CORONERS ACT, 2003

SOUTH  *AUSTRALIA*

FINDING OF INQUEST

An Inquest taken on behalf of our Sovereign Lady the Queen at Adelaide in the State of South Australia, on the 24th, 25th, 26th, 27th and 28th days of February 2014, the 3rd, 11th and 14th days of March 2014 and the 17th day of June 2014, by the Coroner's Court of the said State, constituted of Anthony Ernest Schapel, Deputy State Coroner, into the death of Jason William Hugo-Horsman.

The said Court finds that Jason William Hugo-Horsman aged 15 years, late of 7 Possingham Drive, Mount Barker, South Australia died at Mount Barker, South Australia on the 9th day of October 2010 as a result of compression of the neck consistent with hanging. The said Court finds that the circumstances of his death were as follows:

1. Introduction and cause of death

1.1. Jason William Hugo-Horsman was 15 years of age when he died on Saturday 9 October 2010. His father, Mr David Horsman, found Jason hanging from a beam in the shed of the family premises at Mount Barker. Mr Horsman managed to free Jason. Efforts by Mr Horsman to apply first aid, including CPR, were unsuccessful. Efforts by ambulance personnel to resuscitate Jason were also unsuccessful. It is clear that Jason was already dead at the time he was found.

1.2. A post-mortem examination performed by Dr Neil Langlois, a consultant forensic pathologist at Forensic Science South Australia, established that the cause of Jason's death was compression of the neck consistent with hanging[1]. I find that to have been the cause of Jason's death. Aside from the ligature mark on Jason's neck that was

[1] Exhibit C1a

associated with the act of hanging, Dr Langlois also found fine linear incised wounds in an irregular criss-cross pattern on the left wrist together with associated nearby superficial linear wounds. Within the same area there also appeared to be an older superficial linear wound. On the flexor surface of the left forearm the word 'FEAR' had been superficially cut into the skin. On the left and right superior pectal regions there were superficial fine linear wounds on the skin measuring about 3cm in length. There were other scattered abrasions and superficial wounds on the right forearm, the right hand and the left knee. It was known prior to these events that Jason had a propensity to cut himself superficially. There seemed little doubt that this behaviour was associated with serious emotional and mental anguish that Jason had been experiencing for some time and in respect of which he had been seen by a local general practitioner and the child and adolescent arm of the South Australian public mental health services. Analysis of blood obtained at the post-mortem examination revealed 0.016% alcohol, which is a relatively small concentration. No other common drugs, illicit or otherwise, were detected in the bloodstream. In particular, no benzodiazepines such as diazepam, otherwise known as Valium, or antidepressants were detected, notwithstanding that Jason had been prescribed diazepam.

1.3. Jason had been home on his own for some hours immediately prior to his death. There is no evidence of the involvement of any other person in his death. It is clear that Jason was solely responsible for the act that took his own life. Jason did not leave a note.

1.4. Earlier on the day in question, Jason, his parents and his sister had attended the home of family friends in Mount Barker in order to help celebrate an 18th birthday. As explained in the statement of Jason's father[2], the family had been at this premises since the afternoon. Jason had appeared to be in good spirits at the function. At that time Jason was on a curfew in respect of recent behavioural issues. Towards the late afternoon he was told by his father that he should go home. Mr Horsman gave Jason a house key so he could let himself in. Jason walked home, leaving the family friends' premises sometime between 5:30pm and 6pm. Jason's parents and sister remained at the party. At about 6:50pm Mr Horsman telephoned their house and spoke to Jason. There was nothing unusual about Jason's demeanour during the call. In fact, Jason and his father shared a joke during their conversation. It is evident that

[2] Exhibit C13a

Jason was alone at the premises from that time forward until his act of hanging. Jason was discovered when his family returned from the friends' premises at around midnight. I mention these circumstances in some detail because in the course of Jason's treatment during that year, his being at home alone on a Saturday evening had been identified as a recurring scenario in which Jason was possibly at his lowest ebb and one which might have been avoided. More of that later.

2. Background

2.1. Jason's parents were Mr David Horsman and Ms Wendy Hugo. Jason was born on 20 July 1995. At the time of his death in October 2010 he was in Year 10 at Mount Barker High School. Jason's sole sibling was a younger sister.

2.2. The evidence and statements of Mr Horsman, Jason's father, suggest that it was in late 2009 and early 2010 when Jason's behaviour became problematic. In December 2009 Jason was referred to the Child and Adolescent Mental Health Service (CAMHS) in respect of his parents' concerns at that time. There is a referral to CAMHS contained within the clinical record of Southern Mental Health, Southern CAMHS which is dated 2 December 2009 as well as a client registration form dated 2 and 3 December 2009 that records information apparently imparted by one or both of Jason's parents to the effect that Jason had been bickering with his mother for 12 months or so, that he felt angry or sad all of the time and he cried. The document refers to Jason using a punching bag to deal with stress and that although he was said to be ambivalent about therapy, his mother believed that he would 'come along to CAMHS'[3]. The same document refers to a family history of depression which I understand is a reference to Jason's mother having been on antidepressant medication for some years.

2.3. Notwithstanding that the referral took place in December 2009, Jason did not see any of the therapists at CAMHS Mount Barker office until February of the following year. In the intervening period an incident occurred that involved Jason's alleged participation in the theft of money from premises in Macclesfield. This had occurred in January. Jason's father told the Court that the incident was complicated by the later discovery of damage to a vehicle on that property and of Jason's possible implication, together with other boys, in that damage. Jason's personal culpability, if any, in the theft or the property damage was not clearly established at the time, but Mr Horsman

[3] Exhibit C11, page 9

told the Court that these events, and the idea that Jason might be sent to prison, which of course would not have occurred, preyed on Jason's mind notwithstanding that the matter was never placed in the hands of the police. Jason's parents grounded him for the first school term of 2010. However, in an attempt to establish peace at home his grounding had to be lifted in March because of his verbally aggressive behaviour towards his mother that included shouting and other intimidating behaviour. Jason's school grades noticeably deteriorated throughout 2010. There was some truancy. According to his mother, Jason's friends also noticed adverse changes in him.

2.4. Jason's father described other negative incidents involving Jason during the course of 2010 that I will mention later.

2.5. Jason's worsening behaviour in 2009 and 2010 was out of character with previous behaviour in childhood.

2.6. It is against this background that Jason and his mother began consulting CAMHS, school counsellors at the Mount Barker High School and a general practitioner. In the months that followed it is clear that Jason's condition failed to improve, and if anything his behaviour became even more problematic. This Inquest examined the question as to whether more could have been done for Jason in the course of his and his parent's interaction with these entities and whether his death by his own hand may have been prevented.

3. Child and Adolescent Mental Health Services

3.1. In 2010 CAMHS occupied an office in Mount Barker. As I understood the evidence this was one of a number of offices incorporated within Southern Mental Health. The staff of CAMHS at Mount Barker included counsellors, psychologists, mental health nurses, a psychiatrist and administrative staff. At the time with which this Inquest is concerned the most senior administrative staff member at the Mount Barker office was a psychologist, Ms Robyn Duckworth, who is the Regional Manager of CAMHS for the Hills and Murraylands regions. Ms Duckworth had administrative responsibility not only for the Mount Barker office, but also for other offices in the regions. CAMHS as a whole had a number of psychiatrists employed within it. The Mount Barker office had the one psychiatrist who was employed on a 0.5 basis, meaning that she worked at the Mount Barker office three days one week and two

days the following week. This person was Dr Susan Shannon, a medical practitioner who received her basic medical qualifications in 1974 and who completed her psychiatric training in 2006 with further advanced training in child and adolescent psychiatry completed in 2008. In addition to working 0.5 at Mount Barker, Dr Shannon worked one day a week at a Murray Bridge facility known as Headspace which was a private practice. Although Dr Shannon was the senior clinician at the Mount Barker office, it appears from the evidence that I heard that she, along with other clinicians, were subject to the administrative oversight of Ms Duckworth, the psychologist. Dr Shannon would not see Jason Hugo-Horsman until August 2010 at a time after Jason's usual therapist, a social worker, went on leave. In August Jason was involved in four face-to-face sessions with Dr Shannon, the last of which occurred in the presence of his father. As things transpired, Dr Shannon's final consultation with Jason, which occurred at the end of August, would be the final occasion on which Jason would be seen by a CAMHS therapist prior to his death in October. To all intents and purposes Jason disengaged himself from the service after that final consultation with Dr Shannon.

3.2. From February 2010 to late July/early August 2010 Jason was seen by one of the CAMHS Mt Barker office's social workers, Ms Vina Hotich. Ms Hotich conducted a number of sessions with Jason, sometimes with his mother, at the Mount Barker office. The therapy consisted for the most part of cognitive and other therapy that did not provide any discernible therapeutic benefit to Jason.

3.3. During the course of Jason's engagement with CAMHS at Mount Barker there were a number of cancelled sessions.

3.4. The true nature of Jason's difficulties was never the subject of formal diagnosis.

3.5. At no stage was Jason prescribed antidepressant or antipsychotic medication during his engagement with CAMHS. However, Dr Shannon at one point prescribed Jason with the sedative, diazepam.

3.6. I will deal in more detail with Jason's involvement with CAMHS later in these findings.

4. The Littlehampton Medical Centre

4.1. The Littlehampton Medical Centre (LMC) was situated at all material times at premises in North Terrace, Littlehampton which is the closest town to Mount Barker. The clinical record concerning Jason's interaction with that practice was tendered to the Inquest[4]. It appears from the record that over the years Jason had consulted doctors at that practice about various medical issues.

4.2. There is no reference in the LMC record to any emotional disturbance on the part of Jason until a presentation on 27 April 2010 when he saw Dr Boris Eskandari-Marandi. He also saw Dr Eskandari-Marandi on 28 June 2010 and on 20 September 2010. He saw another doctor in connection with this issue on 17 June. All of these consultations bar the last occurred during the currency of Jason's engagement with CAMHS at Mount Barker.

4.3. In the event there was no interaction between the doctors of this medical practice and CAMHS about Jason.

4.4. Dr Eskandari-Marandi gave oral evidence at the Inquest.

5. Mount Barker High School

5.1. In 2010 Jason was in Year 10 at Mount Barker High School.

5.2. There were two staff members of the Mount Barker High School who provided counselling services to students. They were Mr Andrew Dunn and Mr Andrew Amberg. Both of these gentlemen provided statements to police and gave evidence in the Inquest[5]. Following Mr Dunn's oral evidence to the Court, he provided a further statement[6]. The Mount Barker High School file relating to Jason was tendered[7]. The file included counselling notes made by Mr Dunn.

5.3. Jason saw both Mr Dunn and Mr Amberg at different times in 2010. As well, it appears that some of Jason's diazepam prescription tablets were made available to the school for the purposes of administration to Jason on an as needs basis.

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[4] Exhibit C12
[5] Exhibits C17 and C18
[6] Exhibit C17b
[7] Exhibit C9

5.4. As will be seen, Mr Dunn appears to have developed a rapport with Jason. Jason would tell Mr Dunn some detail of his thought processes and emotional difficulties. There were two occasions in 2010 on which Mr Dunn felt concerned enough about Jason's frame of mind to have telephoned CAMHS.

5.5. I say here that aside from incomplete note taking by Mr Dunn and Mr Amberg, which did not have any bearing on the outcome here, there can be no criticism of the manner in which they engaged with Jason.

6. Jason Hugo-Horsman sees CAMHS

6.1. Jason was seen for the first time at the CAMHS office in Mount Barker on 11 February 2010. On this occasion he attended with his mother and was seen by Ms Hotich who is a social worker at CAMHS. Ms Hotich gave evidence in the Inquest. As well, in December 2010 she had provided a statement to investigating police[8]. Ms Hotich's CV was tendered to the Inquest[9]. She has a Bachelor of Social Work that was attained from Flinders University in 2001. Her CV describes certain other qualifications and relevant training that includes training in the '*early identification of psychosis in young people*', a one day course in 2009. There are other training instances mentioned in the CV including training related to suicide risk assessment and suicide intervention. Ms Hotich has been a part time clinical social worker with CAMHS at Mount Barker since September 2009. As a social worker Ms Hotich was not able to prescribe medication. If medication needed to be prescribed in respect of any client, it would have to be prescribed by a medical practitioner which of course would include the part-time psychiatrist, Dr Shannon, to whom I have already referred. Ms Hotich was qualified to administer a number of therapies including cognitive behavioural therapy.

6.2. As I understood the evidence the decision to assign Jason's case to a social worker, and in particular to Ms Hotich, would have been made at a meeting conducted prior to Jason first being seen. Thus the decision to assign Jason to a social worker as distinct from another type of CAMHS therapist would have been made before any person at CAMHS had any personal contact with him. This is not to say that in an appropriate case a client might not at some point be reassigned to a different therapist, but in respect of Jason, Ms Hotich would continue to see him in her capacity as a counsellor

[8] Exhibit C14a
[9] Exhibit C14

until she went on leave for a number of weeks towards the end of July 2010. At no stage during the course of Ms Hotich's engagement with Jason did she consider referring Jason to another more qualified therapist until her leave was imminent.

6.3. Ms Hotich saw Jason at the CAMHS office at Mount Barker on a number of occasions between February and July 2010. The dates of those meetings were 11 and 25 February 2010, 6 and 14 May 2010, 17 June 2010 and 2 and 23 July 2010. That last date was the day before Ms Hotich commenced four weeks leave. She did not see Jason again after that date. In addition to Ms Hotich seeing Jason himself, she also separately saw Jason's mother on the first occasion of 11 February 2010. The same occurred on 25 February 2010. On 18 March 2010 Ms Hotich saw Jason's mother on her own. It is noted that Jason was meant to attend on that occasion but did not. In fact it was indicated on that occasion that Jason did not want to come in any more. There was, as is noted in the CBIS client summary, a further refusal to attend on 8 April 2010. Ms Hotich saw Jason's mother again on 29 April 2010 at which meeting Jason's mother told Ms Hotich that she had taken him to a doctor. Ms Hotich saw Jason's mother in an 'emergency appointment' on 28 May 2010. On that day Jason was meant to attend but did not attend. Ms Hotich also saw Jason's mother on 17 June 2010 after Jason himself had been spoken to on the phone on 10 June 2010 and indicated he did not want to come in on that day. I will refer to the events of 10 June 2010 in more detail later in these findings.

6.4. Thus it is that Ms Hotich had face to face contact with Jason on seven occasions. There were a number of telephone contacts which, for the most part, were about Jason's failures to attend on other occasions.

6.5. It is clear when one examines the engagement between Jason, his mother and Ms Hotich, that the engagement and the therapy that it provided was superficial and did not produce any meaningful improvement in Jason's frame of mind or behaviour. As will be seen, if anything, Jason's frame of mind and behaviour worsened after Ms Hotich stopped seeing Jason at the end of July 2010. Jason did not see any other therapist at CAMHS during the period during which he was seeing Ms Hotich. In this regard I should refer here to the National Institute for Health and Clinical Excellence reference guide dated September 2005 entitled 'Depression in children and young

people - Identification and management in primary, community and secondary care'[10]. This document was promulgated in the United Kingdom in 2005. It can be referred to in these findings as the NICE guidelines. It refers to an entity called CAMHS which, to begin with, was confusing because the reference to CAMHS is not a reference to the South Australian entity of the same name. The CAMHS mentioned in the document is a mental health authority in the United Kingdom. Nevertheless, there appears to have been a measure of adoption in respect of some of these guidelines by CAMHS South Australia. The document was received in evidence primarily to illustrate accepted policies in respect of the prescription of antidepressant medication to adolescents, but it also deals with other therapies short of prescribing such medication. It refers to a number of tiers of management, some of which contemplate the conducting of a multidisciplinary review of the patient/client. I was told during the course of the Inquest that although there was provision for the conducting of multidisciplinary reviews within CAMHS in South Australia, they did not occur as such with any degree of regularity, or possibly at all, in the course of a client's engagement. Ms Hotich told the Court that as far as she was concerned multidisciplinary team reviews simply did not occur in 2010[11], but that at her discretion she could involve a therapist from '*another discipline*' in a client's case[12]; whereas Dr Shannon said that they did occur but in limited circumstances[13]. No such review occurred in Jason's case which represents a missed opportunity for more effective management of his difficulties. The NICE guidelines also suggested that alternate therapies such as those that might be provided within CAMHS South Australia by counsellors and psychologists would be administered for at least three months or within four to six sessions before further review. Although during the course of this Inquest the applicability of this document to the South Australian position remained not entirely crystal clear, there certainly appears to have been some adoption of the three month or four to six session guideline before consideration might be given to therapies other than those provided by social workers or psychologists. In particular it appears from these guidelines that medication would not be offered or considered until those guidelines had been fulfilled. There appears to have been a measure of slavish adherence to this aspect of the guidelines by CAMHS South Australia, regardless of whether or not this document had formal

[10] Annexure CADS- 3 attached to the affidavit of Clive Arthur David Skene, Exhibit C16
[11] Transcript, page 227
[12] Transcript, page 171
[13] Transcript, page 440

applicability to CAMHS in this State. As an illustration of this, Ms Hotich saw Jason for a period in excess of three months and for greater than four to six sessions before she considered introducing a more qualified therapist into his matter, and even then only when she went on leave. I will deal with the appropriateness of that when examining the expert evidence that was provided to the Court by experienced and independent clinical psychiatrists who reviewed Jason's case.

6.6. I now deal with Jason's engagement with CAMHS in some detail, and in conjunction with his interaction with his general practitioner and his school counsellors. As indicated earlier, the first engagement between Ms Hotich and Jason occurred on 11 February 2010 on which occasion Ms Hotich also saw Jason's mother, Ms Wendy Hugo. On this occasion both Jason and his mother completed a 'Strengths and Difficulties' questionnaire. For the most part the information about Jason's frame of mind came from his mother whom Ms Hotich recorded as having said that she had first contacted CAMHS after many weeks of arguing with Jason. There had been sullenness and moodiness and difficulty getting him to school on time. Ms Hugo had described him as not participating in family life. She also described him as feeling sad and angry at the same time, all of the time. She referred to the recent incident involving the house break-in and the associated alleged stealing and vandalism. She also reported that Jason had tried to be physically intimidating towards her and had sworn at her. On this occasion Ms Hugo was noted to have stated that she had not taken Jason to a general practitioner as she did not '*want him medically diagnosed*'. This sentiment was one which Ms Hotich would have been liable to embrace having regard to her own philosophy in respect of the services that CAMHS provided and of her perception of the philosophy of her employer. For instance, she told me in evidence that she believed that CAMHS' philosophy was that diagnosis of mental illness was not meant for people under 18 years of age and that they did not consider themselves:

> '… to work in a medical setting, we consider ourselves to work in a therapeutic setting with a focus on, things are not good right now but they can get better again and that's (sic) seems to work very well with families with children and adolescents.' [14]

6.7. In her witness statement Ms Hotich stated that in her opinion Jason was somewhat difficult to engage with on this first occasion. He would sit with his arms folded,

[14] Transcript, page 224

would look out of the window and had little eye contact. I note from Ms Hotich's handwritten notes of the consultation with Jason[15] that there does not appear to have been any information of consequence imparted by him during the course of that consultation, or at least anything that was out of the ordinary for an adolescent.

6.8. On this occasion Ms Hotich conducted a service plan report[16] that summarised Jason's '*Current Functioning*' as including '*parenting adolescence issues*', describing him in these terms:

> 'Moody teenager. Some risk taking (he participated, with peers, in a possibly criminal act, late last year). Issue has been addressed.'

The section entitled Current Treatment Goals stated the current aim to be:

> 'Increased knowledge and understanding of adolescence, info re parenting teenagers. Family directed negotiations re rules and boundaries.'

6.9. Ms Hotich also conducted a written risk assessment[17] that described the risk of '*harm to self*' as '*significant*'. The overall assessment of risk was stated on this document to be *'high'* with the details of the clinical judgment relating to that assessment as being '*with a family history of depression and Jason's high level of risk taking and emotional disturbances, the risk is deemed to be somewhat between medium to high*'. In her oral evidence before the Court, Ms Hotich explained that there had been several risk factors that had concerned her in respect of Jason that caused her to believe that she needed to see Jason again in the near future. She stated that she had rated the risk of self-harm as significant because he had been in significant trouble with the law and that he was only 15. In addition, she had information that he had been in a fight which could also have involved him getting into trouble with the law and also with his school, where she believed the fight had started. So there was a risk of suspension and disengagement from school and, given his intense emotionality and family history of depression, she regarded his risk as high. Ms Hotich stated to the Court that from the time that she first saw Jason she had always regarded the risk as significant and high[18].

6.10. The risk assessment document that was compiled at this first meeting with Jason is a dedicated risk assessment tool that is on the CAMHS computerised CBIS system.

[15] Exhibit C11, page 53
[16] Exhibit C11, page 10
[17] Exhibit C11, page 11
[18] Transcript, page 88

The same applies to the service plan report that sets out the care plan for Jason[19]. These were the only such documents completed during the course of Jason's engagement with CAMHS. In her oral evidence about her risk assessment made on the first occasion, Ms Hotich did not suggest that she believed that Jason had been at risk of physically harming himself, notwithstanding that in her description of the risk as set out in the risk assessment document her use of the word '*significant*' was used in respect of *'risk of harm to self'*.

6.11. The second session that involved personal contact between Jason and Ms Hotich occurred on 25 February 2010. Again Jason's mother attended. She was seen alone in the first instance in what Ms Hotich has described in her handwritten notes as '*a long session*'. Indeed, the notes in relation to her discussion with Ms Hugo are significantly longer and more detailed than those in relation to her session that day with Jason. In her notes in respect of her session with Ms Hugo, Ms Hotich has set out advice as to the altering of parenting strategies and in respect of setting wider boundaries. There is also reference to a suggestion that the whole of Jason's family should undertake meditation sessions with her to which Ms Hugo indicated that this might be especially useful for her daughter. In the notes regarding her session with Jason alone there appears to be further discussion about his family dynamics for the most part and his annoyance at being grounded at that point in time. It is not at all easy to see what therapeutic benefit was imparted or derived as far as Jason is concerned.

6.12. Ms Hotich did not see Jason again until 6 May 2010. In the intervening period Ms Hotich had seen Jason's mother personally and had been advised that Jason had not wanted to attend. As well, he had refused to attend early in April 2010. On 29 April 2010 Jason's mother had advised Ms Hotich by phone that she had taken Jason to their doctor who had encouraged Jason to re-engage with CAMHS.

6.13. Jason had seen Dr Eskandari-Marandi on 27 April 2010. In Dr Eskandari-Marandi's clinical record of that consultation he noted that Jason had poor concentration at school and had experienced outbursts at home. He also indicated that he had been in trouble with a bad group of friends. Significantly Jason indicated to Dr Eskandari-Marandi that he had been to CAMHS but '*did not see the point*'[20]. This would not be

[19] Exhibit C11, page 10
[20] Exhibit C12, page 3

the only occasion on which Jason indicated that he felt that he was deriving no benefit from his engagement with CAMHS. Dr Eskandari-Marandi noted that he advised Jason to stop consuming energy drinks and alcohol, and not to smoke. He also suggested to Jason that he re-engage with CAMHS and speak to the school regarding his poor concentration. Dr Eskandari-Marandi noted an intention to review Jason if there was no improvement. Dr Eskandari-Marandi would again see Jason on 28 June 2010 and 20 September 2010. Another doctor at the practice would see him on 17 June.

6.14. Jason saw CAMHS again on 6 May 2010 when he had an individual session with Ms Hotich. In her witness statement Ms Hotich describes this session as a very good session in which Jason seemed interested and engaging. Two pages of notes describe his anxiety and panic attacks, difficulty sleeping with nightmares and waking feeling scared. He also described anger and a desire to fight with people. He described physical symptoms such as copious sweating, shaking, feeling faint, an inability to walk straight and feeling no pain. In addition he described twitchiness, dizziness and wobbly legs. Ms Hotich recorded that Jason was keen to continue the assessment '*of what goes on inside his head*' and indicated that he would return next week. She noted that she explained to him the usefulness of calming exercises and a need to practice them. It was apparent that on this occasion for the first time Jason enquired about medication with a notation by Ms Hotich to the effect that CAMHS more commonly does not suggest medication. Ms Hotich in her statement also states that she advised Jason that there were a number of proven strategies to deal with his problems before medication needed to be considered. By this stage Jason had been seeing CAMHS for nearly 3 months.

6.15. The next session that Ms Hotich conducted with Jason occurred on 14 May 2010. On this occasion Ms Hotich describes Jason as having been more forthcoming about himself, especially about his low esteem, shyness and avoidance behaviours. On this occasion Ms Hotich conducted what is known as a Depression Anxiety Stress Scale (DASS). As explained in her statement Ms Hotich said that she administered this test for the most part because Jason seemed to want a clinical assessment of his problems and this appeared to be a means to demonstrate to him that she took his concerns seriously. In her oral evidence in Court, Ms Hotich further explained that in order to keep Jason engaged, she perceived a need on Jason's part to validate what he was

worried about. It is apparent that Jason's own scepticism in the value of his engagement with CAMHS, and the pointlessness to him of that engagement, becomes a recurring theme. On this occasion, as described by Ms Hotich in her statement, Jason appeared to be somewhat impatient in respect of the measures with which Ms Hotich was endeavouring to provide Jason including breathing relaxation exercises. She could detect his impatience from his tone of voice and body language. I have already mentioned the fact that at the end of April 2010 Jason had told Dr Eskandari-Marandi that he had been to CAMHS but had not seen the point of it. As will be seen, in due course Jason expressed his views as to the pointlessness of even seeing the psychiatrist when this took place in August, such that he chose to disengage himself from the service once and for all.

6.16. The DASS assessment conducted on 14 May 2010 involved a list of 42 propositions that the subject person of the test could signify disagreement with or agreement with at certain levels. Ms Hotich had to consult one of the CAMHS psychologists at Mount Barker to interpret the results. As it transpired, the test in Jason's case was rated as severe for stress, extremely severe for anxiety and extremely severe for depression. I cite some examples of Jason's responses. The proposition that Jason '*felt sad and depressed*'[21] elicited a response from him to the effect that the proposition applied to him to a considerable degree or for a good part of the time. There were similar less than encouraging responses to propositions such as whether he had lost interest in just about everything, as to his worth as a person, whether life was not worthwhile, whether he was very irritable, close to panic and in respect of his enthusiasm about things. Indeed, it is fair to say that in respect of just about every proposition, Jason furnished very negative responses. The utility of this test was the subject of evidence during the course of the Inquest and some of the evidence suggested that it is a test that has limited value, is not commonly used in general, and not commonly used by psychiatrists in particular. Be that as it may, the test could have signified nothing positive or encouraging about Jason's frame of mind as of mid May 2010. Nor was it in any way consistent with any improvement since Jason first started seeing CAMHS in February.

[21] Question 13

6.17. Ms Hotich's notes of the consultation of 14 May 2010 reveal that Jason had experienced a panic attack and was worried about having another, and it revealed his stress at being involved with a girl who lived too far away from him. He also referred to the '*crazy things going on in his head*'. The therapy that appears to have been administered includes breathing exercises in respect of which Jason indicated that he would '*try+ practice that*'. At this point it was just over 3 months since Jason had first engaged with the service.

6.18. On 28 May 2010 Ms Hotich saw Jason's mother in what has been described in the CBIS client summary as an *'emergency appointment'*. Jason had been scheduled to attend during that afternoon but failed to attend. On this occasion Jason's mother told Ms Hotich of Jason's occasional cutting behaviour and of escalating negative behaviour generally, that included verbal abuse and a wrestling episode between herself and Jason that had occurred the previous night. Jason's mother told Ms Hotich that Jason had a swastika scar on one of his wrists and that he had purchased a 'flick' knife. As to Jason's appointment that day, Jason's mother told Ms Hotich that he had told her that '*he did not want to come here*'[22].

6.19. I have referred to the involvement of staff at Mount Barker High School. On 28 May 2010, the day on which Jason was meant to see Ms Hotich at CAMHS, Jason presented to Mr Andrew Dunn, a counsellor at the Mount Barker High School. Mr Dunn prepared approximately one page of typewritten notes in respect of this meeting. Jason mentioned the fight with his mother of the night before and how it had become physical and had involved wrestling. He mentioned a relationship with a girl from Noarlunga. He told Mr Dunn that he felt very sad all of the time but was not sure of the reason for this. He described highly emotional behaviour in which Jason said that he was liable to breakdown and cry and stayed away from school in order to avoid the resulting embarrassment. He told Mr Dunn that he was seeing Ms Hotich from CAMHS but that he had not been regularly attending because he felt it was not '*going anywhere*'. He mentioned that he had anxiety and depression and in particular experienced anxiety attacks. Mr Dunn noted that he strongly encouraged Jason to keep his appointments with CAMHS because of their greater qualifications than his, and the fact that he had been referred to CAMHS meant that he required more professional assistance than Mr Dunn could provide. It is worthwhile observing that

[22] Exhibit C11, page 40

Jason appears to have been more open with Mr Dunn in this one session than with Ms Hotich in multiple sessions with her so far. Mr Dunn became concerned about Jason and, as will be seen, acted on these concerns on more than one occasion.

6.20. Following his 28 May meeting with Jason, Mr Dunn spoke in person with Jason's mother, Ms Wendy Hugo, he believes '*a couple of days after 28 May 2010*'[23]. It will be remembered that that date was the most recent occasion on which Jason's mother and Ms Hotich had met in the absence of Jason who had declined to attend CAMHS that day. It is obvious that Ms Hugo's meeting with Mr Dunn was reflective of Ms Hugo's escalating level of concern in relation to Jason, concern that she had expressed to Ms Hotich in person. At her meeting with Mr Dunn, Jason's mother expressed her anxiety about Jason's mental health and general behaviour, and in particular his self-harming which she described as '*scratching*' with a knife. She was seeking advice from Mr Dunn as to what she could do. Mr Dunn suggested a mediated or mutual meeting between Jason and his parents. The salient feature of the meeting between Ms Hugo and Mr Dunn was the request by Jason's mother for Mr Dunn to assess Jason's level of risk and in particular whether the self-harming behaviour by way of scratching with a knife could develop into something more. Mr Dunn's noted response had been that it was difficult to say as by that stage he had only met Jason on the one occasion, but he noted that he told Jason's mother that he felt at that time that Jason was at significant risk.

6.21. In his witness statement[24] Mr Dunn explained that he believed Jason was at significant risk because he seemed to be overwhelmed with the issues in his life that included the breakdown in the relationship with his mother, lack of engagement at school and exclusion from his social group with a lack of coping strategies. The fact that there had been a physical confrontation between Jason and his mother concerned Mr Dunn. Mr Dunn stated that he attempted to arrange a mediation meeting with Jason and his family but it did not take place.

6.22. Mr Dunn gave oral evidence. I found him to be an impressive and careful witness and a genuine and dedicated counsellor. I accepted his evidence. Following his separate discussions with Jason and Jason's mother in late May 2010, Mr Dunn telephoned Ms Hotich at CAMHS on 10 June 2010 and expressed the concerns that by then had been

[23] Exhibit C9, page 14
[24] Exhibit C17

developing in his mind about Jason. When Mr Dunn gave evidence at Inquest, he no longer had any recollection of this communication, and he had not made a note of the discussion. However, Ms Hotich made notes of their conversation, so there is no question but that this discussion had occurred. Ms Hotich noted that Mr Dunn said that he was very concerned about Jason in terms of issues that he identified as self-harming, suicidal thoughts and truancy. He referred to his proposed mediation meeting that had not come to pass. Ms Hotich noted that it was agreed with Mr Dunn that they would be in touch as needed and it appears to have been understood between them that they would both attempt to see Jason on a weekly basis, at least until the current 'crisis' had eased. Following this telephone call from Mr Dunn, Ms Hotich rang Jason and attempted to see him but was met with the response from Jason that he was sick that day and did not want to come in. He indicated that he was willing to come in the following week and assured Ms Hotich that he would be '*okay until then*'[25].

6.23. Ms Hotich did see Jason a week later on 17 June 2010. Ms Hotich also saw Jason's mother on the same occasion. I note that on the same day Jason and his mother attended the Littlehampton Medical Centre and on this occasion saw a Dr Andrew Bigwood. It appears from Ms Hotich's notes that the doctor's appointment had occurred prior to her own consultation. The notes of Dr Bigwood's consultation suggest that certain information was imparted to him about Jason, although it is not clear whether it was furnished by Jason or his mother, as it appears that Ms Hugo was seen separately. In any event what was described to Dr Bigwood was behaviour that included some self-harm, involving the carved swastika on Jason's arm. Jason himself appears to have told Dr Bigwood that he had been vomiting, had low energy such that everything was an effort, and that he was depressed with poor concentration. Dr Bigwood noted that Jason had negative thoughts, although was not suicidal. A plan was devised that included cessation of alcohol and the imparting of advice regarding his lifestyle. There is an oblique clinical note to a possible psychiatry reference. No medication was prescribed.

6.24. At Ms Hotich's meeting on the same day Jason advised her that his moods had not really changed but that he had been doing some breathing exercises and was using strategies involving thoughts about happy things. He indicated that he was sleeping

[25] Exhibit C11, page 5 – CBIS Client Summary dated 10 June 2010

better. This made Ms Hotich think that Jason was perhaps moving forward. There was some discussion about cognitive strategies. As far as Jason's frame of mind was concerned he indicated that he felt '*mopy*' all the time with no energy and that everything was almost too big an effort. He also mentioned his anger at home. In Ms Hotich's witness statement she indicated that she suspected on this occasion that he was not all that interested and was bored with the topic of cognitive strategies. There is good reason to believe that her impression is completely correct.

6.25. The appointment on 17 June 2010 with Ms Hotich was the first appointment since Mr Dunn of the Mount Barker High School had spoken on the phone to Ms Hotich about his concerns regarding Jason self-harming and having suicidal thoughts. I do not see in Ms Hotich's notes of her session with Jason anything relating to Mr Dunn's stated concerns of the week before. There is no inquiry nor response noted in relation to the issue of self-harming nor of suicidal thoughts and in particular whether Jason had entertained such thoughts. She noted that she did show him his DASS results and explained them to him. There is no note of the explanation that she gave. In her oral evidence Ms Hotich agreed that the information from the school counsellor, Mr Dunn, represented the first occasion on which the topic of suicidality had been mentioned in relation to Jason[26]. Mr Griffin, counsel assisting, asked Ms Hotich in cross-examination when it was that she thought that things were progressing beyond her own capabilities. To this Ms Hotich answered:

> 'It's hard to pinpoint. Maybe around the time of when the school counsellor rang.' [27]

Ms Hotich explained that her impression was that the school counsellor had been informed of Jason's suicidality by concerned students at the school. Ms Hotich agreed with Mr Griffin that if Jason had been suicidal it would be something that would be quite beyond the assistance that a school counsellor could provide[28], and when asked as to whether she agreed that it was something quite beyond what she herself could provide, she said:

> 'It would be the point that I should consider a referral to the psychiatrist.' [29]

[26] Transcript, page 210
[27] Transcript, page 209
[28] Transcript, page 210
[29] Transcript, page 210

Ms Hotich stated that '*in theory*'[30] she could have made such a referral to some other person in her establishment, such as one of her senior colleagues or the psychiatrist[31]. She was asked these questions in cross-examination and gave the following answers:

'Q. Is there any reason why you didn't do that on this particular occasion.
A. I don't know, I don't have an answer for that, really.
Q. I'm sorry.
A. I don't know.' [32]

As things transpired, no further consideration was given to the recruitment into Jason's matter of a more senior colleague or the psychiatrist for over a month. Incredibly, Ms Hotich admitted in her evidence that at her session with Jason on 17 June 2010 she did not ask Jason about suicidal ideation. She acknowledged that it would have been natural to have asked him whether he had been experiencing any suicidal ideation and she accepted that she should have asked him that[33]. In the notes that Ms Hotich made of her session with Jason's mother on the same day there is also no evidence of any exploration with her of the subject of suicidal ideation.

6.26. The notes of further sessions that Ms Hotich conducted with Jason and/or his mother do not provide any evidence of inquiry on her part concerning suicidal ideation.

6.27. Ms Hotich saw Jason and his mother next on 2 July 2010. In the intervening period Jason had been to see Dr Eskandari-Marandi. This doctor's appointment had occurred on the morning of 28 June 2010. On this occasion Jason had reported to Dr Eskandari-Marandi that he was no better, was still tired with interrupted sleep and had poor concentration. The doctor noted that there were superficial cuts to the wrist and that Jason had been self mutilating. He noted that Jason would be teary and cried and was easily irritated. Dr Eskandari-Marandi also noted that Jason was seeing the counsellor at CAMHS and that a *'psychiatrist'* had been consulted. This in fact was not the case as Jason was still seeing only Ms Hotich; Jason's seeing a psychiatrist had not been discussed at that point. Dr Eskandari-Marandi's notes as to his suggested management included an entry that Jason should continue with the counsellor and that he himself would contact CAMHS '*re ? management*'. I observe that at the CAMHS appointment of 2 July 2010, that was to take place after this

[30] Transcript, page 210
[31] Transcript, page 211
[32] Transcript, page 211
[33] Transcript, page 235

medical appointment, Ms Hugo, as noted by Ms Hotich, told Ms Hotich that 'Dr Boris' of the Littlehampton practice wanted to talk to CAMHS, with the added notation '*(Will try next wk.)*'.[34] In the event there would be no communication between Dr Eskandari-Marandi and CAMHS either next week or at all.

6.28. In his evidence Dr Eskandari-Marandi told the Court that at the 28 June appointment he believed that Jason's state had deteriorated since he had last seen him[35]. He had not received any correspondence from CAMHS nor the psychiatrist whom he appears to have erroneously believed was already involved in Jason's management. His assumption was that Jason and his mother had returned to consult him because he was not getting better[36]. Basically, Dr Eskandari-Marandi was planning to touch base with CAMHS to see whether medications were being considered, to ascertain what their plan was and to '*make sure we are all on the same page*'[37]. As to why Dr Eskandari-Marandi did not in the event contact CAMHS, he stated in evidence that there were teething problems with a new building that they were occupying and that he was distracted at that time. Dr Eskandari-Marandi told the Court that he would have liked the opinion of a psychiatrist particularly in relation to the question of medication[38]. He said that as a general medical practitioner he would not have been confident enough to prescribe antidepressant medication for an adolescent. When asked as to what attitude he might have adopted if he had known on 28 June 2010 that Jason had not in fact seen a psychiatrist by that time, Dr Eskandari-Marandi said that he would probably have suggested initiating a psychiatric consult[39]. When asked as to why at that point his presentation warranted psychiatric assessment as distinct from the therapy that might be provided by a CAMHS counsellor, he said:

> 'I think just his deterioration in his mental state, he was more agitated, his sleep still wasn't good, his level of frustration had gone up because he had started cutting himself. He was teary.' [40]

6.29. On 28 June 2010 Dr Eskandari-Marandi considered Jason to be depressed and that Jason's mental state had reached a stage where a psychiatrist's opinion as to whether

[34] Exhibit C11, page 33
[35] Transcript, page 120
[36] Transcript, page 120
[37] Transcript, page 120
[38] Transcript, page 128
[39] Transcript, page 130
[40] Transcript, page 130

medication would be appropriate needed to be obtained[41]. But Dr Eskandari-Marandi's assumption at that stage was that Jason had been seeing two types of therapist at CAMHS, a counsellor as well as a psychiatrist, and his further assumption had been that having noticed Jason's deterioration, his counsellors had instigated a psychiatric review through CAMHS[42]. Dr Eskandari-Marandi acknowledged that if he had contacted CAMHS as he had planned, he inevitably would have established that at that point in time, contrary to his belief, Jason had not been seeing a psychiatrist[43]. It therefore seems reasonable to infer that if Dr Eskandari-Marandi had contacted CAMHS and had spoken to Jason's counsellor, he would have recommended, firstly, that a psychiatric review should take place and, secondly, that medication should be considered by the psychiatrist. In that event it seems to the Court that it would have been very difficult, in the face of such medical advice, for a counsellor such as Ms Hotich to have resisted such a suggestion. Dr Eskandari-Marandi's failure to contact CAMHS represents something of another missed opportunity to have altered the chain of events that was to unfold.

6.30. To summarise Dr Eskandari-Marandi's position, if he had contacted CAMHS he would have enquired to see if CAMHS had appreciated that Jason had not improved and, if anything, had declined[44], to see if they were aware of his cutting behaviour and increased level of frustration and whether that had been addressed or not. He would have established that no psychologist or psychiatrist had been consulted and that Jason had simply been seeing a counsellor, a matter that Dr Eskandari-Marandi acknowledges would have surprised him[45].

6.31. On 2 July 2010 Jason reported to Ms Hotich that he had no energy and that it was hard to get out of bed. He indicated that nothing had really changed. He said that he gets '*pissed off*' at everything. The notes of this session indicate that Jason harboured regrets about a relationship with a girl and had issues in respect of his own self image. On this occasion it appears Jason enquired about medications for sleep and anxiety. In her statement Ms Hotich says that he was not really interested in strategies about how to stop automatic negative thoughts and about relaxation techniques.

6.32. A further appointment for 9 July 2010 was not kept by Jason.

[41] Transcript, pages 130-133
[42] Transcript, page 134
[43] Transcript, page 134
[44] Transcript, page 148
[45] Transcript, page 148

6.33. Jason attended an appointment at CAMHS on 23 July 2010 which was the last occasion on which Jason saw Ms Hotich. Jason said that things were still not better and that he felt angry and had experienced mood swings. He described instances of feeling like crying and of waking up and feeling miserable. He also expressed feelings of loneliness. He stated that he had performed some self-harming a couple of weeks before. He says that he found this enjoyable as it gave him an energy burst and made him feel removed from everything. He indicated that he sometimes thought that he should have scars as a result. He described concentration problems, particularly in the classroom. As far as his emotion was concerned she noted that he was sad, lonely and wanting to get away. Jason described his loneliness as being 8 to 9 out of 10. On this occasion Jason indicated that he was not convinced that he did not have bipolar disorder. He asked about medication and in her statement Ms Hotich states that she obtained the impression that he firmly believed that a pill would fix his problems. On this occasion Ms Hotich offered him a different intervention strategy called Emotional Freedom Technique that involves the use of fingers to tap on certain acupuncture points on the body, combined with positive affirmation and bilateral eye movement. She performed that with him and this appeared to reduce his sense of loneliness from 8 to 9 out of 10 to about 2 out of 10. Jason indicated that he was happy to perform more of this activity on the next occasion. Ms Hotich explained to Jason that she was about to go on leave for four weeks and that she would refer him to their psychiatrist for continuing support, but also for an assessment for bipolar. She also explained that the psychiatrist was the person who would be able to prescribe medication and that he should speak to her about that subject. Her final note of that final session with Jason indicates that at that time she was not sure if Jason would in fact see Dr Shannon.

6.34. In that final session with Ms Hotich on 23 July 2010 Jason indicated to her that usually his biggest mood swings occurred on Saturday nights when his family went to friends for a barbeque and it was on this occasion that he would do most of his crying and cutting. In his evidence before the Court Mr Horsman confirmed that from time to time Jason would be left home alone on Saturday nights when the rest of the family attended a friend's place. Although Jason himself went with his family to the friends' home on a number of occasions, he did stay home alone on a number of other occasions. Mr Horsman told the Court that this had not struck him as being out of the ordinary. He just thought that it was normal for a 14 or 15 year old boy to want time to himself. Mr Horsman thought he was doing Jason a favour by letting him stay

home on his own because it demonstrated that they trusted him. Mr Horsman told the Court that on no occasion when he came home after one of the Saturday night barbeques had he found Jason distressed or crying[46]. Mr Horsman stated that he had never thought that there was any risk involved in leaving Jason alone. Nobody ever explained to him what might be the dangers of leaving him unsupervised or unattended, particularly if he was in an emotional or vulnerable state[47]. When asked as to what he would have done if he had realised the dangers, he said:

> 'Absolutely, we never would have gone out for a night. I mean I realise that you can't - I can't spend every - I couldn't spend every waking minute with him but I wouldn't have left him for hours alone.' [48]

Mr Horsman told me that his wife never expressed any concerns to him about leaving Jason alone and, if anything, agreed with Mr Horsman's notion that they were showing Jason trust. It is obvious and I so find that Jason's parents were not aware that Jason's being alone on a Saturday evening represented a situation of heightened emotional turmoil for him. Jason's worrying assertions as to his vulnerability when home alone on Saturday evenings, which were made at the session of 23 July 2010, were not imparted to his parents. The very scenario that was associated with Jason's most troubled frame of mind would be replicated on the night of his death.

6.35. While acknowledging that parents must assume a large measure of responsibility for the emotional welfare of their children, and have responsibility to identify and avoid situations that might give rise to a child's emotional turmoil, it should have been obvious to those at CAMHS that the information that Jason imparted about his moods on a Saturday night might not be readily appreciated by his parents and that it would have been wise for them to have been brought into the picture about that issue.

7. Jason sees Dr Susan Shannon

7.1. Ms Hotich commenced her leave on 25 July 2010 and returned to work at CAMHS on 26 August 2010. Ms Hotich told the Court that before she went on leave she had a discussion with Dr Shannon about Jason. Ms Hotich told the Court that she was keen to obtain a second opinion about Jason because she was not sure if she may have missed something. There were symptoms of anxiety and depression. Jason was quite

[46] Transcript, page 69
[47] Transcript, page 62
[48] Transcript, page 62

angry and his moods were fluctuating. He wanted to see a doctor and was keen for pills to fix his problems. Ms Hotich told the Court that she recalled talking to Dr Shannon about this and told Dr Shannon that Jason had described quite significant anxiety symptoms. She testified that she told Dr Shannon that Jason had been asking about medication and had queried whether he was bipolar. There is no handover note as such between Ms Hotich and Dr Shannon, but Dr Shannon would have had access to all of the notes and other documentation that Ms Hotich had compiled.

7.2. For Dr Shannon's part, she told the Court in her oral evidence that on or about 23 July 2010 Ms Hotich asked her to perform two particular functions with respect to Jason, the first one being to assess him with regard to bipolar disorder due to Jason's own concern in that regard, and secondly to keep an eye on Jason during the period of four weeks over which Ms Hotich would be away[49]. Dr Shannon told the Court that Ms Hotich did not say anything about Jason's desire to be given medication[50]. Dr Shannon also stated that Ms Hotich had not said anything about being keen to obtain a second opinion about Jason. Dr Shannon suggested that their conversation took 5 or 10 minutes at the maximum. Other than that, Dr Shannon said that she familiarised herself with Jason's circumstances and with what had happened to date by looking through the file, although that may have been limited to reading the intake referral, the initial consultation documentation, the Strength and Difficulties questionnaire and very likely the most recent note from Ms Hotich. To Dr Shannon, the issues surrounding Jason concerned problems with mood and anger.

7.3. It is apparent that Dr Shannon brought the following beliefs to her assessment and management of Jason over the next month, namely (i) that the majority of clients that she saw at CAMHS were suffering some sort of depressive order or mood disorder[51], the most common presenting complaint being anxiety disorder, (ii) that the principles in relation to the treatment of adolescents presenting with anxiety and or depressive disorders are different from those that might pertain to an adult, (iii) that in the case of a young person therapists are much more likely to use psychological therapy rather than medication[52], (iv) that medication for an anxiety disorder might be considered after psychological therapies had been administered over a reasonable length of time – in the vicinity of three months, possibly up to six months; severity of symptoms

[49] Transcript, page 326
[50] Transcript, page 328
[51] Transcript, page 318
[52] Transcript, page 318

would also be another matter to be taken into account, (v) that antidepressant medication for adolescents would be '*second line*'; that is to say psychological therapies would be used first, (vi) that at that point in time the preferred approach was individual management of clients by individual therapists as opposed to the multidisciplinary team approach to management[53], and that (vii) it is not always essential to arrive at a specific clinical diagnosis for a client in order to properly manage the client, such that an actual diagnosis of a major depressive disorder or a major depressive episode would be rare.

7.4. Dr Shannon made an appointment for Jason to see her on 2 August 2010. Jason would keep that appointment. I note that in the intervening period Jason had attended at the CAMHS office at Mount Barker at about 9am on 30 July 2010 and was told by CAMHS staff that neither Ms Hotich nor Dr Shannon were in the office. A proposed arrangement to see someone else at the office came to nothing when Jason later indicated on the phone that he was not feeling very well and was not going to come in. It appears that the appointment for 2 August 2010 was made at that time. There is no session note in relation to this first appointment between Jason and Dr Shannon which is a shortcoming that Dr Shannon acknowledges. The CBIS client summary note of two lines records that this initial session with Jason occurred with his mother and that it took place over a period of 60 minutes.

7.5. Dr Shannon saw Jason on a further three occasions on 12, 16 and 30 August 2010. 30 August 2010 was the final occasion on which Jason saw Dr Shannon or for that matter any other therapist at CAMHS. There are typed session notes in relation to the three sessions in August 2010.

7.6. The session notes for Dr Shannon's consultation on 12 August 2010, which appears to have taken place with Jason on his own, reveal that there was discussion concerning Jason's moods that included occasions when he felt that he would cry for no reason, although he did indicate that his mood had improved. Jason enquired about mood stabilising meds to which Dr Shannon indicated that she did not believe that he had bipolar disorder. She also mentioned the serious side effects of medication that would

[53] Transcript, pages 321-322

be prescribed for such a disorder and indicated that she would not expect that he needed to take any medication of that kind. Dr Shannon made this note;

> 'I would prefer to look into the conflict which seems to be driving both his anger and his depression, and it seems to be with his parents. Offered to have a session with either Mum or Dad nad (sic) he will ask them to come next time.' [54]

There was some discussion concerning some possible uncertainty about his own sexual orientation, a matter which he said was not really bothering him.

7.7. Dr Shannon next saw Jason with his mother, Wendy Hugo, on 16 August 2010. This session followed an incident that Jason's father described to the Court as follows. Jason had phoned Mr Horsman at work in a very distressed condition. He was making noises but not forming words or making any sense. Mr Horsman had left work straight away but by the time he arrived home in Mount Barker, Jason was calm. Jason told his father that he had been so upset at school and had begun feeling worse and worse. A friend had walked him home. Jason had punched objects in the shed which had resulted in the destruction of a mirror. Mr Horsman told the Court that it was at this point that he had started to become seriously concerned '*that there were things going on that I couldn't understand*'[55]. In Jason's session with Dr Shannon on 16 August 2010 Jason made reference to this incident. He said that he had missed a class, had felt strange and sweaty with loss of balance and an inability to walk or talk properly. He thought he might have been hyperventilating at that time. Once home and in the rear shed he looked at himself in the mirror and had felt such self-loathing that he smashed his head into the mirror and broke it. Dr Shannon noted that he felt that his mood was '*out of control*'[56]. This incident had occurred on the previous Thursday. A similar outburst of angry behaviour was described as having occurred the night previous to this session. Ms Hugo indicated to Dr Shannon that she was worried that Jason would smash things and hurt himself.

7.8. Jason indicated in this session that he needed something so that he could feel '*out of it*'. He said he would prefer a mood stabiliser, but Dr Shannon again explained that she did not believe Jason was suffering from bipolar disorder. In the event Dr Shannon prescribed diazepam, which is a sedative, to be taken at a maximum of three tablets per day. Dr Shannon noted that Ms Hugo '*can use if Jason is getting out of*

[54] Exhibit C11, page 23
[55] Transcript, page 33
[56] Exhibit C11, page 22

control at home'. According to Mr Horsman, Jason did take diazepam tablets on a few occasions but had stated that he did not think it was the right medication for him[57]. On the other hand, Mr Horsman said that on occasions when Jason took a diazepam tablet his demeanour noticeably changed, almost to the point of apparent intoxication.

7.9. Following the session with Dr Shannon on 16 August, Jason came to see Mr Dunn at the Mount Barker High School. This occurred two days later on 18 August 2010. He came to tell Mr Dunn know that he had been prescribed medication by CAMHS. Mr Dunn noted that the medication seemed to be working well but that Jason was worried that it might be working a little too well and was fearful of addiction. Mr Dunn noted:

> '• He was told by his Psych that he was to have a maximum of 3 tablets per day and was currently taking 1 per day and occasionally another one if required.'

This statement by Jason is clearly a reference to the fact that Dr Shannon had prescribed diazepam at a maximum of three tablets per day. The reference to Jason's '*Psych*' must be a reference to none other than Dr Shannon given that she was the prescribing psychiatrist. At this meeting with Mr Dunn, Jason told him that the medication was balancing his feelings but that it was not stopping his feelings of self-harm and contemplations of suicide. Mr Dunn noted that they discussed Jason's suicidal thoughts and that Jason explained that he had thought how it '*might be easier if he wasn't here*'. The final notation in respect of this meeting was as follows:

> '• Contacted CAMHS and spoke to Jason's Psych to inform her of our conversation regarding suicide.'

7.10. Unlike Mr Dunn's phone conversation with Ms Hotich in June, Mr Dunn still has an independent recollection of this later conversation. In Mr Dunn's oral evidence before the Court, Mr Dunn expanded upon Jason's asserted contemplations of suicide. He told the Court that when Jason mentioned something about not wanting to be here, Mr Dunn elicited from Jason that he had heard about a cliff near Hahndorf. When further questioned about that Jason said that he did not know exactly where the cliff was, and had no means of getting there apart from on foot. Thus the likelihood of this being used as a means of suicide did not, in Mr Dunn's mind, give rise to an imminent risk. Regardless of that, Jason's utterances in this regard would tend to demonstrate to a reasonable person that Jason's thoughts of suicide had gone beyond the

[57] Transcript, page 38

conceptual and had progressed to a consideration of the means by which it might be achieved.

7.11. In any event, Mr Dunn told the Court that following this meeting with Jason he phoned CAMHS to inform them of Jason's assertions regarding suicide. Mr Dunn's first statement provided in relation to this matter[58] evinces a belief that Jason had an appointment with CAMHS later on the day of their meeting, but as seen he had seen Dr Shannon two days beforehand on 16 August 2010 and did not have another appointment with her until 30 August. Mr Dunn said that he would have contacted CAMHS within one or two days of his meeting, if not on the same day. Mr Dunn states that he wanted to ensure that CAMHS knew about Jason's suicidal ideation before Jason presented for his next appointment with CAMHS. Mr Dunn states that he recalls reporting to the CAMHS worker that Jason had been talking about the cliff that he had found near Hahndorf. Unfortunately Mr Dunn could not recall the identity of the person to whom he spoke. Mr Dunn's notes do not identify the person to whom he spoke except that, as seen above, they describe the person to whom he spoke as female and as '*Jason's Psych*'. It will also be observed that in another section of the same set of notes Mr Dunn used the same word, namely '*Psych*', to describe the person who had indicated to Jason that he was to have a maximum of three tablets per day. An inference is available, therefore, that Mr Dunn would have contacted, or at least have attempted to contact, that same person and that it was Jason's '*Psych*', namely Dr Shannon, to whom he spoke when he informed a female person at CAMHS of his conversation with Jason regarding suicide. When asked by me whether by his use of the expression '*Jason's Psych*' he was intending to convey through that note that he had spoken to the same person whom Jason had described as his '*Psych*', Mr Dunn said that would be how he would read his notes, but that he could not recall exactly. He alluded to the possibility that the use of the word *'Psych'* was a generic term to describe any person to whom he may have spoken at CAMHS. However, he indicated that the person to whom he had spoken at CAMHS was more likely to have been the same person who had indicated to Jason how he should take his tablets. On that basis, that person of would have to have been Dr Shannon.

7.12. 18 August 2010 was a Wednesday and a day on which Dr Shannon would not have been in attendance at the Mount Barker office. Although Mr Dunn's meeting with

[58] Exhibit C17

Jason occurred on that day, I have already alluded to the fact that Mr Dunn believed that he could have made the call to CAMHS within a day or two of that day.

7.13. Mr Dunn did not recall any occasion on which he had spoken to Dr Shannon. He stated in his evidence that he had not had any previous dealings with Dr Shannon prior to August 2010. However, a telephone message slip dated 19 August 2010 timed at 4:40pm that evidenced the leaving of a message by Mr Andrew Dunn of the Mount Barker High School for 'Sue'[59], was produced to the Court from CAMHS' records. The message slip is silent as to the nature of the call, and the person 'Sue' is not otherwise identified. There was no convincing evidence that there had been at that time another person called 'Sue' working in the Mount Barker CAMHS office. This document was not made available at the Inquest until after Mr Dunn had given his oral evidence. In the light of the production of that document a further statement of witness was taken from Mr Dunn. In that statement he asserts that it is possible that he may have made the telephone call to CAMHS on 19 August 2010, but also asserts that he does not recall making contact with Dr Sue Shannon. In short, the message slip did not take the matter any further in establishing or reviving Mr Dunn's recollection of the identity of the person at CAMHS to whom he spoke. I accept Mr Dunn's evidence that at some time following his meeting with Jason on 18 August 2010, Mr Dunn telephoned the CAMHS office and spoke to a female person and told that person of his concerns about Jason's suicidality in the terms that he described in his evidence. The identity of the person to whom he spoke is another matter.

7.14. I have mentioned the evidence about Mr Dunn's call in some detail for a number of reasons. Firstly, within the CAMHS file relating to Jason[60] there is no note or other record of this conversation having taken place. Secondly, there is no evidence within the CAMHS file that any action was taken in relation to this information. Thirdly, Dr Shannon in her evidence denied that she was the person to whom Mr Dunn spoke. Dr Shannon also asserted that she did not think that she had seen the previous information in the file about Mr Dunn's earlier phone call on 10 June 2010 to Ms Hotich in which he had told Ms Hotich of his concerns about Jason's suicidal thoughts. In her oral evidence before the Court Dr Shannon denied that she had received a call from the school on 18 August 2010 because she had not been in the Mount Barker office that day, but had been at Headspace in Murray Bridge. This

[59] Exhibit C21
[60] Exhibit C11

explanation had limited weight having regard to the fact that Mr Dunn had already told the Court that the call was not necessarily made to CAMHS on that day. In any event Dr Shannon had no recollection of any such conversation with Mr Dunn and was not told by any other employee of CAMHS about such a conversation, involving as it did a report to CAMHS about Jason's suicidal ideation. She stated that she would have expected that kind of information to have been passed on to her, which having regard to the nature of the communication and her role in Jason's care, seems something of an understatement. As for the telephone message slip, Dr Shannon said that she did not believe that she had spoken to Mr Andrew Dunn on 19 August 2010[61] but that if she had been made aware of such a message, she would have made an attempt to call him back[62].

7.15. If Dr Shannon had been told of Mr Dunn's concerns on or about 18 August 2010, and in particular had been told about Jason's suicidal thoughts and his having identified a cliff to jump from, and had ignored that information, not noted it and had not taken any action in respect of it, it would be difficult to avoid a conclusion that it represented an egregious clinical error worthy of condign criticism. She was, after all, Jason's treating psychiatrist. To my mind such a finding could and should only be made on clear evidence. While an inference is available that when Mr Dunn referred in his notes to having spoken to *'Jason's Psych'* the person to whom he imparted that information about Jason's suicidality was Dr Shannon, the difficulty is that Mr Dunn could not identify the person to whom he spoke and he alluded to a possibility which cannot be ignored that he was describing a person generically, that is to say a therapist at CAMHS of an unidentified type. In all of the circumstances, particularly having regard to the damning nature of such a finding, I am unable to make a positive finding that the person to whom Mr Dunn spoke was Dr Shannon.

7.16. Dr Shannon next saw Jason with his father on Monday 30 August 2010. In the intervening period an incident involving Jason had occurred on Tuesday 24 August 2010. The incident appears to have been prompted by his mother's discovery that he was wearing makeup. There may have been other catalysts as well. A physical fight between Jason and his mother had ensued and during the course of the altercation he

[61] Transcript, page 466
[62] Transcript, page 466

had produced and threatened her with a knife[63]. Jason then left the house with the knife and when approached by police in a nearby street in Mount Barker, Jason waved the pocket knife in the general direction of the police vehicle and shouted at police to leave him alone. An attempt on Jason's part to get away by alternately running and walking was unsuccessful. Jason dropped the knife and was arrested for carrying an offensive weapon. Under caution and in the presence of his father, Jason told police that he had been extremely angry after a verbal and physical altercation with his mother at home and that he just wanted the police and everyone else to leave him alone. He told police that he did not intend to threaten anyone and would not have tried to hurt anyone with the knife. He acknowledged that what he had done was wrong and stupid. The police apprehension report states that Jason repeatedly said that he was just so angry at his mother and had not been permitted to take his medication to help him calm down once the altercation had commenced.

7.17. Also in the intervening period between the final two sessions with Dr Shannon, Jason took an overdose of Panadol of approximately 16 tablets. This had occurred on the previous Monday. Evidently having taken the Panadol he vomited at school.

7.18. On 30 August 2010, the day of Jason's final session with Dr Shannon, Jason approached Mr Dunn at Mount Barker High School and told him that he had been arrested after a physical fight with his mother. Jason's description of the incident included an allusion to having beaten his mother quite badly and his having threatened her with a knife. The police had located him and he had been charged. He was now on a curfew and a condition of his bail was that he must live at home. Jason told Mr Dunn that he could not quite remember how it all started, apart from the fact that he was angry and he thought that his mother had intentionally bumped him when they passed each other in the hallway. He said that he '*lost it*'[64]. Ms Hugo's version, as also imparted to Mr Dunn, and apparently independently of his consultation with Jason, was that Jason had hit her, had put her in a headlock and that she had to bite him to make him let go. The knife was then produced.

7.19. In Mr Dunn's meeting with Jason on 30 August, Jason did not say anything to Mr Dunn about having taken an overdose of Panadol in the preceding week. However,

[63] According to Mr Horsman this was not the first occasion on which Jason had produced a knife during the course of an argument with his mother. On the previous occasion Ms Hugo had called the police because he had left the house with the knife. He had been found by police and brought to the police station where a police officer counselled him.
[64] Exhibit C9, page 16

when Jason and his father saw Dr Shannon at CAMHS later on the same day, the Panadol overdose as well as the incident involving Jason's mother and the police were all mentioned to her. Jason also told Dr Shannon that sometimes he would just go to his room and cry and could not really work out why he was crying.

7.20. In her oral evidence Dr Shannon told the Court that she interpreted Jason's having consumed 16 tablets of Panadol as an attempt to take his own life. Regardless of whether that interpretation is accurate or not, it is apparent that Jason had engaged in serious life threatening behaviour.

7.21. The notes of this consultation with Dr Shannon reveal very little more than what I have just described. While the Panadol incident is noted, the assessment made by Dr Shannon that the overdose had been accompanied by an intention of Jason's part to take his own life is not noted. Nor is there any form of risk assessment recorded in respect of Jason's risk of self-harm having regard to that overdose and having regard now to the fact that he had assaulted his mother, threatened police and was now before the Courts in respect of that incident. There is also no plan recorded for Jason's future management. What is known, and I will come to the circumstances of this in a moment, is that on that very same day Dr Shannon wrote what is described in the CBIS client summary as a '*therapeutic letter*' to Jason and his parents[65]. The letter advised that Dr Shannon intended to pass Jason back to Vina Hotich now that the latter was back at work, but urged Jason to feel free to keep in touch if there was any more that Dr Shannon could do. Dr Shannon wished Jason all the best. The letter was accompanied by two documents, for the most part directed towards Jason's parents, that described strategies for management of Jason's '*meltdowns*'. In the letter Dr Shannon described this documentation as '*a couple of things that might help when Jason feels things are getting out of control*'.

7.22. Mr Horsman states that Jason had wanted him to ask the psychiatrist for antidepressant medication. He had intimated to his father that he did not think that the sedatives prescribed were the right medication for him. Mr Horsman's own researches on the internet had revealed information which suggested that antidepressants were not recommended for teenagers. Mr Horsman said he raised that issue with Dr Shannon and '*she just reinforced what I had seen on the internet and*

[65] Exhibit C11, page 73

did not prescribe any'[66]. As they were leaving the appointment in the car, Mr Horsman explained to Jason what he had read on the internet and also stated that, according to the psychiatrist, antidepressant use in teenagers can lead to suicidal thoughts. There was some discussion between them about the effect that any such action on Jason's part would have on his father.

7.23. The contents of the letter of 30 August 2010 need to be examined against Mr Horsman's impression of this session which, it will be remembered, was the first occasion on which Mr Horsman had personally attended a CAMHS appointment. Mr Horsman said that Dr Shannon did most of the talking and that when Mr Horsman enquired about antidepressants, Dr Shannon had told them that due to an increased risk of suicide ideation, they were not normally prescribed to teenagers. She also told Mr Horsman that if Jason overdosed on Panadol he should be taken to hospital. Dr Shannon did not discuss any further proposed course of treatment but had simply said that she did not see a need to see Jason anymore[67]. During the discussion in the car, Jason told his father that he did not '*get anything out of that session*'[68]. He said that he thought it had been a waste of time. Mr Horsman told Jason that he more or less agreed. In fact, Mr Horsman told Jason in terms that he thought the session '*was pathetic*'[69].

7.24. The 30 August 2010 session was the last involvement that Jason had with CAMHS. The circumstances surrounding the cessation of Dr Shannon's involvement with Jason require some discussion. Ms Hotich gave evidence that when she had gone on leave she had an expectation that she would resume Jason's management upon her return[70]. As seen, Mr Horsman suggested in evidence that during the final session on 30 August Dr Shannon had said that she did not see a need to see Jason anymore. Mr Horsman added that he thinks Dr Shannon probably had assumed that Jason would revert to seeing Ms Hotich. Such an assumption would have accorded with Ms Hotich's own existing expectations. Dr Shannon's notes of this session do not refer to the issue as to whether or not she or Ms Hotich would continue to see Jason. Jason's continued engagement with the service is not a topic covered by the notes. Mr

[66] Exhibit C13, page 7
[67] Transcript, page 46
[68] Transcript, page 47
[69] Transcript, page 47
[70] Transcript, page 170

Horsman's evidence is consistent with the notion that the issue as to whether this was going to be Jason's last session with Dr Shannon, at least for the time being, had already been predetermined regardless of what was to transpire during that session. Certainly, in light of the contents of Dr Shannon's letter of 30 August to Jason and his parents in which she said that she would pass Jason back to Ms Hotich, the matter of Dr Shannon's continued involvement in Jason's case was settled by the close of business that day.

7.25. Dr Shannon told the Court that on 30 August 2010 she would have liked to have undertaken '*one more wind-up session*' with Jason[71]. What she had in mind was an attempt to get both of Jason's parents in with Jason so that they could '*just pull it all together*'[72]. Dr Shannon gave evidence that she was directed by Ms Duckworth to hand back Jason to Ms Hotich. Having regard to the fact that Dr Shannon wrote her letter that day, and at a time after she had seen Jason, she believes that it must have been on the day of 30 August 2010 that her boss, Ms Duckworth, directed her to hand Jason back to Ms Hotich. She said that this direction was given in accordance with the arrangement that Dr Shannon was to look after Jason while Ms Hotich was away and that when Ms Hotich came back she was to give Jason back. Dr Shannon said that despite her better judgment she did not object at the time to handing Jason back[73]. It will be remembered that Ms Hotich had returned to work during the previous week. In cross-examination by Mr Griffin, counsel assisting, Dr Shannon conceded that the matter of her continued involvement in Jason's case may have been settled earlier than 30 August 2010[74]. Regardless of the timing of any decision that had been made for Dr Shannon to hand the matter back, she did not have any further involvement with Jason after 30 August 2010. Importantly, when directed by Ms Duckworth to hand the file back, she did not tell Ms Duckworth about Jason's Panadol overdose[75]. She agreed, therefore, that any decision Ms Duckworth may have made was not a fully informed one[76]. Indeed, she agreed that if Ms Duckworth had made that decision actually knowing about the Panadol overdose, such a decision might possibly be seen

[71] Transcript, page 366
[72] Transcript, page 366
[73] Transcript, page 404
[74] Transcript, page 430
[75] Transcript, page 442
[76] Transcript, page 442

as perverse[77]. When asked as to why Dr Shannon did not tell Ms Duckworth about the Panadol overdose she said:

> 'I don't know - I think at that stage I felt that it needed to go back to Vina. Vina had indicated to me that she wanted to take it back. I was prepared to be in a secondary role and continue to offer a further session together with Vina as the primary service. I think it was just - there was an awkwardness about who was actually directing this at this stage, and I think I should have been more forthright in directing it myself.' [78]

7.26. Dr Shannon said that she should have stood up to Ms Duckworth and that it was her fault that she did not[79]. As to the manner in which Jason was handed back to Ms Hotich, she told the Court that she could not remember what she had told Ms Hotich about events that had occurred during the time that she had been seeing Jason, but she said that she remembered thinking to herself that it was fairly clearly laid out in the notes, including the difficult times with the overdose and his out of control behaviour. Dr Shannon at no time suggested that she had in any sense been debriefed by Ms Hotich about what had taken place or that there had been any verbal imparting of material information between the two of them. Dr Shannon said this in relation to her handing back of Jason to Ms Hotich:

> 'My memory is very scant. I can remember just telling her that the family had been in, Jason had been in, members of the family had been in. I can't even remember, I think probably I just said 'Look, it's all in the notes, you know, it's all there. Just go and read it'.' [80]

Dr Shannon did not convey any opinion as to diagnosis in respect of Jason, nor any opinion as to how Ms Hotich should manage Jason. She said that she had felt that '*the deal*'[81] was that she would look after Jason for the four weeks and that when the four weeks were up she would give him back; Ms Hotich had been Jason's therapist for some months before Dr Shannon had come along and felt that she had a good rapport with him and she felt that she should continue. When specifically asked whether she had told Ms Hotich about the Panadol overdose and the incident with the mother involving the knife, Dr Shannon said that she could not remember whether she had discussed it specifically but her attitude had been that it would have been possible

[77] Transcript, page 442
[78] Transcript, pages 442-443
[79] Transcript, page 367
[80] Transcript, page 365
[81] Transcript, page 365

for Ms Hotich to get everything from the notes. She said she could not remember saying anything specifically to Ms Hotich about Jason's risk. She said:

> 'There was a significantly increased risk here, more than I realised, I think, considerably more than I realised.' [82]

7.27. Ms Robyn Duckworth gave oral evidence in the Inquest. She is a psychologist and was the most senior administrative officer in the Mount Barker CAMHS office. Ms Duckworth gave evidence that Ms Hotich had told her that she thought that she should obtain a psychiatric assessment for Jason and suggested that as she was about to go on leave for a month, Dr Shannon should perform the psychiatric assessment and continue to look after Jason over the time that Ms Hotich was on leave. When Ms Hotich returned from leave Ms Duckworth sensed that there was some confusion about Ms Hotich's continued role such that she advised Ms Hotich to speak to Dr Shannon about that and to work out with her who would be best to continue with the case[83]. Ms Duckworth told the Court that she had a less clear recollection of speaking to Dr Shannon about Jason. She believed that she may have said to Dr Shannon that Ms Hotich was confused about her own role and that Dr Shannon should connect with Ms Hotich and for them to work out together what would be best for Jason[84]. She had no recollection of specifically directing Dr Shannon to pass Jason back to Ms Hotich, although Ms Duckworth has wondered whether Dr Shannon may have interpreted it in that way[85]. Ms Duckworth told the Court that she would not have given any such direction because she would not have had sufficient knowledge about the case. She added that it would not be appropriate for anyone to be clinically supervising the psychiatrist[86]. Ms Duckworth said that she knew nothing of the information that had been imparted to Dr Shannon on 30 August 2010 until she read the file after Jason's death. No-one had told her of the Panadol overdose nor of any other concerning incident. If she had known about those matters, she probably would have suggested that the three therapists sit down and discuss what should happen with Jason. Ms Duckworth told the Court that when she read the file after Jason had died, and had read specifically about the overdose, she had been '*very shocked*'[87]. She told the Court that she would not have instructed Dr Shannon to hand a file back without

[82] Transcript, page 366
[83] Transcript, page 599
[84] Transcript, page 600
[85] Transcript, page 601
[86] Transcript, page 621
[87] Transcript, page 632

enquiring of Dr Shannon, or having been told by Dr Shannon, what the current position was in respect of the patient's condition. She said:

> 'No, certainly not. It wouldn't be appropriate. I mean it wouldn't be appropriate for anybody for somebody to just come in and say 'This is what you must do' without inquiring more about the situation. That would be really clinically unwise.' [88]

7.28. There was an element of uncertainty about the precision of Ms Duckworth's recollections. Ms Duckworth acknowledged as much. However, I accept her evidence that she would not have directed Dr Shannon simply to hand back the file to Ms Hotich without further enquiry or discussion about the current state of Jason's matter. In particular, I accepted her evidence that she knew nothing of any Panadol overdose or other concerning suicidal ideation. Dr Shannon did not purport to have told Ms Duckworth about the Panadol overdose or recent developments in Jason's case. It was Dr Shannon's responsibility to have imparted any relevant information to Ms Duckworth that may have affected a decision on Ms Duckworth's part to redirect the clinical management of a client to a lesser qualified therapist than a psychiatrist. I find it to be intrinsically unlikely that Ms Duckworth would have directed Dr Shannon to hand Jason's management back to Ms Hotich if she had known about Jason's current frame of mind.

7.29. Ms Hotich had returned from leave on 26 August 2010. The CBIS client summary reveals that there was an appointment to see Jason at 9:30am that day and that Ms Hotich was the therapist who was expected to see Jason. However, when it was revealed that a further appointment had been made to see Dr Shannon on 30 August 2010, Ms Hotich's appointment was cancelled. Ms Hotich told the Court that she recalled very little of the circumstances in which Jason's matter was handed back to her[89], although she denied that Ms Duckworth had told her to pick up Jason's management when she returned from leave[90]. Ms Hotich's impression was that Ms Duckworth had not been involved in this process. Ms Hotich did tell the Court that she remembered that Dr Shannon told her something of Jason's doubts about his sexual orientation. She also remembered that she had been a little disappointed with the outcome of Jason's time with Dr Shannon as Dr Shannon seemed not to have followed up in assessing his anxiety and depression. She had the impression that Dr Shannon was more focussed on the family conflict. Ms Hotich testified on her oath

[88] Transcript, page 640
[89] Transcript, page 95
[90] Transcript, page 170

that she only became aware of the Panadol overdose sometime after these events when she read the entire file, although she states that she knew something of the knife incident and that this must have been part of the information that Dr Shannon gave her when she resumed Jason's care. There is no direct evidence to refute this assertion. In the witness box Ms Hotich became emotionally distraught when she was asked about her then reaction to finding out about the Panadol overdose only after Jason's death. She said that the Panadol overdose was pertinent information that she should have known. If she had known about the Panadol overdose she would have done a number of things differently. She said:

> 'A number of things. I would have probably first gone back to Dr Sue and say 'What happened, what did you do, what have you put in place in terms of safety plans, have you assessed Jason as to where he is and what he thinks about that suicide attempt now, have you talked to his mum or dad about a safety plan' and if she hadn't done it that I would then go and do that at the earlier opportunity.' [91]

Naturally all of this begged the question as to why it was that Ms Hotich would not have readily seen reference to the Panadol overdose in the session notes of Dr Shannon's last session of 30 August 2010. Ms Hotich suggested that it was quite possible that Dr Shannon's session note of 30 August 2010 was not on the file when the matter was handed back to her, although she said that she was not sure about this[92]. She suggested that the typed notes of Dr Shannon may not have made it onto the physical file until after Jason's death[93]. I add here that Ms Duckworth told the Court that Dr Shannon's typewritten notes were all on the file when she examined it on the Monday following Jason's death. I find that the notes were on the file at the time of Jason's death. I am unable to find whether or not Ms Hotich saw those notes prior to Jason's death. Regardless of whether the notes were or were not on the file at the time Ms Hotich was expected to resume Jason's care, or whether Ms Hotich saw them or not at that time, the undisputed lack of any meaningful dialogue between Dr Shannon and Ms Hotich about what had taken place while Ms Hotich was on leave is to say the least very surprising. Dr Shannon told the Court that she believed she was entitled to take the view that her notes were available for Ms Hotich to read and for that reason there was no need in her mind for information such as an attempt on the patient's own life to be verbally conveyed between one therapist and another. For Ms Hotich's part it is surprising that in the light of information that she herself possessed

[91] Transcript, page 98
[92] Transcript, page 195
[93] Transcript, page 195

about Jason's possible suicidality, imparted as it had been by Mr Dunn in June, that she would not explore that topic with Dr Shannon, a psychiatrist, who had been seeing her client while she was away on leave. Ms Hotich told the Court that she did not even know whether Dr Shannon had made any diagnosis in respect of Jason when, on her own version of events, that was one of the matters that she had hoped Dr Shannon would explore while she was on leave. Ms Hotich also admitted in her evidence that when she returned from leave she did not know what Jason's diagnosis was[94]. She did not know for instance whether, if Dr Shannon had made any diagnosis, it was in any way different from the impression of Jason that she had formed herself. If Dr Shannon's diagnosis had been different from her own impression, she would have needed to defer to that[95]. Ms Hotich demonstrated a reluctance to agree to the proposition that in order for her to continue with Jason's care after she returned from leave, she would need to know what Jason's diagnosis was, if any[96]. But Ms Hotich did accept that in order to establish clarity in relation to Jason's diagnosis she would have needed to converse with Dr Shannon[97]. She was asked:

> 'Q. Why didn't you do that?
>
> A. I think at the time it would have amounted to questioning some of what she was telling me.' [98]

This answer, together with all of the other matters that failed to be the subject of discussion between Ms Hotich and Dr Shannon, is manifestly inconsistent with the notion that CAMHS was operating as a multidisciplinary service. The failure to share relevant information on a verbal basis in and of itself demonstrates a lack of any meaningful multidisciplinary approach. The therapists who cared for Jason at any given time were acting alone and autonomously and not as a team. It represents a lamentable level of camaraderie within that office at that time.

7.30. Dr Shannon in her evidence stated that in the light of the information that had been imparted to her in the final session of 30 August 2010, especially the information about an actual suicide attempt, that Jason was at significant risk. She did say that she did not have any feeling that he was at an imminent risk. She said that the fact that he had made a suicide attempt put him at a higher risk than previously because although

[94] Transcript, page 175
[95] Transcript, page 175
[96] Transcript, page 176
[97] Transcript, page 177
[98] Transcript, page 177

he had spoken of suicide in the past, he had not acted out on any such thought. Nevertheless, Dr Shannon acknowledged that in respect of the information imparted to her on 30 August 2010 that she should have formalised any assessment of risk on the appropriate CBIS documentation[99].

7.31. Dr Shannon told the Court that she had formulated in her own mind a management plan for Jason that involved ensuring that Jason's parents were '*staying in close*'[100] and that her main therapeutic endeavour at that stage was to ensure that Jason had family that would protect him. She said that it appeared to her that Jason's relationship with his family had improved[101]. Dr Shannon also spoke of the protective factors as a result of engagement with his family[102]. Dr Shannon told the Court that she could not recall whether she had read Ms Hotich's note of 23 July 2010 that included reference to Jason's biggest mood swings occurring on a Saturday night when his family attended at a friend's premises for a barbeque, during which he was crying and cutting. Dr Shannon went on to say that she is not certain that she would have interpreted this as meaning that he would be home alone, or whether it meant that it actually identified a risk[103]. In any event Dr Shannon states that her feeling was that Jason's family were very engaged with him, that they were very concerned and that they were very watchful[104]. The difficulty with that is that for any assessment to have been made by Dr Shannon that Jason's family were very watchful, they would needed to have known about Jason's vulnerabilities on a Saturday night. Needless to say, any ambiguity about that information could have been easily clarified by speaking to Jason about that herself, or by conferring with Ms Hotich as to what she was referring to. One would have thought that if Dr Shannon believed that Jason's family was a significant protective factor, the family should have been made aware of the fact that Jason was most vulnerable when he was not in the presence of his family and home alone. In addition, it would have been difficult to be confident about the protective effect afforded by the family relationship when it was reasonably clear that Jason, especially in the light of the events of the previous few days, had a fractious relationship with his mother. Also as part of Dr Shannon's plan she stated that but for the fact that she was directed to hand Jason's matter back to Ms Hotich, she would

[99] Transcript, page 379
[100] Transcript, page 359
[101] Transcript, page 360
[102] Transcript, page 363
[103] Transcript, page 398
[104] Transcript, page 453

have arranged for a family meeting[105] at a further appointment with herself. In the event such an idea was overtaken by the direction that she hand the matter back, and one supposes, also by Jason's disengagement from the service. All of this of course constitutes another reason why if, as she asserts, Dr Shannon was directed to hand Jason's matter back, she was not more insistent upon retaining Jason's matter. In addition, Dr Shannon said that at some stage in the future they could have considered medication[106]. Of course, none of these thoughts or plans were ever reduced to writing. There is no evidence that any of these thoughts were shared with either Ms Hotich or Ms Duckworth. The letter that Dr Shannon wrote to Jason and his parents dated 30 August 2010 mentions none of those thoughts or intentions, but simply said '*I will pass you back to Vina now she is back, but feel free to keep in touch if there is anymore I can do*'[107] and I have already referred to the documentation that accompanied the letter that spoke of meltdowns and the like.

7.32. All of this uncertainty concerning Jason's future management and engagement with the service could have been avoided if on 30 August 2010 and following a true multidisciplinary approach had been taken to Jason's management. At the very least there should have been a meeting between Dr Shannon and Ms Hotich, with Ms Duckworth as well preferably, to discuss Jason's case. In this context Dr Shannon agreed with the proposition that it would be fair to say that multidisciplinary team reviews at that time were only occurring in the case of the most severe patients[108]. One would have thought that Jason's placement at significant risk would have put him in a category of at least severe. She also agreed that a multidisciplinary team review would only occur if a therapist took the initiative to initiate that review[109]. Dr Shannon conceded that it would have been a good idea for a review to have taken place as at 30 August 2010[110]. It seems obvious that if such a review had taken place it is inevitable that both Ms Hotich and Ms Duckworth would have been made aware of Jason's significant risk, and in particular have been informed of the Panadol overdose and of his recent concerning behaviour towards his mother. That being the case, it is almost inconceivable that Jason's matter would have been handed back to Ms Hotich with an, at best, uncertain contribution from Dr Shannon in the future.

[105] Transcript, page 431
[106] Transcript, page 448
[107] Exhibit C11, page 73
[108] Transcript, page 440
[109] Transcript, page 440
[110] Transcript, page 441

7.33. It is clear that Ms Hotich telephoned Jason on 17 September 2010. It appears that an appointment had been made for Jason to attend that day, but he failed to do so. In the telephone conversation between Ms Hotich and Jason that day, Jason is recorded in the CBIS client summary as having said that he was actually feeling better now and saw no need to come in anymore. Ms Hotich noted that she had said that she was still a bit concerned that his mood swings and/or anxiety might come back. She noted that Jason was clearly reluctant to attend and that she was unable to change his mind. However, Jason is noted to have agreed that Ms Hotich could contact him in a few weeks' time to see how he was going, and that if he was having a bad time again he would be able to come in. There is nothing in the note about suicidality or the Panadol overdose. Ms Hotich told the Court that she did not believe Jason when he said that he was feeling better[111]. The telephone call of 17 September 2010 was the last personal interaction she had with Jason. It would be the final communication that any member of the Mount Barker CAMHS' staff had with Jason.

7.34. 30 August 2010 also represented the date of the final occasion on which Mr Dunn at the Mount Barker High School saw Jason. From time to time Jason had also seen Mr Andrew Amberg who is an Assistant Principal at the Mount Barker High School as well as a student counsellor. During the third term of 2010 Mr Amberg had been holding meetings with a small group of students with respect to an imminent Operation Flinders camp. Jason was included in the group of students. At that time Jason was frequently absent from school and so Mr Amberg had to follow Jason up to ensure that he had consent from his parents to attend the camp and had attended to the medical requirements for the program. He also had to supply Jason with boots. As far as Mr Amberg could tell, Jason seemed to be looking forward to the camp. He had no concerns that he would self-harm. Although he knew that Jason had previous issues with self-harm and depression, he knew that Jason had also been prescribed medication. The camp involved a wilderness therapy program run by the Operations Flinders Foundation. It was to consist of an eight day camp in the wilderness to build self-esteem and practices and behaviour to stimulate self-confidence. Mr Amberg had organised for Jason to attend the camp because Jason had been identified as a student at risk. He had been a truant and had disengaged from school life. At no stage did Mr Amberg have contact with CAMHS, but of course Mr Dunn did.

[111] Transcript, page 96

7.35. It was in connection with Jason's attending the camp that Jason saw Dr Eskandari-Marandi on 20 September 2010. This would be the final occasion on which Dr Eskandari-Marandi saw Jason. Dr Eskandari-Marandi told the Court that Jason required a medical clearance to take part in the camp. Jason presented with a form that Dr Eskandari-Marandi had to sign. Dr Eskandari-Marandi also told the Court that Jason '*seemed to be in a better place at the time than the previous encounter*'[112]. Jason had put on some weight. Dr Eskandari-Marandi cleared him for the camp.

7.36. Dr Eskandari-Marandi did not ask Jason about his current interaction with CAMHS and so did not establish that Jason had disengaged from that service. He said that he would have attempted to ascertain the reason for that had he realised that Jason had become disengaged from CAMHS. If it was simply a case of Jason refusing to see CAMHS, he would have considered alternatives such as referring him to a private psychologist. Dr Eskandari-Marandi told me that at the time he did not identify any urgency to dig deep into Jason's interaction with CAMHS[113].

7.37. Jason took his own life before the Operations Flinders camp took place.

8. The evidence of Mr Clive Skene

8.1. Mr Clive Skene is the Director of the Child and Adolescent Mental Health Service in the southern metropolitan and southern country regions of South Australia (Southern CAMHS). Mr Skene is a clinical psychologist who obtained his original degree in 1979 as well as a Diploma in Applied Psychology from the University of Adelaide in 1983 and a Master of Clinical Psychology from the Flinders University of South Australia in 1987. Mr Skene has been the Director of Southern CAMHS since March 2001.

8.2. Mr Skene provided an affidavit together with several documentary exhibits[114]. Mr Skene also gave oral evidence in the Inquest.

8.3. Mr Skene described CAMHS as a voluntary therapy service for young people up to the age of 18. He also described it as a publically funded multidisciplinary service that provides a range of assessment and therapeutic interventions to children, young

[112] Transcript, page 123
[113] Transcript, page 129
[114] Exhibit C16

people and their families who are experiencing mental health concerns and disorders. Mr Skene explained that the service was voluntary in the sense that the services are offered until no longer required. There is no compulsion in respect of the treatment or therapeutic service. The multidisciplinary nature of the service is a reference to the different types of qualified therapists, the majority of whom are social workers. There are other therapists such as clinical psychologists, occupational therapists, mental health nurses and child and adolescent psychiatrists.

8.4. Mr Skene described the role of the regional manager, in this case Ms Duckworth, and stated that the regional manager is responsible for everything that happens within that person's team. However, the different types of professional therapists have professional accountability such that, for example, the psychiatrist in the team would be professionally responsible to the chief psychiatrist of the service.

8.5. Mr Skene had no involvement in the therapy provided to Jason. He had no knowledge of Jason's matter until after his death.

8.6. Mr Skene told the Court that following Jason's death the service conducted an adverse event review. Mr Skene furnished the report in respect of the adverse event review and this was attached to his affidavit[115]. The report identified four discrete findings that were stated as having been 'contributing' to the event the subject of the report. Two of those findings are relevant for the purpose of this coronial finding. Firstly, the report identified:

> 'Contributing statement 1: The absence of a clear model for Multidisciplinary Team (MDT) reviews contributed to solo case management which led to underutilisation of roles and responsibilities of the MDT. This decreased the opportunity to gain clinical opinion from the wider team which led to a limited diagnostic focus and consequent treatment plan.'

The other relevant finding was:

> 'Contributing statement 4: Lack of formal process to guide administration, interpretation and consequent use of results of psychological assessments by 'non psychology' staff.'

This Court has also found that those matters contributed to a sub-optimal delivery of therapy to Jason.

[115] Exhibit CADS-5

8.7. The adverse event report sets out a number of recommendations, two of which I reproduce below:

> 'Recommendation 1: That a framework be developed for complex youth which articulates the frequency and structure of multi disciplinary holistic clinical review and allocation of clinical responsibility within the team for each client. This framework must be communicated to all members of the team and include routine risk assessments and updated care planning. That all multi disciplinary case conferences are documented to capture the role and responsibilities of stakeholders, including primary health, family, employment providers (where appropriate) ensuring that staff are aware and engaged in crisis and relapse prevention plans. This must be filed within the client file.
>
> Recommendation 4: A formal procedure is developed to guide use of all psychological tests with clear protocols around the interpretation of results and resultant therapy interventions to follow.'

8.8. A flow diagram within the adverse event report also identifies a number of more detailed findings in respect of which the Court also agrees. They include:

> 'Lack of Clinical Lead onsite to provide clinical consultancy and support to less experienced staff'', 'lack of formal handover process with designated roles and responsibilities for follow-up of complex clients', 'no documented handover capturing risk assessment and treatment objectives, including clinical challenges', 'lack of process around the interpretation of results and development of action plan', 'results obtained not informing the overall clinical picture of complex adolescent', all of which findings were said to lead to a 'Limited Diagnostic clarity and treatment plan in case notes to guide practice'.'

8.9. The adverse event review report was promulgated upon the completion of the adverse event investigation on 1 December 2010. Mr Skene's affidavit explains that the subject matter of Recommendation 1 involved the formalisation of pre-existing CAMHS clinical review directions into a separate multidisciplinary team protocol which had come into force in November 2010. In his oral evidence Mr Skene told the Court that the recommendation concerning multidisciplinary team reviews was basically a formalisation of already existing multidisciplinary processes. He explained that although there had been an existing structure for such reviews in place, they did not have a formal recording of the processes and that they may not have been labelled as multidisciplinary team reviews as such. These less formal reviews had occurred when staff felt that a client needed multidisciplinary input[116]. Mr Skene further explained that such a process would occur on a case by case basis and that staff were encouraged to discuss cases with other members of staff, or with staff

[116] Transcript, page 481

within their supervision, or within multidisciplinary team processes, and to base decisions around a consensus of the combined experience of the members of the team. He explained that this could not be achieved with respect to every case, particularly within Southern CAMHS, because the pressures on them were '*enormous*'[117].

8.10. Mr Skene made some other observations concerning the multidisciplinary approach to therapy. He acknowledged that none of the CAMHS therapists should act in complete isolation from each other and that this was why they had review processes. He said that the purpose of these processes was to engage the skill base of the whole team in more difficult cases. He would certainly not support any therapist, even a psychiatrist, retaining sole responsibility for a young person. He suggested that a judgment had to be made concerning the degree of self-harm and the intent behind and lethality of such behaviour, '*but certainly anything that was regarded as high risk or more should be discussed across the organisation or the team*'[118]. Mr Skene was of the view that a multidisciplinary team approach had in fact been applied in the case of Jason Hugo-Horsman in the sense that Dr Shannon had ultimately become involved[119]. I reject that characterisation of Jason's therapy. There was no such discussion of the kind envisaged by Mr Skene, and the difficulty with that characterisation is that there had been very limited interaction between Ms Hotich and Dr Shannon; both of those therapists in reality acted in isolation from each other. Effective interaction would at least have involved verbal discussion between the two therapists about Jason's recent risky behaviour, what could be done to manage risk and the identification of a means by which Jason's engagement with the service could be maintained.

8.11. Moreover, it is difficult to gauge the degree of confidence that can be placed on assurances of appropriate change in relation to the establishment of an effective multidisciplinary approach to therapy when it is evident from the State Coroner's findings in the matter of the death of Michaela Jayne Mundy[120] who died after these events on 9 July 2012, and which matter had also involved the services provided within the Mount Barker CAMHS office, that Ms Mundy's therapy also failed to embrace a multidisciplinary team approach, the therapy having been provided solely by Ms Hotich between July and November 2011.

[117] Transcript, page 525
[118] Transcript, page 557
[119] Transcript, page 557
[120] Inquest 25/2013

8.12. Mr Skene also gave some evidence concerning the place of medication in the treatment of adolescents. I have already referred to the NICE guidelines, a copy of which was attached to Mr Skene's affidavit. He also referred to the Suicide Prevention Australia guidelines. Mr Skene suggested that the guidelines, and the literature, all said the same thing, namely:

> 'Basically, that someone 15 years or younger should not be medicated in the first instance and certainly not in the first three months of treatment and that that should only be considered if they don't respond to other forms of treatment.' [121]

In this context when asked about the types of medication that might be prescribed for anxiety and depression, Mr Skene acknowledged that, as a psychologist with no prescription rights, he was not an expert in psycho medication, but he said this:

> 'Some of those things, there are warnings associated with them because there are particular medications that are in the first two or three weeks of the young person taking them, the risk of suicide is greatly increased, and that is well known and well documented.' [122]

The suggestion by Mr Skene that particular medications result in the risk of suicide being greatly increased, and which was a circumstance that was well known and well documented, would be strongly resisted by the independent psychiatrist Professor Robert Goldney, whose evidence I will discuss in detail in due course. Mr Skene did acknowledge that if the clinical judgment was that medication was considered to be appropriate in the case of a particular individual[123], it would be the responsibility of the prescribing clinician to make that assessment. However, he also asserted in his evidence that the provision of medication was very rare in their client load[124]. This approach to treatment of the young would naturally come as no surprise in the light of Mr Skene's beliefs regarding the risks associated with the use of medications in young persons and having regard to his position of authority within CAMHS.

8.13. Mr Skene acknowledged that in the case of Jason Hugo-Horsman there were a number of '*clear inadequacies*'[125] which in the main, in his view, involved inadequate record making as opposed to inadequate clinical therapy. He referred in this context to the absence of use of risk assessment tools other than within the initial

[121] Transcript, page 491
[122] Transcript, page 492
[123] Transcript, page 574
[124] Transcript, page 508
[125] Transcript, page 518

documentation at the beginning of Jason's therapy[126] and the lack of an adequate care plan, save and except for the first[127]. In particular, in respect of Jason's Panadol overdose and the reported episode of violence, he referred to the absence of any evidence that a number of pertinent questions had been asked or noted, such as whether Jason had taken all of the drugs that were available.

8.14. Mr Skene acknowledged that the information that was imparted to Dr Shannon should have prompted a further risk assessment and an adjustment of Jason's care plan[128].

8.15. Mr Skene also believed that it was an omission on Dr Shannon's part to have failed to place notes of her first session with Jason on 2 August 2010 in his file. As well, Mr Skene regarded the failure of the August communication from Mr Dunn of the Mount Barker High School to have been passed on to the relevant therapist at CAMHS to constitute a significant omission. Mr Skene regarded that as a highly significant communication[129] as it was relevant to Jason's risk of self-harm. He agreed that this information, coupled with the later revelation about the Panadol overdose, would have warranted appropriate action in regard to the assessment of Jason's mental state[130]. He stated that there subsequently should have been very close scrutiny of Jason, possibly culminating in a decision to take Jason to the Women's and Children's Hospital Emergency Department for further assessment. He regarded an actual attempt at suicide as being one of, if not the most important of, the five major indicators generating concern in young people.

8.16. Mr Skene was asked to comment upon the fact that Jason ultimately disengaged himself from the service at a time when his risk was high. He suggested that it would have been appropriate in such circumstances to attempt to make contact with the individual or the family in order to ascertain the child's '*level of safety*'[131]. He stated that one had not only to consider risk factors, but protective factors as well. He suggested the following by way of a protective strategy:

> 'If you felt that there were sufficient protective factors in place, in other words, the family were aware, they were very vigilant, they didn't have any weapons or firearms or if they did they were safely locked away, those sorts of things would be the things that I would check on to make sure that the family was aware and also that they knew what to

[126] Transcript, pages 251-253
[127] Transcript, pages 520, 523
[128] Transcript, page 524
[129] Transcript, page 564
[130] Transcript, page 565
[131] Transcript, page 566

> do in terms of both closely monitoring the young person as much as possible or if they felt that there was a sudden deterioration or improvement in their demeanour, any sudden change in their demeanour that they should act quickly to take them to the Children's Hospital.' [132]

Such an approach would naturally accord with common sense, but unfortunately, as seen, there was no such strategy even considered in Jason's case.

9. The evidence of Dr Catherine Ludbrook

9.1. Dr Catherine Ludbrook is a psychiatrist. She is a Fellow of the Royal Australian and New Zealand College of Psychiatrists and has a Certificate of Child and Adolescent Psychiatry from the same College. Dr Ludbrook is currently a consultant psychiatrist in private practice. Among other duties, Dr Ludbrook spends a number of hours each week employed by the Boylan Inpatient Services at the Women's and Children's Hospital in a teaching capacity. Dr Ludbrook specialises in adolescent and young adult psychiatry.

9.2. Dr Ludbrook was asked by counsel assisting the State Coroner to provide an overview of and a report in relation to Jason's management prior to his death[133]. As well, Dr Ludbrook gave oral evidence in the Inquest.

9.3. Before turning to Dr Ludbrook's evidence concerning Jason's management it is as well to refer to some general evidence that she gave about matters such as medication for adolescents and the need or otherwise for diagnosis of a specific mental illness in an adolescent.

9.4. Dr Ludbrook's approach is that when she sees teenagers she assesses their mood and any mental health sickness the person might have, all of the stresses in their life and to develop a plan as to how she would address that situation. She would use antidepressants if she felt they were warranted as an adjunct to her plan. She does prescribe antidepressant medication in her practice. Dr Ludbrook added that in making a decision as to whether or not to prescribe, and in respect of what medication might be prescribed, she regarded continued oversight of a case and the monitoring of psychiatric symptoms involved, such as depression and anxiety, as important[134]. Continuity of care also meant that one could monitor risk. Dr Ludbrook did not

[132] Transcript, page 566
[133] Exhibit C24a
[134] Transcript, page 680

regard it as essential for a formal diagnosis to be made before antidepressant medication such as Prozac (fluoxetine) could be given to an adolescent[135]. Nevertheless, she stated that if one is not going to assign a specific label to an illness, it is important to otherwise provide a formulation that provides direction to the appropriate treatment[136]. Dr Ludbrook told the Court that one would look at each individual on a case by case basis and that if she felt that when looking all of the factors that might be contributing to a mental illness that little headway in terms of improvement was being made, and if the adolescent was finding it extremely difficult coping, she would explore with the adolescent and his or her parents the advantages and disadvantages of antidepressants. Whenever Dr Ludbrook prescribes antidepressants she includes the parents in the decision making process.

9.5. As to the known reluctance in some quarters to prescribe SSRIs[137] to an adolescent, Dr Ludbrook acknowledged that the evidence for the benefit of antidepressants in adolescents is significantly less than in the case of adults, and that fact combined with recognised concerns regarding increased suicidal ideation and agitation means that one would need to balance the risks associated with prescription of SSRIs against the possible benefits[138]. I observe there that Dr Ludbrook appeared to distinguish increased suicidal ideation as a result of SSRI consumption from increased incidence of actual suicide. Dr Ludbrook did not at any time suggest that antidepressant medication in adolescents gave rise to an increase in the incidence of actual suicide, which as already seen was the view that Mr Skene appeared to articulate in his evidence. Professor Goldney, as will be seen, expressed a more robust view about the benefits of anti-depressants.

9.6. As to the question of diagnosis generally, Dr Ludbrook expressed the view that while it is possible to place symptoms into a diagnostic category, it is not necessarily helpful. However, Dr Ludbrook was of a firm view that in any event it is still necessary for those treating the individual to keep their eye on the risk of self-harm[139].

9.7. Dr Ludbrook gave some general evidence concerning the issue of risk of self-harm. She suggested that the most accurate assessment of risk is achieved when the therapist has developed a strong therapeutic relationship with a young person. She suggested

[135] Transcript, page 683
[136] Transcript, page 683
[137] Selective Serotonin Reuptake Inhibitors – a commonly prescribed form of antidepressant.
[138] Transcript, page 685
[139] Transcript, page 683

that much effort needs to be devoted to that issue. Once such a relationship is developed, the adolescent tends to be open and this enables a more accurate assessment of risk[140].

9.8. Dr Ludbrook expressed a view about the need to interact with general practitioners in the management of an adolescent and stated that in cases where the therapist is aware that a young person is seeing a general practitioner, communication between the treating mental health service and the general practitioner is important[141].

9.9. In her report Dr Ludbrook expressed a number of opinions about the management of Jason. She states that there were several areas in which communication, documentation, assessment and follow-up could have been improved. However, she did not think that it could be said that these factors directly contributed to his death. She expressed a further view that she believed that the most protective factor in Jason's management would have been the development of a stronger therapeutic alliance with Jason.

9.10. After having read the transcript of evidence given prior to Dr Ludbrook's own evidence, she told the Court that she had formed a clearer picture in her mind of what had been an escalation of risk as presented by the Panadol overdose and the phone call that she understood had been made from the school. She expressed the view that she believed that all of that lent weight to the advisability of Dr Shannon continuing an oversight of the case including the monitoring of psychiatric symptoms, in particular those of depression, anxiety and of the facts associated with those symptoms. She expressed the view that continuing oversight would have enabled monitoring of the risk and thereby have provided greater clarity in respect of decisions such as those in respect of medication that might be utilised. Dr Ludbrook suggested that if the psychiatrist Dr Shannon had maintained the principal ongoing contact with Jason, she would have been in a better position to make such decisions[142]. Dr Ludbrook also believed that it was important for CAMHS to have continued to attempt to re-engage with a person in Jason's circumstances, and the lengths to which one might go in order to do that would depend on the level of risk that had been assessed. Dr Ludbrook also believed it was important for Ms Hotich and Dr Shannon to have held a discussion as to the engagement process, including a consideration of

[140] Transcript, page 693
[141] Transcript, page 702
[142] Transcript, page 680

such matters as which of them had formed a better therapeutic alliance with Jason. All this was important especially given that Jason disengaged himself at a time of risk. Dr Ludbrook expressed a firm belief that it was Dr Shannon who had been in a better position to assess that ongoing risk and to manage it[143].

9.11. Dr Ludbrook raised two other criticisms of Jason's management, the first being that the communication between CAMHS and the general practitioner was inadequate at times and that a lack of coordination in such circumstances means that it is difficult to provide optimal treatment. The other area of criticism concerned the manner in which the revelation of Jason's moods on Saturday nights had been managed. While acknowledging in her report that many decisions are made throughout sessions as to what to explore and what to leave, Dr Ludbrook suggested that it may have been helpful for Ms Hotich to have explored Jason's statement about his biggest mood swings occurring on Saturday nights. In her oral evidence Dr Ludbrook reiterated that view[144]. She suggested that this had been an opportunity to establish Jason's tolerance of being alone.

10. The evidence of Professor Robert Goldney

10.1. Professor Goldney is a psychiatrist who was also requested by counsel assisting the Coroner to provide an overview of and report[145] in relation to Jason's management. Professor Goldney also gave oral evidence at the Inquest.

10.2. Professor Goldney is a former Head of the Discipline of Psychiatry at the University of Adelaide and a past President of both the International Association of Suicide Prevention and the International Academy of Suicide Research. Professor Goldney told the Court that the topic of suicidal behaviour and mood disorders has been his primary area of research. Suicide and suicide prevention was the subject of Professor Goldney's doctoral thesis. He has addressed adolescent development and suicidal behaviour, including in relation to the use of antidepressants. Professor Goldney has conducted a clinical practice throughout his career.

10.3. Before dealing with Professor Goldney's evidence concerning the management of Jason Hugo-Horsman, I mention some aspects of evidence that Professor Goldney

[143] Transcript, page 700
[144] Transcript, page 695
[145] Exhibit C19

generally gave in relation to suicide and suicide prevention, particularly as it relates to adolescents and young people.

10.4. Professor Goldney told the Court that in the last few years there has been an increase in adolescent suicide, including in Australia[146], for reasons that are perhaps not fully understood. Indeed, Dr Ludbrook had given similar evidence. However, Professor Goldney postulated a twofold explanation for this increase, being the decreasing incidence of diagnosis coupled with a reluctance on the part of the medical and psychiatric profession to prescribe antidepressant medication to adolescents[147]. Professor Goldney told the Court that people have been '*too scared to diagnose and treat depression in adolescents*'[148] and opined that the evidence is now pointing towards a trend whereby antidepressants were not being utilised enough in young people. Professor Goldney recounted that in 1990 a paper had been published expressing concern about the possibility that newly discovered SSRI medications might be associated with suicidal behaviour. Subsequent to that there were a number of studies undertaken which examined the same question and although an association with suicide was not definitely demonstrated, there was believed to be a link between medication and suicidal ideation and agitation. That caused certain regulatory authorities, including those in Australia, to issue a 'black box warning' which led to a reduction in the use of antidepressant medication and a reduction in the diagnosis of depression in younger people. More recently, however, one study undertaken revealed that less than 2% of adolescents who died by suicide had actually taken antidepressants. Professor Goldney stated that when one considers that depression is the most common diagnosis in people who commit suicide, including adolescents, '*it's really inconceivable to consider that, you know, antidepressants have stimulated suicide*'. Professor Goldney postulated that a more likely explanation for increasing suicide trends is that antidepressants have not been used sufficiently in young people with depression. The consensus now, according to Professor Goldney, is that the pendulum has swung too far and that the warnings about antidepressants and suicide are now considered to have been '*a little bit over the top*'[149]. In 2010 a joint paper

[146] Transcript, pages 713, 798
[147] Transcript, page 798
[148] Transcript, page 713
[149] Transcript, page 713

based on several studies[150] compiled by experts including Professor Goldney, concluded that:

> 'The rarity of SSRI usage prior to adolescent suicide is not supportive of the assertion that SSRIs are associated with increased suicide in young people. Given the prevalence of depression associated with youth suicide, it favours the conclusion that most adolescents dying by suicide have not had the potential benefit of antidepressants at the time of their deaths. This finding should allow practitioners, with appropriate precautions and as part of a comprehensive management plan, to more confidently prescribe SSRIs for young people with moderate to severe clinical depression.'

More recently a paper published on 23 January 2014 by Goran Isacsson of the Department of Clinical Neuroscience, Karolinska Institutet, Karolinska University Hospital – Huddinga in Stockholm Sweden and C L Rich, Professor Emeritus of Psychiatry at the University of South Alabama, USA expressed the same general conclusions[151]. This paper explored the data leading to the black box warnings to which I have already referred and also addressed the effectiveness of antidepressant treatment in general and the relationship of suicide rates to antidepressant treatment. It concluded with certain recommendations in respect of the use of antidepressants in the treatment of young people. The conclusions expressed by the authors of this paper included the following: that in the decade following the issuing of warnings regarding suicidality among young people taking antidepressants there had been a number of observations including that there had been a measurable decrease in the diagnosis of depression and the prescribing of antidepressants in several countries including the US, the UK, Canada, Australia and Sweden, but that there had been a measurable increase in the numbers of suicides among young people in the same countries with the exception of the UK. The authors observed that there is no evidence of the emergence of increased risk of suicide among young people who use antidepressants. Indeed, a large independent study had found that antidepressant medication, specifically fluoxetine (Prozac), was the most effective treatment for major depression in young people. In that study there had been no observed increase in treatment emergent suicidality. The other key conclusion of the authors was that the black box warnings had been based on biased data and invalid assumptions, one explanation being an element of confusion between suicidality with actual incidence of suicide. The authors of the paper recommended firstly that drug authorities

[150] 'Are adolescents dying by suicide taking SSRI antidepressants? A review of observational studies' – 2010 Dudley, Goldney and Hadzi-Pavlovic

[151] Exhibit C19c entitled 'Antidepressant Drugs and the Risk of Suicide in Children and Adolescents' – Goran Isaacson, Charles L Rich, published online 23 January 2014

revaluate the basis for imposed warnings on antidepressant medicines and that in the absence of substantial evidence supporting the warnings they should be removed. Secondly, they recommended that physicians and other health providers with prescription privileges should continue to be educated regarding the importance of aggressively treating depression in young people, using antidepressants when indicated and, thirdly, that physicians and other professionals who treat depressed young people must always be aware of the risk of suicide and observe them closely for any signs of increased risk of suicide and that this approach was necessary regardless of the type of treatment being provided.

10.5. On more than one occasion during his evidence Professor Goldney scathingly referred to the evidence that had been given by Mr Skene about the association between antidepressant medication and suicide. Professor Goldney told the Court that Mr Skene's evidence literally worried him. He said that Mr Skene was quite wrong when he said that it was well documented that suicide is increased in young people taking antidepressants. It will be recalled that Mr Skene told the Court[152] that the risk of suicide is greatly increased and that this was well known and well documented. Professor Goldney regards that assertion as being absolutely wrong. Professor Goldney acknowledged that there was some evidence that suicidal ideation might be increased, but there was no evidence that the incidence of actual suicide was increased[153]. Professor Goldney added:

> 'If in fact that is the sort of attitude that is permeating that service, I fear for it. It's just wrong.' [154]

Professor Goldney's reference to the 'service' was an allusion to the fact that Mr Skene's statement about the link between antidepressants and suicide in the young was made in his capacity as the Director of Southern CAMHS. I have allowed for the possibility that in his evidence Mr Skene was referring to an increase in suicidal ideation as distinct from the incidence of actual suicide, but it is clear that Mr Skene's remarks had been calculated to validate the reticence within his service to prescribe antidepressants in the young when recent evidence suggests that this approach needs to be revised. I add here that whatever interpretation is to be placed on Mr Skene's evidence I prefer the evidence of the eminent psychiatrist Professor Goldney.

[152] Transcript, page 492
[153] Transcript, pages 715, 818
[154] Transcript, page 715

10.6. In respect of antidepressant medication, Professor Goldney made the following additional observations:

- There are occasions when a person's depression may be so severe that one would seriously consider the use of antidepressants even initially;
- One may use antidepressants in conjunction with other therapies;
- That in a case where a person has continuing symptoms, it might be appropriate to conduct a trial of antidepressant medication because, to use Professor Goldney's expression, '*if you hit upon the right medication it can make an enormous difference to the person*'[155];
- That one might use antidepressants in children or adolescents regardless of whether three months has elapsed or a number of sessions with no response have transpired, in other words when the NICE guidelines have not yet been fulfilled; he said, 'So there are some children adolescents who are so depressed, that to leave them for four sessions is simply untenable, because there are some adolescents, they can be so depressed, their concentration is so poor that they can't attend or participate in some of the CBT therapy sessions.' [156]

In this regard it will be remembered that Jason evinced little in the way of motivation to engage in the therapies offered by Ms Hotich and, in the event, regarded his whole engagement with CAMHS as a waste of time, hence his disengagement from that service.

10.7. As to the question of diagnosis in adolescents, Professor Goldney opined that as far as mental illness is concerned, he believed that the same principles applied in respect of the treatment of both adults and adolescents. He suggested that there was a need to develop a very good clinical therapeutic relationship with the patient, be they an adolescent or an adult. In respect of the management of adolescents specifically, Professor Goldney said that it is necessary to have regard to the fact that major illnesses experienced in adulthood such as severe depression, bipolar disease and schizophrenia can develop in mid to late adolescence. While acknowledging that in adolescence one might not have a clear delineation of the disorders, one might see the disorders in evolution. Thus if a person has severe symptoms it is important to consider what these illnesses might be developing into. In Professor Goldney's opinion the sooner one can pick up a diagnosis, or a provisional diagnosis, the sooner one can offer appropriate management[157]. Professor Goldney was of the view that there did not appear to have been an appreciation of the possibility of an emerging

[155] Transcript, page 719
[156] Transcript, page 757
[157] Transcript, page 718

serious mental illness in Jason's case. That said, Professor Goldney acknowledged that there may be disorders that are gradually emerging which do defy neat diagnostic classification. Such disorders might begin with vague feelings of unease and anxiety followed by depression, but with no traumatic symptomatology until the age of 19 or 20[158]. Professor Goldney that one has to keep one's options open in any diagnostic exercise.

10.8. In any event Professor Goldney, like Dr Ludbrook, was of the view that it is still necessary to consider the question of risk of self-harm and that one needed to obtain a good clinical history that involves asking questions about suicidal thoughts, suicidal plans, whether the person has the means to kill himself, whether there were ruminations about death and other severe symptoms of depression such as the hearing of voices. Professor Goldney expressed the opinion that these questions had to be repeated over time in order to properly monitor the progress of the person over that period of time. Professor Goldney agreed with cross-examining counsel that a person with significant risk of self-harm who presented to an organisation such as CAMHS should ideally be seen by the most senior clinician in the office[159].

10.9. Professor Goldney has a view about the significance of cutting. Its significance in his view depends upon the nature of the cutting, whether it was deep cutting as distinct from more delicate cutting, the former being of greater significance and possibly indicative of the emergence of a psychotic illness. Although cutting elevates risk to a lesser degree, even delicate cutting in his view can be associated with an increased rate of suicide in the longer term. In any event Professor Goldney stated that cutting is an indication of psychopathology which needs to be taken seriously. He regards cutting as something of a 'crossing of the Rubicon' and something that places the self cutter into a different category. In older people it is almost certainly an indicator of severe depression, whereas in most adolescents it is a relatively transient phenomenon. Regardless, the adolescent is more at risk for later having depression or of subsequently killing themselves[160].

10.10. As far as the operation of multidisciplinary environments is concerned, Professor Goldney stated that in a multidisciplinary team that is working well one enlists the assistance of colleagues. Professor Goldney made the observation that in a

[158] Transcript, page 727
[159] Transcript, page 819
[160] Transcript, page 763

multidisciplinary setting it might be purely serendipitous as to the type of therapist to whom a patient is assigned. This might also result in the patient being '*stuck with somebody who, you know, doesn't sort of fit you*'[161]. Professor Goldney said that there is a need for proper triaging at the time at which the patient first presents, such triaging being totally consistent with the multidisciplinary team approach[162].

10.11. I turn to Professor Goldney's opinions in respect of Jason's management. It should be made clear to begin with that Professor Goldney had access to material in the form of Facebook communications, musings and drawings on the part of Jason that were discovered only after his death and which, therefore, were not available to those treating him, a circumstance that Professor Goldney understands. I did not regard Professor Goldney's knowledge of this material as having coloured or influenced his expert opinion as to the proper management of Jason prior to his death.

10.12. Professor Goldney expressed the view that with the benefit of the subsequently discovered material, in other words with the benefit of hindsight, Jason was perhaps closer to the point of having developed a psychotic illness, possibly mixed affective disorder, but in any event even without recourse to that material in his view there was something significant happening with Jason and that Jason's matter had not been a case involving simple family issues. Professor Goldney suggested that there had been many pointers to something sinister gradually emerging with Jason. He was of the view that there had been a number of missed diagnostic opportunities. For example, from the initial assessment of Jason there had been several psychometric instruments that had been used that pointed to something more severe than psycho-social problems[163]. Professor Goldney regarded the DASS questionnaire as not having been understood by the person who had administered it. He opined that the severity of Jason's responses were not appreciated[164]. Jason's case was more complex than a case involving the outpourings of a young man rejected by his girlfriend[165]. Similarly, Professor Goldney expressed the view that Ms Hotich appeared to have placed undue focus on Jason's mother's issues rather than on Jason himself[166].

[161] Transcript, page 821
[162] Transcript, page 821
[163] Transcript, page 731
[164] Transcript, page 731
[165] Transcript, page 732
[166] Transcript, page 744

10.13. Professor Goldney on more than one occasion in his evidence suggested that when Jason's management was looked at in the round, CAMHS had merely '*fiddled at the edges*'. He regarded some of the therapeutic techniques administered by Ms Hotich as '*just crazy stuff*'[167]. While acknowledging that some of those measures might help some people, they do not help people who have a significant psychiatric condition. He believed that some measures would not have provided much benefit in addressing depression or anxiety in Jason. It was not surprising to Professor Goldney that Jason had tended to reject those measures. As another example of what he meant by fiddling at the edges, Professor Goldney pointed to the prescription of diazepam of Dr Shannon. He regarded the prescription as illogical, likening it to administering cough mixture for pneumonia. The difficulty was that the diazepam prescription was not calculated to address Jason's underlying problem[168]. Moreover, Professor Goldney suggested that there are certain dangers associated with the prescription of a sedative in a case such as Jason's where the sedative effect may lead to disinhibited behaviour[169]. While Professor Goldney acknowledged that it could be argued that the prescription of diazepam was reasonable, he added that he did not think it was prudent, and as seen before viewed it as another example of fiddling at the edges and not properly addressing the underlying problem. The fact that there was no subsequent monitoring of Jason's diazepam consumption was also a matter for concern[170].

10.14. As to the question of antidepressant medication, Professor Goldney was of the view that medication other than diazepam should have been considered. As to the question of whether an SSRI should have been considered, Professor Goldney said that he would have preferred for Jason a trial of a so-called atypical antipsychotic drug which is of value in treating mood disorders as well as in dampening down aggression.

10.15. Professor Goldney was of the view that while Jason's mental health fluctuated over time, overall it did not improve[171]. As an example, Professor Goldney regarded the emerging information as to self-harm and Jason's suicidal ideation as an indication of his lack of improvement. He suggested that Jason's mental health went into decline

[167] Transcript, page 758
[168] Transcript, page 806
[169] Transcript, page 766
[170] Transcript, page 750
[171] Transcript, page 745

over a period of time[172]. The fact that he had not improved after the first three or four contacts with CAMHS should have prompted:

> '… clear reassessment of where things were going and particularly with the information about the self-harm and suicidal ideation, a full psychiatric assessment.' [173]

In this context Professor Goldney referred to what appeared to have been a rather casual arrangement between Ms Hotich and Dr Shannon that had involved Dr Shannon babysitting the matter while Ms Hotich was on leave as distinct from the instigation of a proper assessment[174]. Professor Goldney was rather critical of this arrangement. He suggested that Ms Hotich's request that Dr Shannon see Jason should have been made earlier than it was and that a note should have been written explaining Ms Hotich's concerns[175]. As to the timing of when Jason could have been referred to the psychiatrist, Professor Goldney identified the occasion when the DASS test was administered. This was a time when Jason himself was clearly concerned about his condition. He had looked up his symptoms on the internet. Alternatively, Professor Goldney agreed that the 10 June 2010 communication from the school counsellor in respect of concerns of self-harming, suicidal thoughts and truancy would have been an appropriate trigger for referral.

Professor Goldney had a number of other criticisms in respect of Jason's management. Professor Goldney opined that undue focus seems to have been placed on Jason's mother's predicament rather than that of Jason himself. In this regard I refer to the numerous occasions upon which Ms Hotich was engaged in consultations with Jason's mother alone. Professor Goldney questioned the impression this may have made on Jason, having regard to a need on Jason's part no doubt to have felt '*special*'[176] and the fact that the problem was that of Jason's as distinct from that of his mother. Professor Goldney expressed the view that it was as a result of Jason thinking that he was not getting what he felt he needed that he probably became disengaged from the service[177].

10.16. Professor Goldney was also critical of the fact that there was no contact between CAMHS and the general practitioner. Professor Goldney believes that having noted

[172] Transcript, page 745
[173] Transcript, page 780
[174] Transcript, page 745
[175] Transcript, page 781
[176] Transcript, page 744
[177] Transcript, page 745

an intention to initiate contact with CAMHS, the general practitioner should have done so. Professor Goldney suggested that the failure to do so was somewhat mitigated by the fact that Dr Eskandari-Marandi could reasonably have believed that CAMHS knew what they were doing and that Jason was in safe hands.

10.17. Professor Goldney had a number of criticisms in respect of the handling of the case by Dr Shannon. Professor Goldney questioned Dr Shannon's appreciation of the significance of the incident involving the Panadol overdose and the contemporaneous events involving Jason's mother. Professor Goldney was unimpressed by the fact that in Dr Shannon's own evidence she apparently could not recall if she had asked Jason about suicidality on the occasion of the appointment on 30 August 2010. Professor Goldney said:

> '… to not be able to recall if she'd asked about suicide with him, doesn't seem to me to be consistent with her being fully alert to the gravity of the situation.' [178]

To be fair, although Dr Shannon did not make any notation of any enquiry about suicidality at the 30 August consultation, she did say that she believed such an enquiry did happen but that it did not get recorded[179]. However, Dr Shannon agreed with me that if on that occasion she had made any enquiry of Jason about suicidality there would have been no more obvious question to ask than why he had consumed the Panadol. She believed that his answer had been along the lines of that he felt like giving up or that he did not want to go on or that he did not want to have his life any more[180], all of which would be worrying answers that one would have expected to see noted. There is not note. Professor Goldney suggests that if Dr Shannon had asked more questions about Jason's involvement with a knife she may have uncovered other worrying behaviour, and that he strongly suspected that if such had emerged her concern would have been greater[181]. Once it was interpreted that Jason's overdose of Panadol was behaviour that put had his life at risk at the very minimum, Professor Goldney remained unconvinced that a full clinical assessment had then been undertaken; at the very least it was not properly documented. Such assessment should have included inquiries as to whether Jason had in fact wanted to kill himself, whether since the overdose he had experienced persistent ruminations about death, whether he could sleep, as to the quality of his powers of concentration and whether he had the

[178] Transcript, page 804
[179] Transcript, page 372
[180] Transcript, page 374
[181] Transcript, page 804

means at his disposal to end his own life. Depending upon the result of those inquiries, a medical practitioner might then have to consider whether a person in Jason's position should be admitted to hospital[182]. Professor Goldney did not regard the letter and attachments that Dr Shannon sent to Jason and his parents on 30 August 2010 as an adequate care plan. For example, there should have been documentation about Jason's medication and about responsibility for following his progress up in respect of that aspect of his treatment. There also needed to be clear delineation of what the current treatment in respect of Jason was[183]. Professor Goldney saw no documentation that he would have considered to be a care plan in the later part of his treatment. He regarded it as imperative that new and updated care plans be compiled and placed on the file at various points in time. The events and circumstances that should have prompted periodic revision of Jason's care plan included the accumulated knowledge about self-harming behaviour, his suicidal ideation and the lack of response to treatment. In this context Professor Goldney referred to the fact that CAMHS' procedures in any event appeared to require an updated care plan every three months regardless of the circumstances[184].

10.18. As far as risk assessment is concerned, Professor Goldney opined that an assessment of risk of suicidal behaviour should have been undertaken by Dr Shannon. Professor Goldney reiterated that there appeared to be no evidence of any proper inquiry of Jason of matters relevant to risk when he was seen on 30 August 2010[185]. Professor Goldney expressed the view that a person who presents to CAMHS with significant risk should ideally be seen by the most senior clinician within CAMHS, and that would be the most senior clinician in the office[186]. While the fact that it was appropriate for 'primary care' to be handed back to Ms Hotich by Dr Shannon on or around 30 August 2010, there should have been continuing input from the medical practitioner to monitor medication. The difficulty was that in Professor Goldney's view there did not appear to have been a full assessment made by Dr Shannon. If she had conducted a full assessment she may have appreciated that she was the person in the best position clinically to manage and monitor Jason due to the possibility of an

[182] Transcript, page 755
[183] Transcript, page 771
[184] Transcript, page 772
[185] Transcript, pages 742- 743
[186] Transcript, page 819

emerging severe psychiatric illness. Professor Goldney said that Ms Hotich was not in a position to do that whereas a psychiatrist is. He said:

> 'That would be the way that a consultant should operate in that setting, but I don't think she got to that stage because of not taking a full assessment and history of what happened.' [187]

In this regard Professor Goldney referred to the undesirability of a service operating when it only possesses a part-time psychiatrist. Nevertheless, genuine concerns about an individual patient needed to be stated and documented regardless[188].

10.19. Professor Goldney expressed reservations about Ms Hotich's knowledge about risk of a person who is engaged in suicidal behaviour. He regarded it as a non-sequitor for Ms Hotich to have been on the one hand concerned about Jason's state of mind but on the other not entertaining concern that he would actually kill himself. He pointed out that on the basis of the literature, if a person has engaged in self destructive behaviour, that person is by definition more likely to kill him or herself in the long term. He did not believe that a social worker was trained to appreciate these aspects of risk. He referred to the paradox of a person in Ms Hotich's position not knowing what she did not know[189].

10.20. For the Court's part, I do not accept that Dr Shannon conducted a proper and adequate risk assessment of Jason on the occasion of the appointment of 30 August 2010. No such assessment is documented. No concerns were drawn to the attention of the office manager, Ms Duckworth, herself a qualified psychologist. There was no proper handover between Dr Shannon and Ms Hotich when Ms Hotich returned from leave. The file was simply handed back with an expectation on Dr Shannon's part that Ms Hotich would see the references to the concerning matters that had been documented, namely the Panadol overdose and the incident between Jason and his mother. A proper evaluation of risk would have involved Dr Shannon specifically drawing all of that to Ms Hotich's attention. It would also have involved in the opinion of the Court Dr Shannon herself having a continuing input into the matter. In short, if Dr Shannon had properly conducted a risk assessment, the manner in which Jason's case was handed back to Ms Hotich would not have been so casual.

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[187] Transcript, page 770
[188] Transcript, page 770
[189] Transcript, page 759

10.21. Professor Goldney had a number of things to say about the CAMHS structure and they manner in which it operated. He regarded the structure as not ideal. He aligned a number of shortcomings within Jason's management with certain unsatisfactory aspects of the structure. He believes that any notion that the various therapists are equal in expertise in his view is to be rejected. He believes that a psychiatrist has special training which social workers and psychologists do not have. Furthermore, a psychiatrist has more effective means to engage other medical services. In addition, some general practitioners have a reluctance to send patients to a service such as CAMHS, seeking a psychiatric opinion, only for the patients to be assessed by whoever is on call thereby not obtaining the opinion sought. Professor Goldney questioned why a reasonable assessment made by a general practitioner should be followed by the backward step of the patient then being seen by a social worker or psychologist, and then, at the whim of the social worker or psychologist, the patient may see a psychiatrist only '*down the track*'. Professor Goldney described such a scenario as '*crazy*'[190]. In short, while he appreciated that some of his views are considered as '*heretical*'[191], Professor Goldney was of the view that the ideal structure involves having the best available and best qualified person seeing the patient[192].

10.22. Professor Goldney referred to mental health services such as CAMHS, while outwardly asserting to be part of a general healthcare system, being something of a '*law unto themselves*'[193]. He did not regard there being any worthwhile dichotomy being drawn between a medical service and a therapeutic service. He eschewed any such difference and was critical of the '*anti-medical ethos of some of those services where, you know, severe psychiatric illness simply isn't sort of acknowledged*'[194]. And Professor Goldney referred to the assertion that CAMHS employed a multidisciplinary approach as '*playing with words*'[195]. While acknowledging that social workers and counsellors were important in such a structure insofar as they have expertise in areas that a psychiatrist does not have[196], and while also acknowledging the utility of psychologists whom he regarded as being '*extremely good*'[197], particularly in relation to cognitive behaviour therapy when administered properly,

[190] Transcript, page 774
[191] Transcript, page 775
[192] Transcript, pages 774-775
[193] Transcript, page 784
[194] Transcript, page 776
[195] Transcript, page 785
[196] Transcript, page 776
[197] Transcript, page 777

Professor Goldney referred to the danger presented by therapists not knowing what they do not know.

10.23. Professor Goldney suggested that there could be improvements in the structure of CAMHS. While acknowledging that there is a place for the multidisciplinary approach in the structure, he observed that Jason's matter was all undertaken in a '*very leisurely way*'[198]. In Professor Goldney's view there appeared to be an element of serendipity about the type of therapist a person is assigned to. Professor Goldney's view is that there is a need for proper initial triage[199]. Professor Goldney believes that it would be more therapeutic if a person were able to see the most experienced person in the first instance, thereby saving much time and effort. While acknowledging that there may be issues concerning availability of child psychiatrists in the first instance, Professor Goldney believed that the management structure and pervasive ethos of CAMHS was a difficulty. He said:

> 'And that is partly influenced by politicians, who think they're going to get a better service on the cheap by employing people who may not have as high a qualification.' [200]

Professor Goldney was of the view that the idea that persons should not have their conditions medicalised needs to be challenged[201].

10.24. When specifically asked as to how one might improve the structure of CAMHS, or at least the service provided by the structure, Professor Goldney said a number of things including the desirability to have the best trained person in a leadership role, being a person whose views would be respected by others in the service[202]. In this regard Professor Goldney said a psychiatrist has undertaken broader training and has wider experience and is able to incorporate some of the biological as well as the psychosocial issues.

11. <u>Was Jason Hugo-Horsman's death preventable</u>

11.1. In her report Dr Ludbrook expressed the opinion that there were a number of areas in which communication, documentation, assessment and follow-up could have been improved. However, she did not believe that these factors directly contributed to Jason's death. Whether they had indirectly contributed was in her view very difficult

[198] Transcript, page 778
[199] Transcript, page 821
[200] Transcript, page 788
[201] Transcript, page 826
[202] Transcript, page 778

to judge. She did express the opinion, however, that the most protective factor would have been the development of a stronger therapeutic alliance with Jason. This would have maximised his chances of talking about and addressing the multiple stressors in his life, which in turn may have reduced the instability of his mood.

11.2. Dr Ludbrook spoke of the scenario in which Jason was home alone on Saturday evenings. In her report she suggested that it may have been helpful for Ms Hotich to have explored Jason's statement that he had experienced his biggest mood swings on Saturday nights when his family were at a friend's residence and during which he would engage in crying and cutting. In her oral evidence Dr Ludbrook reiterated that Jason's tolerance or otherwise of being alone in this scenario was a matter that she would have liked to have explored[203].

11.3. In his evidence Professor Goldney stated that he regarded the Saturday night scenario as a vulnerable time for Jason. Professor Goldney appeared to entertain the view that it would have been natural for Jason's parents to have realised that Jason would have been distressed about having to stay at home as a result of any curfew. In addition, the need for Jason's parents to keep an eye on him because of potential suicidality was a matter that he hoped would have been understood by them[204]. I am not certain that I would agree with this approach in the particular circumstances that prevailed. As seen earlier, Mr Horsman believed that it was of benefit for Jason to have time to himself. He did not appreciate that there was any risk of him being left alone on Saturday evenings. There had been no occasion on which Jason had been found distressed or crying after such an event. I think it fair to conclude that Mr Horsman did not know of Jason's vulnerability in respect of this scenario. In his written final submission to the Court, Mr Horsman states that he still does not understand why Dr Shannon did not see that Jason, and even his immediate family, were possibly at serious risk and why she did not warn Mr Horsman of the possible consequences. He states that he would not have left Jason alone for extended periods such as on the occasion of his death.

11.4. It is easy to be wise after the event, particularly having regard to the fact that Jason took his own life in the very circumstances that he himself had described to CAMHS as giving rise to his greatest emotional instability. On the other hand, it would not

[203] Transcript, page 695
[204] Transcript, pages 752-753

have been a difficult thing for Jason's parents to have been advised of Jason's frame of mind on a Saturday evening and that this scenario should be avoided in the future.

11.5. In his written final submission Mr Horsman acknowledges that there were a number of contributing factors over a long period of time in respect of Jason's decision to take his own life. Mr Horsman states that he understands that even if Jason had not ended his life when he did, that he still would have been at high risk, perhaps for a long time, and may have ended his life sometime in the future for other reasons.

11.6. Professor Goldney in his report states as follows:

> 'Finally, I should emphasise that although I have expressed reservations about certain aspects of Jason's management, this should not be taken as asserting that if the issues I raised had been addressed, then his death would necessarily have been prevented.' [205]

In his oral evidence, Professor Goldney sates that although he does not believe that Jason derived the full potential benefit of the services offered by CAMHS, he states:

> 'So really in a sense he has not had the potential benefit, and I say potential because I can't guarantee that he'd still be alive even if everything I said had take (sic) place.' [206]

12. Conclusions

12.1. The Court reached the following conclusions:

1) In spite of the fact that CAMHS Mount Barker was meant to provide a multidisciplinary service, the only meaningful therapy that was provided was provided by a social worker, Ms Hotich. The involvement of the psychiatrist, Dr Shannon, was transient and if anything was counterproductive in ensuring that Jason would continue to be engaged with the service. I draw the inference that following Jason's consultation with Dr Shannon on 30 August 2010 Jason concluded that there was a pointlessness in continuing to seek assistance from CAMHS and that his father, Mr Horsman, came to more or less the same conclusion. It was a conclusion that was not unreasonably drawn in the circumstances;

2) Ms Hotich continued to engage with Jason as Jason's sole therapist for an unduly extended period of time. Jason demonstrated no meaningful improvement between February and August 2010 when Ms Hotich went on leave for

[205] Exhibit C19, page 13
[206] Transcript, page 779

approximately one month. In the meantime, what did emerge about Jason was that he was at risk of self-harm as evidenced by the information that was imparted by the Mount Barker High School counsellor, Mr Dunn, to Ms Hotich in June 2010. Ms Hotich herself acknowledges that she did not think that she asked Jason about suicidal ideation in the next consultation following her coming into that information[207]. She accepts that she should have. She now acknowledges that she should have referred Jason to another therapist at CAMHS at a point earlier in time than her imminent leave in August 2010. She acknowledges that she felt that the problem became larger than what she was able to cope with[208]. She acknowledges that things had progressed beyond her own capabilities and she acknowledges that this had occurred around the time that the Mount Barker High School counsellor telephoned her in June 2010. It was at this point that she acknowledges that she should have considered referral to the psychiatrist[209]. The Court agrees with all of those acknowledgements. Jason should have been referred to the psychiatrist at Mount Barker CAMHS at the very latest at that time;

3) There was no proper risk assessment of Jason undertaken in June 2010. Nothing was undertaken or done specifically in order to mitigate the risk of Jason committing self-harm. The fact that Jason was considered to be at risk of self-harm had been identified by Jason's general practitioner, Dr Eskandari-Marandi. This belief engendered an intention on Dr Eskandari-Marandi's part to contact CAMHS. In the event, Dr Eskandari-Marandi did not contact CAMHS. It is possible that Dr Eskandari-Marandi's failure to do that is as a result of an erroneous belief on his part that a CAMHS psychiatrist had already been consulted by 28 June 2010 when in fact that was not the case. In any event, Dr Eskandari-Marandi's failure to contact CAMHS is to be regarded as a missed opportunity for those responsible for Jason's therapy at CAMHS to have taken into account genuine concerns on the part of an experienced medical practitioner that Jason was at risk of self-harm;

4) Jason's management and therapy at the hands of Ms Hotich was unduly focussed on Jason's family difficulties and other social issues and not sufficiently premised

[207] Transcript, page 235
[208] Transcript, page 208
[209] Transcript, page 210

on the possibility that Jason was possibly developing a serious mental illness. In any event, his management did not sufficiently take into account the need to address what was known about his risk of self-harm;

5) On or about 18 August 2010 Mr Dunn, the counsellor at Mount Barker High School, spoke by telephone to a female employee of CAMHS' Mount Barker office to inform CAMHS of a conversation that Mr Dunn had with Jason on that day in which Jason had expressed suicidal ideation, and in particular had explained that he had thought it might be easier if he did not exist. Jason also explained that he had identified a means by which he could end his life, namely a cliff in the hills. The Court has not been able to identify with sufficient certainty the female person to whom Mr Dunn spoke on this occasion. Although I make no finding as to the identity of that person, I am not prepared to make a finding that the person was not Dr Shannon. The information was not recorded in the CAMHS file for Jason. Either the information was not properly considered by Jason's therapist, who at that time was the psychiatrist Dr Shannon, or the information did not reach Dr Shannon, either scenario being grossly unsatisfactory;

6) On 30 August 2010 Dr Shannon consulted with Jason and his father. This was the last occasion on which Jason saw any therapist at CAMHS. On this occasion Dr Shannon was advised that in recent days Jason had taken an overdose of Panadol and had been involved in an incident with his mother and police. Dr Shannon interpreted the Panadol overdose as an actual attempt by Jason to take his own life. Certainly, this constituted life threatening behaviour. I find that Dr Shannon did not properly evaluate this information and did not conduct any proper or worthwhile risk assessment in respect of Jason's risk of self-harm and suicide. Nor did she compile any proper or appropriate plan in relation to Jason's continued management;

7) Thereafter, Jason's case was effectively handed back to Ms Hotich. I find that Ms Hotich was not verbally made aware of the information concerning the Panadol overdose and the incident involving Jason's mother and police. There was no effective verbal handover from Dr Shannon to Ms Hotich. Although this information was documented by Dr Shannon in a file note, I have with some hesitation accepted Ms Hotich's evidence that she did not read that note. I find,

however, that it was a significant omission that Ms Hotich either did not read the note or, if the note was not available, properly inform herself through word of mouth consultation with Dr Shannon as to the current status of Jason's matter and his general condition. I find that Dr Shannon should have ensured, by whatever means of communication, that Ms Hotich was aware of the information regarding Jason's Panadol overdose and of his other worrying behaviour of which Dr Shannon was aware;

8) I find that at around the time a decision was made for Jason's matter to be handed back to Ms Hotich upon her return from annual leave, the office principal administrative officer, Ms Duckworth, who was a psychologist, was not properly informed of recent developments regarding Jason, including the information that had been imparted at the 30 August 2010 consultation with Dr Shannon. Any administrative decision that was made in that regard was not a fully informed one. I am not certain when this decision was made. If the decision to have the matter handed back to Ms Hotich had been made prior to Dr Shannon's 30 August session with Jason, the decision should have been reconsidered in the light of the information that would be imparted at that session. If the decision was made after that session on 30 August, the decision should have taken into account the information imparted about Jason at that session;

9) I find that Dr Shannon should have retained oversight of Jason's case, having regard to the existing risk of self-harm. I find that greater efforts should have been made to re-engage Jason with the service following his disengagement on and after 30 August 2010;

10) In my opinion, Jason's parents should have been specifically advised by CAMHS Mount Barker that Jason had experienced low mood to the point of crying and cutting on Saturday evenings when his parents were absent. To my mind the parents should have been advised to avoid that scenario. Jason's death may have been prevented on 9 October 2010 had that particular scenario been avoided. However, it cannot be said with any degree of certainty that Jason's suicide may have been prevented altogether;

11) Regardless of the quality of Jason's management at CAMHS, and that of his general practitioner, it cannot be said with certainty that Jason's suicide would have been prevented;

12) This Inquest has to my mind exposed a number of shortcomings in respect of the CAMHS structure as it existed in 2010. These included:

a) No proper triaging procedure whereby the appropriate therapist was selected in the first instance. It will be remembered that Jason's case was virtually triaged over the telephone;

b) What appears to have been a guideline whereby a patient might remain with the same therapist, possibly a social worker, for an extended period of three months or for a stated number of sessions, was too rigidly applied and did not take into proper account the lack of progress or improvement that a patient might exhibit. It also did not take into proper consideration adverse changes in a patient's condition, such as in Jason's case an increase in risk of self-harm. I agree with the observation of Mr Homburg, counsel for Dr Shannon, that in the absence of a proper multidisciplinary team approach the level of primary care available to any particular client was essentially predetermined. The entire resources within CAMHS were not routinely brought to bear unless a particular worker realised they needed assistance;

c) The multidisciplinary approach was at that time illusory because the individual therapists involved in Jason's care effectively operated alone. This is evidenced by the fact that there was inadequate interaction and communication between Ms Hotich and Dr Shannon, and to a lesser extent Ms Duckworth. It is also evidenced by the fact that there was no proper meeting between any of the therapists involved in Jason's management. I agree with Mr Homburg's submission that this 'silo' approach to care, as he puts it, carries with it a risk of producing clinical and therapeutic shortcomings. For example, such an approach results in the primary means of communication between CAMHS staff being via the clinical record as opposed to proper word of mouth consultation and sharing of information. The fallibility of that approach is demonstrated by a number of matters including the fact that Dr Shannon did not read the entirety of Ms Hotich's

notes, Ms Hotich did not read the more important entries in Dr Shannon's notes, any verbal handover or hand back or referral was cursory, lines of communication were poor and there was a degree of confusion on the part of Dr Shannon and Ms Hotich as to who should be doing what in relation to Jason;

d) CAMHS exhibits a lack of awareness of the current understanding of the risks and benefits associated with the administration of antidepressant medication to adolescents;

e) The CAMHS structure has been shown to be bottom heavy in that it is unduly reliant on the efforts and skills of social workers. This is not in any way said disparagingly. There is no doubt that there is a place for social workers in an entity such as CAMHS, but this case has demonstrated that at the time with which this Inquest is concerned a social worker tended to retain the management of a patient for an unduly long period and that a psychiatrist was only brought into a patient's management in exceptional circumstances. This case has demonstrated that the psychiatrist needs to be brought into and retain close oversight of the management of a patient at an earlier time, especially when risk of self-harm or suicide has been identified as it was here on two separate occasions.

13. Recommendations

13.1. Pursuant to Section 25(2) of the Coroners Act 2003 I am empowered to make recommendations that in the opinion of the Court might prevent, or reduce the likelihood of, a recurrence of an event similar to the event that was the subject of the Inquest.

13.2. The Court makes the following recommendations directed to the Minister for Mental Health and Substance Abuse and the Director of CAMHS:

1) That CAMHS implement a genuine multidisciplinary team approach that possesses the following features:

a) the triaging of clients in the first instance should not be made on the basis of a telephone referral alone, but should be made after the client has been seen by a CAMHS therapist;

b) that the triage assessment, and in particular the decision as to the type of CAMHS therapist who will be responsible for the client's care in the first instance, be made by the most senior therapist within the individual CAMHS facility;

c) that any practice or tendency for CAMHS therapists to operate as individual practitioners and not as part of a multidisciplinary structure should be curtailed with immediate effect such that a client experiences input into their care from all disciplines acting in concert, not merely from the one discipline acting alone or multiple disciplines acting separately from each other;

d) that CAMHS administrators have limited input into deciding the type of therapist that might appropriately be assigned to a client's care during the currency of a client's treatment, and that in any event any such decision should not be made by an administrator unless that person is a psychologist or a psychiatrist and is a person fully informed as to the client's current and longitudinal history.

2) That within the operations of CAMHS that in the event of any suicidal ideation and/or self-harm being identified in respect of a client, it be deemed mandatory for that client to be referred immediately to a CAMHS psychiatrist who should thereafter have continued oversight of the case;

3) That all therapists within CAMHS who treat depressed young people be reminded that they must always be aware of the risk of suicide and to observe them closely for any signs of increased risk of suicide and that this approach is necessary regardless of the type of therapy provided and regardless of whether or not a formal diagnosis of a recognised mental illness has occurred;

4) That within CAMHS all risk assessments and management plans for clients be referred to, unless compiled by a psychiatrist, to a therapist of the level of psychiatrist for the psychiatrist's input and evaluation;

5) That any practice or requirement that involves the need for a period of three months to transpire or for a set number of sessions to have occurred before a client can be considered for further intervention by more senior therapist, or be considered for medication. Any such referral should be based on clinical grounds as they exist in respect of the particular client. In any event, delay should be

eliminated where the client's clinical situation warrants an expedited approach to therapy;

6) That CAMHS consider the evidence of Professor Goldney and the materials that he produced to the Inquest in respect of a revised approach to the prescription of antidepressant medication to adolescents and that CAMHS revise its practices regarding prescription if it is considered necessary or appropriate in the light of that material. In particular, I recommend that the Director of CAMHS together with the Chief Psychiatrist give careful consideration to the recommendations set out in the Isacsson paper of 23 January 2014 referred to herein;

7) That CAMHS reinforce with its therapists the desirability for consultation with a client's general practitioner or other private medical practitioner regardless of any perception as to whose obligation it may be to initiate such consultation. Such consultation should include, but not be limited to, discussion concerning the type of CAMHS therapist who is involved in the client's care and its appropriateness, the type of therapy currently being administered or to be administered, the appropriateness of the client's care plan and the appropriateness of the client's risk assessment as well as discussion concerning the appropriateness of medication in respect of the particular client;

8) That insofar as it is necessary, that the Minister for Mental Health and Substance Abuse provide the necessary resources to CAMHS to enable more frequent and more meaningful consultation between CAMHS therapists, such as social workers and psychologists, with CAMHS psychiatrists. If this requires the employment of a greater number of psychiatrists within the service then I recommend accordingly.

Key Words: Suicide; Psychiatric/Mental Illness

In witness whereof the said Coroner has hereunto set and subscribed his hand and Seal the 17th day of June, 2014.

Deputy State Coroner