indications - - -

Okay?---And I recall in particular, the conversation was surrounding longstanding marijuana – but there was a suspicion there had been acute change with other substances recently.

…

Okay. And when you say it was long – did you have any further details about how long this had been happening?---When – in the days leading up to it. So he wasn't definitely – there seemed to be an acute decline in the days leading to the admission.

Okay?---But there was als – she did also suggest, to my recollection, that there was a – there were – like, it had been kind of fluctuating as well. That was the handover from them. [73]

b. Dr Tu advised the Court that the reference to Dylan having cluster B personality vulnerabilities was a conclusion he had drawn based on the description he was provided, namely a person who reacts inwards and presents as being emotionally labile with certain maladaptive coping strategies, and very intense relationships. He was cautious and advised the Court that at this point in time, this conclusion was being treated as a possibility only by him.[74]

c. Dr Tu advised the Court in oral evidence that collateral could be obtained by a MHC or a clinician, but generally they did not double up. [75] He agreed that prior to his review, he did not contact Dylan's mother because Ms Hirvella had already obtained the collateral.[76]

[97] Dr Fajumi is of the opinion Dr Tu should have spoken with Dylan's mother before Dylan was discharged. This was in the context Dylan had been detained under an EEA, had to have medication, and had been agitated. That would have been to ensure Dylan's family were okay with what was being proposed. In her practice, once the Registrar had spoken with the family, she would ask the Registrar to come back to her so they could formulate a plan.[77] Dr Fajumi stated,

I would say that it's very important to get collateral from the – the family, especially if you're going to discharge the patient…you really need to be clear – clear that the family onboard, that you – you spoke with them and you've got a clear picture. Because when somebody is intoxicated or

[73] T1-73 at lines 4-30.
[74] T1-71 at lines 37-48.
[75] T1-76 at lines 1-8.
[76] T1-38 at line 43.
[77] T3-46, lines 1-7

recently intoxicated, their memory, their ability to provide a history is not all – is not always going to be reliable. So you want someone to – to give you – your assessment a bit more of a – of a boost basically, so you've got things covered.

[98] While there was a 20 minute conversation, Ms Hirvella could not recall the full details of that conversation. Dylan's mother has provided her best recollection. Dr Tu has also provided his recollection of what he was told. The entry concerning collateral information in the clinical record is one sentence. I find the documentation by Ms Hirvella of the collateral information she obtained from Dylan's mother to have been unsatisfactory.

[99] Based on Dylan not previously having had any previous mental health presentation, Dylan's presenting symptoms, the recollection by Dr Tu and Dylan's mother's evidence, I find that there was no detailed interrogation by Ms Hirvella regarding Dylan's drug use, the events leading up to his admission, the strangulation attempts on his girlfriend, Emma, and his thoughts to kill his parents. There was also no phone call to Emma, who Dylan lived with on a day to day basis. I appreciate Ms Hirvella engaged with Dylan's mother for an approximate 20 minute period to elicit information. However, on the information available to me, I find the collateral information obtained by Ms Hirvella was likely deficient.

[100] Dr Tu stated it was not his usual practice to reach out to a victim of an assault (Emma). I find this problematic in the circumstances of Dylan's recent strangulation attempts and potential ongoing risk to Emma. Especially in the circumstances when Dr Tu had determined the risk of harm would remain if Dylan was to continue using drugs, and that Dylan was to be discharged home where he lived with Emma in a granny flat at his parents' home. At the very least, Dr Tu should have asked Ms Hirvella to contact Emma to discuss the proposed discharge plan and what safety precautions were in place for Emma.

[101] I find in the presenting circumstances, Dr Tu should have spoken directly to Dylan's mother (who was in the ED) regarding his assessment of Dylan, and the proposed discharge of Dylan. I note following Dylan's death, he has changed his practice, and now is in contact with families when he reviews patients.[78]

Second Assessment by Ms Hirvella

[102] As articulated by Counsel Assisting,

Ms Hirvella advised the Court that in undertaking assessments of these types, she as a clinician would build rapport, collect collateral, discuss recent events with a patient.[79] She would gather information from all sources possible, and have a discussion or a narrative to tease out the issue or main presenting complaint. She would also ask for history of any kind of violence that was perpetuated or any history of trauma, along with

[78] T1-96, lines 40-44
[79] T1-14 at lines 45-47; T1-15.

questions about suicide, self-harm and substance use in the conversation with the patient.[80]

[103] Ms Hirvella thought Dylan's presentation was consistent with intoxication from drugs.[81] In exploring this further, she thought it was from the acid he had stated he had taken over the weekend, but she did not interrogate this further. For example, what drug or drugs he had taken that day, how much, and when was the last time he took the drug(s). Further, there is no documentation of how often Dylan had taken acid in the past, the date and time he last used, and what had happened in the past when he had taken it. There is also no history of Dylan's use of marijuana, including when he started using it. Ms Hirvella acknowledged if she had obtained this information, she would have written it in the records.[82] Despite there being a section for it, she did not document how often Dylan was using Hallucinogens (which included 'acid') on the Triage Screen.[83]

[104] In determining what was causing Dylan's symptoms, Dr Fajumi thought it was important to determine the timing of Dylan's substance use, for example if he had said he used yesterday, it would be expected that the agitation would be present for 24 hours or so.[84] Dr Fajumi agreed it was incumbent on a clinician suspecting symptoms being associated with drug intoxication to ask what drug was taken, when it was taken, the usual side effect and how often the drug was taken.[85]

[105] While Ms Hirvella thought the primary reason for Dylan's symptoms was intoxication from drug use, she conceded the symptoms Dylan was portraying might appear with a patient who had a psychiatric condition rather than a patient affected by substances but thought it would be unusual.[86]

[106] I find that there was a deficiency in Ms Hirvella's assessment of Dylan in relation to the onset of his symptoms in the context of his drug use and presenting symptoms. This particularly in circumstances where acute drug intoxication was thought to be the cause of Dylan's acute behavioural disturbance in the ED, and he had been a long term daily user of marijuana.

[107] Ms Hirvella did not recall seeing the entry at 3.53pm wherein a RN reported Dylan was 'attempting to strangulate self with hands'. She does not consider that would have changed what she did because Dylan tried to strangle himself while she was talking to him. She said, '*sometime people do that to display their distress, and he was distressed and – um – when he was talking about what he'd done to the girlfriend over the weekend*'.[87] Ms Hirvella did not identify Dylan was at risk of self-harm in the risk screening tool. Ms Hirvella conceded this was an error and she should have answered this in the affirmative.[88]

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[80] T1-15 at lines 8-15.
[81] T1-12, line17
[82] T1-26, line 27-24
[83] Ex C2.8
[84] T3-5, line 23
[85] T3-5, lines 38-49; T3-5, lines 1-14
[86] T1-50, line 4-7
[87] T1-17, lines 3-33
[88] T1-20, lines 11-33

[108] I acknowledge Ms Hirvella did record Dylan had tried to strangle himself with a belt in the progress notes and that she identified that Dylan's risk status had changed. Ms Hirvella appropriately escalated Dylan's care to the consultant because she was not comfortable with discharging Dylan without further review and assessment. While she informed the consultant of the strangulation attempt with the belt, it is unlikely the consultant was informed of the earlier attempt at 3.53pm. Ms Hirvella provided a handover to Dr Tu and awaited the outcome of his assessment.

[109] I find Ms Hirvella took appropriate action once she had determined Dylan's risk profile had changed because of his attempt at self-harm in the ED.

Assessment by Dr Tu

[110] Dr Tu had around one and a half years of specialty psychiatric training when he assessed Dylan.

[111] Counsel Assisting has set out the facts concerning the assessment. I adopt the summary:

a. Ms Hirvella provided the following evidence of the handover she gave to Dr Tu:

> *I called him straight up, and I had told him what had – like, the reasons for the presentation today. I told him that I'd seen him with Dr Hayman earlier and he was intoxicated – appeared to be intoxicated, so we charted him some medication and then I'd come back to review him. I'd spoken to mum. I told him what he had done, you know, his behavioural disturbance over the weekend, that he'd strangled his partner, that he'd been using substances, acid and cannabis, and what he – what had just happened in the interview room, that he'd try to strangle himself with a belt, and could he please come and see.*[89]

b. When asked by Kings Counsel for MSHHS whether, in the course of the handover to Dr Tu, she omitted anything Dylan's mother had told her, Ms Hirvella stated *"---Oh, no, no. I – I told him – I would have – I, my best recollection is that I told him all of the circumstances that had led up to their [indistinct] collateral"*.[90]

c. Dr Tu's evidence of the handover provided to him was consistent with, and furthered, the version provided by Ms Hirvella, namely:

> *The handover – going back – would have included his initial presentation, brief summary of the EEA.* [Ms Hirvella] *did also discuss the previous assessments, so she had completed briefly, with Dr Gemma Hayman, the handover from the ED RMO that did the initial referral to the mental health team, the conversations that she had had with Dr Priyangika, the escalation in the ED that had led to requesting another*

[89] T1-22 at lines 38-46.
[90] T1-62 at lines 35-37.

psychiatric registrar review. And also the handover from ED nursing staff to [Ms Hirvella].[91]

d. Prior to seeing Dylan, Dr Tu reviewed the Redland Hospital records and CIMHA records independently,[92] and obtained a handover from ED nursing staff and security officers. Of the latter, Dr Tu stated it was reported to him that Dylan had settled down after his attempt of self-harm, was apologetic for his actions and was described as pleasant whilst waiting for review.[93]

[112] Dr Tu recounted his assessment of Dylan, he stated,

> *So when I spoke to Dylan, I guess the key point would be – I would say in part of the review that he was able to stay in a very congruent conversation with me. He was '[indistinct]he was lucid, he was able to engage in quite a – quite a detailed conversation surrounding his own mental health. His – I – so when was asked him – or when I asked him why, he said he was in quite a stress – becoming quite a good point question – when I asked him why he was feeling suicidal, he was able to express quite clearly that he was regretting what he had done, his actions. That's he spoke very fondly of his partner, and that he wanted it to be known that this was not him, and the fact that he acted completely out of character, and he was regretting what he had done and the potential consequences was what was driving his thoughts of suicide at that point in time.*[94]
>
> ….
>
> *He was able to very clearly identify it was a psychotic episode. He, in his own – or not in his own words, but he was able to describe feeling that he had to save them, and – when he was doing it. And that he was experiencing quite distressing thought, he was only able to give kind of vague descriptions, and I did not note that if I pressed him too far he'd become more upsetting, and that is – and often times, it would not be unusual. For example, if a patient had experienced traumatic experiences, and what he had gone through, what had been deemed traumatic, there would be very limited benefit to press and get every specific detail out of a trauma when it was already quite clear and evidence that what he was experiencing would have been in keeping with – whether we call it drug intoxication or was like a psychotic episode, the specifics of it at that point in time wouldn't have added any more to the assessment. It would have just re-traumatised him.*[95]

[113] I accept Dr Tu had the benefit of physically assessing Dylan over Dr Fajumi who only had the benefit of the clinical progress notes. I also accept Dylan had capacity and was able to relay his history to Dr Tu. Dr Tu's clinical note was comprehensive. I further accept Dr Tu's role was to undertake a 'first response' ED assessment to mitigate Dylan's immediate risks.

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[91] T1-69 at lines 42-48 and Ex. B4- Statement of Dr Tu at [5], [6] and [8].
[92] T1-70 at lines 3-5; Ex. B4- Statement of Dr Tu at [10].
[93] Ex. B4- Statement of Dr Tu at [11].
[94] T1-77, lines 30 to 42
[95] T1-78, lines 44 -49; T1-78, lines 1-7

[114] Dr Tu formed the opinion during his assessment that,

a. Dylan was no longer experiencing delusions or the acute fear for his family.[96]

b. Dylan was fearful that those thoughts would come back, and he would act on those again and that he may harm his loved ones while unwell.[97]

c. Dylan was able to describe the voices which were all negative comments – it was his own voice which was in keeping with negative self-talk and internal monologue.[98]

d. Dylan was able to advise he was no longer experiencing the reported auditory hallucinations and the delusional beliefs.[99]

e. Dylan did not present as a patient who was acutely psychotic.[100]

[115] As to Dylan's drug use, Dr Tu says he and Dylan were in agreeance that Dylan had identified the hallucinogens were what triggered his thoughts. Dr Tu highlighted to Dylan that the marijuana would likely be prolonging any thought of psychotic experiences he had. Dylan did not think the benefits of taking marijuana outweighed the potential risks. He had used it for a long time and had never experienced those more distressing thoughts until the hallucinogens.[101]

[116] Dylan purely attributed his psychotic symptoms to the LSD instead of the marijuana and did not think he needed to wean off the marijuana. Dr Tu said,

> *So that was my opinion, because I was seeing a gentleman who had recently experienced, and in complete agreeance, psychotic symptoms, and you know, put more of that weight heavily on the hallucinogens as opposed to marijuana, whilst we know it does increase the vulnerability, and he – and we had the discussion – he was aware [indistinct] you know, at this point in time. You know, I'm undergoing a lot of stress, the really helps me calm down.*[102]

[117] Dr Tu thought when he saw Dylan, his improvement in symptoms, was in keeping with a resolution of an acute intoxication. He says Dylan was presenting as a person going through a very significant situation crisis and as a result, he was able to exclude a diagnosis of acute psychosis. He says Dylan would have had a resolved acute drug-involving intoxication.[103]

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[96] T1-79, line 34
[97] T1-79, line 36
[98] T1-80, line 40
[99] T1-80, line 49
[100] T1-81, line 24
[101] T1-81, lines 39-49
[102] T1-82, line 22
[103] T1-86, line 43

[118] I explored the proposition that Dylan had been suffering from an acute drug intoxication which had resolved by the time Dr Tu had seen him.

a. Dr Tu acknowledged his starting point was the information he had been provided.[104]

b. A primary psychotic illness was quite low on the differentials because Dylan admitted to using substances and there had been a clear precipitant.[105]

c. Dr Tu did not have any recollection of what drugs (if any) Dylan had taken the day he presented to hospital, but he was able to draw the link between the two.[106]

d. Given the LSD had been taken on the weekend, when Dr Tu was talking about acute intoxication he was thinking more along the lines of marijuana and alcohol.[107]

e. By the time he saw Dylan, Dylan was able to clearly explain that his distress was driven by things that had occurred over the previous few days, two weeks, not ongoing symptoms.[108]

f. Dr Tu was of the view the acute intoxication on presentation was due to marijuana, alcohol, and the psychotic symptoms due to the LSD.[109]

g. Dr Tu said as an intoxication resolves, a patient becomes more lucid, and they can reflect on what they did when they were intoxicated.[110]

[119] On the day of Dylan's presentation to the ED, the QAS arrived at Dylan's home at 11.08am. He was triaged in the ED at around 12.10pm.[111] There is no evidence Dylan had consumed any alcohol on the day of his presentation and there is no reference to that in the clinical record. Further, Ms Hirvella did not suspect Dylan was intoxicated from alcohol. Dylan regularly smoked 6 to 8 cones of marijuana a day. The triple zero call was made at 10.06am. There is no evidence Dylan had used marijuana from this time to his presentation to the ED, noting Police waited with him until the QAS arrived and there is body warn camera footage reflecting this.

[120] Dr Tu was asked how a diagnosis of acute drug intoxication could be made in such circumstances and he acknowledged he was not able to say when the last time Dylan had smoked marijuana (or for that matter the last time Dylan had ingested any drug).[112]

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[104] T1-88, line 20
[105] T1-88, line 29
[106] T1-88, line 41
[107] T1-89, line 5
[108] T1.89, line 5
[109] T1.89, line 25
[110] T1-89, line 48
[111] ExC2.53
[112] T1-91, line 25

[121] Dr Tu accepted there were no specific dates and times recorded regarding the onset of Dylan's symptoms (acute intoxication or otherwise) in correlation with his drug use. It was Dylan's own self-reports that the LSD had caused his psychotic experience that Dr Tu relied on.[113]

[122] Dylan was administered the Olanzapine and Valium at 3.52pm. Dr Fajumi explained the combination of Olanzapine and Valium together had a very sedating effect, and it has an anti-psychotic effect and can produce quite a significant reduction in symptoms. However, said, that you would need to take Olanzapine for a few days to maintain the improvement.[114]

[123] As to the use of Olanzapine, Dr Halangoda stated that one dose would not resolve drug induced psychosis because a patient needs to be on a stable dose of antipsychotic for at least seven days or longer. The reason Dylan was given it was to manage his acute behavioural disturbance not to treat the psychosis.[115]

[124] I accept the medication administered to Dylan in the ED was not to treat a psychosis but was to settle Dylan's symptoms to allow for an appropriate mental health assessment to be undertaken.

[125] I accept Dylan reported the likely precipitous, be it coincidental or not, for his psychotic symptoms was the ingestion of LSD. The amount and the precise date or time when Dylan last took LSD was never established by any clinician.

[126] Dylan's strange behaviours started on or around 20 to 22 September 2022. They became so concerning to his mother that she made a triple zero call to the QAS on the evening of 23 September 2022. The behaviour continued, fluctuating through to his presentation to the ED on 27 September 2022. His mother reported at 10.15am that morning to the local community mental health clinician that Dylan had become more paranoid, was acting strangely, and had just run off down to the back yard.

[127] The cause for the alleged acute intoxication on the morning of 27 September 2022 was not established. It was assumed it was due to drug use.

[128] Dylan's acute behavioural disturbance had settled when Dr Tu examined him. It is likely this was due to a combination of the effects of the medications he had been administered, and Dylan not being intoxicated or having had any marijuana (or any other drugs) since at latest, 10am that morning.

[129] An acute drug intoxication was Dr Tu's starting point for Dylan's symptoms on the day of his presentation to the ED. Dr Fajumi's evidence was that more interrogation as to Dylan's drug use was required.

[130] In circumstances where Dylan had had psychotic symptoms, had no previous presentation to a hospital for mental health issues, had suspected acute drug intoxication on presentation to the ED, and had had a suspected fluctuating drug

[113] T1-98, line 44
[114] T3.36, line 48; T3.37, lines 1-15
[115] T2.42, line 15

induced psychosis, I find there was a deficit in Dr Tu's assessment of Dylan. There was no detailed exploration by Dr Tu as to the behavioural disturbances Dylan had experienced in correlation with Dylan's drug use prior to his admission to the Redland Hospital ED. This included what was causing Dylan's acute symptoms on the day of his presentation in the context that his symptoms (or strange behaviours as reported by his family) had commenced on or around 20 to 22 September 2022.

[131] I accept Dylan had presented to the ED with an acute behavioural disturbance and that it had settled by the time Dr Tu assessed Dylan. Noting the Urine Drug Screen was positive for marijuana and Dylan was a daily user, the cause for his acute behavioural disturbance was suspected to be an acute intoxication but, on the evidence, this cannot be definitively established. This is because the relevant questions as to Dylan's drug use in the context of his symptoms were not asked.

The appropriateness of the diagnosis made by Dr Tu

[132] For the reasons detailed below, while I find the diagnosis by Dr Tu was appropriate, I accept the evidence of Dr Fajumi that the primary issue for Dylan was a drug induced psychosis, not the situational crisis.

[133] Dr Tu formed the opinion that Dylan's presenting symptoms were due to an acute intoxication. This was because an organic delirium had been ruled out, and an acute psychosis was also ruled out. He thought Dylan's ongoing symptoms were due to some borderline personality traits.[116]

[134] In his clinical record, Dr Tu formed the impression Dylan had presented with a situational crisis after committing acts of violence 'whilst acutely intoxicated/experiencing recurrent drug-induced psychosis in the context of heavy poly-substance abuse'. Further he recorded that, Dylan's 'drug-induced psychosis' had since resolved.

[135] Dr Tu recorded the differential diagnosis as 'Situational crisis, accentuation of personality traits, drug-induced psychosis (resolved)'.[117]

[136] The discharge documentation recorded Dylan's diagnosis as 'drug-induced psychosis; Homicidal ideation; Suicidal ideation'.[118]

[137] Dr Fajumi stated that she was confused by Dr Tu's differential diagnosis and stated,

> *So what you would normally write is, you know, what your impression is of the diagnosis is the top one and DDX is your differential, so what other diagnoses you think there might be. So for example, in Dylan's case, what you might have said is diagnosis – drug-induced psychosis; differential diagnosis – situational crisis – I mean accentuation of personality traits,*

[116] T1-87, lines 4-34
[117] Ex C2.5
[118] Ex C2.46

> *that's not a – that's not a diagnosis. So you might say situational crisis or something else. But it's -they've not actually put what they think the diagnosis is, so I've assumed that – they put DDX, but I've assumed they thinks that's what the diagnosis is, if that makes sense.*[119]

[138] Dr Tu explained a situational crisis was when a person has undergone tremendous amount of stress, like Dylan had. He says in response to that Dylan had a very intense emotional reaction.[120] Dr Tu did believe Dylan was presenting as acutely psychotic but that he had a resolved drug-involving intoxication, and what would probably in hindsight be an adjustment disorder.[121] He found Dylan to be lucid and able to engage in very complex discussions around symptoms of mental illness and diagnostic criteria. He says this was not consistent with a person who is psychotic.[122]

[139] Dr Halangoda, the consultant psychiatrist, understood from the information she had seen that Dylan's diagnosis was that he presented with a situation crisis, had some psychotic symptoms which were resolved and that he came in crisis because of his relationship issues or what had happened over the weekend. This led to Dylan experiencing increased suicidal ideation, distress, and self-harming behaviours.[123]

[140] Dr Tu in consultation with Dylan had determined the causal nexus of Dylan's psychosis was due to the LSD. This is what Dr Halangoda recalled being told. She said,

> *So he – Mr Bell is clearly able to identify – because he's been using cannabis for a very long time – he'd never been in this situation, but he used – ah – LSD. He clearly identified that as a trigger. So he didn't want to continue to – he – so – so he has reservation of – around giving up cannabis, but he clearly identify LSD has triggered this episode when he's used…*[124]

[141] Dr Tu recorded Dylan had been experiencing recurrent drug-induced psychosis in the context of heavy poly-substance abuse but as referred to above did not correlate Dylan's drug use with the presenting symptoms which trigged Dylan's acute presentation to the ED.

[142] Dr Halangoda thought Dylan's psychosis was precipitated by taking LSD on top of cannabis.[125] She relied on the information she was provided from Dr Tu and Ms Hirvella.

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[119] T3-18, lines 27-34
[120] T1.71, line 5-8
[121] T1.86, line 48
[122] T1.100, lines 38-41
[123] T-2.57, lines 25-30
[124] T2-47, line 45
[125] T2/47, line 9

[143] Dr Halangoda was of the impression Dylan had some psychotic symptoms due to intoxication which had resolved.[126] She said once the acute drug intoxication was resolved, the psychosis would resolve, but said it can come back if the person continues to use.[127]

[144] Dr Fajumi formed a different view. She believed that on Dylan's presentation to the ED, he was drug-affected and psychotic, and acknowledged it is possible to be drug-affected and not psychotic. She though opined Dylan was both, drug affected, and psychotic, and said in her view Dylan had a drug-induced psychosis until proven otherwise.

[145] Dr Fajumi thought a drug induced psychosis was a relevant diagnosis because Dylan was still using marijuana. Dr Fajumi explained the difference between a drug induced psychosis versus drug use causing a person to develop an ongoing psychosis,

> *So drug-induced psychosis refers to when someone becomes psychotic as a result of ingesting something, so usually whilst they're intoxicated. The second option, what you said, is when substance misuse has precipitated a psychotic episode, which is slight – slightly different. So cannabis can precipitate a psychotic episode, and by that, what happens is they're still psychotic even when they're no longer intoxicated. So that's slightly different. Whereas a drug-induced psychosis, when they're not intoxicated, they're no longer psychotic, whether it's cannabis or ice. So there's a difference. So we talk about cannabis precipitating a psychotic illness or psychotic episode and we talk about drug-induced psychosis, so they're slightly different.*[128]

[146] Dr Tu referred to Dylan having cluster B personality vulnerabilities, history of deliberate self-harm and that he presented with a chronically elevated risk of harm to himself, fluctuating at times with emotional distress. In his statement he says,

> *Whilst I did not formally diagnose Dylan with borderline personality disorder (BPD) on my review, his reviews in the emergency department identified multiple traits that are consistent with BPD. As such, I made reference to local guideline around the acute management of people with BPD to support my treatment.*[129]

[147] There was an exchange between Counsel for MSHHS and Dr Fajumi regarding Dr Tu's diagnosis. She stated,

> *I just have a number of issues with that – with the risk formulation, starting right from the top. It starts with giving Dylan's cluster B personality vulnerabilities and history of deliberate self-harm. He presents as chronically elevated risk to harm – risk to self to harm with – risk of harm to self which fluctuates with times of emotional distress. Firstly, I don't* ***– I***

[126] T2-42, line 36
[127] T2.42, lines 7-11
[128] T3-26, lines 1-10
[129] Ex B4, para 55

don't think there is any evidence that he had cluster B personality vulnerabilities. I think that what we're looking at is someone with – who is psychotic, and the nature of his psychotic illness, the – it fluctuated, but essentially he was psychotic*. So what the formulation says is that having an admission would not mitigate those risks. Now, the reason why I disagree with that is that* ***when you have somebody who is not known to you who – there – there's a question mark about the diagnosis****.* ***There was a question mark****. You – you're not really sure what you're dealing with here. The purpose of the admission, it's not about saying, you know, preventing a suicide, it's – it's about assessing that person. It's about having a period of assessment to understand what is going on for that person who formed – your formulation to manage the risks as you see them. Right. That's the purpose of admission. And my view is that* ***there is an assumption made that an admission would not be helpful, and I disagree.*** *I think that's an assumption made. It's made –* ***my view is that it's made on the belief that – that essentially the – there was a personality diagnosis,*** *and I read in Dr Tu's later report – um – he mentions the fact that admission is not helpful in patients who have sort of personality disorders, borderline personality, and in those cases, you know, it's inappropriate, sometimes, to admit. Um – I would say a couple of things to that. The first thing I would say is that patients who have a borderline personality disorder present in crisis. It can't be entirely appropriate to admit in that situation when the crisis – the issue is about lengthy admissions, not admission, but lengthy. By lengthy, I mean weeks. But even patients with a diagnosis of a borderline personality disorder, it can still be appropriate to admit if they're in time – in crisis. The issue is I don't think Dylan had a borderline personality disorder, I think he had a drug-induced psychosis, and I think he was presenting at sufficient risk to staff and others to warrant an admission and assess those risks, and to further assess him as well.*

But to my point, though, Doctor – well, let me just deal with one point on the run. He's not diagnosed by Dr Tu, is he, as having a borderline personality disorder. The suggestion – the risk formulation is that he might have some cluster B personality vulnerabilities. That's a different thing, isn't it?---But that's in the first line, though.

Yes?---So when you're writing a formulation, you put what your primary – you know, thoughts are about why – why is this person presenting in this way. Right. That's how you write your formulation. That's how we're taught to write. Why is this patient presenting this way at this moment in time? Right. So my – my reading of the formulation is – maybe I'm correct – but my reading of the formulation was that the primary view was that this is due to personality issues, and then you've got – you've got drug-induced issues. He's put it down as, right at the bottom there, as – in term of drug-induced psychosis resolved. So the – to my reading, the primary issue is the cluster B personality issues, because for – drug-induced psychosis is now resolved so is not an issue.

Well, the primary issue is this, isn't it, Doctor, you and Dr Tu seem to be agreed that there was a drug-induced psychosis; yes?---Yes.

And the acute phase has gone. You agreed about that as well?---I think that he was no longer acutely psychotic, like, does – not the same as meaning he's no longer psychotic. (emphasis added)

[148] I clarified this with Dr Fajumi by asking, 'in this case, drug-induced psychosis means that Dylan had been – from your perspective, that Dylan had been using marijuana for quite some time and that was inducing a psychotic episode?' She responded, "*Yes, but – the thing with Dylan is that because he was using every day, you'd have to say that, you know, when was he not intoxicated? That's the difficulty*".[130] Dr Fajumi was of the opinion Dylan's drug induced psychosis was being caused by cannabis rather than LSD.[131]

[149] The refence to intoxication appears to be consistent with Dr Tu's assessment that Dylan's acute symptoms on the day of his presentation were due to intoxication, and on the basis, there is no evidence to support Dylan had consumed alcohol on that day, this would be due to marijuana. By the time Dr Tu saw Dylan, while the question was not asked, it seems very unlikely Dylan had consumed any marijuana after at the latest 10am.

[150] Dr Fajumi said while Dylan was no longer acutely psychotic, this did not mean that he was no longer psychotic. She thought the description of Dylan's presentation as a situational crisis denigrated what was actually going on.[132]

[151] I acknowledge Dr Tu had the benefit of personally assessing Dylan and exploring his symptoms.

[152] I accept,

a. Dylan was the best person in the circumstances to recount his drug use and the effects of those to Dr Tu.

b. Dylan presented with an acute behavioural disturbance be that from an acute intoxication and/or the remnants of a drug induced psychosis which settled following the administration of Valium and Olanzapine.

c. Dylan had had a drug induced psychosis which had resolved by the time Dylan was assessed by Dr Tu but the psychosis had been recurrent.

d. The precipitous of Dylan's drug induced psychosis as reported by Dylan was LSD with marijuana.

e. Dylan had presented in a situational crisis which manifested in his anxiety, guilt, and fear that he would do things again (strangle his partner), have thoughts of hurting his parents or partner again, or harming himself.

[130] T3-26, lines 14-18
[131] T-3 - 26, lines 25-28
[132] T3.45, line 17-20

f. The accentuation of Dylan's personality traits referred to as his emotional instability and vulnerability was consistent with the information his mother had provided to Ms Hirvella.

[153] The difficulty is that the precipitous for Dylan's alleged acute intoxication on his admission to the ED was not established. This in circumstances Dylan had reportedly taken LSD before 23 September 2022 in the context he had reported to the QAS paramedics on 24 September 2022 he thought the symptoms he had been experiencing were due to LSD use. Further, that his symptoms (strange behaviours) had commenced sometime around 20 to 22 September 2022.

[154] It may have been that Dylan had smoked marijuana the morning of his presentation to the ED and that his psychotic symptoms which had been fluctuating over the preceding five to seven days had been exacerbated each time he used marijuana. On the day of his presentation his psychotic symptoms settled following the administration of the Olanzapine and the Valium. The original trigger for the commencement of Dylan's strange behaviours may have been the LSD but this was not established in the context of Dylan's strange fluctuating behaviours over at least five to seven days, and on the basis it was not established when he last took LSD.

[155] While I find the diagnosis by Dr Tu was appropriate, I accept the evidence of Dr Fajumi that the primary issue for Dylan was his drug induced psychosis. The issue then becomes whether it was appropriate for Dylan to have been discharged home, given Dylan's recurrent drug psychosis over the preceding five to seven days, his reluctance to stop using marijuana as he thought it was helpful to him, and his ongoing risk to himself and others.

Whether Dylan should have been discharged from the ED, or held for a period of observation, either in the ED or via an admission to the mental health ward

[156] Recognising the decision to discharge a patient, is a clinical decision by the attending clinician. For the reasons detailed below I find the prudent course in this case was that Dylan should have been admitted to the Hospital for a period of observation. This in the circumstances,

a. Dylan had not previously presented to a hospital for mental health issues;

b. Dylan was admitted to the ED under an EEA due to an acute behavioural disturbance;

c. Dylan had been experiencing fluctuating psychosis symptoms from 20-22 September 2022;

d. Dylan required medications to be administered to address his behavioural disturbance;

e. Dylan attempted to self-harm on three occasions in the ED;

f. Dylan had a continued risk of harming himself or others in the context of continued drug use;

g. Dylan was seeking admission because he was scared of hurting himself or others.

[157] There is no evidence to support Dylan could not have been admitted to the mental health unit. There were two choices for the clinicians, admit Dylan for a period of observation and assessment, or discharge him home with follow up care.

[158] In making the decision it was necessary for the clinicians to weigh up the potential risks and benefits for each scenario. As to the balancing exercise, Dr Fajumi advised it was about weighing up the risks of the person hurting themselves or others if they are not admitted. She said if a person is seeking admission, they are engaging with the process, and it is not necessary to have to consider taking away the person's liberty which requires a higher threshold in determining if admission is required.[133]

[159] Prior to becoming aware of Dylan's self-harm attempts in the ED, Ms Hirvella had explored discharge with Dylan. This became somewhat irrelevant after she had escalated her concerns to Dr Halangoda, and Dr Tu was asked to assess Dylan.

[160] It was for Dr Tu to assess Dylan, including his suitability for discharge, and to then make that decision in consultation with Dr Halangoda. I acknowledge Ms Hirvella's earlier assessment would have provided Dr Halangoda with some additional information to inform her decision about the plan for Dylan.

[161] Dr Fajumi was of the opinion Dylan should have been admitted for a period of observation over the decision by the treating team to discharge Dylan. She stated,

> *what's important in a drug-induced psychosis, is a period of observation – you want to observe the person, what's happening – and also you want to make sure, obviously, they're not using, in order to clarify that diagnosis. Um – the other – the couple of things I also want to raise is that, look, for most people that use substances, they do not become psychotic to this extent. The vast majority of people do not become psychotic. For those that do, what that's telling me is that this person is predisposed to developing a psychotic illness, and there's a high proportion of people who have drug-induced psychosis initially, who go on to develop a functional psychotic illness like schizophrenia. So that's just something to – to bear in mind. But you – you need a period of time from this – when they used and the time – and how long will symptoms last for…*[134]

[162] I enquired if a period of observation could be done as an outpatient. She responded by stating,

[133] T3.15. lines 32-41
[134] T3-6 at lines 39-49.

depends on the risks that are present. So in Dylan's case, definitely an inpatient. The reason I say that is because he was brought to the emergency department under the Mental Health Act. So he's already – there's already a concern there that – that meant that somebody was concerned enough to detain him under the Mental Health Act – um – as opposed to him turning up voluntarily, for example. The other thing to think about is the fact that there was a history of him being – being quite disorganised and – um – the family were concerned about psychotic symptoms. There was a report that he'd wandered in the street naked. So there was other things that made you concern that, actually, if he's still in intoxicated and we let him go home, he might be at risk of misadventure, for example…[135]

I think that what we're looking at is someone with – who is psychotic, and the nature of his psychotic illness, the – it fluctuated, but essentially he was psychotic. So what the formulation says is that having an admission would not mitigate those risks. Now, the reason why I disagree with that is that when ***you have somebody who is not known to you who – there – there's a question mark about the diagnosis. There was a question mark.*** *You – you're not really sure what you're dealing with here.* ***The purpose of the admission, it's not about saying, you know, preventing a suicide, it's – it's about assessing that person. It's about having a period of assessment to understand what is going on for that person who formed – your formulation to manage the risks as you see them. Right. That's the purpose of admission*** …(emphasis added)

[163] Dr Fajumi clarified in Dylan's case the admission was not to address his substance misuse but to assess the impact of that use. If it was that he was still a bit psychotic for some days and then it resolved, the question to ask Dylan was 'what are you going to do about your drug use? She acknowledged nobody could stop him from using.[136]

[164] As documented in Dr Tu's clinical record, Dylan himself had been seeking admission. Dr Tu recorded, 'Continue to remain hesitant surrounding discharge. Initially' – 'despite initially accepting ACT', and 'AODS'. When Dylan was asked why he felt hospital would be better, he said he was scared. This was not only about facing the consequences of his actions but also that he would do something similar again, and harm himself.

[165] Dr Tu was asked in the context of this information and on the basis, Dylan had attempted to self-harm on three occasions in the ED, was there any other mechanism beside hospitalisation to observe him. He stated,

---And I guess the – I guess one of the things about reading the notes is that we don't get a – quite a clear picture, and there's a very succinct summary written of, like, quite a long conversation. So there is obviously going to be that anxiety. He's a very anxious young man. Um – he was worried that he was going to do things again, very sensitive young man, self-punishing – um – internalising a lot of that distress. So it's – and almost the – like

[135] T3-7 at lines 20-35.
[136] T3-42, lines 9-14.

> *obviously catastrophising, "Oh, what if this happens again?"* ***The – over the conversation, you know, we did go back and forth a few times, where he'd be like, "Oh, no, I still really want to come into hospital", and then we've kind of revisited, "Okay. So what are the goals of the mission? Because coming to hospital, it is an artificial environment.*** *Um – and yes, we can remove you from the stressors, but what are we going to achieving? Are the stressors still going to be there when you go home?" And we were able to come to that, like, unfortunately, yes. The – an admission wouldn't take away from what he had done, and an admission wouldn't – um – doesn't – wouldn't help suddenly fix everything and make it all go away. And there would be steps that he needed to take to try to repair his relationships and recover, and get back to – you know, his sort of very quite fulfilling life, and an in-patient which will take away from that. Had he said, "I'm still experiencing all of this stuff. I think I'm going to do it again because I'm still having these thoughts. My family is in danger. I'm possessed by the devil", very, very different story. But even in my conversation, and just clarify – I was able to clarify like his previous conversations with ED, like all the previous people.* ***I was like, "Are you experiencing it now?" And he was – very clearly able to tell me, "Of cour – of course I'm – like, that's not me. I don't feel like that anymore."*** *And that – so we were kind of – went back and forth, and he was like, "Yes, okay. Let's try this." Now, with any sort of discharge plan, and I have very strong recollection because this is something that I do with every single patient. It is always, hey, if you go home and the plan we put in place doesn't work out, call triple zer – come right back.*[137] (emphasis added)

[166] Dr Tu said the discussion about discharge was by consensus. They discussed the benefits versus the downsides of admission. By the end of the review Dylan was happy to give discharge with supports a try.[138]

[167] The supports were those documented by Dr Tu in his progress notes and included the AODs referral and the zero suicide protocol (an assertive follow up program).

[168] As to the discussion about discharge Dr Tu had with Dylan, there was an exchange between Counsel for MSHHS and Dr Fajumi,

> *We heard evidence from Dr Tu that Dylan was quite literate, he could speak quite freely about mental health issues because he was a support worker?---Mmm-hmm. And they had a discussion between them about what the best mode of care was, and they discussed it together until they agreed that it would be a discharge. If the patient is accepting of the plan, that's another reason for optimism, if you – if the clinician has come to trusting the patient?-*
>
> *---Look – well, my reading of the record was that Dylan asked for admission and he was told it wasn't beneficial, it wasn't going to help him. That's my reading of the – of what happened, is that he requested admission, he didn't*

[137] T1.115, lines 20-47
[138] T1.120, lines 17-30

want to go home because he didn't think it'd be safe, and – and the response was that being admitted was not going to help. He was told it wouldn't be helpful. So - - -
Yes ?---And then - - -

And then the evidence of Dr Tu ?---And then - - -
was a bit more nuanced. He said there was a discussion, and that Dylan ?---Yep.

accepted that maybe after all outpatient would be better, discharge, and if - - -?---Yeah, but that was after being told – wait, can I just say that was after being told that an admission was not going to be helpful, and I think that – ***I mean, if someone said that to me as a patient, the doctor said to me, "You being admitted is not going to be helpful", I mean, I don't know what other response he would had to that, to be perfectly honest****.*[139] (emphasis added)

[169] It was explored with Dr Tu as to what other options were available, for example a short stay unit for 12 hours. He felt it was more comfortable for patients to be at home, than keeping them in the ED while they are not voicing an imminent attempt, and while they are not acutely psychotic. He said this is where assertive supports come into play, which includes reliance on the family for support.[140]

[170] Dr Tu says he would have relayed that Dylan was scared of doing something again and harming himself and that he had attempts of self-harm in the ED to Dr Halangoda. He says though he would have also said Dylan was very engaged in the safety plan and that would have helped drive Dr Halangoda's ultimate decision.[141]

[171] Dr Halangoda says she was informed by Ms Hirvella that Dylan had tried to strangle himself with a belt and then tried to strangle himself with a shirt.[142] She was not aware (as Ms Hirvella was not aware) of the attempt at 3.52pm.

[172] Dr Halangoda could not recall being told that Dylan was scared of harming himself again. In the context of the self-harm attempts in the ED, she was asked if that would have changed her management, she stated,

I don't think so because he haven't had any – he – he was fearful, actually [indistinct] because I will be very concerned someone has no fear at all to kill…themselves…this is serious to me if someone doesn't have – emotions or no affect or they don't – they don't care about hurting anyone else or hurting themselves or – so I will be very concerned. But he's someone – if he's very fearful of doing something and he feels like, 'I can't do it, I don't have it in me', that is less serious than the other one. [143]

[139] T3,42, lines40-49; T3.43, lines 1-16
[140] T1.117, lines 18-39
[141] T1.116, lines 8-25
[142] T2.24, line 40
[143] T2-41, lines 30 - 38

[173] As to the plan to discharge Dylan, Dr Halangoda says Dylan was not suffering psychotic symptoms when assessed by Dr Tu. She felt with the discharge plan proposed and the safety planning, it was appropriate to discharge Dylan. This included the prescription of Seroquel for his anxiety and agitation, which Dylan had found helpful previously.[144]

[174] I accept the decision to discharge Dylan was a clinical decision. Dr Tu had the advantage of assessing Dylan in person. He was comforted that Dylan was lucid and that he was able to engage with him regarding his potential diagnoses, and that Dylan's psychotic symptoms had resolved. I also accept that an admission would not have assisted in addressing Dylan's substance abuse issues and that he would not have received any psychological therapy as part of his admission.

[175] It is a balancing exercise. Dylan feared hurting himself, his family, or his girlfriend, and was seeking admission. It was suggested by Dr Tu that an admission would not have been helpful to Dylan. In the end Dylan agreed to be discharged. I agree with Dr Fajumi that by Dr Tu advising Dylan that admission would not be helpful, this likely persuaded Dylan to agree to the proposed discharge. Dr Fajumi opined Dylan required admission.

[176] I consider the prudent course in the circumstances is that Dylan should have been admitted for a period of observation. If not, it was imperative that appropriate safety planning needed to be in place, and the plan discussed with Dylan's mother. For the reasons outlined below, it was not.

If it is submitted he should have been held for a period of observation, the appropriateness of the safety planning in writing or otherwise, and the steps put in place to implement the safety planning by Ms Hirvella, Dr Tu and Dr Halangoda.

[177] For the reasons detailed below I find there was a deficit in the safety planning put in place for Dylan prior to his discharge from the Redland Hospital.

[178] A safety plan is distinct from a discharge plan.[145] It is described as a collaborative process between the patient and family to identify how to manage suicidal thoughts and how to mitigate those risks.

[179] Dr Tu admitted he was not involved in the safety plan but agreed that as part of the plan,

a. Dylan's family should have been informed that he was scared and that he might do it again.

b. That Dylan had three attempts of self-harm by strangulation in the ED and to limit his access to means.

c. That there was an ongoing risk for Dylan and that he was still going to be distressed.

[144] T2.36, lines 28-35; T2.37, line 17- 40
[145] T2.62, line 26

d. To watch for any potential sudden changes.

e. Keep a close eye on him for substance use, alcohol, and 'even' weed.

f. Be aware there is an acute care number (1300 MH CALL).

g. Ensure Dylan is taking his medications.[146]

[180] Dr Tu was asked if in hindsight, he would have kept Dylan overnight given what occurred. He responded he would not have; in circumstances the expected safety planning and the follow-up was in place.[147]

[181] Dr Halangoda did not specifically discuss the safety plan with the clinicians because they were experienced clinicians. She said, "*they know how to do that. They're training in this – doing these safety plans and they know how to do that*".[148] She trusted Dr Tu to formulate an appropriate safety plan.[149]

[182] In relation to the information provided to the family, she says from the documentation, Ms Hirvella discussed the plan. Dr Halangoda said,

> *I remember specifically I asked Dr Tu in the light of what happened after the initial assessment, go back to the mum and – uh – explain the plan. Explain the situation. Explain the plan. If there are any concerns, get back to me…*[150]

[183] Dr Halangoda then conceded she was not sure if she had asked Dr Tu to do that personally, or that she said 'we need to discuss'. She said that somebody had to do it.[151]

[184] Dr Halangoda was aware that Dylan had ongoing suicidal ideation; that he was continuing to experience negative self-talk; that Dylan had attempted self-harm in the ED; and that he was scared of doing it again in the sense of self-harm. Her expectation for safety planning was that Dylan's family would have been advised,

a. Dylan had attempted self-harm in the ED. [152]

b. Dylan still had ongoing suicidal ideations.[153]

c. Dylan was still having negative self-talk about what had happened and the events that had occurred, and that he was very fearful about acting in a similar way again.[154]

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[146] T1.116, lines 29 – 49; T1.117, lines 1-14
[147] T1.118, lines 5-10
[148] T2.59, lines 26-28
[149] T2-59, line 33
[150] T2, lines 16-22
[151] T2-238, one 27-31
[152] T2.40, lines 37-49; T2.41, lines 1-11
[153] T2.40, lines 37-49; T2.41, lines 1-11
[154] T2.40, lines 37-49; T2.41, lines 1-11

d. Dylan was scared of harming himself again.[155]

[185] Dr Halangoda conceded in circumstances where Dylan was at risk of suicide, a documented safety plan should have been given to Dylan and his family.[156]

[186] Ms Hirvella was asked by Dr Tu after he had reviewed Dylan to organise the discharge. He asked her to call Dylan's mother. She said she had gone on to work on the next patient but did as she was asked. The plan was for assertive follow-up with the acute care team.[157]

[187] Ms Hirvella says she discussed all the elements in the documented discharge plan with Dylan's mother. That is, that there would be a transition of care to the Acute Care Team, that a referral would be made to the Alcohol and Drug Service and that there was a script for some medication for Dylan. She did not recall discussing Dylan's risk of self-harm but did discuss the Zero Suicide Framework. She remembers telling Dylan's mother Dylan's substance use would fluctuate his risk.[158]

[188] Dr Fajumi was asked about safety planning, she advised,

> *So a discussion with – first of all, I think the* ***family needed to be aware of what happened in the Emergency Department****. That would be the first thing. And I think that there needs to be a conversation about how that was going to be managed in the home. So for example,* ***what would happen if he tried to hang himself again****, you know,* ***how was that going to be managed****.* ***Do the family feel comfortable with managing that****? So that's the first thing is – the first thing is they need to know what happened in the Emergency Department. And then gather their response from that. So you tell* ***the family, look, this is what happened in the Emergency Department. We're wanting to discharge him home. What are your thoughts. Okay? And you'd base your safety planning on the response.*** *Because you're discharging this person into their care. So I'd want to know that the family feel confident that they can manage that. I'd need to know that they would know what to do if things escalate, who to contact, when to contact them. Um, I'd need them to know that they had the resources that they needed. So that's probably the most – and also,* ***if they felt uncomfortable, that they were okay to say, no, we – we don't think we could manage that****. So those – that's the information that I would need – um – because if he's going home to live with them –* ***I'd also need to know exactly who – exactly where is he going to go.*** *So my understanding of the situation is that Dylan was living on the same property as his parents but with his partner in a – like a granny flat at the back. Now, I also am aware that he had –* ***tried to strangle his partner, so I'd be wondering, okay, so is he – where's he going – is he going to go back with Emma or is he going to his parents*** *– who is actually going to be keeping an eye on him here. Who is going to take that on, is it*

[155] T2.42, lines 5-7
[156] T2.47, lines 5-13
[157] T1.55, lines 2-9
[158] T1.65, lines 1-49

going to be mum, dad, Emma. So there's just disparity as to what their roles were, who's doing what and when. (emphasis added)

[189] Dr Fajumi added the safety plan needed to include discussions about what would happen if Dylan did not cooperate with what his family needed to do in response.[159]

[190] Dr Fajumi thought it would be helpful to reduce the safety plan to writing and for it to be provided to the family.[160] Ms Hirvella advised at the time of Dylan's discharge the safety plan did not need to be documented and that clinicians could provide a verbal safety plan. It was her understanding that both were acceptable.[161]

[191] The October 2021 Suicide Prevention Practice - Queensland Health Guideline, includes a section on 'Safety Planning'. The author states,

> [It] *is a collaborative process between staff, the consumer and ideally their family and friends which occurs during the engagement phase and regularly throughout the treat and transition phases of the suicide prevention pathway. The goal is to support the consumer to identify how they can manage their suicidal thoughts while also reducing access to lethal means.*
>
> *The process of developing a suicide safety plan assists the consumer to identify their individual warning signs and available resources and strategies they can use to manage thoughts, emotions and circumstances that cause distress. The strategies include a list of supportive and emergency contacts and agreed steps to any foreseeable changes. The suicide safety planning intervention and documented plan should be regularly reviewed, refined and reinforced.*
>
> *The suicide safety planning intervention should include counselling on access to lethal means for consumers, family and other support persons. Counselling on access to lethal means requires clinicians to assess the consumer's access to potential means (including prescribed medications and other substances) and enact strategies to remove, restrict or delay access to these means.*
>
> *All persons and service providers with a role in supporting the consumer's safety should understand their responsibilities, with their names recorded on the safety plan. An agreed plan of action in the event of a crisis or escalation in suicide risk should be clearly documented.*
>
> *The suicide safety plan should complement any other risk management plans and is an integral part of a comprehensive care plan for a person with suicide risk.*

[159] T3.17, lines 14-17
[160] T3.17, line 7
[161] T1-58, line 33

> *The consumer should hold a copy of their documented safety plan and provide one to others involved in the development of the plan and other key people and services that form their own support system. If a consumer prefers with their consent, this can also be provided by staff.*[162]

[192] Ms Hirvella was asked about safety planning. She said she told Dylan's mother to hold Dylan's medication and to dispense those to him. She wrote, '*phone call to mum re plan. Happy with plan, will pick up, prescription medication and will hold and dispense'*.[163] Ms Hirvella was asked if that was the extent of the safety planning and she said, '*Possibly, but I can't recall – um – accurately*'.

[193] Ms Hirvella was asked to recount her discussion with Dylan's mother, she stated,

> *Did Dr Tu give you any parameters to the best of your recollection about what he wanted you to discuss with mum?---Yes. So I've written that down on page 10 of exhibit C3. So he was to be discharged at acute care with assertive follow-up, with a zero suicide protocol. To have a medical review with one of the psych reg's, and to offer Brief Therapies Clinic and AODs.*
>
> *Okay. And can you take the court through your discussion with mum please?---Yes.*
>
> *To the best of your recollection?---To the best of my recollection I called mum and she was in the car park, and I discussed with her, in particular, the zero suicide protocol, and stated to her – and, you know, the referral to AODs, but in particular, the assertive follow-up due to history, and I told her that if that zero suicide protocol is an assertive follow-up, and that they will call him every day. If they can't get a hold of him, they will call her. So to keep the phone around, to be waiting for the phone call. And that it happened – you know, they follow up assertively, which means every day, and trying to get a hold of someone.*[164]

[194] In Dylan's mother's email recollection of events which she wrote on 1 December 2022, she advised,

a. There was no further follow up conversation after the one she had prior to Dylan being assessed.

b. Dylan came out to them and told them that he could go. She had to ask for a script (she was given one for Quetiapine not Olanzapine[165]).

c. When they reached the car park they received a telephone call from the ?psychologist (this was Ms Hirvella) to say she was at the other end of the hospital and that she could not get back to speak to them in person.

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[162] Ex B5.4, pages 4-5
[163] T1-23, line 32
[164] T1-23, lines 8-23
[165] The initial plan prior to Ms Hirvella escalating Dylan's self harm attempts was to discharge him with Olanzapine. This was changed to Quetiapine after Dr Tu assessed Dylan.

d. Ms Hirvella told her to start Dylan on the script.

e. Ms Hirvella advised Dylan had wanted to stay in hospital but was refused as they did not have the facility for him. She said they had a plan for him and that the drug and alcohol service would call Dylan the following day to set up a treatment plan.[166]

[195] Dylan's mother states,

> *She did not elaborate or invite questions. She did not mention he was a suicide risk or that he had attempted twice while in the hospital. She nor any hospital staff made any mention he was a suicide risk or that he had attempted twice while in hospital. She nor any hospital staff made any mention of Dylan being suicidal and did not mention suicide or warn us in any way that we should watch him for suicide or self himself. I thought later, this gave me a false impression that he was not in any danger. She also said that if they didn't get through to Dylan on the phone the next day they would call me.*[167]

[196] It is uncertain on the evidence if the Zero Suicide Plan was mentioned to Dylan's mother. There is no documentation that it was discussed. I accept it is likely it was mentioned briefly by Ms Hirvella as part of the 'plan' but not discussed in any substantive way, including what it was and why Dylan was being commenced on it.

[197] I accept Dylan's mother was not informed of Dylan's three attempts of self-harm in the ED, that he had an ongoing risk of self-harm, and of harming his parents and his girlfriend in the context of his ongoing drug use. I am of the view she should have been warned of all of this and strategies discussed as to how to keep everyone safe.

[198] There was a failure by the mental health treating team to ensure Dylan had an appropriate safety plan in place and that his family were aware of that plan.

Whether there were any interventions that would have changed the outcome for Dylan

[199] This is a difficult proposition. I accept the predictability of suicide remains elusive.

[200] As documented in Dr Tu's contemporaneous clinical note, at the time of his assessment Dylan was reporting 'AH (auditory hallucinations) telling him to harm himself but has been trying to resist'; 'Long-standing suicidal ideation but never this bad'; he was 'scared' of 'doing 'something similar again and harming himself'; 'ongoing SI (suicidal ideation) without clear intent nor plan'; and was at 'an acutely elevated risk of harm to self'.

[166] Ex B1, p3
[167] ExB1, p3

[201] Dr Tu formed the opinion an acute hospital admission was not appropriate in Dylan's case and that his risk could be managed in the community with the discharge plan he had established, and appropriate safety planning. Dr Fajumi formed a different view and when asked about the negative aspects of an admission to an acute mental health facility which were raised by both Ms Hirvella and Dr Tu, she stated,

> *---I disagree because, look, it's – it's – we know that acute mental health units can be very unpleasant places for people; I accept that. But when admitting someone, there's a balance between the risks and the benefits. So – and that's something that you take into consideration when you admit somebody to hospital. You think about what the harms might be, and what the benefits might be. So in this situation, you've got somebody presenting with suicidal and homicidal ideation. That is clear. We don't know what kind of experience he might have experienced on that unit. He might have been – he might have had – not had any issues with any of the patients. It's possible, but we don't know that. What we know is, at the moment, he's suicidal – well, they say, he's presenting with suicidal, homicidal ideation. Okay. So your assessment – and you make – you make your recommendations based on that, not on the fact that he may have a horrible experience on a ward, which he might have, but you don't know that. That – that's speculation.*[168]

[202] Dylan required some form of intervention to manage his acutely elevated risk of self-harm, be that hospitalisation or an appropriate safety plan. He was not provided either. There was a missed opportunity to appropriately manage Dylan's known risk of self-harm. However, it is not possible to say with any degree of certainty what would have occurred had either of these interventions have been instituted.

[203] While there is supervision, and while it is relevantly uncommon, even in an acute hospital environment, a patient can self-harm. I do not doubt if Dylan's family had been advised of what had occurred in the ED, and that he likely had a drug induced psychosis that they would have watched him closely. Tragically this may also not have changed the outcome.

[204] Saying this, I consider it is possible had Dylan received different treatment it would have changed the outcome. This opportunity though was sadly lost for the reasons I have identified herein.

[168] T3.15, line 10 to 22

Findings required by s. 45

Identity of the deceased:

Dylan James BELL

How he died:

Dylan had a fluctuating drug psychosis and presented with an acute behavioural disturbance to the Redland Hospital ED. He attempted to harm himself on three occasions by strangulation (hands and belt) in the ED and had an ongoing risk to himself and others with continued drug use. He was discharged home from the ED, and approximately 18 hours later, died from hanging using his belt.

Place of death:

24 Pioneer Road, Sheldon, 4157, Queensland, AUSTRALIA

Date of death:

28 September 2022

Cause of Death:

Hanging

Comments and Recommendations

[205] Following Dylan's death, Metro South Addiction and Mental Health Services reviewed the care Dylan was provided. Counsel Assisting has summarised the communication-related issues and recommendations:

a. In reviewing Dylan's death, Metro South Addiction and Mental Health Services acknowledged the following communication-related issues arising from Dylan's presentation and management:

i. citing lack of facilities as a reason for discharge when communicating with families;

ii. contacting the patient's nominated next of kin post-discharge per the Zero Suicide Pathway;

iii. the communication and language used when discussing plans of care and treatment decisions with families and what involvement of families means; and

iv. the lack of a formal safety plan in initial care provision.[169]

[169] Ex. B5.1- Attachment 1 to Statement of Dr Balaji Motamarri- MSAMHS SQISU Focussed Analysis at pp. 14-15.

b. Of these, Metro South Addiction and Mental Health services recommended:

   i. that citing a lack of facilities was not an appropriate reason for discharging a patient and this should not have been communicated. This feedback should be provided to the Bayside Mental Health ED treating team;

   ii. that the absence of communication to Dylan's next of kin (his mother) post discharge should be discussed at the Bayside Morbidity and Mortality Committee Meeting;

   iii. that the communication and language used when discussing plans of care and treatment decisions with families be discussed at the Bayside Morbidity and Mortality Committee Meeting to ensure staff were aware of the requirements of developing a comprehensive care plan; and

   iv. that a formal safety plan is useful as it generally provides more context around who the patient prefers to talk to about their mental health, further contact with appropriate persons to be made to obtain collateral in the community setting. This feedback should be discussed with the Mental Health ED team for reflective practice.[170]

c. Dr Motamarri provided the safety plan available for completion at the time Dylan presented, and the updated version to the Court.[171] He expressed that while it remained the case that it was not mandatory to hand copies of plans to the patient and their families, his view was that it should be. He advised the Court he intended to take this view back to clinical governance.[172] Dr Motamarri also provided evidence of the development of a patient/carer brochure outlining warning signs, triggers and crisis contact information.[173]

d. Of what is required within a safety plan, Dr Motamarri opined:

> *It has to tease out the most important point. I think one of the discussions that I have put forward is what we call case approach, where we talk about chronological assessment of suicide. There we talk about exactly what we are talk – we are discussing now. We talk about this. Ideally, best practice is to discuss all the issues, but sometimes, when people are in very significant distress, they may not be able to tease out everything, so hence early warning signs would be a good way to go with and some of the salient points is a good way*

[170] Ex. B5.1- Attachment 1 to Statement of Dr Balaji Motamarri- MSAMHS SQISU Focussed Analysis at pp. 14-15.
[171] Ex. C8- Safety Plan Final 2020 and Ex. B10.10- Attachment 10 to Third Statement of Dr Balaji Motamarri- Safety Plan.
[172] T2-74 at lines 14-37.
[173] Ex..B10.11- Attachment 11 to Third Statement of Dr Balaji Motamarri- Patient Brochure.

to go with it. To answer your question, yes, that would be ideal and best practice - - -[174]

e. He also stated:

> *Our understanding here is a safety plan is a plan when they're having some disturbance or some distress. How they act on it. Historical context may not be very – I – I – I'm struggling for the words – may not be very useful if it is given to the carers and friends as well because we don't want to divulge too much information there, and this was predominantly focused on*, "What do I do when I'm distressed? What do I do? Who do I go to? What do I do?" *That's why that was the reason, but that's the reason why we probably did not include, but it's a point of discussion that I will take it back to my clinical – director of clinical governance and review that. It's a valid point, and I don't see a no to it, and we'll have to discuss that. It's a very good point.*[175]

f. The following exchange between Dr Motamarri and the bench then occurred:

> *Dr Motamarri, just on that point. So as I'm understanding it, the safety plan, as its designed, is to give to the consumer, not necessarily to give the context to the family as to what's occurred, but you're – as I'm understanding you, you're going to take that away and speak from a clinical governance perspective because in this case it's clear that there was a communication breakdown in the sense of the family not being aware of all of the things that happened in the ED and what – how Dylan was feeling before he left the ED?---Absolutely right, your Honour. Yes, your Honour. We'll take that back.*[176]

[206] Dr Fajumi was critical of the updated safety plan. She stated,

> *Look, I would say that's a wellbeing plan. Um - - -*
> *So how could that be improved?---Look, it – the first box there's about, you know, managing early warning signs. So I mean, that's helpful, but I – it's just not specific enough. So – so for example, what I'm talking about is, when it comes to suicidal behaviour, suicidal thoughts, there – often there's a graduation. So the first step is, is I start feeling anxious and agitated. When I feel like this, I'm going to do that. When I feel like this, I want to do that. So this is talking about – so "activities that help me feel safe and calm". Right. So that's not the same as "activities to stop me from feeling suicidal". It's just a bit too vague, in my opinion. So we're dealing with someone with quite severe suicidal thoughts, it needs to be a lot more detailed, because often there's a stage where a person is – when my pati – I'll tell you what I do with my patients. I ask them to give me a colour-coded – coded system. So green means I'm fine, I'm good, everything's fine.*

[174] T2-81 at lines 37-44.
[175] T2-85 at lines 29-38.
[176] T2-84 at line 44 -T2-85 at line 4.

Orange means I'm not travelling so well. I'm starting to have suicidal thoughts, I need some help, and I'm going to – and then red is I'm not safe. I need to go to hospital now. Right? And at each stage, the person – I want my patient to describe to me what they're experiencing and what would help them at that time to – so it's very specific, and it's, you know, using a traffic light system. So red is – so if they say to their mother or father "I'm a red", they know you go straight to ED. All right. This is helpful, but I think it's a bit vague and it's lacking in a bit of detail, is what I would say. It's sort of a, like, more wellbeing type thing.[177]

[207] In this case Dylan was not only expressing suicidal ideation but was expressing homicidal ideation concerning his parents and his girlfriend, with actual physical violence of two strangulation attempts of his girlfriend prior to his admission to the ED. He attempted to self-harm three times in the ED.

[208] As I have indicated above, I consider the prudent course in this case (or any case like it) would have been to admit Dylan for a period of observation and assessment. However, if an alternative view is adopted by a treating clinician, it is imperative that there is an appropriate safety plan in place not only for the patient but also for the family and partner.

[209] I acknowledge Dr Tu has already changed his practice in relation to speaking directly with family when assessing a patient like Dylan. I appreciate there are various pressures and challenges for mental health clinicians, particularly in the ED environment, and I believe the clinicians in this case were all acting in good faith and trying to assist Dylan. Saying that, I consider there is an opportunity for the clinicians to reflect and learn from this case.

[210] I acknowledge Metro South Hospital Health Service have advised they will consider Dr Fajumi's feedback regarding the draft 'Safety Plan' document. I implore them to do so and recommend in accordance with s46 of the Coroner Act that Metro South Hospital Health Service (and other health services)

Review the process of Safety Planning in the ED setting to ensure the patient and their support person(s) are provided with a practical written document outlining their risk of harm and how to manage that risk. Importantly, the Safety Plan should refer to any attempts of self-harm made while in the care of the health service and harm minimisation in relation to those self-harm attempts on discharge.

I am of the opinion as part of the review, there should be an additional plan be it part of the safety plan given to the patient, or separately for the family in circumstances where a patient expresses homicidal ideations. It should mandate a conversation with the person(s) living in the residence the patient/consumer is being discharged to, and if the homicidal ideation is not directed at persons living with the patient, the target(s) of the homicidal ideations should be contacted, to ensure they are prepared for the patient to be discharged, and if so, what strategies are in place to manage the risk

[177] T3.17, lines 35-49l T3.18, lines 1-8

to those persons. I consider this should be clearly documented in the clinical record.

[211] There were references during the Inquest to the new Redland Hospital Crisis Support Space. As I understand it, it opened in or around June 2024. The website indicated, 'People over the age of 16 can be referred from the emergency department or other co-responders from 2pm to 8.30pm, Wednesday to Sunday'. It is staffed by peer workers with lived experience and mental health clinicians. The space is described as providing 'a welcoming, calm and therapeutic area where people can receive much needed care away from the ED'.[178]

[212] This service may have been a helpful facility for Dylan had it have been operational in 2022. I encourage the expansion of the service to provide a therapeutic environment for mental health patients in crisis, and to relieve the pressures which are inevitable in the acute ED environment.

[213] Pursuant to s48 of the Coroners Act, I do not consider there is any information gathered during the coronial investigation that might cause a professional body to inquire into, or take steps in relation to, the conduct of any clinician.

[214] As is standard practice for all health care related deaths, a copy of these findings will be provided to the Office of the Health Ombudsman. In this case, I also intend to provide a copy of these findings to the Office of the Chief Psychiatrist, and Clinical Excellence Queensland.

I close the Inquest.

Melinda Zerner
Coroner

BRISBANE

[178] https://refer.metrosouth.health.qld.gov.au/news/redland-hospital-opens-new-crisis-support-space#:~:text=About%20us%20The%20new%20Redland%20Hospital%20Crisis,people%20experiencing%20mental%20health%20crisis%20or%20distress.