FINDINGS, RECOMMENDATIONS and COMMENTS of Coroner K J Stanton following the holding of an inquest under the *Coroners Act* 1995 into the death of:

AZ

Contents

Record of Investigation into Death (With Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

(These findings have been de-identified in relation to the name of the deceased and the name of the family by direction of the Coroner pursuant to s57(1)(c) of the *Coroners Act* 1995)

I, KENNETH STANTON, Coroner, having investigated the death of AZ with an inquest held at Hobart in Tasmania make the following findings.

Hearing Dates

27th – 30th May 2019, 21st February 2020

Representation

Counsel Assisting the Coroner:	Ms A Shand
Counsel for the State of Tasmania:	Mr P Turner SC
Counsel for the Albert Road Clinic:	Mr T Cox
Counsel for Dr Simons:	Mr A Crocker
Counsel for Mr NB:	Self Represented

Introduction

1. AZ was the only and much loved child of NB and KB. His parents were both actively involved in his upbringing although they had divorced when AZ was five years old.

2. AZ had a normal childhood. He had seen psychologists under a mental health plan when he was almost nine years old and again when he was ten, but he had otherwise been generally healthy.

3. In 2016, AZ was living with his mother in Taroona. His father stayed with them regularly. AZ was a student in year 10 at Hutchins, a private high school in Hobart.

4. In late 2016, he experienced deterioration in his mental health and functioning. That deterioration was associated with an injury playing soccer which prevented him from continuing that sport, a disagreement with his parents about his use of electronic

devices, and the end of his relationship with his girlfriend. His school marks dropped, and he became reluctant to attend school.

5. In October 2016, AZ was treated by general practitioners for depression. In December 2016 and January 2017, he was treated by Dr Jason Westwater, a psychiatrist.

6. In January 2017, he spent some time as an inpatient at the Wyndham Clinic Private Hospital in Victoria. On 13th February 2017, he was admitted as an inpatient to the Albert Road Clinic (ARC) in Victoria under the care of Dr Christine Simons, a psychiatrist. He was discharged from that clinic on Saturday, 5th March 2017.

7. Two days later, on 7th March 2017, he died as a result of falling from the Alum Cliffs, Bonnet Hill in Tasmania.

Findings Recommendations and Comments under s28(1) of the Coroners Act 1995

8. Section 28 of the *Coroners Act* 1995 provides as follows.

> ***Findings, &c., of coroner investigating a death***
>
> *(1) A coroner investigating a death must find, if possible –*
>
> *(a) the identity of the deceased; and*
>
> *(b) how death occurred; and*
>
> *(c) the cause of death; and*
>
> *(d) when and where death occurred; and*
>
> *(e) the particulars needed to register the death under the Births, Deaths and Marriages Registration Act 1999 .*
>
> *(f) . . . . . .*
>
> *(2) A coroner must, whenever appropriate, make recommendations with respect to ways of preventing further deaths and on any other matter that the coroner considers appropriate.*
>
> *(3) A coroner may comment on any matter connected with the death including public health or safety or the administration of justice.*
>
> *(4) A coroner must not include in a finding or comment any statement that a person is or may be guilty of an offence.*
>
> *(5) If a coroner holds an inquest into the death of a person who died whilst that person was a person held in custody or a person held in care or whilst that person was escaping or attempting to escape from prison, a secure mental health unit, a detention centre or police custody, the coroner must report on the care, supervision*

or treatment of that person while that person was a person held in custody or a person held in care.

9. I find the deceased was AZ. AZ was the son of NB and KB. He was born in Hobart on 3rd December 2000 and aged 16 at the time of his death. He was a student.

10. I find that he died between 4:28p.m. and approximately 6:45p.m. on 7th March 2017 at the Alum Cliffs, Bonnet Hill in Tasmania.

11. Those findings are sufficient for the purposes of s28(1)(a), (d) and (e) of the Act. However, I also need to consider how AZ's death occurred and the cause of his death. It is also necessary to consider whether to make any comments or recommendations under s28(2) and (3) of the Act.

How death occurred and the cause of death

12. The obligation to find how death occurred refers to the means or mechanism by which AZ died and extends to the circumstances attending the death. That is, I am required to find by what means and in what circumstances the death occurred: *Re The State Coroner; ex parte Minister for Health* (2009) 38 WAR 553 per Buss JA at [42].

13. In this case the means or mechanism of death was multiple blunt traumatic injuries, particularly head injuries, sustained in a fall from height as detailed in the post mortem report of Dr Donald Ritchey. However, the circumstances of AZ's death include the fact that he was being treated for mental health issues including thoughts of suicide and that he had recently been discharged from the Albert Road Clinic in Victoria where he had been treated by Dr Simons.

14. The cause of AZ's death is a question of fact which must be determined by applying common sense to the facts of the case. While the satisfaction of the but-for test is a useful negative criterion when considering causation, it is not sufficient. Further, considering the issue of causation is not limited to considering direct natural and probable causes, causes proximate in time or even real effective causes. It is not limited to matters materially contributing to the death or to causes that are reasonably foreseeable: *Re The State Coroner; ex parte Minister for Health*, above, per Buss JA at [44] and [45] referring to *W R B Transport v Chivell* [1998] 201 LSJS 102 per Lander J at [20]-[21].

Legal principles to be applied when considering comments or recommendations

15. The power to comment and make recommendations is subordinate and incidental to the power to make findings relating to how deaths occurred and their causes. The powers to comment and make recommendations arise as a consequence of the prime function to make findings about how death occurred and the cause of death. It is well established that an inquest ought not be held solely to enable comments or recommendations to be made. The power to make such comments and recommendations is not free standing. The coroner has no power to conduct a roving commission of inquiry into any matter connected with the death: *Harmsworth v State Coroner* [1989] VR 989 per Nathan J at 996.

16. However, once the inquest is held, although the limits on the power to comment are not easily defined, it is wide so long as it is connected with the death: *Commissioner of Police v Hallenstein* [1996] 2 VR 1 per Hedigan J at 7. Similarly recommendations must be made with respect to ways to prevent further deaths whenever appropriate. The reference to "further deaths" requires that the recommendations arise out of or have some connection to the findings in respect of this death. In *Attorney General v Copper Mines of Tasmania Pty Ltd* above, Blow CJ said the duty to investigate the circumstances leading up to the death includes doing so with a view to making recommendations with respect to ways of preventing further deaths and other appropriate matters: at [45]. An expansive or inclusive approach to the investigation is appropriate: *Attorney General v Copper Mines of Tasmania Pty Ltd* [2019] TASSC 4 per Blow CJ (at [39] with whom Pearce J and Marshall AJ agreed at [48] and [50] respectively) referring with approval to *Preece v West* [2012] VSC 327, (2012) 40 VR 521 per Maxwell P and Harper JA.

17. Applying those principles to this matter, the hearing of the inquest dealt with the following issues:

    a. Whether AZ's death was a result of suicide, or accidental fall, or other misadventure;

    b. The appropriateness of the treatment provided to AZ at the Albert Road Clinic and the decision to discharge AZ; and

    c. The availability and the adequacy of services in Tasmania to treat mental illness and manage the risk of suicide for adolescents such as AZ.

Was AZ's death the result of suicide or accidental fall?

18. AZ's body was found at the bottom of the Alum Cliffs by his father, Mr KB. I acknowledge how distressing that must have been for Mr KB. His backpack was subsequently found at the top of the cliff not far from where he must have fallen. It is clear that AZ fell from the top of the cliff adjacent to where he was found.

19. There was some lay and expert opinion evidence as to whether AZ committed suicide or fell accidentally. That evidence essentially involved an interpretation of the objectively established facts. Properly understood the opinions expressed were more in the nature of submission than evidence although some of the expert opinion was based on the expert knowledge of the witnesses. The expert witnesses with no interest in the resolution of the question, i.e. the witnesses other than Dr Simons, all considered suicide to be the most likely explanation for AZ's death. In the end, it is my role to form my own conclusion about that. That is what I have done.

20. There were no eyewitnesses to AZ's fall. No-one saw whether he accidentally slipped and fell or whether he intentionally jumped. In any event, because AZ's state of mind is central to this conclusion it inevitably depends on inferences.

21. The physical possibility of accident exists. AZ was not wearing secure footwear. The area at the top of the cliff was loose and crumbly underfoot. AZ had a high alcohol reading for a young and inexperienced drinker, perhaps as high as 0.139 grams of alcohol per 100ml of blood. That would have led to loss of coordination, poor balance, and dizziness. All of those factors suggest the physical possibility of an accidental fall.

22. In respect of AZ's intention, some of the evidence points with varying degrees of weight to the possibility that AZ did not intend to end his life. He had been positive the day he died. He wrote to some of the other patients at the Albert Road Clinic in positive terms. He had baked a cake. He had plans to attend a joint 17th birthday party with two of his good friends and participate in other activities with friends. He did not leave a note indicating an intention to suicide. He told his mother that he was fine when, concerned for his welfare, she rang him in the hours before his death. His internet searches on the day of his death related to alcohol and not to suicide. Although he had expressed suicidal thoughts in the past, he had not implemented them. Suicide would be a rare outcome of the issues AZ faced. While those matters

alone might point to the absence of any intention to end his life, they are not inconsistent with such an intention formed or renewed at or shortly before his death.

23. Some of the evidence is equivocal as to AZ's intention. For example, he sent a Snapchat message to friends showing him holding a partly consumed bottle of brandy with the caption "Party Time." Viewed in light of an assumption that the fall was accidental that could be seen as indicating his intention to consume alcohol and nothing more. On the other hand, assuming an intention to commit suicide it could be seen as an indication of a resolve to take action on previously unimplemented suicidal thoughts, perhaps with the support of alcohol induced disinhibition.

24. Another equivocal fact is that AZ was seen walking down the middle of the road on the route from his house to the cliffs where he died. That could show an alcohol induced lack of coordination or disinhibition consistent with an accidental fall or a lack of concern for life saving precautions consistent with an intention to shortly end his life.

25. There is other evidence which clearly points towards a suicidal intention by AZ. The method by which AZ died was readily available to him. He had been to the cliffs before. He was distressed about the prospect of returning to school at the start of the 2017 school year. The day before he was due to do so, he had a driving lesson with Dr NB during which he ran to the edge of the cliffs. On that occasion, she had to spend an hour with him at the cliff edge before he would return to the car. He died at those cliffs the day before he was due to return to school after being discharged from the Albert Road Clinic.

26. The period immediately following discharge is a period of heightened risk of suicide. AZ's death occurred within that period.

27. AZ had experienced low mood for an extended period and expressed hopelessness. He had contemplated suicide for months before his death. He had undertaken research on methods of suicide on his phone.

28. In December 2016, he told Dr Westwater that he had suicidal ideas weekly. They included jumping off cliffs near his home. He told Dr Westwater that in the past he had instinctively "not jumped." However, any instinct for self-preservation was manifestly absent as he walked down the middle of the road to the cliffs in the hours

before his death. Any motivation for self-preservation would have been attenuated by his intoxication.

29. AZ expressed suicidal ideation on his admission to the Wyndham Clinic on 10th January 2017. The risk assessment completed on his admission to that Clinic recorded previous "thoughts to jump off a cliff."

30. AZ was admitted to the Albert Road Clinic on 13th February 2017. The nursing admission notes record that he had thoughts of jumping off a cliff "all the time" although the progress notes record there was no current plan or intent. The psychiatric examination notes on his admission also record suicidal ideation with no current plan or intent but note a moderate risk of impulsivity. The care plan prepared upon his admission included suicidal ideation as a presenting problem to be addressed.

31. On 19th February 2017, the ARC progress notes record that AZ said he was still having suicidal thoughts with a "plan to go off a cliff when he is discharged."

32. On 28th February 2017, AZ absconded from the clinic. He was seen attempting to enter an apartment building on the other side of the road. He referenced but denied an intention to jump in front of a car. He was irritable and guarded in answering questions but he did reveal a suicide plan existed. He would not disclose that plan.

33. The ARC adolescent team meeting report for 1st March 2017 recorded that he had "concrete thinking in respect of suicide." On that day the nursing progress notes indicate he claimed to be high risk. He said he had suicidal thoughts although described them as fleeting saying he "would not do anything in front of people." The clear implication of that statement is that he would be prepared to implement a suicidal intention away from the view of others. It seems likely he was alone when he died. The progress notes concluded the level of risk was ambiguous. The nursing progress notes for that day record that "AZ feels like he wants to die."

34. On 2nd March 2017, the progress notes record hopeless themes in his thinking including of "…going back to Tasmania and wanting to die." The progress notes record no overt or active suicidal ideation or intention. Clearly that does not exclude covert and presently inactive thoughts of suicide. The very next day he expressed a desire to be discharged which would see him return to Tasmania.

35. The submissions advancing the proposition that AZ's death was accidental rather than the result of suicide came principally from Dr Simons. Counsel for Dr Simons carefully and, with respect, skilfully cross-examined and put that position in submissions as firmly as it could be put. It is understandable that Dr Simons would not want to accept that one of her young patients committed suicide shortly after being discharged from her care. Further, if AZ took his own life that might raise questions about her assessment of the risk of suicide in AZ's case. It might raise concern about the adequacy of Dr Simons' opinion that AZ's expressions of suicidality "dialectically represent a safe space of low external expectation." Dr Simons referred to AZ's expression of suicidal thoughts as being his way of communicating his distress and inability to cope rather than an indication of an actual intention to suicide.

36. AZ's expressions of intention may have created a space of low external expectation for him. They may have been a means of dealing with his distress. But that was in no way a safe space. Rather his statements are also entirely consistent with an intention to act on them. Indeed, they express a persistent, if not consistent, intention to do so. That intention may have fluctuated. But with the benefit of hindsight, it is abundantly clear that for many weeks and or even months AZ developed a "concrete" intention to end his life in precisely the manner it ended: jumping off cliffs near his home after he was discharged and returned to Tasmania away from the view of others.

37. There is also a tragic logic to his intention which would bring about the ultimate end to his distress and inability to cope. AZ died in precisely the way he had said he would when he talked about deliberately ending his life. In my view, it is abundantly clear that AZ died by suicide. That then raises the question of what, if anything, could have been done by way of treatment and discharge management to prevent that.

Treatment at and discharge from the Albert Road Clinic

38. AZ's father, Mr KB, raised a number of criticisms connected with AZ's management at the ARC. Although Dr NB's death prevented her participation in the hearing of this inquest, in her correspondence with the Coroner's office prior to her death she raised a number of criticisms of AZ's treatment at the ARC. I acknowledge the importance to AZ's parents of understanding how, despite their best efforts to

obtain high quality treatment for AZ, that care did not prevent his suicide. It is therefore appropriate to consider some of the issues raised by AZ's parents about his care.

39. The expert evidence of the eminent psychiatrists who reviewed AZ's treatment at the ARC does not support any suggestion that his treatment was inadequate in the ways suggested by AZ's parents. The only evidence to the contrary was that of Mr KB. Without doubt he was sincere in his opinions. But those opinions carry little weight given his lack of relevant expertise. I do not consider there is any criticism warranted of the medication provided to AZ during his stay at the ARC, the ideology of the ARC, or AZ's treatment by a registrar rather than consultant psychiatrist.

40. There were incidents where AZ was spoken to about his behaviour which appear to have negatively impacted his mood. He was the only male patient on the ward and was involved in massaging the necks of female patients. AZ was also spoken to about an incident where he put a chicken on another patient's back on 28th February 2017. There is nothing to suggest his conduct was other than innocent. But it is important, particularly in a mental health unit, to ensure that appropriate boundaries are maintained. Conversations about such matters will always be difficult. Such conversations need to respect the privacy of other patients as well as anticipate AZ's response. They need to be managed with tact and compassion. Even then it would not be surprising if AZ responded negatively to conversations about those matters. It would seem he did. But in my view the conduct of the ARC personnel was not inappropriate in dealing with those matters.

41. It is important for note taking and record keeping in respect of treatment to be adequate. Legibility is an important part of that. It is necessary for notes to be reviewed including to gain an overview of a patient's condition and treatment over time. However, the nature and extent of the notes must be viewed in light of the fact that the staff members would be familiar with the writing of their colleagues. There is verbal exchange of information as well. In my view, there is nothing about the note taking and record keeping by the ARC or Dr Simons which is inadequate.

42. I accept that the ARC gave an appearance of being reluctant to provide complete records to AZ's parents after his death. A punctiliously cautious approach to such disclosure could, as it appears to have done in this case, plant and fertilise seeds of suspicion. On the other hand, it is obviously necessary to preserve the confidentiality

of other patients. Redaction to protect that privacy is justified. On occasions there may be sound clinical reasons for judicious management of the extent of disclosure. Be that as it may, in this case, the disclosure of records is an event occurring after AZ's death. There is no utility in making any further comment or recommendation about that matter in the context of this inquest.

43. Complaint was also made about the unprofessional attitude of staff. As I understand it, the principal complaint in that regard is Dr NB's evidence that when she was with AZ after his death, she rang the ARC asking to speak to a staff member. She was told the particular staff member was not available and that he was "barking mad." If that call occurred in the way described by Dr NB, it was most unfortunate. It could properly be characterised as unprofessional. The fact of the complaint serves as a reminder of the need for constant vigilance in maintaining a high degree of sensitivity in all communication with the family of patients. The type of communication complained of could, as it appears to have done in this case, create impressions with the family which suggest poor quality of the interactions and communications during treatment. However, that was an event which occurred after AZ's death and again I do not consider it is appropriate to make any finding or further comment or recommendation about that in these proceedings.

44. In my view, most of the matters raised by AZ's parents about the quality of AZ's care are not objectively justified. However, there are some matters which warrant further consideration. They are:

    a. Security at the ARC;

    b. AZ's diagnosis; and

    c. The circumstances surrounding his discharge from the ARC.

Security at ARC

45. Mr KB complains that security was virtually non-existent during daylight hours. Indeed, AZ was able to abscond despite the observation regime applicable to him at the time he absconded.

46. The ARC is a voluntary treatment facility. It is not appropriate for security to be such as might exist where involuntary detention is a possibility. There are sound

clinical reasons why it must not be a de facto prison. Nonetheless, it is a facility for treatment of vulnerable adolescents with mental illness including those, such as AZ, experiencing suicidality. It is concerning that a vulnerable adolescent with suicidal thoughts was able to abscond without being immediately observed. The fact that AZ was able to abscond as he did suggests a review of the observation and security arrangements at the ARC would be desirable. However, any issues with security at the ARC did not have a causal connection with AZ's death. It is not a matter that has a sufficient connection to AZ's death to require any recommendation or comment to be made. For that reason, I do not consider the matter further.

Diagnosis

47. The diagnosis recorded in the discharge summary from the ARC on 5th March 2017 was "MDD ?ASD." That indicates a diagnosis of Major Depressive Disorder and the possibility of Autism Spectrum Disorder.

48. There is evidence supporting the diagnosis of a depressive illness. Dr Sale expressed the view AZ was experiencing a major depressive disorder. Professor McGorry considered it was clear that AZ was suffering a depressive illness with additional symptoms of anxiety and irritability. Dr Groves considered that AZ suffered an episode of major depressive disorder together with generalised anxiety disorder. Although none of those psychiatrists treated AZ, they all give sound reasons for their conclusions.

49. AZ's general practitioner sent relevantly identical referral letters to the Wyndham Clinic and to the ARC dated 5th January 2017. Those letters indicate a diagnosis of major depression on 6th November 2016 and indicate he was prescribed Fluoxetine for that condition. The discharge summary from the Wyndham Clinic on 13th January 2017 recorded major depressive episode as the only diagnosis. The record of the psychiatric examination of AZ at the ARC on 13th February 2017 refers, inter alia, to symptoms of anxiety with panic attacks and depressive symptoms although the provisional diagnosis is "GAD," i.e. generalised anxiety disorder with panic attacks. The ARC inpatient nursing admission sheet refers to depressive symptoms.

50. Dr Westwater treated AZ in late 2016 and early 2017 before and after his admission to the Wyndham Clinic and before his admission to the ARC. His opinion was that AZ suffered depressive symptoms as a result of stressors but he wasn't convinced

AZ had a major clinical depressive episode. Dr Westwater's opinion as to whether or not AZ suffered from a depressive illness is equivocal. A diagnosis of a depressive illness, even a major depressive disorder, is not excluded by that opinion. But as one of the psychiatrists treating AZ, Dr Westwater's diagnostic caution carries significant weight.

51. Notwithstanding her entry in the discharge summary of the ARC indicating a diagnosis of major depressive disorder, Dr Simons said in her evidence that she did not think that diagnosis was correct. She said she did not think it was correct at the time she made the entry in the discharge summary. On her own admission, Dr Simons therefore knowingly recorded a false diagnosis in a critical patient record. That is a serious lapse in professional judgment on her part.

52. Dr Simons' explanation for making that false entry was that AZ's mother, a general practitioner, was wedded to the idea of a major depressive episode. Dr Simons therefore recorded that diagnosis to avoid a rupture in the therapeutic relationship with AZ's mother. Care and discretion are no doubt important in dealing with the parents of adolescent patients. That will often require careful choice of words and topics for discussion. But it is difficult to see how anything other than the truth can be a sound basis for a therapeutic relationship. Even if that explanation is correct, it is such a serious lapse in professional judgment that it makes the explanation difficult to accept. That in turn gives rise to doubts about her credibility and reliability generally.

53. Be that as it may, nothing turns on the particular diagnosis in this case. The treatment AZ received was unlikely to have been significantly different. It is not clear that his risk of suicide would have been assessed differently. Although Dr Simons' conduct in recording a false diagnosis is clearly unprofessional, no further comment or recommendation in that regard is warranted as part of this inquest.

Discharge

54. AZ was discharged from the Albert Road Clinic on 5th March 2017 after spending 20 days there as an inpatient. There are two matters which need to be considered in respect of that discharge. The first is the decision to discharge AZ at all. The second is the way that decision was managed.

The decision to discharge

55. The decision to discharge AZ involved many complex and competing considerations. On the one hand, AZ had consistently expressed specific suicidal plans, including jumping from a cliff after he was discharged. Continuing in the relatively safe and secure environment of an inpatient mental health unit would mitigate the risk that he would act on such statements. On the other hand, the efficacy of the treatment provided at the Albert Road Clinic relied on his voluntary participation. In addition, the basis upon which AZ had agreed to admission was that he could leave if he wanted to. He had expressed the desire to be discharged. Refusing to honour that agreement could negatively impact the trust he would have in those supporting him, including his mother.

56. One way for AZ to remain an inpatient would be to make an Assessment Order under s29 of the *Mental Health Act* 2014 (Vic). In his report, Dr Sale suggested consideration should have been given to taking that course. Some of the criteria for making an Assessment Order were met. AZ had a mental illness. Without treatment there was a risk of serious harm to AZ. The tragic events which followed his discharge establish the nature and extent of that risk.

57. However, making an Assessment Order involving involuntary detention is an extreme step in the management of mental illness. There are disadvantages to pursuing that strategy. In this case, it would have required disrupting AZ's stability by placing him in a public inpatient unit in Victoria. The mere fact of expressed suicidality does not necessarily justify involuntary detention otherwise every suicidal person could be subjected to an involuntary Assessment Order. To that end, s29 requires the risk of harm to flow from the absence of <u>immediate</u> treatment. Professor McGorry expressed the view that the immediate risk at the time of discharge did not justify requiring AZ to be treated as an involuntary inpatient. In the end even, Dr Sale accepted that. There was no contrary expert evidence. The weight of evidence is to the effect that it would have been inappropriate to make an Assessment Order requiring AZ to be admitted to a public mental health facility as an inpatient. I find that to be the case.

58. That does not mean the choice was as stark as involuntary detention or discharge. It seems no-one thought discharge was the preferred option. The original plan was

for AZ to stay longer. Dr Simons encouraged AZ to come back. She clearly thought there was more to be achieved by further treatment. Indeed, until the meeting on 4th March 2017, she had been encouraging him to stay on the ward. She was taken by surprise when it became clear the meeting on 4th March 2017 was to discuss discharge. Dr NB said she thought AZ was not ready to be discharged. She said she expected that to be raised by Dr Simons in their meeting on 4th March 2017. Although Mr KB was not involved in the decision to discharge AZ at the time it was made, he did not think AZ was ready for discharge.

59. The basis of AZ's admission was that he could leave when he wanted to. It would seem he was seeking to have that condition honoured. Doing so could be seen as important in maintaining the therapeutic relationship with AZ. Nonetheless it may be that ongoing encouragement to stay could have kept him on the ward for longer. At the very least he could then have benefited from further treatment which may have reduced the risk of suicide.

60. Whatever AZ's views, the ultimate legal authority for the decision about whether or not AZ would be discharged rested with his parents. Given Dr NB's expressed support for the view AZ should not be discharged, if Dr Simons had pressed for AZ to stay, that might have received some support from Dr NB.

61. As I understand Dr Simons' evidence, she does not accept that Dr NB was unsupportive of discharge. If that is the case, a discussion with Dr NB in AZ's absence about the benefits of AZ remaining on the ward would have been appropriate. That did not occur.

62. In the end, although Dr NB is a medical practitioner, the responsibility for managing the discussion about discharge rested with Dr Simons. I consider it would have been prudent to discuss that issue with Dr NB's separately. If that discussion had occurred, AZ might have accepted appropriately firm encouragement from his mother and Dr Simons to stay on the ward. Although AZ's mother was a medical practitioner with her own views, if Dr Simons' disagreed with those views, she could have persuasively expressed that disagreement.

63. In the end, a middle ground was selected by discharging AZ with a plan for him to return for further treatment a few weeks later. With the benefit of hindsight, that was insufficient to manage the risk. But viewed at the time, it was clear that further

work was required. AZ had expressed the desire to leave. Failure to meet that desire could have negatively impacted the therapeutic relationship between Dr Simons, Dr NB, and AZ. Allowing discharge and providing a focus for future treatment was not inappropriate.

Information given to AZ's parents at the time of discharge

64. Even if Dr Simons did not disagree with the decision to discharge AZ, it was necessary to ensure the risk of suicide on discharge was appropriately managed. In order for AZ to benefit from a future admission, he had to survive until then. Unfortunately, he took his life before that could occur. That raises the question of whether more could have been done on his discharge to lower the risk of suicide.

65. Self-evidently, and as Dr Simons and the other psychiatrists stated, management of suicide risk is a crucial part of discharge planning for a patient such as AZ. The expert evidence established that discharge planning needs to be tailored to the circumstances of the individual. It needs to strongly and actively involve the carers or parents of the patient. Whether they are able to manage the risk safely needs to be considered because they will be the ones mitigating it. They need to be looking out for the patient. They should agree to the risk management strategy. To achieve those objectives, it is important that the risk is discussed with the parents. They should be provided with critical information about the risk. That includes what AZ had been saying about suicide.

66. Dr Simons maintains that her safety planning for AZ's discharge was appropriate. She made arrangements for AZ to see Dr Westwater. Although Dr Simons did not know when that might occur, it was in fact arranged for the Wednesday after his discharge. All the expert evidence agreed that was a timely arrangement. She alerted the school to AZ's return and the need for special arrangements to be made for him. That would have been implemented had AZ returned to school although he did not survive to do that. AZ was also returning to the care of his loving and intelligent parents who had successfully cared for him before. All of those factors were designed and likely to reduce the risk of suicide. They were appropriate considerations in assessing and managing the risk of suicide.

67. Dr NB and Mr KB both suggest that Dr Simons did not give them sufficient information about the risk of suicide when AZ was discharged. In general terms, Dr

NB and Mr KB were both aware of the risk of suicide. That risk was a significant factor leading to his admission to the ARC. The question is therefore not whether they should have been made aware of that risk but whether they should have been given more specific advice about the nature of the risk and managing that risk. In order to consider that issue, it is necessary to make findings about what Dr Simons discussed with AZ's parents in that regard.

68. In the case of Mr KB that is a simple task. Mr KB was not given any information about the risk of suicide on discharge. No-one from the ARC met with him or discussed that with him. It would seem it was left to Dr NB to pass on any information she received. I consider it would generally be desirable that discussions about matters related to suicide risk should occur with both parents, particularly where they are separated. That did not occur in this case. But there is no real suggestion the failure to have separate discussions had any impact on the management of AZ's risk of suicide. The real criticism made by AZ's parents is that the risk was not adequately discussed with either of them, particularly Dr NB. That involves consideration of what was said at the meeting between AZ, Dr NB and Dr Simons on 4th March 2017.

69. Dr NB provided a statutory declaration dated 9th May 2017. In that statutory declaration, she said she did not think AZ was well enough to leave and she was hoping that Dr Simons would recommend that AZ stay. Dr NB said she didn't feel able to promote that view because she had promised AZ he could leave if he wanted to. Dr Simons did not advise AZ was unwell or not fit to leave the clinic. She provided no advice as to what to expect when he left or how to help him or manage any known suicide risks. She said Dr Simons sought a promise from AZ that he would not self-harm which he gave and which Dr Simons described as his contract with her. Dr Simons also suggested AZ should not go to school on Monday but should return to school on Tuesday.

70. Prior to her death, Dr NB also provided material to be considered at the inquest. That material was not verified by statutory declaration or affidavit. But it included a transcription of her notes of the meeting with Dr Simons on 4th March 2017. That transcription is generally consistent with Dr NB statutory declaration of 9th May 2017. It also provided a commentary on the differences between Dr NB recollection of the meeting of 4th March 2017 and what Dr Simons says in her notes of that

meeting. Dr NB denied any reference by Dr Simons to ongoing statements of suicidality by AZ.

71. On 4th March 2017, Dr Simons made notes of the meeting with AZ and Dr NB on that day. Those notes are consistent with the account given in Dr NB statutory declaration.

72. On 8th March 2017, after she was informed of AZ's death, Dr Simons made some further notes about the meeting of 4th March 2017. She did that immediately following the phone call informing her of AZ's death. In those notes, she recorded that AZ had seemed genuine with a denial of suicidality and the appropriateness of a plan to go home and return in one month. She later wrote out a summary of AZ's admission and a more detailed account of the meeting on 4th March 2017. Those notes state:

- The interview started with Dr NB smiling looking positive and relaxed saying, "AZ says he wants to leave."
- AZ said he did not want to stay.
- It was agreed he would come back in one month.
- He said he wanted to go back to school on Tuesday, not Monday.
- Dr NB acknowledged that it was important that he not have any stress saying, "I know. No expectations."
- Dr NB was happy with the decision.
- Dr NB thought that AZ was anxious and Dr NB wondered if she was wrong to stop the Seroquel.
- Dr Simons suggested that the choice of anxiolytic be discussed with Dr Westwater, but in the meantime Valium should be continued.
- AZ specifically denied suicidality saying, "I would not do that."
- AZ was not detainable, he contracted to live and return for further treatment and that appeared to be genuine.

73. In a letter to the Coroner's Associate dated 19th April 2018, Dr Simons further amplified what she says occurred at the meeting of 4th March 2017. She said:

> *"55. … Dr [NB] entered the room first, smiling and positive and said, "[AZ] says that he wants to come home". I replied that I was surprised and that I thought we were on plan to stay one further week. I asked [AZ] what he was thinking about discharge and he replied, "I have had enough, I want to leave". This was said in an even, reasonable voice and tone.*
> *56. It was revisited that there had been a plan that [AZ] could discharge back to being an outpatient with Dr Westwater if he felt he did not like being an inpatient or had had enough. This had been agreed by Dr [NB],[AZ] and myself and was the condition under which he had originally agreed to "give it a go".*
> *57. The meeting then became a potential exit meeting. I allowed Dr [NB] to stay because I wanted her to hear what was discussed.*
> *58. Discharge planning begins before admission, in that a young person is not admitted unless they have a reliable follow up pathway. [AZ] had his pathway back to Dr Westwater as an outpatient.*
> *59. Part of discharge is a review of the admission. [AZ] agreed that he had become more comfortable with psychiatric consultation, even finding interest in understanding his thoughts and feelings, had learned some skills which he was beginning to implement.*
> *60. I attempted to engage him to stay the extra week with compliments on his work effort but he did not shift.*
> *Suicide risk assessment:*
> *61. … It is alleged that I did not perform a suicide risk assessment.*
> *62. I did perform a suicide risk assessment as part of the meeting with [AZ] and Dr [NB] on 4 March 2017. Performing a risk assessment on discharge from a psychiatric facility is standard practice. I was especially careful to conduct this risk assessment in front of Dr [NB} so that she could observe [AZ]'s responses.*
> *63. The risk assessment took approximately 20 minutes to perform which is a long time when trying to engage with an adolescent.*
> *64. The conversation addressed [AZ]'s safety. I pointed out that the understanding that he could leave did have to meet the requirement of safety which took priority over his request to be discharged. I told him that I was aware that several of the group had talked about killing themselves on discharge and that he was involved in those discussions. I said that I know all sorts of things are talked about among the young people but now was the time to tell it like it is. I looked into [AZ]'s eyes and made eye contact with him. I said, "I am asking if you are safe to go home and if you have any plans to kill yourself?" He looked me in the eye and said, "I would not do that". His statement carried belief because of [AZ]'s [demeanour] when he answered me, and because it was said in conjunction with further discussions where [AZ] had disclosed his plans for the future such as reuniting with his friends, expressing eagerness to return to*

his house and his pet cat, and his acceptance of returning to the Clinic in 4 weeks' time.

65. I did not introduce the topic of [AZ]returning to school, this was raised by [Az]. I asked what he would do when he got home. He replied, "And I do not want to go to school until Tuesday. I am not going in Monday." I replied, "About school …." at which point his mother interjected, "I know, I know, no pressure!" In an entry in the clinical records on 15/2/2017[AZ] noted his mother's expectations of his study.

66. I had been about to ask if he really wanted to go back to school for the month or negotiate his school return and to clarify his mother's expectations or to undertake alternate activity. [AZ] had identified his mother's anxiety about his poor study habits and attitudes and concerns for his future as a major stressor in his doubt about the quality of his future. However, having had [AZ] suggest his return to school and his mother spontaneously acknowledge that academic expectations were inappropriate; it seemed a satisfactory and safe outcome. I stated that going to school would be just about going to be with friends and reconnecting. [AZ] had recorded feeling supported at school by teachers and his [counsellor].

67. At no time did I tell [AZ] or his family that "[AZ] was to immediately return to school" (as alleged in the statement by [AZ]'s parents dated 24 June 2017).

68. I emphasized to both [AZ] and Dr [NB] that returning to school was about being with his friends. While [AZ] would not have wanted to recommence year 11 study with homework and assessments, being at school with friends, with known and supportive staff, in known patterns, without academic expectation, seemed quite different and the most comfortable and safe place for him.

69. I also felt that it was better and safe for [AZ] in that he had expressed a willingness to return to school rather than return home with his parents (and no school) which seemed likely to risk conflict.

70. I stated that on the following Monday I would email school about his discharge and return to school and that I was confident that they would fit in with [AZ]'s wishes. It was clear from correspondence and information from Dr [NB] that school was very supportive.

71. I asked, "What about devices?" [AZ] volunteered to give them up at bedtime as he had been doing at the unit, saying he was used to it now.

Plan for return to Albert Road Clinic and further discussions about safety:

72. I then asked if [AZ] would return to Albert Road Clinic in one month and he agreed. On the discharge summary I made an entry next to 'Intention to Readmit' by ticking this box and entering the date of 3/4/2017. I then asked if he could state that he would keep himself safe until his return and [AZ] agreed. This intervention is not about a belief that it is a 'contract' that keeps people safe. I did not frame the safety question as a contract.

73. Research shows that if a person intends to suicide they will do so and contracts make no difference. It was used in this situation to strengthen the therapeutic alliance with [AZ]. [AZ] belonged in the hard to treat category of patients who are low on trust, chronically hyper-aroused and difficult to engage.

> *The first stage of therapy with such patients is attending to the alliance. [AZ] had stated that he seeks care and concern. His therapist (at the time of the Discharge Meeting, me) expressing concern about whether he lives or dies is a move to meet both his wish for care and attention and to enhance the alliance for the next sector of therapy.*
>
> *74. [AZ] had expressed to Dr Lewkowski (entry in ARC notes) that he likes attention, and for people to be concerned about him, that he wished he did not but that he was aware of it. Some of the symptom enhancement expressed by young people on the unit is in the category of this care seeking [behaviour] and the unit is very familiar with it.*
>
> *75. As part of my risk assessment of [AZ] at the time of his discharge I noted he had given a rational explanation for his discharge and had a positive plan for the future, of his choosing. He appeared to be truthful during this meeting and he had a history of being truthful whilst in the Clinic. He denied suicidality and accepted prompt readmission. The assessment was thorough.*
>
> *76. [AZ] told staff he was homesick and wanted to see his friends and his cat. Recognising the impact of these feelings, the plan to go home, reconnect, reassure himself socially, with all educational pressures removed, and come back seemed to meet best outcome criteria.*
>
> *77. Dr [NB] was present for all these stages of the session and left expressing satisfaction with the outcome. At no time did Dr [NB] express any concern to me about [AZ]'s discharge. Had she done so I would have repeated the interview."*

74. In her evidence, Dr Simons said that in the meeting of 4th March 2017 she drew attention to the fact that AZ said to the other patients that he would kill himself when he got home. She said that was a discussion of four or five sentences. She said she let her comment linger in the moment. Dr NB did not seek more information and Dr Simons took the lead from her. I take that to mean that Dr Simons considered that Dr NB had grasped the significance of those statements in respect of the risk of suicide. Dr Simons says that was adequate detail.

75. There is agreement between Dr NB and Dr Simons that Dr Simons sought and obtained an assurance from AZ that he would not suicide when he was discharged. I find that occurred. However, there are real difficulties determining what else was said at the meeting of 4th March 2017 about the risk of suicide for AZ.

76. The only persons other than Dr Simons who were present are now dead. Dr NB's account of that meeting cannot be tested. The material she has provided before her death creates the impression that she held a very clear view that the treatment of AZ by Dr Simons and the ARC was negligent. In general, the evidence of the experts did not support that view. The material from Dr NB carried with it an impression of

heightened emotion. Such emotion is understandable. She had tragically lost her much loved only son. But that lack of objectivity carries with it a risk of unintentional exaggeration or reconstruction which requires some caution in accepting all the assertions of fact she made.

77. That does not mean I automatically accept what Dr Simons says about the discussions at that meeting. Dr Simons has given a number of different accounts of that meeting. In her first notes of the meeting made on 4th March 2017, she makes no specific reference to discussion about AZ's ongoing suicidal statements. Neither does she refer to such discussion in her expanded notes of that meeting made on 8th March 2017. The absence of reference to discussion about Az's ongoing suicidal statements in those notes would suggest that topic was not discussed at the meeting on 4th March 2017. However, in the notes on 8th March 2017, Dr Simons does refer to AZ denying suicidality at that meeting. Given the summary nature of the notes of both of those accounts, the omission of reference to AZ's ongoing statements about suicide does not unequivocally suggest a failure to discuss them.

78. In her report to the Coroner, Dr Simons says that in the meeting of 4th March 2017 she told AZ she was "aware that several of the group had talked about killing themselves on discharge and that he was involved in those discussions." At the hearing of the inquest her evidence was that she said, "I know all sorts of things are talked about among the young people but now was the time to tell it like it is," after which AZ denied an intention to suicide. Those statements refer to some of the patients talking about an intention to suicide after discharge. Neither statement contains a specific reference to AZ in particular saying he was going to kill himself after he was discharged. Even allowing for the fact that Dr Simons sought assurance from AZ that he would not suicide, those comments are ambiguous about whether AZ had previously said he would kill himself on discharge.

79. When she gave evidence at the inquest, Dr Simons initially referred only generally to discussion at the meeting on 4th March 2017 of statements of suicidal intention made by AZ while an inpatient. When questioned by counsel assisting, Ms Shand, Dr Simons said part of the meeting included a section that went over the fact that AZ had been talking about suicide during his admission. She said that had been a general comment about the fact that there had been ongoing suicidal ideation. She denied reference to the specific method of suicide he had discussed. The impression created

by that evidence when it was given was that specific details of AZ's suicidal statements were not discussed at the meeting of 4th March 2017.

80. It was not until later in Ms Shand's questioning that Dr Simons' evidence came to assert that she said to AZ at the meeting on 4th March 2017, "…that I knew that it included killing himself when he was discharged."

81. I do not accept Dr Simons' evidence that at the meeting on 4th March 2017 she referred specifically to AZ's expressed intention to suicide after he was discharged. My reasons for that are as follows.

82. The fact that Dr Simons' was prepared to knowingly record a false diagnosis in the discharge summary demonstrates a willingness on her part to make false statements in important documents. Whatever her motivation for that might have been, it adversely affects her credibility and reliability requiring careful scrutiny of her evidence where it is not otherwise supported.

83. That adverse view of her credibility and reliability was supported by the impression I formed in respect of her evidence generally. It seemed to me to be highly self-serving involving complicated rationalisations which appeared to be designed to deflect any possible criticism of her. For example, her position was not simply that AZ may not have committed suicide but that he did not do so. If that was right, it would remove any causal connection between his treatment and death. As I indicated above, although there are some factors supporting the suggestion that AZ did not suicide, it is abundantly clear that he did. The development of her statements about what was said at the meeting about AZ's suicidal statements carried with it a similar impression. From no reference to discussion of those matters in her initial notes, she then said she "was aware that several of the group had talked about killing themselves on discharge and that he was involved in those discussions" which developed into stating that she "knew it included killing himself when he was discharged."

84. I do accept that Dr Simons referred to discussions about suicide amongst the patients generally, using words to the effect that there had been discussion among the patients about committing suicide on discharge. That is consistent with the approach Dr Simons otherwise took which was to approach matters indirectly in order to maintain the therapeutic relationship. But I do not accept her evidence that

she referred specifically to AZ's previously stated intention to suicide when he returned home.

85. However, even if Dr Simons' evidence about what was said is accepted, she relied on Dr NB drawing inferences about the risk of suicide after discharge based on AZ's suicidal statements. She thought the inference would have been apparent to Dr NB. It would seem Dr NB did not get that message.

86. Although Dr NB was a medical practitioner, she was AZ's mother and had entrusted his treatment to a specialist. Making assumptions about the inferences Dr NB might draw is fraught with danger. A more effective way of communicating the risk would have been to express it sensitively but accurately and realistically to Dr NB in AZ's absence. Dr Simons did not do that.

87. Even on the version most favourable to Dr Simons, the particular method of suicide AZ had referred to was not brought to Dr NB attention. Dr Simons sought to justify the absence of specific reference to those matters on the following bases:

    a. The discharge was unexpected which meant the usual discharge planning had not occurred. Nonetheless, she thought the discharge interview went well, that she got the tone right, and that she had achieved the climate for discharge and thought she had done enough.

    b. AZ had made many statements of suicidal intent. There was nothing new in that. Those statements were properly interpreted as distress signalling and not necessarily as statements of genuine intention. Although they needed to be taken seriously, they represented a safe place for him because they led to reduced external pressure.

    c. AZ said he would not suicide at the interview. That appeared to be a genuine statement.

    d. AZ was in a safe stable state when he left. He was in a positive state and had been for several days.

    e. AZ was going home to intelligent parents with developed parenting skills, one of whom was Dr NB whose skills Dr Simons respected, perhaps too much.

f. AZ was going home to a changed environment where the stressors were reduced. In particular, he was not going to be pressured to go back to school. His parents understood that. Dr NB had said "I know. No pressure."

g. It is not appropriate to discuss the particulars of suicide on discharge. It is undesirable for AZ to leave the interview with that in his head and it is undesirable and serves little purpose for his parents to be focussed on that.

88. For the reasons discussed below, I do not accept those matters justify the approach taken by Dr Simons in this case.

89. Dr Simons was placed in a position where discharge planning was more rushed than it usually would be. AZ was leaving the ARC prematurely on a weekend. Whether the discharge is planned well ahead or unexpected, Dr Simons was required to manage it appropriately. She took a number of appropriate steps to manage that discharge. But in my view, with the benefit of hindsight, she could have discussed with AZ's parents, Dr NB in particular, practical ways of physically managing the risk of suicide in the days after discharge. There was no such discussion. That failure, particularly in the context of seeking and relying on AZ's assurance that he would not suicide carried real risks.

90. First, that approach does not address the possibility that AZ was not genuine in his statement that he would not suicide or that his genuine intention at that time might change in the future.

91. I accept Dr Simons' evidence that there is an important distinction to be made between thoughts about suicide and an intention to suicide. I also accept her evidence that it is very difficult to ascertain whether or not a statement of intent to commit suicide is genuine. Likewise, it must be difficult to assess whether a denial of such an intention is genuine. As Dr Simons said, psychiatric training does not give the ability to read minds.

92. Allowing for those matters, there is an obvious inconsistency in the way Dr Simons treated AZ's conflicting statements about suicide. On the one hand, she placed substantial weight on the apparent genuineness of AZ's statement in the meeting of 4th March 2017 to the effect that he would not suicide in determining that his

discharge was safe. On the other hand, she also relied on the fact that AZ's prior statements about suicide were not genuine expressions of intention. She referred to the fact that they were a means of reducing perceived pressure on him from others, that they were a dialectically safe place for him. Accepting that determining the genuineness of a stated intention with regard to suicide is difficult, if not impossible, it seems to me the weight should be the reverse of that which appears to have been given to those statements. That is, substantial weight should be given to a recent expression of intention to suicide on discharge particularly when that has referred to a specific available method of suicide.

93. Real weight should also have been given to AZ's expressed intention to suicide when he had recently referred to a plan while refusing to disclose it. That could reasonably indicate an unwillingness to give detail which might see his plan thwarted. In light of that indication, AZ's assurance on 4th March 2017 that he would not suicide, might have been interpreted as an attempt to create an appearance of safety to remove any barrier to his discharge so he could implement a plan to suicide when he returned home. That possibility needed to be given real weight. When considering the steps to be taken to mitigate the risk of suicide in this case less weight should have been given to an apparently genuine denial of suicidal intent and more weight given to AZ's physical safety in addition to preserving a therapeutic relationship.

94. That requirement was strengthened by the fact that AZ's condition had been fluctuating. Although his condition may have been relatively stable for some days, there is no reason to think that stability would be sustained after his discharge.

95. The risk of deterioration in his condition was increased by the fact that it was anticipated he would be returning to school. His suicide actually occurred on the day he was meant to be returning to school. Dr Simons' expressed the view that he was returning to a situation of reduced pressure. Dr NB may have understood there was to be no pressure in that regard. But the fact that AZ volunteered a return to school is as consistent with an understanding on his part that he was expected to return to school as it is with an understanding there was no pressure about that. The fact that he sought to postpone the time of his return to school by one day can be seen as an attempt to maintain some control in respect of that issue in the face of a perception by him that the expectation he would return to school was not substantially diminished.

96. For all of those reasons, the possibility of both a fixed and hidden intention and an impulsive intention needed to be given real weight in the discharge planning. Practical measures to address that risk were required.

97. The second risk of the approach taken by Dr Simons is that Dr NB might have viewed AZ apparently genuine assurance as sufficient to deal with the risk of suicide. In the absence of any advice to the contrary, a parent might reasonably expect that three weeks as an inpatient would have reduced the risk of suicide. The absence of a specific discussion with Dr NB about the particular risks might reasonably suggest to her that the expert opinion was that the risk was low enough not to warrant such a discussion, particularly in light of AZ's assurance he would not suicide. Leaving the matter to inference in that way is inadequate.

98. The third risk of the approach taken by Dr Simons is that the discussion contains no practical physical safety plan. I accept that maintaining the therapeutic alliance and reducing the pressure of expectation on AZ may well be important, perhaps the most important protective measures. I also accept that leaving AZ with a focus on the suicide risk is undesirable. But that does not exclude providing his parents with some practical advice about the nature of the risk based on his suicidal statements and some strategies for managing those risks.

99. Dr Simons thought AZ's parents were intelligent and caring with developed parenting skills. Those characteristics motivated them to obtain expert treatment when the needs created by his mental health issues, including his suicidal thoughts, exceeded their abilities. That is why they sought admission to the ARC and treatment from Dr Simons. They were seeking help for AZ outside of their skills and experience. Relying on the fact that he was being discharged back into their care was insufficient.

100. In any event, whether by deliberate decision or oversight, Dr Simons did not entrust Dr NB with information to the effect that AZ had said he would suicide by jumping off cliffs when he returned home. Neither did she inform her of the known increased risk of suicide in the period post discharge. An experienced psychiatrist such as Dr Simons would be able to have such a frank discussion in an appropriately firm but sensitive way. It is not as if AZ's parents would have found that surprising. It was the risk of suicide that led them to seek admission to ARC in the first place.

101. Had the risk of suicide and a practical safety plan been discussed AZ's parents might have dealt with his discharge home differently.

102. Of real importance is the fact that AZ said he would not suicide in front of anyone. Indeed, his statement at the meeting on 4th March 2017 that he would not suicide can be seen, with an appropriate allowance for ambiguity, perhaps intended by him, to be a statement to similar effect. In any event, the statement that he would not suicide needed to be viewed in light of his previous statements to the effect he would not do so in front of others. It is understandable that he might not want to cause distress by suiciding in front of others.

103. Of equal importance is the fact that AZ said he would suicide by jumping off cliffs. It would have been appropriate to suggest care be taken to avoid giving AZ opportunity to go near any cliffs, particularly on his own. Given her previous experience with AZ at the cliffs where he later died, if AZ's reference to jumping from cliffs when he returned home had been brought to Dr NB's attention that might have caused her significant concern. It might have led to a discussion about whether AZ should be discharged at all. It would certainly have alerted her to the ongoing risk associated with that particular location and method of suicide.

104. The requirement for practical advice about dealing with the risk of suicide after discharge is further strengthened by the general increased risk of suicide at that time. Professor McGorry's evidence would suggest that increased risk exists in the period 24-48 hours after discharge. The ways he suggested managing that risk included personal visits and phone calls from professionals.

105. Although I have the benefit of hindsight, I nonetheless consider Dr Simons should have given Dr NB more information about what AZ had said about suiciding by jumping from cliffs when he returned home and the increased risk of suicide in the days after discharge.

106. Given information about the specific timing and method of suicide AZ had mentioned while at the ARC his parents might have been more vigilant engaging with him during the days after he was discharged, not allowed him near cliffs, and ensured he always had company. Had AZ's parents been aware of those specific matters, they may have been able to take additional steps to prevent him from going to the place where he took his life, particularly during the high-risk period shortly after discharge.

107. For those reasons, as important as clinical judgment is, relying on getting the tone or feel right is not enough. At least in AZ's case, it was necessary to ensure there was a concrete physical safety plan. It would have been appropriate for Dr Simons to explicitly suggest AZ's parents keep a close eye on him rather than relying on an inference to be gleaned from her reference to discussions amongst patients generally about suicide after discharge.

108. Of course, there is no guarantee that would have protected against a fixed and hidden intention to suicide, or perhaps even a firm impulse to suicide. It would appear his parents were taking steps to ensure AZ had consistent company. Mr KB stayed with AZ while Dr NB was at work. They had suggested a picnic together later in the day. It would also appear that they were alert to the risk associated with the cliffs because they went there to search for him after they had not been able to contact him. But they allowed him to go for a walk on his own. There can be no criticism of them for that. With the information they had it was not inappropriate for AZ's parents not to stifle his independence, to afford him some trust. Indeed, it was important not to put pressure on him. Doing so might have increased the suicide risk. But if they been alerted to the particular risks, they might have taken additional steps to reduce the availability of this particular method of suicide, the one Az had spoken about and the one he implemented.

109. For those reasons, I consider more detailed information about the particular risks and managing them could and should have been provided to AZ's parents. In particular, Dr Simons should have told Dr NB about the fact AZ had said he intended to suicide by jumping off cliffs when he returned home. Practical ways of reducing or removing the opportunity for that to occur needed to be discussed with Dr NB. Reducing the opportunity to suicide in the ways he had expressed might not remove the risk entirely, but it might reduce it. Although AZ's mother was a medical practitioner, she might still have benefited from some practical advice about how to physically manage the particular risk which eventuated in this case. A suggestion that AZ's parents should ensure he always had company or even just to keep a close eye on him for the 24 to 48 hours after discharge would have been appropriate. A suggestion to ensure that he could not go near the cliffs, particularly on his own, would have been appropriate.

110. The use of a discharge planning checklist might have prompted a discussion about those matters. Dr Simons said checklists were not appropriate. I can see no reason why they would not be. Of course, they should not displace proper clinical judgment or interfere with the rapport between the clinician and patient. But they might have real benefit in ensuring an adequate safety plan is appropriately prepared, particularly in the event of unexpected discharge. A checklist could ensure that all relevant discharge considerations are addressed, and a practical safety plan developed. Dr Groves referred to various tools to assist with discharge planning including the Suicide Assessment and Safety E-Tool.

111. Given the variety of situations faced by clinicians in dealing with the risk of suicide, I do not think it is possible to generalise from the facts of this case in a manner that would enable a useful recommendation to be made about how suicide risk should be discussed with parents of adolescent patients such as AZ with or without the benefit of a checklist or discharge planning tool. The observations I make in that regard are limited to comments about the management of AZ's discharge in particular.

112. I cannot conclude that raising the risks and addressing additional practical steps to mitigate them with AZ's parents would have made any difference to the tragic outcome in this case. However, neither can I conclude it would not have.

Availability and adequacy of adolescent mental health services in Tasmania

113. AZ had been treated for mental illness at the Albert Road Clinic, an inpatient adolescent mental health clinic in Victoria. He was discharged from that facility two days before his death.

114. One way of preventing AZ's death may have been to detain him involuntarily. The almost unanimous views of the psychiatrists who gave evidence at the inquest was that it is unlikely AZ would have met the criteria in Victoria for involuntary inpatient treatment. The only different view was that of Dr Sale. Even he did not suggest involuntary detention of AZ was certain or even likely, simply that it would have been appropriately considered. The criteria for involuntary treatment of an adolescent in Tasmania are not the same as in Victoria but the evidence suggests that if AZ was to be detained because of his suicide risk psychiatric facilities would be overflowing. I consider it is unlikely he would have been treated as an involuntary

inpatient in Victoria or Tasmania. However, inpatient treatment can also occur voluntarily as it did with AZ.

115. Dr NB was clearly seeking inpatient treatment for AZ. AZ was considered a suitable candidate for such treatment at the Albert Road Clinic. His treating psychiatrist, Dr Westwater, had reservations about the need for such an admission but acquiesced in it and considered it was possible AZ might have been admitted to the Royal Hobart Hospital if there was a suspected high risk that AZ would act on his suicidal ideation. It is likely that if facilities for AZ to be treated as a voluntary inpatient had been available in Tasmania, he would have been treated here as a voluntary patient at some point. The availability of such treatment in Tasmania therefore arises for consideration.

116. At the time AZ was being treated no suitable facilities were available for adolescent inpatients in Tasmania. The importance of having inpatient treatment facilities located in Tasmania is to ensure that young people can access treatment without needing to leave their home where their supports and connections are likely to be. Dr Groves said:

> "*It is preferable that any person, but especially young people, can access treatment as close as possible to their families and natural supports. When this is not possible it is vital that good processes that allow continuity of care and treatment are in place. This relies on establishing effective processes of handover and follow up. This is equally important whether a person is seen wholly in the private or public mental health systems.*"

117. Being isolated from supports may be adverse to the recovery of a young person and potentially even exacerbate their feelings of isolation or disconnection. Despite the best efforts of his parents to spend time with him, AZ experienced the disadvantages of inpatient treatment interstate. He expressed a desire to return home because he missed it and his pet cat. Taking a young person, who is unwell and at their most vulnerable and placing them in a foreign environment away from local supports, loved ones and familiar practices is not conducive to the best therapeutic environment. It would have been preferable for AZ to have been treated close to home.

118. At the time that AZ was unwell, if he was to be treated as an inpatient in Tasmania he would have been admitted to the Royal Hobart Hospital. The options for treating

him would have involved him either being hospitalised in a paediatric ward that did not specialise in adolescent mental health or in an adult psychiatric ward. It is uniformly accepted that neither of these options are appropriate. All of the professional medical experts who gave evidence on the inquest agreed that treating young people in hospital wards that are not specifically designed for adolescent psychiatric care is less than ideal. Paediatrician Dr Anagha Jayakar said:

> "*Neither the General Paediatric wards or Adult Psychiatric wards are suitable for dealing with young persons admitted with a mental illness as their needs are quite different. The staff that look after them have to be specifically trained to deal not only with young people but also those with a mental illness. There are also concerns regarding mixing of young people on an adult ward and exposure to adult inpatients with mental health issues. Young people should be provided with developmentally appropriate care in an appropriate setting – separate from adults.*"

119. That inadequate state of affairs existed despite the fact that in 2015, Coroner Olivia McTaggart made a number of recommendations relating to the establishment of a dedicated inpatient unit for adolescents or young persons, as well as the creation of other positions and facilities aimed at suicide prevention. Of particular relevance to this case, those recommendations included:

    a. The design and establishment of a dedicated inpatient unit for adolescents or young persons between the ages of 12 and 25 years, including treatment for those suffering from an acute state of mental illness or suicidality;

    b. Consideration be given to the establishment of a multi-disciplinary facility for young persons suffering from an acute state of mental illness or suicidality, such facility to have a comprehensive through-care and after-care model to provide ongoing community–based risk management; and

    c. The establishment of state-wide positions of suicide prevention co-ordinators to provide necessary outreach between discharge from hospital and entry into appropriate services to assist with a streamlined approach to discharge planning, collaboration between service providers and continuity of care.

120. At the time of AZ's death, those recommendations had not been implemented. If they had been there might have been no need for AZ to be treated interstate, with all of the disadvantages which flow from that.

121. Dr Aaron Groves, Chief Psychiatrist, gave evidence on this inquest in February 2020. He said that in accordance with the National Better Health Service Planning Framework, six to eight adolescent mental health inpatient beds were required Statewide. He suggested that approximately half those beds should be in Hobart and half should service the North and Northwest.

122. Dr Groves indicated that, having been announced in 2010, the new K Block of the Royal Hobart Hospital would be opening imminently. Within the K Block is a new inpatient ward dedicated to the provision of treatment to adolescents. The unit will contain a two bed suite specifically for adolescents who require mental health care and treatment. It will operate full time with dedicated mental health nursing staff, a consultant child psychiatrist, a psychologist, an occupational therapist and a social worker as well as access to paediatricians. At the conclusion of the inquest hearings K Block was yet to open.

123. With respect to the North of the State, in 2014 there was a plan to develop an eight bed ward at the Launceston General Hospital to provide mental health treatment for adolescents from the North and North West of Tasmania. The model of care for those beds was uncertain but the expectation was that it would be similar to the inpatient ward at the Royal Hobart Hospital. That ward was not open at the conclusion of the inquest.

124. Dr Groves outlined other proposed facilities and services in relation to the provision of mental health care to young people, particularly those at risk of suicide. They included centres at St Johns Park Newtown and the former Peacock Centre in North Hobart. Those centres are intended to provide services for patients with suicidal distress but not requiring inpatient admission. They would provide community-based support including the capacity to deliver the Safe at Home program. He indicated a mental health inpatient precinct at the Repatriation Hospital was being considered subject to available funding. He also referred to reviews being undertaken of the operations of the Child and Adolescent Mental Health Service and a review being undertaken by Professor McDermott.

125. Whilst there are a number of projects being considered, it is apparent that many of them will still take years to be implemented. If community-based services of the type discussed by Dr Groves had been available, AZ could have been referred to them either as an alternative to his inpatient admission at the Albert Road Clinic or on his discharge from that facility.

126. Another advantage of care close to home is that it enables ready access to services which can ensure continuity of care. Professor McGorry referred to the desirability of a mobile team available to talk to the patient on the inpatient unit, perhaps drive them home, and provide in person and phone visits over the 24 to 48 hours after discharge. Although AZ was referred to his treating psychiatrist and an appointment was arranged to occur within days of his discharge, he did not live to obtain the benefit of that appointment. Aside from the care of his parents no other support was provided to AZ immediately after his discharge. As to that Professor McGorry said:

> *"It is quite possible the outcome might have been different if the inpatient unit had been located in Tasmania and there was very active daily outreach follow up with the same treating team with better engagement following discharge."*

127. Professor McGorry gave evidence that 500 to 600 young Australians die every year from suicide. He described these as preventable deaths. In the absence of a terminal illness, if these young people are cared for and looked after during the period of risk his opinion was that they should survive. Professor McGorry is clearly a passionate and respected advocate for improved mental health services for youth, including adolescents. Dr Groves was not as sanguine about the comprehensive success of suicide prevention strategies. Neither am I. But on the evidence before me I cannot exclude the possibility that the availability of and referral to community-based services in the days following AZ's discharge from the Albert Road Clinic might have led to a different outcome.

Recommendations

128. I recognise the competing demands on public resources, including the competing demands within the health system. But it is clear the needs for adolescent mental health services were not met in Tasmania at the time of AZ's death. To the extent that they have not yet been implemented, I respectfully adopt and reiterate the

recommendations made by Coroner McTaggart in 2015, particularly those referred to in paragraph 119 above.

129. In addition, I consider that particular attention should be paid to follow up care for Tasmanian patients being discharged from interstate inpatient facilities. I therefore recommend appropriate community-based services be available to Tasmanian residents immediately after they have been discharged from interstate inpatient facilities. To that end, interstate inpatient facilities should be informed of the availability of those services in order to ensure appropriate continuity of care.

130. I also consider that where inpatient facilities, including the Albert Road Clinic, are discharging patients interstate, they should ascertain what, if any, services are available to provide follow up care, particularly in the days immediately after discharge and refer the patient to those services. I recommend that occur.

Conclusion

131. I record the care and attention AZ's father, Mr KB, brought to these proceedings. Although he did not have the benefit of legal counsel, he sought to address the issues of importance to him with dignity while ensuring that all involved kept the value of AZ's life at the forefront of deliberations. It is also appropriate to express my appreciation for the assistance of all counsel appearing at this inquest for their assistance. In particular, counsel assisting, Ms Shand, provided invaluable assistance in the preparation for and hearing of this inquest. Unfortunately, she died before these findings were completed.

132. AZ's tragic death has been a source of deep sadness and intense grief for his family and friends. Indeed, it would seem that as a result of the understandable pain she experienced AZ's mother, Dr NB, took her own life in precisely the same place AZ died. Although it comes too late for her, I take this opportunity to express my condolences to AZ's family and friends.

Dated: the 28th day of January 2022 at Hobart in the State of Tasmania

K J Stanton
Coroner