Coroners Act 1996
[Section 26(1)]

Western *Australia*

RECORD OF INVESTIGATION INTO DEATH

Ref: 30 /15

I, Sarah Helen Linton, Coroner, having investigated the death of ***Jesse Richard DELLAR*** *with an inquest held at the* ***Albany Courthouse*** *on* ***27 - 28 August 2015*** *find that the identity of the deceased person was* ***Jesse Richard DELLAR*** *and that death occurred on* ***27 November 2010*** *on a* ***pathway between Brewster Avenue and Lower King Road, Collingwood Heights, Albany*** *as a result of* ***ligature compression of the neck (hanging)*** *in the following circumstances:*

Counsel Appearing:

Sgt L Houisaux assisting the Coroner.

Ms R Hartley (State Solicitor's Office) appearing on behalf of the WA Country Health Service and the Child and Adolescent Health Service.

Mr G Bourhill (Tottle Partners instructed by MDA National) appearing on behalf of Dr Greenhouse.

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INTRODUCTION

1. Jesse Dellar (Jesse) was a sensitive and complicated young man with a history of psychological disturbance due to various causes. With the support of his family he had sought medical help for many years but he still struggled with bouts of depression and suicidal thoughts.

2. In late November 2010 Jesse was admitted to Albany Regional Hospital (Albany Hospital) for psychiatric treatment following a deliberate overdose of medication. He was 17 years and five months old at the time, so in many ways he was no longer a child, and barely even an adolescent, but neither was he legally or mentally an adult. As it was put by one of the witnesses, Jesse was at that difficult adolescent age where he fell short of having full legal capacity to make his own decisions, but in many domains he was competent to make decisions about himself.[1]

3. Jesse spent four days in Albany Hospital being treated before he ran away during the afternoon of 27 November 2010. Hospital staff, police and members of Jesse's family went looking for him but by the time Jesse was found in a nearby park he had hanged himself and died.

4. A lawyer wrote to the State Coroner on behalf of Jesse's mother raising her, and other family members', concerns that Jesse was not properly supervised or cared for while at Albany Hospital.[2] On 21 November 2011 the State Coroner decided that an inquest should be held in this case pursuant to s 22(2) of the *Coroners Act 1996* (WA).

5. I held an inquest into Jesse's death at the Albany Courthouse on 27 and 28 August 2015. The focus of the inquest was primarily on how Jesse was able to leave the hospital, given the hospital staff were aware of his unstable state of mind and were meant to be supervising him and observing him regularly? More broadly, consideration was given to what care is available in the South West for young people like Jesse with mental health issues?

6. The documentary evidence included two volumes of materials compiled by the Western Australia Police as part of their investigation into Jesse's death.[3] In addition, the Report on the Second Australian Child and Adolescent Survey of Mental Health and Well Being 2015 (2015 Mental Health Report) was tendered,[4]

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[1] T 27.
[2] Letter to State Coroner from Kevin Prince, Barrister and Solicitor, dated 19.10.2011.
[3] Exhibits 1 and 2.
[4] Exhibit 3.

as was some information on the safety of the medication prescribed to Jesse.[5]

7. Oral evidence was also heard from a number of witnesses involved in Jesse's care and the investigation that followed his death.

8. Jesse's mother, father and brother also provided written material to the court after his death expressing their thoughts on matters raised in the inquest, additional recollection of events and continued concerns about aspects of Jesse's care.[6] I have attempted to address the matters they raise in my finding.

9. Jesse's mother invited me to consider reopening the inquest to call additional witnesses.[7] I do not propose to take that action as I consider there is sufficient evidence before me. I note in particular that Ms Nottle wished Dr Zafir to be called, but I have a report prepared by Dr Zafir in relation to this investigation (with relevant notes from his practice) and it does not appear from his report that he would be likely to add significantly more information if called to give oral evidence.[8] Ms Nottle also suggested that another paediatrician, Dr Arvid Lind, could give relevant evidence, but that would appear to relate to the Strattera medication, and as will be apparent from comments in my finding below, I do not consider the Strattera was, on the balance of probabilities, linked to Jesse's death. In relation to the nurses, I have statements before me of the nurses primarily involved in Jesse's care, particularly over the night of 26 – 27 November 2010, which I consider to be sufficient.

10. As to the report of the internal hospital inquiry that followed Jesse's death, which Ms Nottle has also raised, the review was conducted under legislation that does not permit the contents of the report to be disclosed to the Coroner's Court.[9] However, Dr Bowles, the Acting Regional Medical Director of WA Country Health Service (WACHS), advised that following the review the following service/quality improvements were implemented as a result:[10]

    i. Adolescent and suicide risk assessment tools with an escalation response matrix were developed.

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[5] Exhibit 4.
[6] Email to Sgt Housiaux from Keith Dellar 7.9.2015; Letter to court from Shelley Nottle 9.9.2015; Email to Sgt Housiaux from Luke Dellar 11.9.2015.
[7] Letter to court from Shelley Nottle 9.9.2015.
[8] Exhibit 1, Tab 24, 26 – 27.
[9] Letter to Constable Truong from Dr Thomas Bowles 27.4.2011; *Health Services (Quality Improvement) Regulations 1995* (WA).
[10] Letter to Constable Truong from Dr Thomas Bowles 27.4.2011.

ii. Increased liaison between psychiatric services and the hospital, particularly Child and Adolescent Mental Health Service (CAMHS).
iii. Provision of mental health upskilling implemented to staff on general wards.
iv. A review relating to the availability of nicotine inhalers as a therapy, with the intention of decreasing the need for patients to leave the ward to have a cigarette.

JESSE'S BACKGROUND

11. Jesse was born on 24 June 1993 in Perth. His parents also had an older son and later a daughter, so Jesse was the middle child of three children.[11]

12. When Jesse was about a year old his mother realised that he wasn't meeting his developmental milestones, appeared hyperactive and didn't sleep well.[12]

13. Jesse's parents separated when he was about two years old. Jesse was also subjected to a period of child sexual abuse by an acquaintance which occurred sometime from when he was between two and four years of age and continued until he was eight years of age. This compounded his behavioural and emotional issues.[13]

14. He was eventually referred to a community paediatrician, Dr Harry Dumbell, due to these concerns and also concerns about his gait.[14] Dr Dumbell continued to treat Jesse for many years.[15]

15. Jesse was described by his treating doctors as a 'complicated' child and he exhibited various challenging behaviours and developmental delays from an early age. He was diagnosed with ADHD when he was around three years old and trialled on methylphenidate and dexamphetamine, which he didn't tolerate, and eventually placed on Clonidine to help him settle at night.[16]

16. There was also a diagnosis of mild intellectual/learning disability in 2002 around the time Jesse moved with his mother and

[11] Exhibit 2, Tab 1.
[12] Exhibit 1, Tab 7 [6] – [7].
[13] Exhibit 1, Tab 7 [12]; Exhibit 2, Tab 1, letter from Dr Chauvel to Mr Simon Davies 2.7.2002.
[14] Exhibit 1, Tab 27, letter from Dr Lie 8.11.1994.
[15] Exhibit 1, Tab 7 [6] – [8].
[16] Exhibit 2, Tab 1, letter from Dr Chauvel to Mr Simon Davies 2.7.2002 and letter from Dr Dumbell to Dr Lim 16.9.2002.

siblings to Albany.[17] Jesse required extra assistance in his schooling due to his developmental/learning issues and experienced some bullying from other children as a result.[18]

17. In May 2003 Dr Dumbell decided to retrial Jesse on stimulant medication for his ADHD, so he was started on dexamphetamine.[19]

18. On 29 July 2004, when Jesse was in Year 6, he was reviewed by Dr Dumbell again. Dr Dumbell noted that Jessie showed an ongoing beneficial response to regular dexamphetamine doses (which had by then been changed to long acting Ritalin, another stimulant medication). However, he continued to be unhappy, particularly in his school life where he had difficulty in many areas of his learning and ongoing social problems, which were a source of significant stress to him.[20]

19. Jesse showed significant improvement educationally and socially as he finished primary school and moved into high school, so long as he remained on his medication. It was found that when his Ritalin medication was omitted or reduced there was a very noticeable deterioration in Jesse's ability to focus and with behaviour control.[21]

20. As a high school student Jesse found a good group of friends and hobbies, including playing guitar and skateboarding. He continued to struggle in some areas academically but managed satisfactorily with extra support. He remained on long acting Ritalin on a standard dose for four years.[22]

21. At the start of 2009, when he was 15 years old and in Year 11 at school, Jesse decided to take a break from his medication to see exactly what effect it was having on him. During this time his school work deteriorated and his behaviour at school and at home deteriorated quite dramatically. Jesse decided to recommence his medication but on a reduced dose as he found he could maintain his concentration on the lower dose whilst not becoming "zoned out" as he was previously on the higher dosage. He began TAFE studies and workplace based learning as an apprentice mechanic, which he reportedly loved and was doing well in generally.[23]

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[17] Exhibit 1, Tab 7 [13]; Exhibit 2, Tab 1, letter from Dr Chauvel to Mr Simon Davies 2.7.2002 and letter from Dr Dumbell to Dr Lim 16.9.2002.
[18] Exhibit 1, Tab 7 [9] – [10].
[19] Exhibit 2, Tab 1, letter from Dr Dumbell to Dr Lim 19.5.2003.
[20] Exhibit 1, Tab 27, letter from Dr Dumbell to Dr Leslie 9.8.2004.
[21] Exhibit 1, Tab 27, letters from Dr Dumbell to Dr Leslie 14.7.2005 and 6.2.2006.
[22] Exhibit 1, Tab 27, letter to Dr Zafir from Dr Adams 12.1.2007.
[23] Exhibit 1, Tab 27, letter from Dr Bell to Dr Zafir 11.5.2009.

22. As he was turning 16, Jesse's psychiatric care was apparently intended to be transferred from Community Paediatrics to Adult Psychiatric Services. However, it seems Jesse did continue to see a community paediatrician after that time as there were limited services available to him to be treated in the public system as an adult in Albany and the only alternative was to send him to Perth for treatment.

23. In late 2009 Jesse went to live with his father in Karratha. He had made regular visits to his father in Karratha over the preceding years but this was the first time he had gone to live there. While in Karratha Jesse enrolled in school and gained some work detailing vehicles.[24] While living with his father Jesse ceased taking his Ritalin medication. He later reported to Dr Chadwick that the medication had been making him feel quite unwell, given him headaches and made him feel quiet and unsociable.[25]

24. According to Jesse's father, Jesse did well off his medication and was happy and adjusting well.[26] Jesse's mother maintains a different version of events and asserts that Jesse found being off his medication, and being away from his support network in Albany, traumatic.[27] I am unable to form a conclusion as to which account is the most reliable and it may be that there are elements of truth in both but told from different perspectives.

25. There appears to be some consistency in both parents' account that there was an acrimonious dispute between the former couple over child support payments relating to Jesse around this time, and irrespective of who was in the right, both parents appear to agree that the dispute caused Jesse some distress.[28]

26. At the end of 2009 Jesse elected to return to Albany and he had returned to live with his mother by February 2010. He remained living in Albany until his death.[29] He was very close to his older brother, Luke, and spent a lot of time with him on the weekends although he lived with his mother during the week.[30] Luke apparently got into some trouble with the authorities, which caused Jesse to worry about him.[31]

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[24] Email from Keith Dellar dated 7.9.2015.
[25] Exhibit 1, Tab 7 [19]; Tab 27, letter from Dr Chadwick to Dr Zafir 8.6.2010.
[26] Email from Keith Dellar dated 7.9.2015.
[27] Letter from Shelly Nottle to court 9.9.2015.
[28] Exhibit 1, Tab 7 [26] – [28]; Email from Keith Dellar dated 7.9.2015; Letter from Shelly Nottle to court 9.9.2015.
[29] Email from Keith Dellar dated 7.9.2015; Letter from Shelly Nottle to court 9.9.2015; Exhibit 1, Tab 8.
[30] T 21.
[31] Exhibit 1, Tab 17 [9].

27. In about May 2010 Jesse was referred to see a community paediatrician again by his general practitioner, Dr Mark Zafir. Dr Zafir had been seeing Jesse since December 2005.[32] Dr Zafir noted that the plan to refer Jesse to adult services was not practical as Jesse was not able to access the local psychiatric services as they would not deal with adult ADHD and the family would find it difficult financially to manage the costs of a private psychiatrist in Perth.[33] Dr Zafir had prescribed Jesse some Ritalin LA as well as referring him for urgent paediatric review.[34]

28. When Jesse saw the community paediatrician, Dr Chadwick, on 21 May 2010, it was reported that he had had "a fairly difficult time of late."[35] He had been unable to continue with his automotive mechanic apprenticeship, reportedly due to poor concentration issues while he continued to abstain from taking his ADHD medication. Jesse had eventually recommenced taking his Ritalin medication at the start of May 2010 as prescribed by Dr Zafir. Jesse again reported that it made him feel unwell and 'flat'. He said that he felt quite angry a lot of the time but found it difficult to discuss this with members of his family. He also reported ruminant thoughts and difficulty sleeping. Dr Chadwick felt that Jesse showed some features of depression although he denied any suicidal ideations or plans.[36] I note that Jesse's mother disagreed with the diagnosis of depression.[37]

29. Dr Chadwick recommended Dr Zafir consider starting Jesse on an antidepressant and she started him on a low dose of Citalopram, which is an antidepressant and also acts to reduce anxiety, anger and frustration in small doses.[38] Dr Chadwick also flagged a plan to consider changing Jesse to the medication Strattera in the future as an alternative to Ritalin to help with his concentration and attentional difficulties.[39]

30. Strattera is the brand marketing name for atomoxetine. It is a non-stimulant drug used for the treatment of ADHD in children aged 6 years or over, adolescents and adults. However, clinical trials have raised a concern about a possible greater risk of suicidal ideation in children and adolescents receiving this treatment.[40] The same issue is raised by antidepressants.[41] For this reason Strattera is not generally prescribed to children

[32] Exhibit 1, Tab 24 and Tab 26; Tab 27 letter from Dr Bell to Dr Zafir 11.5.2009.
[33] Exhibit 1, Tab 8.
[34] T 72; Exhibit 1, Tab 8.
[35] Exhibit 1, Tab 27, letter from Dr Chadwick to Dr Zafir 8.6.2010.
[36] Exhibit 1, Tab 8.
[37] Exhibit 1, Tab 7 [23].
[38] T 73.
[39] Exhibit 1, Tab 8 and Tab 27, letter from Dr Chadwick to Dr Zafir 8.6.2010.
[40] Exhibit 4.
[41] T 143.

except under the supervision of a specialist. Dr Chadwick is such a specialist.

31. Dr Chadwick did not refer Jesse to a psychiatrist at this time. Although she considered psychiatric input would have been helpful, it was apparent from the information provided by Dr Zafir that Jesse wasn't able to access a public service in Albany and a private option in Perth was not financially viable.[42] There is no psychological service to support the Child Development Service in Albany, so that was also not an option. The only possible option was a referral to Headspace (which is discussed in more detail later in this finding) that is not run as part of the Child Development Service.[43] Unfortunately, it does not seem that Jesse was referred to Headspace at that time although it was open to him to initiate contact himself at any time.

32. Dr Chadwick received a request to call Ms Nottle on 10 June 2010. Dr Chadwick spoke to Ms Nottle by telephone and Ms Nottle explained that Jesse had ceased taking Citalopram as the trial had been unsuccessful. They discussed the possibility of trialling Jesse on Strattera and Dr Chadwick explained the potential side effects "such as nausea, sleep difficulties and increased anxiety and agitation" to Ms Nottle. Dr Chadwick indicated that these side effects are generally temporary and will usually get better after a few weeks.[44] Dr Chadwick then sent a note to a clerical officer on 18 June 2010 to authorise a script for Strattera.[45]

33. Jesse started taking Strattera, under Dr Chadwick's supervision, from mid-June, on an initial dose of 40 mg per day. Dr Chadwick spoke to Ms Nottle by telephone around 21 July 2010 and she reported that the trial of Strattera was going well with no side effects being noted. Dr Chadwick then increased the dose to 60 mgs per day and arranged a follow up appointment in August.[46]

34. Dr Chadwick saw Jesse again on 12 August 2010 in the company of his mother. It was noted that the earlier trial of Citalopram had not made any significant difference to Jesse's symptoms of depression but Jesse reported that he had been feeling really well on the Strattera medication and also feeling much more positive.[47] Dr Chadwick decided to leave Jesse on his current

[42] T 74.
[43] T 74 - 75.
[44] T 76.
[45] Exhibit 1, Tab 8.
[46] Exhibit 1, Tab 8.
[47] Exhibit 1, Tab 27, letter Dr Chadwick to Dr Zafir 23.8.2010.

dosage of Strattera and planned to see him again in March 2011 unless any problems arose at an earlier time.[48]

35. Around this time Jesse formed a relationship with a sixteen year old girl who had a young infant from a previous relationship. Jesse's mother reports that Jesse loved his girlfriend and her child, but their relationship was tumultuous and they broke up and reconciled frequently.[49]

36. According to Jesse's girlfriend, during the time she knew him Jesse was depressed, with a lot of anxiety, most of the time although he managed to hide this side to him from most people.[50] Prior to their relationship she understood Jesse had been smoking cannabis almost daily, but he smoked it less often once they were together because of her baby. He was also a social drinker, but not what she described as a heavy drinker.[51]

ADMISSION TO ALBANY HOSPITAL

37. On 23 November 2010 Jesse took a deliberate overdose of his Strattera medication (20 tablets) reportedly following an argument with his girlfriend and other social stressors.[52] He went to visit his girlfriend and told her what he had done. She informed other people and Jesse was taken by his brother and a family friend to the Emergency Department of Albany Hospital at about 10.00 am.[53]

38. Physically, Jesse was conscious but appeared mildly sedated as a result of the overdose. He was described as pale, with dilated pupils and difficulty talking. His blood tests were reportedly normal.[54]

39. Jesse was admitted to Ward C, a general ward of the hospital, under the care of Dr James Greenhouse. Dr Greenhouse had not treated Jesse before this admission and had treated adolescents with mental health issues infrequently. He had a little more experience in caring for adult patients with mental health problems.[55] Nevertheless, with a background in general practice Dr Greehouse felt comfortable to see Jesse for an initial assessment before then seeking expert opinion.[56] Dr Greenhouse

[48] Exhibit 1, Tab 8.
[49] Exhibit 1, Tab 7 [29] – [33].
[50] Exhibit 1, Tab 17 [5].
[51] Exhibit 1, Tab 17 [10] – [12].
[52] Exhibit 2, Tab 2, Triage form 24.11.2010.
[53] Exhibit 2, Tab 2, Triage form 24.11.2010.
[54] Exhibit 1, Tab 9 [12] – [13].
[55] T 58.
[56] T 58 - 59

was involved in Jesse's medical management to deal with his overdose, as well as some initial care of his mental health issues.[57]

40. At the time the 'shared care' model was in place at Albany hospital for psychiatric patients. It was described as a consultative model, where all patients of any age where admitted either under a general practitioner or a senior medical practitioner and assistance was sought from a psychiatrist as it was required.[58] In this case, Dr Greenhouse was the allocated senior medical practitioner, and he could elect to seek specialist psychiatric input, as required.

41. Dr Greenhouse was able to prescribe Jesse medications for his anxiety and agitation without consultation and he prescribed Jesse Diazepam, a benzodiazepine used for agitation, and placed him on two hourly observations. Jesse had already been referred to CAMHS.[59] At that time, Dr Greenhouse was under the impression that CAMHS had a psychiatrist on staff, who would review Jesse.[60] As it turned out, that was not the case but nothing significant turns on this issue as the CAMHS worker referred Jesse to a psychiatrist after their review.

42. Ward C did have a paediatric part to the ward, but Jesse was not placed in that area. Rather, he was placed in a room with adults.[61] One of the nurses observed that it was unusual at the time to have an adolescent in there, although apparently now it is quite common.[62]

43. Dr Greenhouse reviewed Jesse at about 2.00 pm that day. Jesse told Dr Greenhouse that he felt numb but was no longer feeling actively suicidal.[63] He reported that he had suddenly stopped taking his Strattera medication three weeks ago because it caused him nausea and suppressed his appetite. Jesse said while he was coming off Strattera he developed heightened mood swings and increased stuttering.[64] I note that experts at the inquest suggested Strattera may have had an antidepressant effect and relieved anxiety, as well as treating Jesse's ADHD symptoms, so Jesse's sudden cessation of the Strattera may have contributed to his depressed mood and anxiety.[65] Jesse also spoke about personal and family issues.[66]

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[57] T 66.
[58] T 133.
[59] T 55.
[60] T 59.
[61] T 51.
[62] T 51.
[63] Exhibit 1, Tab 9 [22].
[64] Exhibit 1, Tab 9 [24] – [25].
[65] T 80, 144.
[66] Exhibit 1, Tab 9 [26] – [29].

44. That same afternoon Dr Greenhouse initiated contact with Jesse's paediatrician, Dr Chadwick, and they spoke on the telephone about Jesse at around 6.30 pm that evening.[67] Dr Chadwick confirmed Jesse's diagnosis of ADHD and his recent change of medication from Ritalin to Strattera.[68] Dr Chadwick suggested that Jesse should be risk assessed by the hospital psychiatrist. Dr Chadwick also thought it was likely she advised that Jesse shouldn't continue on Strattera or Ritalin until he had seen a psychiatrist.[69] This was confirmed by Dr Greenhouse who had made a note that Dr Chadwick "was not keen to continue either Straterra or Ritalin."[70]

45. Dr Chadwick's instruction in relation to the Strattera was not because she considered that Jesse was experiencing suicidal ideation because of that drug.[71] Dr Chadwick acknowledged during the inquest that there is some concern about Strattera being associated with some suicidal ideation in children. This became more evident in about 2012 (a couple of years after Jesse's death) and a 'black box' warning was added to the medication about the risk of suicidal ideation in children (although as far as Dr Chadwick was aware there have been no actual suicides related to Strattera).[72] At the time Dr Chadwick prescribed Strattera to Jesse she did not warn him or his mother about the increased risk of suicidal thoughts as "it wasn't really identified as a problem at that stage." Dr Chadwick advised at the inquest that it is now a warning that she gives to all families and all parents.[73] That is despite the fact that the statistical risk is extremely low.[74]

46. However, the reality in this case is that Jesse had not been taking the Strattera for a number of weeks, so it is unlikely that any suicidal ideation he was experiencing was attributable to a side-effect of the Strattera.[75] Given the half-life of the drug, it would apparently have been long gone from his system by that time, which is consistent with Dr Chadwick's experience with other patients on Strattera.[76] However, as noted above, Jesse's decision to stop taking the Strattera may have deprived him of some protective effect against his depressive symptoms and anxiety.[77]

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[67] T 55.
[68] T 55.
[69] T 79.
[70] Exhibit 2, Tab 2, Integrated Progress Notes, 24.11.2010.
[71] T 80.
[72] T 79.
[73] T 79.
[74] T 145.
[75] T 80, 144..
[76] T 80, 144.
[77] T 80, 144.

47. They also discussed a referral to Headspace (which is a service that provides mental health and wellbeing support to adolescents).[78]

48. The Integrated Progress Notes show that Jesse went outside for a cigarette and was back on the ward by 7.30 pm. He apparently went outside again for a cigarette, this time in a wheelchair, at 9.00 pm and returned at 9.15 pm. Neurological observations were continued throughout the evening and the only matter of note was that his pupils appeared dilated.[79]

49. Sometime that night Jesse texted his girlfriend and told her that he thought they should stop seeing each other.[80]

EVENTS ON THE WARD 24 - 25.11.2010

50. In response to the referral to CAMHS, on 24 November 2010 (the day after his admission to Albany Hospital) Jesse was assessed by a social worker, Sheree Boots, on behalf of Albany CAMHS. Ms Boots saw Jesse between 9.30 and 10.00 am.[81] After her assessment Ms Boots approached Dr Bradleigh Hayhow, who was working as a Psychiatry Registrar at Albany Hospital at that time.[82] Ms Boots discussed Jesse's case with Dr Hayhow and asked him to review Jesse and provide a specialist psychiatric opinion. Dr Hayhow told Ms Boots that he would be able to see Jesse the following afternoon (being 25 November 2010).[83]

51. Throughout the day Jesse complained of feeling lightheaded, dizzy and described periods of "blackouts."[84] He was reviewed by nursing staff regularly and the documented neurological observations were described as normal. He went outside the hospital regularly throughout the day to smoke, in the company of his mother and friends at various times.[85]

52. Dr Greenhouse recalls seeing Jesse in the hospital corridor at about 2.00 pm and Jesse asked what was happening with his treatment. Dr Greenhouse told him that they were arranging for him to see the hospital psychiatrist.[86] According to Dr Greenhouse, Jesse seemed content with that information.[87]

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[78] T 55.
[79] Exhibit 2, Tab 2, Integrated Progress Notes 23.11.2010.
[80] Exhibit 1, Tab 17 [37].
[81] Exhibit 2, Tab 2, Integrated Progress Notes 24.11.2010, 09.30 – 10.00.
[82] T 22 – 23.
[83] T 23.
[84] Exhibit 2, Tab 2, Integrated Progress Notes 24.11.2010.
[85] Exhibit 2, Tab 2, Integrated Progress Notes 24.11.2010.
[86] T 56.
[87] T 56.

53. At 10.30 pm that evening when Jesse returned inside from smoking he complained of increased agitation and feeling suicidal after "going over his problems."[88] He was counselled by nursing staff and given his charted sedative medication (Diazepam) to help him settle and sleep. Jesse gave verbal assurance to the nurses that he would not self harm in hospital.[89] Jesse's brother was reported to come onto the ward at this time and he expressed concerns about Jesse's mood. The notes indicate the nurse attempted to reassure both boys.[90] Jesse later told the nurse he was feeling better.[91]

54. At 1.00 am Jesse was noted to be still awake. He told nursing staff he was feeling anxious and was unable to sleep. He was given more Diazepam and it appears he went to sleep.[92] The following morning he was still sleeping and didn't wake for breakfast.[93]

55. Jesse was reviewed by Dr Greenhouse on the morning of 25 November 2010, at which time he had still not been seen by the psychiatrist, Dr Hayhow. Jesse told Dr Greenhouse he was feeling safe in hospital but felt he needed a few more days there as he had been feeling down and tearful the day before. Jesse reported his appetite and energy levels were good. He mentioned that his ex-girlfriend had been admitted to the hospital with her baby and Jesse asked if he could spend time with the baby alone. He was told he could do so if the mother gave permission and provided hospital staff supervised the visit.[94]

56. Jesse apparently went and visited his ex-girlfriend in the hospital a number of times that day and she thought he seemed fine and much better than he had on the morning of 23 November 2010.[95]

57. At the time Dr Greenhouse reviewed Jesse he thought Jesse seemed relaxed, quite positive and hopeful he would get his life back on track.[96] This is consistent with the nursing notes of Nurse Wendy Richardson later that day, which record Jesse as appearing alert and orientated with a bright mood and making good eye contact at 1.45 pm.[97] Nurse Richardson believes she may have spoken to Jesse at this time in general terms about the

[88] Exhibit 2, Tab 2, Integrated Progress Notes, 24.11.2010, 23.40.
[89] Exhibit 2, Tab 2, Integrated Progress Notes, 24.11.2010, 23.40.
[90] Exhibit 2, Tab 2, Integrated Progress Notes, 24.11.2010, 23.40.
[91] Exhibit 2, Tab 2, Integrated Progress Notes, 24.11.2010, 23.40.
[92] Exhibit 2, Tab 2, Integrated Progress Notes, 25.11.2010, 05.20.
[93] Exhibit 2, Tab 2, Integrated Progress Notes, 25.11.2010, 08.30.
[94] T 56; Exhibit 2, Tab 2, Integrated Progress Notes, 25.11.2010, Dr Greenhouse.
[95] Exhibit 1, Tab 17.
[96] T 56.
[97] Exhibit 2, Tab 2, Integrated Progress Notes, 25.11.2010, 13.45.

possibility of his discharge.[98] It is possible this may have impacted on Jesse's mood, although that is purely speculative.

58. What is known is that not long after this, Jesse experienced a dramatic change in mood. Jesse's friend, Jasmine Best, came to visit him around midday and spent the afternoon with him. At approximately 3.00 pm Jesse suddenly got up from his bed and started walking off the ward. Jasmine followed him and asked him what he was doing. Jesse said he was tired and needed to sleep. He looked sad and tired when he said this. Jesse then walked into the male toilets at the front of the hospital. Jasmine then reported what had occurred to staff at the hospital front desk.[99]

59. Nurse Richardson was telephoned by the hospital switchboard and advised that Jesse was refusing to come out of the male toilets at the front of the hospital and was stating that he wanted to die.[100] Nurse Richardson and the other enrolled nurse on duty left the ward and went to the toilets. A hospital orderly was already in attendance when they arrived and they were advised Jesse had locked himself in the toilet cubicle.[101]

60. The nurses asked Jesse to open the door but he did not respond. The orderly attempted to open the door first from the outside, and then he jumped up and managed to unlock the cubicle door from the inside. Jesse was sitting on the floor of the cubicle, against the door, but he allowed the hospital staff to open the door and come into the cubicle. Nurse Richardson recalled Jesse was very subdued and did not appear agitated. He did not make eye contact and stared at the floor. With gentle encouragement the nurses were able to get Jesse to stand up and walk back with them to the ward.[102]

61. Jesse remained silent and non-responsive for most of the walk. However, when they were walking along the main corridor to C ward Jesse stated "Mum thinks I'm okay. Nothing's wrong with me. I just want to die and I feel empty."[103] He appeared outwardly sad as he said this.[104] Nurse Richardson attempted to reassure him and continued to walk him back to the ward.[105]

62. The nurses returned Jesse to his room and offered him more reassurance and suggested that he stay in bed. Nurse

[98] T 45.
[99] Exhibit 1, Tab 19 [39] – [48].
[100] T 45.
[101] T 45.
[102] T 46.
[103] T 46.
[104] T 46
[105] T 47.

Richardson asked him if he felt safe in hospital, and he replied that he did not feel safe.[106] This prompted Nurse Richardson to increase him to half hourly visual observations and she informed the nursing coordinator and Jesse's doctor was also apparently informed, although Dr Greenhouse does not mention this.[107]

63. Jesse's friend Jasmine visited Jesse shortly afterwards and he apologised to her. She then left the hospital, intending to return later that night. It seems that Jesse's mother arrived to visit Jesse sometime after this.

64. Nurse Richardson was aware that the psychiatrist, Dr Hayhow, was due to see Jesse at 4.00 pm that day. At approximately 4.20 pm Nurse Richardson saw Jesse attempting to leave the ward and she approached him and reminded him he needed to stay on the ward and wait for his psychiatric assessment. Jesse was agitated and unsettled and his speech was rapid and loud when Nurse Richardson spoke to him. He said "I'm going out for a cigarette to get away from my mum. She's really fucking annoying me."[108] Nurse Richardson walked with Jesse into the lounge area of C ward and talked to him and tried to reassure him. Jesse did not engage with Nurse Richardson but he appeared to be calming down.[109]

65. Nurse Richardson then left Jesse in the lounge, apparently texting on his mobile, and went to speak to Jesse's mother. She explained how Jesse was feeling and Ms Nottle responded in a reasonable manner and agreed to wait in the lounge area to give Jesse some space.[110] Nurse Richardson went back and told Jesse of the plan and he then agreed to return to his bed.[111]

66. Nurse Richardson then rang Dr Hayhow to tell him of the incident and find out where he was as it was past 4.00 pm.[112] Dr Hayhow was just finishing his afternoon clinic.[113] Nurse Richardson asked Dr Hayhow if she could given Jesse some PRN medication and Dr Hayhow agreed and prescribed 1 mg of lorazepam (a benzodiazepine used to treat anxiety).[114] Soon after Jesse was given the lorazepam Dr Hayhow arrived on the ward.[115]

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[106] T 47.
[107] T 47.
[108] T 47.
[109] T 48.
[110] T 48.
[111] T 48.
[112] T 48.
[113] T 32.
[114] T 23, 49.
[115] T 49.

PSYCHIATRIC REVIEW

67. Dr Hayhow arrived on the ward at approximately 4.30 pm. At the time he arrived Jesse was settled in his room. Dr Hayhow reviewed Jesse's medical notes for approximately 10 minutes before next interviewing Jesse's mother.[116] Dr Hayhow spoke to Ms Nottle in private for approximately 40 minutes to gain a sense of Jesse's history. He then interviewed Jesse in private for approximately one hour. During this interview Jesse provided his history and Dr Hayhow assessed Jesse's mental state.[117]

68. Based upon Jesse's medical record, the collateral history provided by his mother and Jesse's own account, as well as his presentation that day, Dr Hayhow's provisional diagnosis was a moderately severe depressive episode with symptoms of anxiety suggestive of co-morbid panic disorder.[118] Dr Hayhow assessed Jesse's immediate level of risk to be low to moderate, but he considered it to be adequately contained within the hospital environment. This risk assessment was based on the fact that, according to Dr Hayhow, Jesse:

    i. demonstrated good therapeutic management;
    ii. stated he regretted his suicide attempt and was glad to have survived;
    iii. denied any plans or intentions to make another suicide attempt;
    iv. spoke in positive terms about the future;
    v. expressed fair insight into both the nature of his problems and some potential solutions; and
    vi. seemed to have improved whilst being in the inpatient hospital environment.[119]

69. In relation to his behaviour in the toilet that day, Jesse told Dr Hayhow he locked himself in to get some "space" and not with any intent to harm himself.[120]

70. Dr Hayhow felt that Jesse's longitudinal or lifetime risk of suicide was high in view of his difficult personal history and burden of psychiatric illness.[121] However, he did not consider him to be at extreme risk of suicide at the time of the assessment.[122] Dr Hayhow did not believe when he examined Jesse that he had any persisting plan or intention to commit suicide at that time. Jesse expressed remorse at his earlier suicide attempt, was

[116] T 23.
[117] T 23.
[118] T 23 - 24.
[119] T 24.
[120] Exhibit 2, Tab 2, Integrated Progress Notes, 25.11.2010, 18.00.
[121] T 24.
[122] T 27.

willing to talk in positive terms about addressing his problems and was generally reassuring about his welfare while he remained in hospital.[123]

71. Dr Hayhow's recommendation was that Jesse should remain in hospital for treatment. This recommendation was made on the basis that:

    i. the most acute factor precipitating Jesse's presentation to hospital remained unresolved, namely, stress as a result of disharmony with his recent girlfriend;
    ii. the protective effect of Jesse's relationship with his mother was under stress;
    iii. Jesse himself expressed a desire to remain in hospital for ongoing support;
    iv. Jesse's mother supported Jesse remaining in hospital due to her high level of concern for both his mental state and his welfare;
    v. there was an outstanding need to arrange appropriate community support and follow up; and
    vi. it would be safest and most time effective to review Jesse's progress as an inpatient.[124]

72. At the conclusion of the assessment Dr Hayhow discussed with Jesse his clinical impressions and management options. Dr Hayhow's management plan included a combination of biological and psychological interventions to address Jesse's depressive/anxiety symptoms, agitation and risk. Jesse agreed to continue his inpatient admission over the weekend and to trial fluoxetine for his depressed mood and anxiety and Quetiapine for his agitation and anxiety, while remaining off atomoxetine until reviewed by Dr Chadwick. He also agreed to explore options for psychological engagement, such as CAMHS and Headspace.[125] Dr Hayhow also indicated he was willing to review Jesse's medications in the adult clinic after he was discharged (possibly on the Monday).[126]

73. After the review Dr Hayhow spoke again briefly to Jesse's mother and she agreed with the proposed management plan.[127] It appeared to Dr Hayhow that Ms Nottle was relieved that Jesse was going to stay in hospital, presumably in the hope that he would receive treatment that would help improve his mental state while there.[128] Ms Nottle states that she went and saw Jesse

[123] T 34 – 35.
[124] T 24 – 25.
[125] T 25.
[126] Exhibit 2, Tab 2, Integrated Progress Notes, 25.11.2010, 18.00.
[127] T 25.
[128] T 39.

afterwards and he reported that he was happy to be able to go home on the Saturday, which suggests perhaps some misunderstanding by Jesse and his mother of the further length of time Dr Hayhow wanted him to stay.[129]

74. Dr Hayhow then rang Dr Greenhouse to communicate his assessment and recommendations. Dr Greenhouse agreed with the management plan and accepted Dr Hayhow's offer to record the new plan on Jesse's medication chart, which was then done.[130] The plan was for Jesse to discontinue atomoxetine (which he hadn't been taking for some time on his account) and commence on a trial of Fluoxetine and PRN Quetiapine. Both drugs are used for the treatment of depression.[131]

75. When Dr Hayhow assessed Jesse he had specifically considered the question of whether Jesse should have unlimited access to his phone and social media versus looking for a means to limit it. On balance, Dr Hayhow felt that because Jesse had indicated that he had supportive social connections and had been engaging with friends and drawing support from them during his admission, on balance it would have done more harm than good to have attempted to restrict his access to his phone.[132] Dr Hayhow referred to "attempting" to restrict his access as there were limits to what could be done in his management given he was not an involuntary patient.[133]

76. Similarly, while he was a voluntary patient, Jesse's ability to move freely around the hospital was difficult to limit.[134]

77. In that regard, Dr Hayhow was asked whether he considered if Jesse should have been made an involuntary patient at the time of the assessment. Dr Hayhow explained that while Jesse "met the criteria of having a major mental illness," he was compliant and was willing to stay in hospital for treatment. Therefore, given the ethos of the *Mental Health Act 1996 (WA)* requires the least restrictive treatment for patients, Dr Hayhow did not consider Jesse met the criteria for being declared an involuntary patient.[135]

78. Dr Hayhow also considered that engaging the *Mental Health Act* might have potentially served to undermine Jesses's treatment by undermining the therapeutic alliance and escalating his

[129] Exhibit 1, Tab 7 [74].
[130] T 25, 30, 62.
[131] T 56.
[132] T 26.
[133] T 26.
[134] T 35 – 36.
[135] T 27.

agitation.[136] Dr Hayhow also understood that Jesse mainly wanted to leave the ward in order to smoke and he commented that it would have been "adding insult to injury to have him withdrawing from nicotine on top of the other problems he was facing."[137]

79. It appeared to Dr Hayhow that Jesse had been utilising leave appropriately and from his point of view "there wasn't really a red flag … that the restrictiveness of his management should be escalated."[138] This is despite the incident earlier that afternoon when Jesse had locked himself in the toilets downstairs.

80. Further, Dr Hayhow explained that as an involuntary patient the only option would have been to place Jesse in G ward with adult voluntary and involuntary patients, some of whom would be suffering from acute psychosis and others who might exhibit disinhibited behaviour. Dr Hayhow noted there was a general hospital policy against doing so, and he specifically thought it was not an appropriate environment for Jesse, even though he was nearing 18 years of age, given his level of vulnerability to exploitation and his previous exposure to trauma.[139]

81. It is also relevant to note that at that time the only secure area of G ward was an environment Dr Hayhow compared to "police cells", which would not have been appropriate for Jesse. Therefore, Jesse would have been housed in the non-secure section of G ward, where the level of environmental restriction would not have been different from what he experienced on C ward. That is, he would have had similar freedom of movement on either ward.[140]

82. The other alternative, which was for Jesse to be admitted to an adolescent unit, would have required Jesse to come up to Perth for treatment away from the support network of his family and friends. Dr Hayhow also noted that access to the Bentley Adolescent Unit would have been limited, so Jesse would have been likely to have waited several days before he could be transferred.[141] If he had remained a voluntary patient, Jesse would also have had to bear the costs and make the arrangements for travel to Perth.[142]

83. Dr Hayhow also observed that one of the themes of Jesse's conversation with him was that he felt like he needed some space

[136] T 27, 36.
[137] T 36.
[138] T 36.
[139] T 28, 40.
[140] T 28 – 29.
[141] T 41 - 42.
[142] T 42.

and some peace. For this reason, Dr Hayhow felt that a high level of observation of Jesse might have been detrimental.[143] It was for this reason that he downgraded the level of formal observations for Jesse, although he was expecting Jesse to still receive a general baseline level of observations.[144]

84. Dr Hayhow's short-term management plan was to return again to see Jesse on Monday with his consultant, Dr Middlemost, to again review Jesse and formulate a discharge plan.[145] Long term, Dr Hayhow had suggested to Jesse that he could see Jesse as a patient in the adult clinic once he had been discharged from hospital, since there wasn't a medical adolescent clinic and Dr Hayhow had felt they had developed a good rapport.[146] In addition Jesse would also see a CAMHS clinician, such as a psychologist or social worker, for individual therapy and possible have some input from Headspace.[147] Sadly Jesse took his life before any of this could occur.

85. Dr Hayhow was not on-call over the weekend so he was not involved in the events leading up to Jesse's disappearance and the eventual discovery of his body over the weekend of 26 to 27 November 2010. Dr Hayhow was informed of Jesse's death by Dr Greenhouse that weekend and he indicated he was very surprised by the news and it caused him to reflect upon his treatment of Jesse.[148] In hindsight and with subsequent experience (he is currently a Consultant Psychiatrist at Fiona Stanley Hospital)[149], the only thing Dr Hayhow could identify he might have done differently would have been to try to arrange some psychiatric nursing follow-up of Jesse over the weekend, prior to the review on Monday, if such a service was available.[150]

AFTER THE PSYCHIATRIC REVIEW

86. After Dr Hayhow's assessment Nurse Richardson noted that Jesse's mood seemed to improve.[151]

87. Jesse's mother, on the other hand, recalls that his mood was changeable every 15 – 20 minutes, which was unusual for him. Ms Nottle left at 5.00 pm[152] and Jesse's friend Jasmine had

[143] T 31.
[144] T 31.
[145] T 30.
[146] T 40.
[147] T 33 – 34.
[148] T 36.
[149] T 37.
[150] T 36 – 37.
[151] T 49.
[152] Exhibit 1, Tab 7 [83].

returned with Jesse's brother at about the same time. They stayed with Jesse until 8.30 pm and Jesse apparently seemed calm and happy during that time.[153] Jesse's mother had gone home by this stage.

88. Nurse Richardson checked on Jesse at 7.40 pm to record his clinical observations and she noted at that time that Jesse had showered and appeared more relaxed and calm. He was engaging readily and chatting to staff.[154] Jesse was no longer on special visual observations by that time, as per Dr Hayhow's verbal orders to Nurse Richardson.[155] Jesse asked Nurse Richardson if he could have nicotine patches as he stated that he wanted to quit smoking. Nurse Richardson contacted Dr Greenhouse and also spoke to the nurse coordinator about the possible introduction of patches but it was agreed not to apply a patch at that time due to Jesse's insomnia, given a possible side effect of nicotine patches is insomnia.[156] Nurse Richardson told Jesse of this decision and that he would have a patch applied in the morning. He apparently seemed content with this plan.[157]

EVENTS ON FRIDAY, 26.11.2010

89. According to the nursing notes Jesse slept well over the night and his observations were generally stable.[158] However, Jesse's friend Jasmine Best recalls that she attended the hospital with another patient at about 1.00 am and found Jesse sitting outside the hospital on the stairs leading to the carpark. Jesse was alone and crying. Jasmine went over to Jesse with Jesse's brother Luke and they spoke to Jesse, who told them that he was physically tired. They took Jesse back to the ward. Jesse's brother spoke to the nurses and asked them to keep a better eye on Jesse. Jesse's brother also gives an account of the same incident, although it is a bit unclear as to when he says it occurred, as he includes reference to Jesse being in the single room that he was moved to in the early hours of 27 November 2010 and also seems to put it in the chronology as occurring after the attempted hanging incident.[159]

90. There is no nursing note recording an incident in the early hours of 26 November 2010. The nursing note of the overnight shift records that "nil agitation or self harm noted overnight" and also

[153] Exhibit 1, Tab 19 [59] – [63].
[154] T 49.
[155] Exhibit 2, Tab 2, Integrated Progress Notes, 25.11.2010, 19.40.
[156] T 49.
[157] T 49.
[158] Exhibit 2, Integrated Progress Notes, 26.11.2010, 05.40.
[159] Email from Luke Dellar to Sgt Housiaux 11.9.2015, 2.

that Jesse was "in sound sleep all over night."[160] Given the seriousness of what is described, it would be surprising if no nursing note was made of such an incident. Constable Truong made further enquiries with hospital staff regarding this incident and no hospital staff could recall such an incident.[161]

91. I note the reference to a similar incident in the nursing notes the evening before, when Jesse came in distressed after a cigarette and Jesse's brother came and spoke to nurses about his concerns (as described above). Although I accept that Jasmine Best and Luke Dellar have given a truthful account of this even occurring, given there is some uncertainty as to the date when it occurred and hospital staff have been unable to assist, I am unable to find that it definitely occurred on this particular morning.

92. The nursing note for the morning of 26 November 2010 records Jesse woke for breakfast and stated that he felt a little unwell without specific symptoms. He was given medication and eventually went back to sleep. The nurse made a note that the doctor should review him.[162]

93. Jesse slept for most of the morning but stated that he still felt tired.[163] Jesse finally got up and showered after midday and had a new nicotine patch applied at 12.45 pm.[164]

94. Jesse was reviewed by a Senior Medical Officer, Dr Paparo, in the afternoon as Dr Greenhouse was not at the hospital on 26 November 2010.[165] Dr Paparo noted that Jesse engaged well and indicated that he felt safe in hospital and he was given some counselling and advice.[166]

95. No concerns were noted in the entry at 8.30 pm. Jesse had requested sleeping medications at 4.00 pm and was encouraged by the nurse to wait until later in the night.[167]

96. Enrolled Nurse Eva McGarva was working the night shift on C ward on 26 November 2010. Jesse was allocated to Nurse McGarva as her patient for her shift, which commenced at 9.00 pm. She had earlier cared for Jesse on 24 November 2010.

[160] Exhibit 2, Integrated Progress Notes, 26.11.2010, 05.40.
[161] Exhibit 1, Tab 1.
[162] Exhibit 2, Integrated Progress Notes, 26.11.2010, 09.30.
[163] Exhibit 2, Integrated Progress Notes, 26.11.2010, 12.30.
[164] Exhibit 2, Integrated Progress Notes, 26.11.2010, 12.45.
[165] T 56.
[166] Exhibit 2, Integrated Progress Notes, 26.11.2010, Dr Paparo SMO.
[167] Exhibit 2, Integrated Progress Notes, 26.11.2010, 20.30.

Nurse McGarva was told during the handover from the day shift that Jesse was improving and might go home in a few days.[168]

97. At about the time Nurse McGarva started her shift Jesse received a phone call from his ex-girlfriend. Jesse reportedly told her he missed her but his family thought it would be best for him if they kept apart. They agreed to remain friends and he still wanted to continue contact with her child.[169] She described Jesse as sounding "really down"[170] when she spoke to him.

98. At approximately 10.00 pm Nurse McGarva conducted her rounds and observed that Jesse had been unsettled and talking loudly on the telephone. Jesse complained that he could not sleep and Nurse McGarva gave him 1 mg of lorazepam to help him sleep. Jesse also complained that his nicotine patch wasn't working because he had to go outside for a smoke. Nurse McGarva recalled that Jesse seemed frustrated at that time.

99. At about 11.00 pm Nurse McGarva asked Jesse to turn off his phone to help him settle and because it was late and she was concerned he might be disturbing other patients.[171] At that time Jesse seemed settled and comfortable and engaged with Nurse McGarva appropriately. Jesse stopped talking on his phone after that, but Nurse McGarva did observe during later rounds that Jesse's phone light was still on and his mobile was still in his hand.[172]

100. At approximately midnight Jesse rang his bell and Nurse McGarva went to his room. She found Jesse sitting on his bed with his mobile phone in his hand. Jesse told Nurse McGarva he had tried to hang himself in the bathroom with a shower cord. Nurse McGarva asked Jesse why he had done that and he told her that he felt that he couldn't cope with things. During this conversation Jesse's speech seemed normal and he appeared to be calm but sad.[173] Nurse McGarva attempted to ask him more probing questions but Jesse became withdrawn and wouldn't answer.[174]

101. Nurse McGarva said she took Jesse's admission seriously.[175] She examined Jesse's neck and did not see any bruises or marks. She conducted Jesse's observations and recorded the results, which were within normal parameters. Nurse McGarva then gave Jesse

[168] T 88.
[169] Exhibit 1, Tab 17 [46] – [49].
[170] Exhibit 1, Tab 17 [50].
[171] Exhibit 2, Integrated Progress Notes, 26.11.2010, 23.10.
[172] T 89.
[173] T 89, 92.
[174] T 92.
[175] T 91.

25 mg of Quetiapine for his agitation, as prescribed by Dr Hayhow, before she left to inform the nurse coordinator of the incident.[176]

102. The ward coordinator called the 'on-call' doctor, Dr Neil Morgan, who ordered that Jesse be given another 25 mg of Quetiapine and advised that Jesse was to be watched closely. The nurses decided to move Jesse to a single room to enable closer observation before they gave him the second dose of Quetiapine.[177]

103. It appears that Jesse had also sent out text messages informing friends that he had attempted to hang himself. One friend telephoned the hospital switchboard at 12.25 am to alert them to the message they had received, and Jesse's brother Luke came into the hospital around the same time to check on Jesse following receipt of the message.[178]

104. After Jesse's brother left Jesse was given another 1 mg of lorazepam and moved to a single room across from the nurses' station.[179] During the move Jesse appeared calm and asked Nurse McGarva, "Am I on suicide watch now?"[180] She told him that the nurses were going to keep a close eye on him. To assist in monitoring Jesse's movements the nurses asked an orderly to guard Jesse's room for the rest of the night.[181] It does not appear from the medication charts that Jesse was given the extra dose of Quetiapine.[182]

105. It was noted in the medical notes that Jesse was seen using his mobile phone at about 2.00 am. When questioned about it he denied sending texts but admitted receiving them. Telephone records show Jesse was using his phone to send and receive texts until 1.42 am that morning.[183] Jesse was asked by a nurse if she could take the phone and lock it in his drawer but Jesse refused. Jesse was told that using his mobile at that hour was not appropriate. He was not seen using his phone after that time. He had appeared drowsy at 2.00 am and was asleep from 3.00 am.[184]

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[176] T 89.
[177] T 89.
[178] T 89 – 90; Exhibit 2, Tab 2, Integrated Progress Notes, 27.11.2010, 00.45.
[179] T 93.
[180] T 90.
[181] T 90.
[182] Exhibit 2, Tab 2, Long Stay Medication Chart No 1 of 1.
[183] Exhibit 1, Tab 22,
[184] Exhibit 2, Tab 2, Integrated Progress Notes, 27.11.2010, 05.00.

EVENTS ON SATURDAY, 27.11.2010

106. On 27 November 2010 Dr Greenhouse passed Jesse in the corridor of C Ward at about 8.15 am. Jesse appeared relaxed and he smiled and said "Hi James."[185] It was not long after this chance meeting that Dr Greenhouse was informed by the nurse coordinator, Kirsteen Stephens, that Jesse had told nursing staff that he had tried to hang himself in the shower with a shower cord the previous night.[186] Dr Greenhouse asked Nurse Stephens if it appeared to be serious suicide attempt, in the sense of whether there was any physical evidence that he had actually done what he said he had done.[187] She replied, "No," and it seems there were no signs of marks on Jesse's neck.[188] Nurse Stephens also told Dr Greenhouse that following this event Jesse had been given a dose of Quetiapine, moved to a single room and placed on half hourly observations. Additionally, he had had all dangerous cords and items removed from his room and a guard placed outside his room overnight.[189] After relating the events that had occurred overnight Nurse Stevens asked Dr Greenhouse to review Jesse.[190]

107. Dr Greenhouse decided to review Jesse after he had attended to two new patients who required urgent attention (he received seven new patients that day).[191] Dr Greenhouse felt confident the review could be delayed because the reports from nursing staff were that Jesse was settled since the event the previous night.[192] Dr Greenhouse appears to also have been reassured by his own brief encounter with Jesse that morning, where Jesse had seemed relaxed and had voluntarily greeted Dr Greenhouse.

108. Dr Greenhouse did not make any specific orders about changing Jesse's observations, which are noted as hourly in the nursing notes that day.[193].

109. When asked if he would have acted differently if there had been evidence that Jesse's reported suicide attempt was serious, Dr Greenhouse agreed and said he would have prioritised seeing Jesse straight away in those circumstances.[194]

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[185] T 56.
[186] T 56.
[187] T 56 – 57.
[188] T 56 - 57.
[189] T 56.
[190] T 57.
[191] T 62.
[192] T 57.
[193] T 58; Exhibit 2, Tab 2, Integrated progress Notes, 27.11.2010, 12.15 Addit.
[194] T 57.

110. Somewhere between 8.30 and 9.00 am Jesse sent a text to his mother referring to his suicide attempt the previous night. He told her he didn't know why he did it and he wouldn't do it again. He said he just wanted to sleep. Jesse also mentioned phone credit in the text.[195] Jesse's mother sent a text back saying she wouldn't give him more credit as she thought the use of the mobile phone was distracting him and not good for his recovery. Jesse replied asking when she was coming to see him and Ms Nottle responded that she would be in after she finished cooking.[196]

111. Jesse's phone records appear to indicate he stopped using his phone at 10.05 am that morning.[197] One of his last messages was to a friend who had told him she was planning on coming to visit him that day. Jesse indicated in his message he was looking forward to the visit.[198]

112. At 12.15 pm an entry was made in the medical notes that Jesse had stated to a nurse that he had smashed his mobile phone so he wouldn't be texting people or receiving texts (presumably a reference to the conversation about texting earlier in the morning). Jesse apparently sent a text to Jasmine Best before he smashed his phone, telling her he was going to do so, although she didn't receive the text until later that day.[199]

113. While speaking to the nurse Jesse requested a higher dose of his nicotine patch as he maintained that it was not working. It was noted that he was waiting to be reviewed by Dr Greenhouse.[200]

114. Dr Greenhouse went to see Jesse in his room at 1.00 pm that day. The orderly was no longer stationed outside Jesse's room at that time.[201] Jesse was asleep and did not rouse so Dr Greenhouse decided to return later to conduct his review.[202] Dr Greenhouse was not concerned that Jesse was asleep during the middle of the day as he knew Jesse had been up during the night, although he also thought it was possible Jesse might have been feigning sleep as he didn't want to talk to him at that time.[203]

115. Jesse's ex-girlfriend noticed a text from Jesse at about 1.00 pm that day, although it is likely it was sent earlier. There was

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[195] Exhibit 1, Tab 7 [85].
[196] Exhibit 1, Tab 7 [87] – [89].
[197] Exhibit 1, Tab 22, page 23.
[198] Exhibit 1, Tab 18 [32] – [34].
[199] Exhibit 1, Tab 19 [82] – [83].
[200] T 58; Exhibit 2, Tab 2, Integrated progress Notes, 27.11.2010, 12.15.
[201] T 58.
[202] T 57.
[203] T 64.

nothing particularly concerning in the content of the text. She tried to call him after receiving the text but his phone was turned off.[204]

116. Nurse Lesley Solly came on shift as the Nurse Manager at 2.00 pm. She was briefed at handover in relation to Jesse and told Jesse was still being closely watched on hourly observations and appeared settled.[205] During the handover Nurse Solly became aware that Jesse had left the ward but he subsequently returned and it was assumed he had gone outside for some fresh air and a cigarette.[206]

117. Nurse Annzolette Maduke-ike took Jesse's observations, which were normal. His demeanour was apparently normal and he seemed calm and cooperative, readily engaging with Nurse Maduke-ike. He requested a nicotine patch and the nurse established that Jesse had removed the patch he had been given earlier.[207] Nurse Maduke-ike asked Jesse if he could wait for the doctor to prescribe another one and Jesse agreed.[208] Jesse then asked to speak to his mother, so Ms Nottle, went and spoke to Jesse in his room.[209]

118. Jesse was very aggressive towards his mother when she walked into the room. He threw things at her and yelled at her. Ms Nottle tried to talk to him but Jesse wouldn't listen. Ms Nottle had never seen Jesse behave like that before. After a few minutes Jesse ran out of the room and Ms Nottle was unable to catch him. She went to the nurse station instead and told Nurse Maduke-Ike that Jesse had run away.[210] Nurse Maduke-Ike then told the other nurses on the ward. Two nurses went to look for Jesse, joined shortly afterwards by hospital orderlies who searched the hospital grounds, and later Ms Nottle. Nurse Stephens then contacted Nurse Solly.[211]

119. Nurse Solly recalled being contacted by Nurse Stephens approximately 10 minutes after the handover. She was told that Jesse had left the ward again following a disagreement with his mother.[212]

120. At 3.00 pm Dr Greenhouse was notified by Nurse Stephens that Jesse had left the ward. Dr Greenhouse immediately went to

[204] Exhibit 1, Tab 17 [52] – [53].
[205] Exhibit 1, Tab 11 [9].
[206] Exhibit 1, Tab 11 [10].
[207] Exhibit 1, Tab 16 [8] – [12].
[208] Exhibit 1, Tab 16 [13].
[209] Exhibit 1, Tab 16 [14] – [16].
[210] Exhibit 1, Tab 7 [102], Tab 16 [22].
[211] Exhibit 1, Tab 16 [22] – [25].
[212] Exhibit 1, Tab 11 [12].

C ward, where he spoke to Jesse's mother. Ms Nottle told Dr Greenhouse that she had had an argument with Jesse regarding his mobile phone bill and Jesse had then left the ward.[213]

121. Dr Greenhouse asked Nurse Stephens to contact the police to ask them to locate Jesse and return him to the hospital. He told Nurse Stephens that he would need to complete a Form 1 pursuant to the *Mental Health Act* first in order to get the police involved. The Form 1 was completed and the police were called by Nurse Solly at 3.07 pm and asked to find Jesse.[214] A copy of the Form 1 was faxed to police.[215]

122. Dr Greenhouse confirmed at the inquest that at the time he completed the Form 1 his primary concern was that Jesse had absconded from the hospital without telling anyone, which was different to his previous behaviour. They needed to know where he was and bring him back to the safe environment of the hospital.[216] Dr Greenhouse did not, however, at that stage believe Jesse was acutely suicidal.[217]

123. The police job was dispatched to the first available officers, Senior Constable Franzinelli and Constable Truong, when they became available at 3.27 pm. Their vehicle was in the Bayonet Head area at the time and they began patrols of that area as it was where Jesse was known to be living prior to hospital. At 3.38 pm police received a call reporting that Karl Hennig, a Bayonet Head local, had ridden down a cycle path and observed a male person hanging by a rope around his neck from a tree near the cycle path at the end of Brewster Rd, Collingwood Park. Mr Hennig recognised Jesse as he had taught him in primary school. It was obvious to Mr Hennig that Jesse was deceased. Jesse was wearing jeans and no shirt.[218]

124. Senior Constable Franzinelli and Constable Truong attended the scene under emergency priority conditions and arrived at about 3.55 pm.[219] They cut Jesse down and ambulance officers arrived shortly after and examined Jesse before declaring him life extinct.[220]

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[213] T 57.
[214] T 11, 57.
[215] Exhibit 1, Tab 11 [15].
[216] T 65.
[217] T 65.
[218] Exhibit 1, Tab 20.
[219] T 11 – 12.
[220] T 12.

125. Jesse's brother and Jasmine Best became aware of Jesse's death after following the ambulance and police cars.[221] They became aware of what had occurred before hospital staff were notified. Luke telephoned his mother while she was waiting at the hospital and told her the news. He then returned to the hospital to be with his mother and they were both understandably distraught.

126. The information was then communicated to the hospital staff and senior doctors, including the doctors involved in Jesse's care, were notified.

127. Constable Truong conducted a preliminary search of the area for items of interest or forensic value but he did not locate anything relevant or appearing to belong to Jesse.[222] In particular, he did not locate Jesse's shirt, which he was wearing when he left the hospital.[223]

128. Later investigations did not identify anyone who reported having seen or spoken to Jesse during the 73 minutes between when he left the hospital and when he was found by Mr Hennig.[224] It was unclear where Jesse obtained the rope he used to hang himself and whether he obtained the cannabis later found in his system after he left the hospital or before. While it is possible, given the levels found in the toxicology analysis, that Jesse located and consumed the cannabis in the time between leaving hospital and being found, no smoking materials or cannabis was found with or near Jesse's body.[225]

CAUSE AND MANNER OF DEATH

129. On 30 November 2010 Dr Daniel Moss, a Forensic Pathologist, conducted a post mortem examination. The examination revealed a ligature and ligature mark around the neck and there was no evidence of other significant injury. There was also no evidence of significant natural disease.[226]

130. Toxicological analysis showed high therapeutic levels of the antidepressant drug citalopram and therapeutic levels of the antidepressant fluoxetine. Diazepam was also present. Tetrahydrocannabinol was also detected, at a level that would indicate use within 24 hours prior to death.[227]

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[221] Exhibit 1, Tab 19 [86] – [88].
[222] T 12, 19.
[223] T 20.
[224] T 19.
[225] T 19 – 20; Exhibit 1, Tab 2.
[226] Exhibit 1, Tab 5, Post Mortem Report.
[227] Exhibit 1, Tab 5, Post Mortem Report and Tab 6, Toxicology Report.

131. At the conclusion of the post mortem investigations Dr Moss formed the opinion that the cause of death was ligature compression of the neck (hanging).[228] I accept and adopt Dr Moss' conclusion as to the cause of death.

132. I find that the manner of death was suicide.

QUALITY OF THE CARE AT ALBANY HOSPITAL

133. Under s 25(2) of the *Coroners Act*, a coroner may comment on any matter connected with the death including public health or safety or the administration of justice. In this case, the quality of the medical treatment and supervision given to Jesse was clearly a matter connected with his death and was a primary focus of the coronial investigation.

Dr Pascu's Review

134. To assist me in that regard, Dr Victoria Pascu, a Consultant Psychiatrist and Head of Clinical Services at Graylands Hospital, reviewed Jesse's care while at Albany Hospital and provided her expert opinion on relevant aspects of the supervision, treatment and care provided to Jesse.

135. Dr Pascu accepted that it was appropriate for Jesse's physical health to be addressed following the overdose and for him to be medically cleared in regard to any physical ill-effects from that overdose before his psychiatric needs were given closer attention.[229]

136. Turning to his psychiatric issues, in reviewing the case Dr Pascu formed the view that Jesse's chronic depressed mood had worsened due to increasing real and perceived environmental stressors in the time leading up to his death. Dr Pascu identified these as including relationship stress with his girlfriend, financial problems with difficulties finding and maintaining employment, his brother's difficulties with the authorities and his ambivalent relationship with his mother.[230] Dr Pascu also noted later in her report that Jesse had ongoing feelings of being abandoned by his father.[231]

137. Based on the information available Dr Pascu noted that Jesse was "sensitive to teasing related to his developmental problems and he became depressed rather than angry in response to

[228] Exhibit 1, Tab 5, Post Mortem Report.
[229] T 107 – 108.
[230] Exhibit 1, Tab 32, 8.
[231] Exhibit 1, Tab 32, 10.

bullying. He reported having strong emotions but he tended not to be able to cry or talk about his feelings. It's possible that he used illicit substances as a way to self-soothe and self-medicate for his inability to regulate his own emotions."[232]

138. Dr Pascu formed the view that Jesse's acute risk to himself at the time of his admission to hospital on 23 November 2010 was high given the multiple cycle social stressors in his life. In Dr Pascu's opinion, Jesse remained an ongoing risk to harm himself given his limited coping, anger management and problem solving skills, more so with the precipitating factors incompletely resolved during the admission.[233]

139. The observation about precipitating factors (some of which had been identified by Dr Pascu and are set out above) being incompletely resolved is a matter that was raised by Jesse's father in his submission following the inquest. Mr Dellar queried why Jesse was allowed continued contact with people who might be exacerbating his symptoms.[234] However, Dr Pascu in her review, considered Jesse's mother, brother and friends to be his supports and noted that having access to the support of family and friends while in hospital has a beneficial effect for patients.[235] Rather than limiting their contact, Dr Pascu suggested that they should have been involved in his treatment as part of a multidisciplinary approach, but with some supportive counselling provided for all of them.[236]

140. Dr Pascu noted that there was limited psychiatric input provided to Jesse upon his initial admission, which she felt was not optimal (although the staff did their very best), but she was satisfied that when the psychiatrist Dr Hayhow did eventually review Jesse he performed a comprehensive assessment and risk assessment which was properly documented.[237]

141. Dr Pascu was also satisfied that the medication plan for Jesse was appropriate.[238]

142. However, Dr Pascu differed from Dr Hayhow in her opinion as to where Jesse should have been placed for care. In Dr Pascu's opinion, she would have preferred to manage Jesse in the mental health ward rather than on the general ward.[239] In her report, she stated that "this case warranted transfer to the mental health

[232] T 105 – 106.
[233] T 106.
[234] Email to Sgt Housiaux from Keith Dellar 7.9.2015.
[235] Exhibit 1, Tab 32, 10, 13.
[236] Exhibit 1, Tab 32, 10.
[237] T 107 - 108.
[238] T 109.
[239] T 108.

ward of the hospital, given the significant risk factors that this young man had."[240]

143. Dr Pascu was complimentary of the care provided to Jesse by the nursing staff in C ward, who she felt "did a great job in doing the best they could monitoring him, ensuring that they kept him safe," but still maintained that the preferred place for his care was in G ward.[241] Dr Pascu acknowledged that Jesse's age and general vulnerability presented a difficulty as to where to house him, which would arise not just in Albany but across the state.[242] In those circumstances, Dr Pascu's opinion was that it would have been appropriate for Dr Hayhow, as a registrar, to discuss the matter with his Consultant Psychiatrist.[243] Dr Pascu acknowledged that this was part of Dr Hayhow's plan after the weekend and noted that at Graylands, where there is greater staff support with a 24 hour, 7 day a week roster for consultant psychiatrists, it might be easier to arrange earlier review.[244] However, in her evidence Dr Pascu emphasised her view that, given the level of risk identified, Jesse's case warranted a review by a psychiatrist (as opposed to a psychiatric registrar) with the consideration of moving Jesse to the authorised mental health ward of the hospital for specialised mental health care.[245]

144. In forming that view, Dr Pascu acknowledged that having young persons admitted to adult mental health units is not the most appropriate avenue, but as Jesse was 17 years and five months (almost 18 years old) consideration for this option would have been appropriate, with a 'one to one' special in place to ensure his safety while in the adult ward.[246] Dr Pascu agreed in oral evidence that it would, nevertheless, be a difficult decision to make given it would possibly expose Jesse to bad behaviour by adult patients.[247] However, Dr Pascu concluded that, on balance, it would have been the appropriate course to adopt given what she considered to be Jesse's "significant acute risk to harm himself"[248] at that time. Obviously, Dr Pascu reached that conclusion with the benefit of knowing what Jesse eventually did, which was conclusive proof that he was at risk, at least at the time he left the hospital on the last occasion.

145. Dr Pascu also commented that she would have expected some liaison with the Bentley Adolescent Unit if his mental state did

[240] Exhibit 1, Tab 32 [7].
[241] T 108.
[242] T 110 – 111.
[243] T 111.
[244] T 111 - 112.
[245] ET 129 – 130; Exhibit 1, Tab 32, 9.
[246] T 115; Exhibit 1, Tab 32, 9.
[247] T 111.
[248] T 10.

not settle on the ward and noted there was no evidence of any liaison with the on call child adolescent psychiatrist at Princess Margaret Hospital nor liaison with a psychiatrist at Bentley Adolescent Unit. I asked Dr Hayhow during his evidence whether this could have been done, he accepted that in retrospect it would have been possible, but he indicated that he did not feel at the time that there were issues that needed to be discussed with a consultant.[249]

146. Dr Pascu also expressed some concern about the emphasis on the biological treatment of Jesse's mental health issues, without adequate attention to the psychosocial aspects, such as counselling.[250] It was apparent from the evidence that there was a plan to engage Jesse in counselling in the future, after discharge, but it was not on offer while Jesse was in hospital, although Dr Pascu considered it would have benefited Jesse.

147. In relation to the care and supervision given to Jesse over the night of 26 November 2010 and into the morning of 27 November 2010, Dr Pascu's primary concern was a lack of documentation in relation to the decision by Dr Greenhouse or another doctor to reduce the level of visual observations (if that decision was made), given the orderly was no longer present during the day and no medical review by a doctor had yet taken place.[251] In that regard, Dr Pascu indicated that, with the benefit of her extensive experience as a psychiatrist, she would have been more cautious in terms of maintaining a high level of visual observations of Jesse until he could be medically reviewed.[252]

148. It is clear from the evidence that Dr Greenhouse did not authorise any downgrade in the levels of observations implemented by the nursing staff overnight, but it is also unclear whether the introduction of the orderly on 'line of sight' supervision was considered by the nursing staff to be a formal increase in the level of observations that required medical authorisation to downgrade. The line of questioning by counsel on behalf of the hospital suggested it might have been seen by nursing staff as an informal measure implemented while an orderly was fortuitously on the ward due to duties in relation to another patient.[253] Dr Pascu accepted that, if that was the case, it was good thinking on the part of the nurses, but it did not alter her concern that the measure was not continued until there was a medical review.[254]

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[249] T 30.
[250] T 115 – 116.
[251] T 113 – 114, 119.
[252] T 114 – 115.
[253] T 129 - 130.
[254] T 130.

149. In relation to Jesse's continued access to his mobile phone, Dr Pascu noted that unless a patient is admitted under the *Mental Health Act* their use of phones can't be restricted.[255] So in Jesse's case, his mobile phone could not be taken away by hospital staff, although they could engage with him about limiting his mobile phone use to appropriate times and monitor which calls were risky rather than supportive and monitor his response in terms of his general risk, as they did.[256]

150. Considering Jesse's mobile phone use in the days leading up to his death, it is relevant to note that Constable Truong cross-referenced Jesse's phone activity (from phone records and significant incidents recorded on the Integrated Progress Notes where he appeared agitated. Police spoke to a number of Jesse's friends who had been speaking to Jesse, or sending text messages to him, prior to each incident. From their accounts there were no precipitating factors or agitating communication that was likely to have caused his increased agitation.[257]

151. In regard to Jesse going outside to smoke, Dr Pascu was also not concerned that this was generally allowed by the hospital and noted that voluntary patients at Graylands (although noting they are adults) are permitted to go outside to smoke and a risk assessment is not done for a patient every time before they go out to smoke.[258] However, in the context of Dr Pascu considering Jesse should have been admitted to G ward, Dr Pascu noted that there ought to have been an allocated smoking area associated with that ward (although the evidence is not clear that it did, in fact, exist) and this would have enabled closer supervision of Jesse while he was smoking.[259] Further, the fact that Jesse was apparently allowed to go outside and smoke a cigarette on the morning of his death, before he was reviewed by Dr Greenhouse, was surprising and concerning.[260]

152. In summary, Dr Pascu's review accepted that the staff at Albany Hospital had endeavoured to provide appropriate care to Jesse within the constraints of their resources, both structural and personnel, for caring for an adolescent. However, Dr Pascu concluded that more ought to have been done to carry out, and document, regular risk assessments,[261] and also strong consideration should have been given to placing Jesse in the

[255] T 122.
[256] T 122 – 124.
[257] T 15; Exhibit 1, Tab 2.
[258] T 118.
[259] Exhibit 1, Tab 32 [9].
[260] T 118.
[261] T 117.

G ward of the hospital with appropriate supervision, such as a chaperone.

153. Ultimately, these measures may not have saved Jesse, as Dr Pascu noted that "if someone wants to kill themselves, they will do it, unfortunately."[262] However, closer supervision of Jesse would have limited his opportunity to act impulsively.

Evidence of Dr Cock

154. Dr Neil Cock, a Consultant Psychiatrist at Albany Hospital and the Clinical Director of the Great Southern Mental Health Service, gave evidence at the inquest in relation to procedures for psychiatric patients at Albany Hospital. In addition, although Dr Cock was not personally involved in Jesse's care, he had reviewed Jesse's medical notes and was in a position to comment on the care given to Jesse, based on his experience as a clinician generally and specifically at Albany Hospital.

155. Since Jesse's death in 2010 Albany Hospital has been rebuilt and now contains a new Mental Health Unit.[263] The new Mental Health Unit replaces the former G ward in the old hospital and, similar to G ward before it, is the only authorised area where involuntary patients can be detained.[264] Neither the old hospital nor the new hospital includes a mental health ward specifically for children or adolescents and there is no specific area or beds in the Mental Health Unit set aside for patients under the age of 18.[265]

156. Dr Cock explained that there are similarities and substantial differences in relation to the inpatient care that could be offered to an adolescent requiring psychiatric care in 2010 and what is offered now.[266]

157. Albany Hospital is still not resourced for inpatient child and adolescent mental health services, so each such patient who requires admission is assessed on a case by case basis to determine the appropriate form, and place, of treatment.[267]

158. As in 2010, admission of young adolescents to the Mental Health Unit (formerly G ward) is still avoided if possible, on the rationale that an adult Mental Health Unit is a "less than ideal place for providing care to a young adolescent and there is potential for

[262] T 117.
[263] Exhibit 1, Tab 31 [5].
[264] Exhibit 1, Tab 31 [7].
[265] Exhibit 1, Tab 31 [8].
[266] Exhibit 1, Tab 31 [9].
[267] Exhibit 1, Tab 31 [8].

aggression or abuse to be directed from other patients towards the adolescent."[268] However, it can still be done if a risk-benefit analysis indicates it is the most appropriate option, generally with a view to a transfer to an Adolescent Unit in Perth.[269]

159. The preferred alternative to admission to the Mental Health Unit remains admission to a general ward, as occurred with Jesse back in 2010.[270]

160. The principal difference in how care is delivered to a child or adolescent on the general ward is that since mid-2013 the patient is not admitted under the care of a psychiatrist, rather than under the care of a general practitioner or senior medical practitioner, as occurred under the previous 'shared care' model.[271]

161. Further, one of the staff psychiatrists, who is employed as an adult psychiatrist, has recently completed the Royal Australian and New Zealand College of Psychiatrists (RANZCP) Certificate in Child and Adolescent Psychiatry, so he is shifting into a role of looking after patients in the difficult age group between 16 and 25 (which was where Jesse fell) with the plan that they are admitted by that practitioner wherever possible, or at least with his close involvement.[272]

162. The service is also generally better resourced than it was in 2010, as is CAMHS, so the amount of input available to a young person admitted to Albany Hospital now is described by Dr Cock as "totally different."[273] For example, there are now three psychiatrists at Albany Hospital.[274] Also, there are psychiatric liaison nurses trained in child and adolescent psychiatry available from 8.30 am to 10.30 pm seven days a week and a psychiatrist is available on call after hours seven days a week. CAMHS is also now resourced to provide daily staff contact throughout the week.[275]

163. According to Dr Cock the effect of these changes is to substantially increase the availability of specialist mental health care to patients at Albany Hospital.[276]

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[268] Exhibit 1, Tab 31 [9].
[269] Exhibit 1, Tab 31 [9] – [10].
[270] Exhibit 1, Tab 31 [10].
[271] T 133; Exhibit 1, Tab 31 [16].
[272] T 133; Exhibit 1, Tab 31 [17].
[273] T 134.
[274] Exhibit 1, Tab 31 [19].
[275] T 134; Exhibit 1, Tab 31 [22] – [23].
[276] Exhibit 1, Tab 31 [24].

164. There has also been a change in the documentation used, with standardised forms being introduced for children and adolescents.[277] The changes should hopefully address some of the concerns raised by Dr Pascu about a lack of documentation of risk assessments and downgrading of observations, which Dr Cock acknowledged was not always done well from a documentation point of view in 2011.[278]

165. In relation to Dr Hayhow's assessment, similarly to Dr Pascu, Dr Cock described the assessment as of high quality.[279] Dr Cock worked closely with Dr Hayhow and they had met the day after Jesse's assessment for another matter, so it was possibly they discussed Jesse's case, but Dr Cock had no specific recollection of doing so. Nevertheless, Dr Cock expressed the opinion that if Dr Hayhow had raised the matter with him at that time, he would have agreed with Dr Hayhow's assessment and plan and would not have considered it necessary to review Jesse himself or revisit the decision to keep Jesse on the general ward, given the limited other options available.[280]

166. Dr Cock indicated that it is highly unlikely that a bed would have been available at short notice at Bentley Adolescent Unit in Perth and, in any event, Dr Cock believed that removing Jesse from his social network would have been unhelpful.[281] Therefore, there were both difficulties associated with transferring Jesse to Perth, and good reasons not to do that.[282]

167. Dr Cock agreed with Dr Pascu that a key question is whether a decision should have been made to place Jesse in an area where he could not have impulsively left the hospital, particularly after his reported hanging attempt. At the time Dr Cock noted it was a judgment call that it was better that it not occur, and this was permitted under hospital policy. Dr Cock also thought it was the right choice to make at that time.[283] However, since that time Dr Cock has put in place procedures to remove that discretion from staff so that if a similar incident occurs with a current patient (such as Jesse's report of attempting to hang himself in the shower cubicle) the patient will automatically be transferred to the Mental Health Unit and kept secure by way of a chaperone 24 hours of the day until psychiatrically assessed.[284] There is no discretion now in that regard.[285] Given what happened with

[277] Exhibit 1, Tab 31 [27i].
[278] T 136.
[279] T 140,
[280] T 138, 140.
[281] T 141.
[282] T 141.
[283] T 140.
[284] Exhibit 1, Tab 31 [30].
[285] T 142.

Jesse, the WACHS has concluded this is the most cautious approach.[286] It is also in line with the observation of Dr Pascu in her report.

168. The procedure to be followed once they are admitted to the Mental Health Unit is set out in the "Vulnerable Patient Procedure" effective from 6 September 2013.[287] The improved structure of the Mental Health Unit creates a capacity to be flexible in how the patient is housed in the unit, which is important for actually implementing the policy.[288]

169. As to the specific events of 26 and 27 November 2011, Dr Cock was the 'on-call' psychiatrist on the weekend that Jesse died. He was not telephoned by staff in relation to Jesse's reported suicide attempt overnight on 26 November 2010. However, having reviewed the notes Dr Cock was willing to state that if he had been informed he would have approved of the actions taken by the nurses in relocating Jesse and increasing his observations, and he would not have considered there was a need to come in to psychiatrically review Jesse prior to the admitting practitioner assessing Jesse.[289]

170. In conclusion, Dr Cock emphasised that the changes to the mental health medical governance model and the substantial improvement to the physical facilities that have occurred at Albany Hospital since Jesse's death are a significant improvement in providing responsive care tailored to the particular needs of all patients, including children and adolescents.[290]

Evidence of other witnesses

171. It is apparent from the evidence before me that the nurses and doctors involved in Jesse's care were greatly saddened by Jesse's death and it prompted some self-reflection about what might have been done differently.

172. During the inquest I asked Dr Hayhow whether he had been concerned about the risk of Jesse initiating a further impulsive suicide attempt while in hospital, given that is what had led to his admission. Dr Hayhow agreed that was a concern as Jesse had described having unstable emotions and there was an element of volatility in his behaviour while in hospital. Dr Hayhow noted the staff were very reassured by his

[286] T 142.
[287] Exhibit 1, Tab 31, Attachment 6.
[288] T 148.
[289] T 148.
[290] Exhibit 1, Tab 31 [29].

presentation some of the time; at other times they were alarmed.[291] Dr Hayhow considered some of that variability could be attributed to adolescence but a great deal of it could be attributed to his psychological problems.[292]

173. Dr Hayhow agreed the history of events suggests Jesse's death was likely the result of a further impulsive decision to commit suicide, rather than a considered and planned act.[293]

174. Dr Greenhouse, in his evidence, also observed the variability of Jesse's behaviour and noted that the strategy for monitoring Jesse depended on how he was behaving on the day. Dr Greenhouse commented that Jesse "was very up and down, so it was very difficult to have a set strategy for him. He seemed to be up one minute and then down the next…so…it was a challenge."[294] Dr Greenhouse confirmed he believes that the new system at Albany Hospital for primary psychiatric admissions is a better system for monitoring patients such as Jesse.[295]

175. Nurse Richardson was also asked about her experience with the changes at Albany Hospital and she commented on a number of positive changes she had experienced in the years since Jesse's death. One such change is the new suicide risk assessment form, which provides a level of care that the patient needs, depending on the score. In Nurse Richardson's experience, there is also much better access to mental health liaison nurses now, including in the evenings if a patient's condition escalates and requires psychiatric review. Further, Nurse Richardson gave evidence that quite often now adolescent patients will come to the ward with a guard, a one-on-one companion, until they have been seen and assessed more closely.[296]

Comment

176. It is apparent from the evidence that at the time Jesse presented to Albany Hospital on 23 November 2010 there were limited options in place to provide tailored psychiatric care for him as an adolescent on the verge of adulthood. Apart from sending Jesse away to Perth if a bed could be found at the Bentley Adolescent Unit (which I accept was unlikely and not the preferred option at that time for Jesse in any event) the two main options were either to house Jesse in the general ward under the care general practitioner with some psychiatric input, as required, or

[291] T 34.
[292] T 34.
[293] T 34 – 35.
[294] T 64.
[295] T 65.
[296] T 53.

alternatively to place Jesse in the adult psychiatric unit known as G ward.

177. Neither option was secure, in the sense that Jesse would be placed in a locked and secure area. The only secure rooms available at the time were entirely unsuitable to place a patient like Jesse. Therefore, whether Jesse had been housed on G ward or in a general ward, he would have had the ability to move about the hospital generally unless he was placed under guard. Even then, as a voluntary patient if he chose to leave a guard would have limited powers to prevent him.

178. The main difference between G ward and a general ward was the greater level of supervision by trained and experienced psychiatric staff if he had been placed in G ward. However, the downside to G ward was that Jesse would have been exposed to adult psychiatric patients, which presented its own risk. At the time Jesse was admitted, I accept that it was reasonable for the doctors admitting Jesse to choose the less confronting alternative of housing Jesse in the general C ward, which was a far less therapeutic environment or a vulnerable patient such as Jesse.

179. Appropriate steps were then taken to have Jesse psychiatrically assessed, and the expert evidence before me indicates that Dr Hayhow's assessment of Jesse was comprehensive and of an acceptable standard. The only divergence in the opinions before me was whether Dr Hayhow may have underestimated how acute was the level of Jesse's risk of suicide while he remained in hospital. Dr Pascu was of the opinion Jesse's risk at that time warranted a move to the G ward, or at least strong consideration of the same, whereas Dr Hayhow and Dr Cock believed the risk was not so apparent that it warranted this step.

180. On balance, I accept that at the time Dr Hayhow assessed Jesse, his responses and general demeanour and history were sufficiently reassuring that keeping him on the general ward, separate from potentially severely mentally ill adult patients, was reasonable. While it might, as Dr Pascu suggested, have been prudent for Dr Hayhow to have consulted his Consultant Psychiatrist, Dr Cock, given Dr Cock's evidence that he would have supported Dr Hayhow's management plan, nothing turns on this issue.

181. The next key event was Jesse's reported hanging attempt on the night before his death. It might seem based on an account of events that night that Jesse's attempt was not a serious attempt to take his life but more of a cry for help. The lack of physical evidence of any ligature mark and Jesse's reports to others immediately following the event would support that conclusion.

However, his actions the next day would suggest otherwise, at least in terms of his genuine suicidality. Irrespective of whether Jesse was serious in attempting to take his life that night, I accept the evidence of the nurses that they treated the report seriously and put appropriate steps in place to monitor Jesse a lot more closely overnight, to prevent a recurrence, including placing an orderly on watch.

182. The nurses also appropriately sought a medical review by Jesse's admitting doctor the next morning. At the time Dr Greenhouse was informed, it does not seem that Jesse was presenting any immediate disturbing behaviour and indeed, appeared to Dr Greenhouse when he saw him briefly to be reassuringly calm and engaging. Unfortunately, as is apparent from the medical record of Jesse's stay, his mood was changeable so that limited reassurance could be taken from such sightings. However, it is also unclear from the evidence what level of observation Dr Greenhouse understood was being performed of Jesse at that time.[297] Dr Greenhouse did recall that he did not authorise a downgrading in the level of observation before he reviewed Jesse and he had indicated in his statement he was told a guard had been placed on Jesse's room overnight.[298]

183. Even if he did perhaps think Jesse still had a guard on his room in the morning, at 1.00 pm when Dr Greenhouse went to see Jesse, it was apparent there was no guard in place. However, Jesse was also asleep and had not exhibited any concerning behaviour throughout the morning. In those circumstances, it was reasonable for Dr Greenhouse to consider that his review could wait until Jesse was awake. It seems from the evidence that even after he did wake up, Jesse's behaviour was calm and not concerning. However, consistent with the general observation of his volatile mood, in the early afternoon he became upset and left the hospital without warning.

184. The hospital staff immediately notified Dr Greenhouse and appropriate steps were taken to search for Jesse and notify the police but regrettably he was not found until it was too late to help him.

185. In hindsight, it is apparent that the better step would have been to place Jesse in the G ward after his report of an attempted hanging on the night of 26 November 2010. According to the new policy introduced by Dr Cock, that would be the automatic response by hospital staff if the same event were to happen today. However, that policy has been introduced as a result of

[297] T 64.
[298] T 56.

Jesse's death and the benefit of a review to see how things could have been done differently. The nursing staff that night, and Dr Greenhouse the following morning, did not have the benefit of that hindsight.

186. In conclusion, I agree with the opinion of Dr Pascu that more thought should have been given to housing Jesse in the G ward, particularly after the events on the evening of 26 November 2010, but I accept that the actions of the staff were not, in all the circumstances, unreasonable or inappropriate that night or the following day. Jesse's impulsive decision to leave the hospital that afternoon and take his life was not an easy one to predict or prevent.

187. I am reassured by the fact that, given the changes to the hospital infrastructure and staffing, as well as the changes in hospital policy, that if similar events occurred today the hospital staff would be in a far better position to contain such a patient and manage them closely until the acute risk had passed. I note that Jesse's father, Mr Dellar, is also happy to hear about the changes to Albany Hospital psychiatric services for young people and is hopeful that this will assist future families to get the best care for their children.

188. I understand that Jesse's mother, Ms Nottle, and brother, Luke Dellar, are still grieving for the loss of Jesse and seeking answers to how his death could occur when he had been taken by them to the hospital for help. They both feel that Jesse might still be alive if his signs of distress had been treated with more urgency by hospital staff and their concerns, if listened to, should have resulted in closer supervision.

189. With the benefit of hindsight, I agree that the doctors and nurses could have made different decisions, and been more cautious in their approach to treating Jesse and increasing his supervision, which might have resulted in a different outcome, at least that day. However, working within the resources available at the time, and with Jesse's best interests in mind, I consider the hospital staff did their best to provide Jesse with appropriate medical treatment that also respected his right to be treated in the least restrictive manner available.

MENTAL HEALTH AND WELLBEING SURVEY

190. In August 2015, around the time the inquest into Jesse's death was being held, the Report on the second Child and Adolescent Survey of Mental Health and Wellbeing was published by the

Australian Government (the Report).[299] The Report is based on a survey conducted in a large number of Australian families with children and/or adolescents aged 4 to 17 years and intends to present a comprehensive picture of the mental health of young Australians.[300]

191. In the Foreword to the Report the Federal Minister for Health noted that while the overall prevalence of mental disorders appeared stable, with approximately one in seven children and young people experiencing a mental disorder in the previous year, the positive news was that access by families and young people to assistance appears to have increased substantially, with the vast majority using a health service.[301] One of those services is Headspace, which I have mentioned above and was a service Jesse was intended to be referred to after discharge.

192. Dr Andrew Wenzel, the manager of Headspace in Albany, gave evidence at the inquest about how Headspace works and what services it delivers to adolescents in Albany. He explained that Headspace is the National Youth Mental Health Foundation, which is nationally funded, with centres across the country as well as an e-headspace available online and a school support service.[302] The Albany Headspace centre was the first opened in WA and it opened in March 2008. They work with 12 to 25 year olds and offer mental health services as well as drug and alcohol support and counselling, general health services, sexual health services, vocational education and career guidance.[303] The majority of their clients self-refer but they can also be referred by others, such as health professionals and school support services.[304] However, the focus of Headspace is on the young person being given some control of the process, so they must be willing to engage with the service.[305]

193. Dr Wenzel was asked about the relationship between Albany Hospital and Headspace Albany and he spoke positively of the general communication between staff from both services, although he noted that "there's always room for increased communication."[306]

194. Dr Wenzel also noted generally that there are a lot more services around for young people now in 2016 and a better awareness in

[299] Exhibit 3.
[300] Exhibit 3, Foreword.
[301] Exhibit 3, Foreword.
[302] T 95.
[303] T 95.
[304] T 96.
[305] T 96.
[306] T 101.

the community of the availability of those services.[307] Dr Wenzel observed that the absence of a designated psychiatric service for adolescents in Albany causes some difficulties, particularly for the 16 to 18 year old age group, which was where Jesse fell at that time.[308]

195. The results of the survey appear to reflect a similar position to what has been described during this inquest, which is that the services available to young people like Jesse are improving, not only in Albany but nationwide. However, there is obviously still significant work to be done given the report also noted the worrying results indicating that approximately one in ten teenagers indicated that they had engaged in self-harming behaviour.[309]

196. In that regard, it is stated in the report that the Australian Government is committed to maintaining a strong focus on prevention and early intervention efforts to reduce the prevalence and impact of mental health problems in our young population.[310]

CONCLUSION

197. Jesse Dellar was a troubled young man who had experienced significant challenges in his early life. With the strong support of his family, Jesse had overcome many of those challenges and had made significant headway in his high school years, forming strong friendships and choosing a career path.

198. It was noted by one of the witnesses that it was apparent from all the documentation that Jesse was a treasured child, much loved by his family and friends.[311] That certainly came through in the evidence at the inquest and the later submissions received from Jesse's family.

199. However, in 2010 Jesse experienced a number of stressors that caused his mental health to deteriorate and he experienced thoughts of suicide. He eventually followed through with these thoughts and, following an attempted overdose, he was admitted to Albany Hospital for treatment.

200. Jesse was treated both for the physical effects of the overdose and then for the psychiatric issues that had led him to take the

[307] T 102.
[308] T 98.
[309] Exhibit 3, Foreword.
[310] Exhibit 3, Foreword.
[311] T 149.

overdose initially. As a late adolescent, Jesse's psychiatric treatment did present some challenges to the staff at Albany Hospital, but they did the best they could to treat Jesse, with the hope of getting him stable enough to be able to discharge him back to the care of his family and put in place a long-term plan to provide him with psychiatric and psychological support in the community. Sadly, that plan was never activated as Jesse impulsively left the hospital and hanged himself on the afternoon of 27 November 2010.

201. Lessons have been learnt from Jesse's death and changes have been implemented at Albany Hospital that will hopefully improve the care that can be offered to young patients in the same position as Jesse. However, it remains a continuing concern for the Australian community that young people such as Jesse can be left with a belief that taking their own life is the best option when they should be looking forward to the future with hope and optimism. As noted above, the Australian Government is taking steps to monitor the prevalence of mental health problems in young Australians. It is to be hoped that with greater attention and resources, future generations of young Australians will benefit from the lessons learnt from the tragic deaths of young people like Jesse.

S H Linton
Coroner
24 March 2016