CORONERS COURT OF QUEENSLAND

REDACTED FINDINGS OF INQUEST

CITATION:	**Inquest into the deaths of Talieha Nebauer, William Fowell and Caitlin Wilkinson Whiticker**
TITLE OF COURT:	Coroners Court
JURISDICTION:	BRISBANE
FILE NO(s):	2014/1211, 2014/2026, 2014/2817
DELIVERED ON:	30 August 2019
DELIVERED AT:	Brisbane
HEARING DATE(s):	22 June 2018, 26 July 2018, 15 to 17 October 2018, 22 to 24 October 2018, 19-21 November 2018, 5-6 December 2018
FINDINGS OF:	John Lock, Deputy State Coroner
CATCHWORDS:	Coroners: inquest, closure of Barrett Adolescent Centre, Commission of Inquiry, transition arrangements for adolescents to adult mental health services, alignment between adolescent mental health services and adult mental health services, dual diagnosis of intellectual disability and mental illness, NDIS, adequacy of care provided, recommendations by the COI, recommendations for the prevention of self-harm and suicide in adolescents and young people.

REPRESENTATION:

Counsel Assisting:	Mr S Hamlyn-Harris
Counsel for Justine Wilkinson (mother of Caitlin Whiticker), Nichole Pryde (mother of Talieha Nebauer) and Vanita Olliver (mother of William Fowell):	Mr G Mullins i/b Shine Lawyers
Counsel for Queensland Health and Children's Health Qld Hospital & Health Service:	Ms E Wilson QC with Ms J Crawford i/b Crown Law
Counsel for West Moreton Hospital & Health Service:	Ms K McMillan QC i/b Corrs Chambers
Counsel for Dept of Child Safety, Youth and Women and Dept of Communities, Disability Services and Seniors:	Ms K Carmody i/b DCSYW
Counsel for Metro South Hospital and Health Service:	Ms M Zerner i/b MSHHS Legal Services
Counsel for Metro North Hospital and Health Service:	Mr J Allen QC i/b MNHHS Legal Services
Counsel for Dr A Brennan:	Mr G Diehm QC i/b Avant Law
Counsel for Nurses S Daniel, P-L Yorke, M McLeod:	Ms S Robb i/b Roberts & Kane Solicitors
Counsel for Dr S Byth:	Ms Houston, Moray & Agnew Lawyers
Counsel for Dr R Stewart and Dr Clavijo:	Mr A Luchich i/b Moray & Agnew Lawyers
Counsel for Ms G Watkins-Allen:	Mr A O'Brien, RBG Lawyers

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Introduction

1. Talieha Nebauer was aged 18 at the time of her death on 6 April 2014. William Fowell was aged 18 at the time of his death on 10 June 2014. Caitlin Whiticker was aged 18 at the time of her death on 5 August 2014. They were all patients at the Barrett Adolescent Centre (BAC) with varying levels of service requirements. They were all part of the transition process following the announcement in August 2013 of the closure of the BAC, and all were provided with, and took up an option for further care post-BAC closure. All three of these young people took their own lives subsequent to the closure of the BAC.

2. The BAC was a 15-bed inpatient service operated by the West Moreton Hospital and Health Service (WMHHS) at Wacol. The BAC came under the banner of the WMHHS's Division of Mental Health and Specialised Services, of which Dr Terry Stedman (psychiatrist) was the Clinical Director. This banner also encompassed The Park Centre for Mental Health.

3. The BAC provided extended treatment and rehabilitation programs for adolescents across Queensland presenting with complex mental health diagnoses including eating disorders, anxiety and mood disorders, severe self-harm and suicidal behaviour. In addition to the inpatient service, the BAC offered a day program service involving a school and structured group activities. It was aimed at assisting the transition of adolescents to alternative services following inpatient admission or generally in terms of achieving developments in areas such as independent living and social skills.

4. According to Dr Stedman the BAC was intended to be closed back in 1999, however, families of consumers and staff successfully lobbied for the retention of the centre as a medium stay inpatient service. Over the following 10 years it was considered by many that the public mental health system had undergone significant reform, including a shift from institution-type service models to more contemporary models of care. The impact of these reforms had seen the care of consumers moved primarily into community-based settings, which supported the consumer to engage in their own local neighbourhoods and local facilities.

5. A key area of the *Queensland Mental Health Plan for 2007 – 2017* had been the development of The Park as an adult-only forensic and secure mental health campus. Dr Stedman stated that in light of this, it was no longer considered contemporary and optimum practice to provide long-term inpatient care for adolescents at the BAC on The Park campus. On 6 August 2013, the then Queensland State Government Minister for Health announced the pending closure of the BAC and that new service options for adolescent extended treatment and rehabilitation would be available in early 2014.

6. WMHHS was then made responsible for identifying appropriate alternative services for the then patients of the BAC, whilst Children's Health Queensland Hospital and Health Service (CHQ) was to consider what other services were needed to be developed for adolescents with extended treatment including those who might otherwise have been admitted to the BAC.

7. In September 2013, Consultant Psychiatrist Dr Anne Brennan was appointed Acting Clinical Director of the BAC, until March 2014. Dr Brennan took over from Dr Trevor Sadler, who had left the role after a long association with the BAC. Dr Brennan then had a significant role in the transitional arrangements that were put

in place for the BAC's patients. The official closure date for the BAC was 31 January 2014.

8. After the death of Caitlin Whiticker in August 2014, the Director-General of Queensland Health appointed health service investigators to report on (amongst other things) the healthcare transition plans developed for the patients of BAC between 6 August 2013 and the closure date in January 2014. That report was delivered on 30 October 2014.

9. On 16 July 2015, The Barrett Adolescent Centre Commission of Inquiry (the Commission) was established with the Honourable Margaret Wilson QC appointed as the Commissioner. Once the Commission was established I adjourned the decision as to whether a coronial inquest should be held until after the Commission reported.

10. The Commission was to consider within its Terms of Reference a number of matters related to the closure of BAC including the basis of the closure decision; the adequacy of the transition arrangements for BAC clients; the adequacy of the care, support and services provided to BAC clients and their families; and the consideration of any alternatives to the closure.[1] The Commission's report was delivered in June 2016.

11. The causes of the death of Talieha, William and Caitlin were considered to be not within the remit of the Commission. I have taken regard to the statement made in the Commission report that the Commission's factual inquiry started at the beginning of the transition and ended around one month after the transition client's discharge from the BAC. Further, it was stated the Commission's Terms of Reference, and its factual inquiry, did not extend to a consideration of the following matters:
    - the immediate cause or root causes of the deaths of the three young people who died in 2014 who had formerly been patients of the BAC;
    - whether those deaths were caused by or contributed to or affected by the closure of the BAC in early 2014;
    - whether those deaths were caused by or contributed to or affected by the transition; and
    - arrangements for and the adequacy of care provided by the various receiving services.[2]

12. Accordingly, following a request by the families of each young person, a decision was made to hold an inquest in respect to each of the deaths. Given the very extensive inquiry conducted by the Commission of Inquiry it was not my intention to traverse over evidence that was considered during the Commission of Inquiry. I have been provided with a very extensive amount of material from the Commission's archives. Relevant material was included in the coronial Brief of Evidence. It was intended to consider the circumstances of the deaths of each young person in separate hearings and hear from a limited number of witnesses focusing on events more proximate to the deaths and then to consider evidence from those who were of relevance to more than one of the three young persons. Finally, the inquest was to consider whether any further recommendations should be considered over and above to those recommendations made by the

[1] BAC COI Report page 639, Exhibit A1 page 652
[2] BAC COI Report page 385, Exhibit A1 page 398

Commission, particularly relating to the prevention of self-harm and suicide in adolescents and young people.

The Issues for the Inquests

13. At pre-inquest hearings held on 22 June 2018 and 26 July 2018, I heard submissions relating to various matters including the issues for the inquest. Subsequently I had regard to a number of helpful written submissions from the legal representatives for the parties granted leave to appear at the inquest and with those submissions in mind, the following issues for the inquest were determined by me as follows:

    In relation to each of the deceased persons, the issues to be investigated at the inquest were:

    i. The findings required by s. 45 (2) of the *Coroners Act 2003*; namely the identity of the deceased, when, where and how he/she died and what caused his/her death;
    ii. The immediate circumstances surrounding each death;
    iii. Whether the fact the Barrett Adolescent Centre had closed had any adverse impact on the mental health of any of the deceased relevant to their death;
    iv. What was each person's mental health condition and how that was managed (including with respect to suicide risks) in the period prior to discharge (say approximately 3 months) from the BAC, and in the period after their discharge up to the time of their deaths.
    v. For each of Caitlin Whiticker, William Fowell and Talieha Nebauer, consideration of the care afforded to them from the date of their respective discharge/transition to their deaths, with specific reference to:
        a) Each adolescent's BAC discharge summary;
        b) Whether the transition arrangements for each of them were implemented;
        c) If there was any variation from the transition arrangements, was that variation relevant to the death;
        d) Whether the standard of mental health care and associated needs such as housing provided to each of the young people after discharge from BAC was adequate for their individual needs.
    vi. Whether any recommendations can be made for the prevention of self-harm and suicide in adolescents and young people.

14. Although each of the deaths were being considered in separate hearing weeks, and the circumstances and causes of their deaths were being considered separately, in order to be clear, a direction was made by the State Coroner on 5 September 2018 pursuant to Section 33 of the *Coroners Act 2003* that the inquest be held into these multiple deaths, which appear to have happened in similar circumstances.

15. In reaching any conclusions it should be kept in mind the *Coroners Act 2003* provides that a coroner must not include in the findings or any comments or recommendations, any statement that a person is or maybe guilty of an offence or is or maybe civilly liable for something. The focus is on discovering what happened, not on ascribing guilt, attributing blame or apportioning liability. The purpose is to

inform the family and the public of how the death occurred with a view to reducing the likelihood of similar deaths.

16. I am also mindful, particularly where there are matters involving health care, that when determining the significance and interpretation of the evidence, the impact of hindsight bias and affected bias must also be considered, that is, where after an event has occurred and particularly where the outcome is serious, there is an inclination to see the event as predictable, despite there being few objective facts to support its prediction.

17. A coroner should apply the civil standard of proof, namely the balance of probabilities but the approach referred to as the *Briginshaw*[3] sliding scale is applicable. This means that the more significant the issue to be determined, the more serious an allegation or the more inherently unlikely of an occurrence, then the clearer and more persuasive the evidence is needed for the trier of fact to be sufficiently satisfied that it has been proven to the civil standard.

18. With respect to the *Briginshaw* sliding scale it has been held that it does not require a tribunal of fact to treat hypotheses that are reasonably available on the evidence as precluding it from reaching the conclusion that a particular fact is more probable than not.

19. Suicide has been defined as[4]: v*oluntarily doing an act for the purpose of destroying one's own life while one is conscious of what one is doing*.

20. It has been said elsewhere[5] that *a coroner cannot make a finding that a deceased person died by suicide if the person lacks the mental capacity to form an intention to end their life. The deceased may have lacked capacity if they were mentally ill, intellectually impaired, psychotic, extremely distressed, under the influence of alcohol or drugs or very young.*

21. In practice, the issue of whether the deceased lacked capacity to form an intention to take his or her own life does not often arise, largely because most people suicide alone or in private and there is little or no evidence as to what the person was thinking at the time. More often there is other collateral evidence such as previous threats to suicide or notes left (or as is more frequently now occurring social media messages) indicating the intention.

Non-publication orders

22. In order to protect the identity of other patients and notifiers of confidential information the following non-publication orders were made:
    a) A non-publication order is in effect with respect to the publication and/or dissemination of other patient details that may arise during evidence, other than the evidence relating to Caitlin Whiticker, Talieha Nebauer and William Fowell.
    b) A further non-publication and/or dissemination order is in place with respect to exhibit C28 and its contents, in particular, details of intakes received by the Department of Child Safety in relation to Talieha Nebauer.

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[3] *Briginshaw v Briginshaw* (1938) 60 CLR 336 at 361

[4] *R v Cardiff City Coroner, ex parte Thomas* [1970] 1 WLR 1475 at 1478

[5] *Suicide Reporting in the Coronial Jurisdiction,* Coronial Council of Victoria Consultation paper, 23 April 2014

c) A non-publication order is in effect with respect to notifier details/identification that was listed in the statement of Jo Cameron in June 2015 as redacted but now appear to have been partly included.
d) A further order that the new version of the statement of Jo Cameron be included with the brief and the parties are to remove the version supplied from their discs, copies of discs or hard copies.
e) A non–publication order is in effect with respect of details/identification of a friend referred to in Exhibit C26
f) A non–publication order is in effect with respect of details/identification of friends referred to in Exhibit C17
g) A non-publication order is in effect with respect of details/identification of a boyfriend referred to in Exhibit D21.1
h) A non-publication order is in effect with respect of details/identification of a person named "T…" in exhibit C25
i) A non-publication order is in effect with respect of details/identification of those persons mentioned in the evidence of Dr Brennan when discussing each of the deceased's social history.

Investigations relevant to each young person

Independent Health Service Investigation Report

23. The Independent Health Service Investigation report was commissioned by the Director-General, Queensland Health (QH) after the death of Caitlin in August 2014 and was authored by Associate Professor Beth Kotze and Ms Tania Skippen. The scope of the review was to provide expert clinical review with respect to:
    - An assessment of the governance model put in place within QH to manage and oversight the healthcare transition plans for the then current inpatients and day patients of the BAC post 6 August 2013 until its closure in January 2014;
    - Advise whether the governance model was appropriate;
    - Advise if the healthcare transition plans developed for individual patients by the transition team were adequate to meet the needs of the patients and their families; and
    - Advise if the healthcare transition plans developed for individual patients by the transition team were appropriate and took into consideration patient care, patient support, patient safety and service quality.

24. An extensive list of documentation was made available to the investigators including patient files, policies, other miscellaneous documentation, written statements and face-to-face interviews.

25. The review was limited in the sense that staff from all receiving services (i.e. those services that took over aspects of the care of the patients as they transitioned from BAC and after BAC closure) were not interviewed, and limited documentation was made available from those services. There was also a "senior nurse" from the Transition Planning Team who was identified as having had a key role in the transition planning process, however, she declined to be interviewed.

26. The report made a number of findings, as follows:
    - The process of transitional planning occurred in an atmosphere of crisis consequent to the announcement of the closure and the standing-down of the senior leader of the service in the context of an unrelated matter, with escalation of distress in a number of the adolescents and staff of BAC.

There appears to have been a contagion effect of distress and anxiety amongst the adolescents and an increase in incidents on the unit. However, whilst the general atmosphere of crisis contributed to the complexity of the situation, it does not appear to have detrimentally affected the process of the transitional care planning for the patients.

- The closure date set an administrative deadline for transition, although all formal communication such as letters to parents and fact sheets/updates suggested that BAC would remain open until all transitions were completed. There was a sense of time-pressure for the BAC clinical staff because of the complexity of the planning process.
- Transitional care planning was led by a small multi-disciplinary team of clinicians headed by the A/Clinical Director of BAC (Dr Anne Brennan). Their task was enormous as they were required to review and supervise current care plans, manage incidents and crises, seek out information about service options that at many times were not readily available, negotiate referrals, coordinate with the education staff and manage communication with patients and their families/carers.
- The process of managing the transition of individual patients was centred on individualised and comprehensive needs assessment (including mental health, health, educational/vocational, and housing/accommodation needs) and care planning, extensive investigation to identify available and suitable services to provide coordinated care in the community settings, iterative planning and collaboration with consumers and families and carers.
- The model of care in existence at BAC had promoted prolonged inpatient care and the forthcoming closure required the rapid development of care pathways to community care.
- Ultimately, the transmission plans were thorough and comprehensive. In each case, at least one reasonable option was able to be identified. The investigators did not find any example where it was not possible to organise a reasonable system of care for an individual.
- The process was wrought with challenges –
  - the changes in established long-term relationships between the clinicians of BAC and the young people;
  - the differences between the culture and approach to care provided in services for adolescents and the culture and approach to care in adult services;
  - the impact of the young person's developmental stage and maturity on their health-seeking attitudes and behaviours;
  - Adolescent's resistance to transfer from a service where they felt safe and 'connected' in a relatively closed environment to a community system of care and, in the case of transfer to an adult system, the different expectations of their maturity and health-seeking behaviour and the different expectations of involvement of their family.
- Whilst there was some drop-out from some aspects of the care organised, the investigators did not identify any examples where a young person was completely lost to care, nor where a core component of care was completely missing.
- There were numerous examples of the BAC staff working in a collaborative way with receiving agencies, as evidenced by the number of times young people were escorted to the other agencies, the detailed discussions and

documentation in relation to risk management, maintaining contact post-transfer of care, and joint working by staff across the agencies.

27. The investigators ultimately found that:
    - The health care transition plans developed for individual patients by the transition team were adequate to meet the needs of the patients and their families; and
    - The transition plans for individual patients were appropriate and took into consideration patient care, patient support, patient safety and service quality.

28. In relation to the timeframes given for the process of transition planning to be developed and enacted, it was noted that the deadline was achieved albeit with a sense of pressure and urgency for the clinical staff especially towards the end. Irrespective of this, the investigators did not identify an individual case in which more time might have resulted in BAC staff providing a better transition plan or process.

29. The report made a general mental health system recommendation, as follows: "*Transitional mental health care for young people is internationally recognised as a complex and often difficult process and poor outcomes such as disengagement from care are well-documented. The BAC process demonstrates positive learnings in relation to good quality transitional planning. It is recommended that these learnings be considered for distillation into the development of a state policy (or review of the current transfer of care policy) that supports mental health transition for vulnerable young people.*"

The Commission of Inquiry

30. It is not intended to repeat in any detail the findings of the Commission of Inquiry or review and analyse the findings. They are accepted. The Commission investigated two broad issues. Firstly, about the decision to close the BAC and how that decision was reached. This was not an issue that was considered by the coronial investigation or the inquest.

31. Relevantly for the purposes of the coronial inquiry, the second broad issue was investigating the transition of the BAC patients to alternative care and arrangements and looking into the adequacy of those transitional arrangements in the care, support and services provided to the patients and their families.

32. The Commissioner provided a briefing statement at the time of delivering her report. This statement usefully summarises in a broad sense the Commission's main findings.

33. The Commissioner noted that several reasons were advanced for closing the BAC, the most prominent being:
    a) That caring for such young people in an institutional setting was not a contemporary model of care; and
    b) That the BAC's location at The Park Centre for Mental Health was inappropriate and fraught, as The Park provided mental health services to adults who were forensic patients or who otherwise needed to be in a secure unit.

34. The Commissioner also stated contemporary thinking clearly favours care of the mentally ill in the least restrictive environment possible. Care in the community, close to family and social supports, is desirable. Contemporary thinking

acknowledges there will always be some people who need inpatient care, whether at acute or sub-acute level, and for varying durations.

35. There was evidence before the Commission by Associate Professor Kotze who described the risk of a disadvantage to a young person due to institutionalism as being due to the fact they may spend very long periods of time in an artificial environment, where imposed on them was the role of patient and there is a sense of things being done to them and relevant relinquishing of decision making in the sense of autonomy and responsibility. Professor Kotze said such young people do not have the opportunity to acquire at the appropriate development stage in life experience the developmental capacities that will enable them to function well as adults. This is compounded by the artificial nature of an institution.

36. The Commissioner stated that for some years there had been a plan to relocate the BAC, but its implementation was delayed by planning and environmental issues and the estimate of what it would cost had risen. That project was cancelled in mid-2012 and the funding was reallocated.

37. Significantly, before that was done, the Commissioner noted there was no analysis of the needs of the young people who accessed the BAC; no express consideration of how those young people would be cared for; no consultation with specialist child and adolescent psychiatrists; and no community consultation.

38. The Commissioner stated those who wanted to see the BAC closed pressed ahead. An Expert Clinical Reference Group (ECRG) was formed to consider models of care for adolescents with severe and persistent mental illness. ECRG was told there was no money available to build a new facility. Nevertheless, ECRG advised that a design-specific, clinically staffed, bed-based service was essential for adolescents requiring medium term extended care and rehabilitation. It warned that if the BAC were closed before the establishment of such a facility, interim service provision would be associated with risk. The Commissioner stated that advice was not heeded.

39. The Commissioner also commented that while there is a clear preference for an emphasis on community care, the preponderance of expert evidence before the Commission pointed to a number of conclusions:
    a) A small group of adolescents require care in an inpatient extended treatment and rehabilitation facility;
    b) There is a possibility, but it can be put no higher than that, that such a facility may not be needed if and when a full suite of community-based services is available;
    c) There is likely to be a need for such a facility even when the full suite of community-based services is available; and
    d) In any event, the full suite of community-based services was not available more than 2 ½ years after the BAC was closed, and it was not imminent.

40. In February 2014, CHQ Hospital and Health Service started implementing a new suite of extended treatment and rehabilitation mental health services for adolescents and young people with severe, complex and persistent mental illness. This was called the Adolescent Mental Health Extended Treatment Initiative (AMHETI). It was designed as a suite of treatment and rehabilitation services enabling adolescents to move between levels of service according to changes in the acuity, severity and complexity of the mental illness and associated needs at any particular time. AMHETI included five service elements;

- Assertive Mobile Use Outreach Service–a new outpatient service rolled out since July 2014
- Child and adolescent day program–already established but with new programs
- Youth Residential Rehabilitation Units–a new community bed-based service operational since February 2014
- Step up/stepdown unit's–a new community bed-based service established by mid-2017
- Statewide sub-acute beds–a new service consisting of tier 3 beds recommended by ERCG the expert clinical reference group.[6]

41. Given the above the Commissioner recommended the establishment of a bed-based extended treatment and rehabilitation unit for young people with severe and complex mental illness. This unit could form part of an adolescent non-acute mental health facility on, or adjacent to, the campus of a general hospital in Southeast Queensland. The Commissioner was not recommending the BAC should be replicated in a new location.

42. In relation to the AMHETI suite of services, Professor Kotze told the Commission, having them in place at the time of closure would not have made any difference to these young people because of the bespoke nature of the plans and the length of time they had each been at the BAC. Professor Kotze noted the suite of services were more likely to benefit others coming into the system who did not have the trajectory already in train as was the case for patients such as Talieha, William and Caitlin.

43. The Commission investigated the transitional arrangements for a number of BAC patients including those for Talieha Nebauer, William Fowell and Caitlin Whiticker. The Commission did not consider the causes of the deaths, which were already being investigated by the coroner.

44. Dr Sadler's evidence described transition in these terms: "*Transition is the time leading up to discharge. From the time of admission, the objective was to transition BAC adolescents back into the community, if possible. There was and could be no said timeframe for this transition. Such a course needed to be considered in the context of the individual needs and the circumstance of each BAC adolescent.*"

45. Dr Sadler's statement also noted that BAC "*facilitated the transition process by addressing each adolescent individually, with the intention to make them feel and become independent, and by providing longer periods of leave to partial hospitalisation, day program attendance if it was appropriate and beneficial, on occasions outpatient care, to in the end having only contact by telephone or drop in whenever necessary. Throughout this process each adolescent was being supported in the integration into the community and linking with other service providers who are already involved through the Care Planning Workup.'*

46. Dr Sadler also noted in his statement that *"if an adolescent in BAC had turned 18 years of age, had shown minimal improvement following the treatment received at BAC and were likely to experience long-term mental health problems, transitions was made to an appropriate Adult Mental Health Service (AMHS)….If the adolescent was to be transferred to a community service of the AMHS, the phase of crossover engagement with the AMHS was usually over a period of two months*

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[6] BAC COI chapter 27 page 503

or more. In the meantime BAC continued other phases of supporting the adolescent transitioning to the community".

47. Vanessa Clayworth was a Clinical Nurse Consultant (CNC) at BAC and was an important member of the transition panel set up by Dr Brennan. She stated in her second statement to the Commission that in the absence of any like facility to BAC this meant that unless an adolescent required acute inpatient care, he/she needed to transition back into his/her community. It was for Dr Brennan to summarise the adolescent's case with reference to the clinical record and if possible identify a tentative discharge date. The panel's focus as a group was to identify each adolescent's community reintegration needs together with the skills which he/she would need to develop to achieve reintegration.

48. Ms Clayworth stated that once a patient had been discharged from BAC there were no arrangements to review, follow up or monitor the outcome of the transitional arrangements. The responsibility for the adolescents then ceased upon hand over to the receiving service, given BAC ceased to exist as a facility.

49. Dr Brennan also noted that transition needs to be tailored to the young person's needs, and be gradual, involve good communication and if possible parallel streams of care. Transition in mental health care at this stage of life, when there is peak incidence of emerging mental disorders and the highest rate of discontinuity of care in early onset disorders, needs to take into account the myriad of extraneous forces involved, including transition from school to higher education and/or employment, transition from a child role within the family unit, and the development of relationships with other autonomous young adults. It is particularly challenging for those already in the care of the state or who are unable to reside with their families. This group is at a higher risk of self-harm, suicide, homelessness, incarceration, unemployment and ongoing mental health and physical health disorders.[7] As Dr Brennan stated at the inquest, transition is a process and not a point in time.

50. The Commission noted it was widely accepted that psychological and emotional development may not keep pace with chronological development. The Commission also noted transition from an adolescent mental health service to an adult mental health service can be fraught. The two systems are based on different principles, and generally care for cohorts is markedly different in age, diagnosis and chronicity. While both services promote recovery and rehabilitation, they are based on different principles. The adolescent service is based on a biopsychosocial model and the adult service on individual treatment, including medication and other therapies. Education and vocational training are integral to the adolescent model, but not part of the adult model.[8] Dr Brennan is recorded as saying Adult Mental Health Services and Child and Adolescent Mental Health Services are structured differently. There are issues about consent and confidentiality and responsibility for clinical care and there are differing priorities regarding funding and allocation of resources, which are scarce across all ages, services and disorders.[9]

51. The Commission noted it is uncontroversial that young people are at increased risk of service disengagement during this critical time period, and it is imperative that the process be managed as well as possible. Optimal transition has been described

[7] BAC COI chapter 18 page 339
[8] Chapter 18 BAC COI Report page 339
[9] Chapter 18 BAC COI Report page 340

as fulfilling four inter-related criteria: Continuity of care, at least one transition planning meeting, good information transfer, and parallel care.[10]

52. Dr Brennan in her first statement to the Commission provided details as to the membership and rationale of the transition panel set up. Dr Brennan commenced at BAC on 11 September 2013 to act in the clinical director role having been approached a few days earlier. At the time the long term Clinical Director, Dr Sadler had left the position. As there had been an announcement the BAC was closing in January 2014 it is fair to say there was some imperative to move the current patients through a transition process expeditiously. Dr Brennan did not receive a handover of the patients by the previous clinical director.

53. Dr Brennan stated that to develop a transition care plan it was necessary to get to know each patient and understand them, the history, the family, their strengths, and difficulties and hopes for the future. It was also important to understand their previous involvement with services and therapists in order to identify services that were developmentally appropriate and accessible both physically and financially, that could deliver good quality care in the least restrictive environment, while providing an appropriate level of security and addressing any risk of harm.

54. In an overall sense, the Commission determined the transition plans for all of the identified transition clients (and therefore including Talieha Nebauer, William Fowell and Caitlin Whiticker) were adequate and took into account the specific elements of the transition planning, including accommodation, clinical care and education.

55. The Commission noted the transition plans as proposed by Dr Brennan for Talieha. William and Caitlin, were individualised plans that were developed addressing their individual mental health, social and developmental needs. They were described by Professor Kotze as bespoke in nature and developed individually for each.

56. The Commission also found the care, support and services provided to transition clients were adequate, although in respect to several they were not ideal.

57. The Commission found systemic problems affected the transitional arrangements for the care, support and services available to some of the transition clients. It was noted a number of the clients were chronologically adults but developmentally were adolescents. They had extremely high treatment needs, high acuity and high complexity. What emerged from the Commission evidence, particularly in relation to the management and implementation of safety risks, was the stark difference between the framework of an adolescent inpatient mental health service and that of an adult community mental health service.[11]

58. This issue of the differences in framework of an adolescent and adult service was specifically addressed by the Commission. The Commission noted that in Australia, as well as other parts of the world, there has long been a structural divide between child and adolescent health services on the one hand and adult health services on the other. In Queensland an adolescent had been defined as someone aged between 13 and 17 years. However, definitions of adolescents and related terms varied. By way of example the World Health Organisation defines

[10] Chapter 18 BAC COI Report page 340

[11] BAC COI Report page 393, Exhibit A1 page 406

adolescents as between 10 and 19 years, while referring to the 15–24-year-old group as youth and adolescents and young adults. This issue will be further explored in context to the recommendation phase of the inquest findings.

Information particular to Caitlin Whiticker

Background

59. Caitlin resided in Townsville with her mother, Justine Wilkinson and an older brother. Ms Wilkinson's marriage to Caitlin's father broke down in 2003, although he continued to remain an important person in their lives.

60. At age five Caitlin was diagnosed with significant hearing loss, which impacted on her speech and social interactions.

61. At age 11 she started to show signs of anxiety. Her schooling attendance began to suffer and she developed anorexia nervosa and panic attacks. She commenced receiving treatment from a private psychologist, her GP and headspace in Townsville.[12]

62. In 2010 and 2011 when she was 14-15 years, Caitlin had a number of incidents of self-harm requiring hospital admissions. In March 2011 she was admitted to the BAC. Ms Wilkinson visited her from Townsville every two months and Caitlin saw her father every second weekend.

Mental Health Care provided at BAC

63. Dr Stedman's statement provided a useful overall summary of the mental health care provided by the BAC to Caitlin.

64. Caitlin had been referred to BAC from headspace in Townsville with concerns she was refusing to go to school and perhaps suffering from depression and anxiety. She came to BAC with a history of suicide attempts and self-harm. She had been initially treated at Townsville Child and Youth Mental Health Service for depression, irregular sleep, school refusal, self-laceration, anorexia, paranoid thoughts and suicidal ideation. There had been a number of involuntary admissions to the Townsville Hospital Mental Health ward as a result of self-harm.

65. Caitlin was first admitted to BAC on 1 March 2011. An admission assessment from psychologists noted a potential historical precipitant was due to family issues and particularly the relationship with a particular relative. There were 10 separate admissions and discharges during which she accessed numerous periods of leave. Whilst she was at the BAC she received individual psychotherapy, medication, social and family therapy, remedial teaching and skilled nursing.

66. Her final discharge as an inpatient was on 16 August 2013. After that date she was being transitioned through Phoenix House, a fully supported transitional accommodation program run by the Carina Youth Agency through Metro South Hospital and Health Service (MSHHS). That program is an intensive therapeutic program for young people with high and complex needs. It was staffed 24 hours a day with two staff on shift at all times. Phoenix House offered a short-term program of up to six months.

[12] headspace is a national organisation providing mental health services to 12-25 year olds with over 100 centres throughout Australia

67. Caitlin remained a day patient at BAC after 16 August 2013. Her last attendance at BAC was on 12 December 2013. It seems the official date of discharge as a day patient is noted in the records as being 27 November 2013 (the day of her voluntary admission to Mater Children's Hospital), however, Caitlin continued to return to the BAC school/day program up until 12 December 2013.

68. Upon discharge from BAC, the recorded diagnoses were Bipolar Effective Disorder, Aspergers disorder and Mixed Anxiety and Depressive Disorder. Her admission at BAC was characterised by persistent anxiety, agitation and erratic behaviour.

69. There had been a number of serious incidents involving Caitlin whilst she was at BAC but only when she was on leave. Some of the more serious are as follows:
    - In April 2011 while on leave with her mother Caitlin attempted suicide and required admission to the Townsville Hospital;
    - In February 2012 while on leave with her father Caitlin harmed herself and required admission to the Nambour Hospital; and
    - In April 2012 Caitlin tried to exit a moving car.

70. Involuntary treatment orders were made in November 2011 and February 2012. The latter order was not revoked until a year later in March 2013.

71. The then Director of the BAC, Dr Trevor Sadler prepared a clinical report dated 17 August 2012 and at that time noted that although Caitlin's level of suicidality had stabilised, it was still present and she remained a potential for self-harm or suicide in a dissociated state. He also noted a constant theme over the past three years had been difficulties with her family. He considered her safety could only be maintained, particularly in the evenings, with the support of staff, which could only be done as an inpatient.

72. Lithium was introduced into her medications in 2012 and Vanessa Clayworth recorded in a progress note on 23 November 2012 that since its introduction it had assisted in stabilising Caitlin's mood with a significant decrease in impulsive behaviours and agitated state.

73. During her admission at BAC, Caitlin attended the BAC school as well as participating in a range of recreation therapy, psychological skills training, occupational therapy, speech pathology, psychology and pharmacy. At the time of discharge, she was on the following medications:
    - Lithium 450mg for bipolar effective disorder;
    - Escitalopram 20mg for depression;
    - Quetiapine 25-100mg daily for insomnia;
    - Clonazepam 0.5mg for agitation;
    - Diazepam 2-5mg three times daily for agitation.

74. It appears from the case notes in mid-2013 that discussions were held with team leaders who considered that Caitlin could soon transition to independent living run by Princess Alexandra Mental Health Service (PAHMHS). Caitlin was then put in touch with Phoenix House towards the end of July 2013 with a gradual introduction and final move in mid-August 2013. Phoenix House was to provide supported accommodation for a limited period while further transition to living independently in the community continued. BAC progress notes indicated that Caitlin was excited about the move to Phoenix House and was ready to move from BAC.

75. Caitlin was referred to the PAHMHS on 22 October 2013. Her case manager from sometime in mid to late 2013 at BAC was Clinical Nurse (CN) Susan Daniels as well as Registered Nurse (RN) Peta-Louise Yorke. RN Yorke often worked night shifts, which did not coincide with dates and times Caitlin chose to attend. A recovery plan was developed, which involved a self -reflection upon what Caitlin considered to be her strengths and weaknesses, early warning signs, triggers and what had/had not worked well in the past to manage early warning signs and triggers. Caitlin had been continuing to challenge her anxiety with community access tasks and noted she felt well supported by Phoenix House.

76. CN Susan Daniels was responsible for coordination of the community support services and recalls she made referrals to mental health services, found a GP practice for Caitlin and liaised with Phoenix House and her community psychologist Dr Georgia Watkins-Allen. CN Daniels stated that prior to the BAC closure they may have had some involvement for a limited time during the transition so the transition was a more gradual process. She stated the transition for day patient process was very individual; so she could not say how long they may have been involved. She stated Caitlin could be sporadic and disengage with services, which could put her at risk.

77. CN Daniels agreed Caitlin had a strong desire to be independent but it had been challenging to find accommodation with appropriate support. CN Daniels stated in her statement to the Commission that Caitlin was already at the end of her transition phase from BAC to the community when she became involved. Her sporadic attendance at BAC made this drawn out and challenging to finalise. She stated she considered the transitional arrangements to be adequate, but if there had been no pressure to close the BAC she may have monitored Caitlin's rapport building with the new services to encourage her attendance and to ensure their contact with her and encourage her not to withdraw from those supports.

78. On 7 November 2013, Caitlin was accepted into the Mood Team at the PAHMHS for ongoing outpatient care and case management. Her mood was noted to be stable at this time. Caitlin also formulated with CN Daniel a Recovery Plan on 7 November. She was formally referred to the Mood Team on 21 November 2013.

79. RN Peta-Louise Yorke stated in her statement she was a care coordinator for Caitlin in association with Vanessa Clayworth, although she now agrees this was not totally accurate. Rather she was a joint Case Coordinator with CN Daniels. It appears RN Yorke was not involved in formulating the transitional arrangements for Caitlin.

80. The BAC case records notes a number of attendances by Ms Yorke on Caitlin during the transition process. On most occasions it was recorded that Caitlin was bright and reactive and appeared well. It was recognised Caitlin's mood could fluctuate a lot. On 24 November 2013 the description of a telephone call to Caitlin included that she was engaging in conversation and was bright and reactive. Ms Yorke was told a youth worker from Phoenix House wanted to speak to BAC staff that week regarding her transition from Phoenix House. A concern was expressed Caitlin may have been stressing about the transition from Phoenix House to more suitable community accommodation

81. On 27 November 2013 Ms Yorke considered Caitlin's presentation had changed significantly and this was when Dr Brennan organised for an admission to Mater

Children's Hospital. The presenting description as recorded by Ms Yorke in the notes was that Caitlin was flat and depressed in mood and difficult to engage.

82. Dr Brennan conducted a mental state examination on 27 November 2013. She found Caitlin to be dysphoric and despite being very guarded, revealed she felt suicidal. In light of Caitlin's history of making serious suicide attempts without warning when dysphoric, Caitlin was transferred by Dr Brennan to the Mater Children's Hospital Mental Health Unit for risk containment and further assessment. Caitlin remained in the Mater until discharged to the PAHMHS Mood Team on 12 December 2013.

83. Dr Brennan's discharge summary to Mater for this event stated it was clear Caitlin's deterioration in mood and attendance at BAC coincided with an erratic compliance with lithium and noted that monitoring of compliance was not at an appropriate level. Dr Brennan again recorded Caitlin had identified a relative's hostile behaviour distressed her and alluded to a traumatic experience at age 12.

84. Dr Brennan in her evidence at the inquest stated the BAC records indicated it seemed Caitlin was not taking as much lithium as she had been prescribed yet she had gastrointestinal symptoms consistent with lithium toxicity. Dr Brennan stated a person who is non-compliant with her prescription medication might take too little, take too much or may do both. In Caitlin's case despite stopping lithium she still had a certain level in her system and her symptoms were consistent with toxicity from the date when she reported them. Dr Brennan considered Caitlin needed more careful monitoring of her lithium levels, which is why she was anxious to have a GP appointed to assist in this function.

85. Alicia Martin, psychologist, was Caitlin's case manager at the Mater. It seems Ms Martin took over from BAC with respect to Caitlin's transition of care to PAHMHS from this date.

86. On 28 November 2013 Ms Martin interviewed Caitlin in the presence of a psychiatric registrar where Caitlin confirmed a deterioration in her mood and suicidal ideation and wanted an admission. Ms Martin and psychiatrist Dr Gladwell had a teleconference with Dr Brennan and obtained collateral history with the goal of the admission to be stabilisation of lithium levels, review anti-depressant medication and safety and containment.

87. Ms Martin later spoke to Caitlin's BAC case manager CNC Clayworth for further collateral information. This collateral history confirmed that before the introduction of lithium Caitlin had periods of elevated and depressed mood, a history of becoming catatonically depressed, had no history of self-harm but did have a history of two serious suicide attempts. CNC Clayworth reported that when Caitlin was elevated in mood she displayed irritability, agitation, aggression, destruction to property and homicidal thoughts. When depressed she also demonstrated a lack of self-care and attention to activities of daily living. It was ascertained her optimal therapeutic lithium level was 0.8.

88. At the time of her admission to Mater Children's, Caitlin had been residing in Phoenix House for approximately four months and she was in the process of transitioning to accommodation at the *"Single Women's Support and Housing Program" (*SWISH).Ms Martin had been told by a support worker at Phoenix House they had noticed a deterioration in Caitlin's mood in the recent week. It was reported that Phoenix House and SWISH had reviewed the transition plan for

Caitlin's move to semi-independent living and she would now retain beds in both programs to allow a more gradual transition.

89. Ms Martin also liaised with MSHHS Burke Street Clinic as it was clear Caitlin's admission to Mater would overlap with her intended period of engagement with adult mental health services through the Burke Street Clinic, which was to commence prior to her 18th birthday on 4 January 2014.

90. During her admission to the Mater, Caitlin's presentation improved with her becoming less guarded and maintaining better eye contact. Dr Gladwell determined Caitlin's mental state had improved sufficiently to plan a discharge and this was created in discussions with Caitlin and Emma White, her new case manager at PAHMHS. Discharge was to occur on 12 December 2013. On 8 December Ms Yorke received a verbal hand over regarding medication changes from Mater Children's Hospital. Later that day Alicia Martin spoke to Mater CH to make an arrangement to enable Caitlin to visit BAC to say goodbye.

91. On 10 December 2013 an appointment was made for Caitlin to consult with Dr James Noon and other team members at the Burke Street Clinic and a detailed hand over letter giving details of Caitlin's history, medication, risks, current mental state and current issues was provided by Dr Gladwell. The discharge plan could only be described as thorough and included timing of the discharge, discharge medication regime, follow-up appointments with other care providers, practicalities of who would pick up Caitlin and when, and medication availability on discharge.

92. On 12 December 2013 Caitlin attended the BAC for the last time to say goodbye to everyone. Her mental state appeared to be settled.

93. On 18 December 2013, supporting documentation was provided by CNC Clayworth to Caitlin's new case manager (Emma White) and psychiatrist (Dr Subramanian Purushothaman) at the PAH Mood Team. The documentation included an assessment interview carried out on 3 December 2010, intensive case workups for the duration of her admission, occupational and speech therapy reports, recovery and treatment plans and discharge summary dated 27 November 2013.

94. On 16 December 2013, Emma White collected Caitlin from her accommodation for an initial case management meeting. Her past history with therapies over the last couple years, accommodation, education, employment and other goals were also discussed. It was noted Caitlin was soon to go on a family holiday and Caitlin was given the details of emergency numbers and a list of medications to take with her on holiday. Ms White said in her evidence before the Commission she had some concerns about her going on holiday and started to speak to Caitlin and the treating team about that event. Ms White stated she was able to satisfy herself that Caitlin was in a good space to go on that holiday.

95. On 18 December 2013 a stakeholder meeting with Emma White, Nicole Munro, Dr Brennan and CNC Clayworth was held to discuss Caitlin's transition from the BAC to the PAH Mood Team.

96. On 8 January 2014 Caitlin had a telephone conversation with Emma White as arranged and informed Ms White the family holiday had been "awesome". Caitlin attended an appointment on 13 January 2014 by which time Caitlin was now

engaged with her new adult service. At that point in time Ms White considered Caitlin was still in a good space.

97. On 29 January 2014, Dr Brennan wrote to WMHHS management about contact she had made with Caitlin. Caitlin had reported to Dr Brennan she was well engaged with the PAH Mood Team and was still in supported accommodation but was transitioning to independent living. She was linked to her community GP and 'doing so well that her GP queried her diagnoses'. Caitlin reported she was coping well with life and expected to continue like this.

Transition Plan

98. In respect to the transition plan for Caitlin, Dr Brennan noted the diagnoses of bipolar affective disorder, Asperger's disorder and problems of adjustment to life cycle transitions. The risks identified were suicide, self-harm, unwanted pregnancy and vocational/educational under achievement.

99. Caitlin's case was reviewed at a transition panel meeting on 23 October 2013. In her evidence before the Commission, Dr Brennan stated she was alarmed by Caitlin's medical history and considered Caitlin's significant response to lithium indicated bipolar disorder. She thought Caitlin's irregular visits to a psychologist were inadequate and Caitlin also needed to be referred to a psychiatrist and to a GP. It was noted Caitlin already had supported accommodation at Phoenix House. The plan was to link her with the adult PAH Mood Team under psychiatrist Dr Jelesic-Bojicic, with case management from Nicole Munro and Emma White. She was to be linked with a GP, Dr Susan Byth. Transitional arrangements to the PAH Mood Team were put in place by BAC staff. Due to Caitlin's unplanned admission to the Mater Hospital it was this hospital that facilitated the eventual transition.

100. The education component of the plan was looked after by Carina Youth Support Agency. Caitlin was encouraged by Ms White to continue at the BAC school at Yeronga to finish Access 10. At one point Caitlin was considering transferring to the Albert Park Flexi-school.

101. In her evidence before the Commission, Dr Brennan agreed there was no document headed "Transition Plan" for Caitlin but she had the components of transition care in place. Dr Brennan stated an important component of the transition plan was that Caitlin had a case manager who would be fully aware of all appointments, facilitate them, liaise with the therapist and psychiatrist and be very aware of any needs for other alternative accommodation or other supports.

102. Ms Clayworth noted Caitlin's case was presented by BAC in a meeting with the Metro South Hospital and Health Service on 6 November 2013 after a referral to the Early Psychosis Unit had been declined with a view to facilitating referral to the mood team. In late November 2013 Caitlin required a brief admission to the Adolescent Inpatient Unit at Mater Children's Hospital after having expressed hopelessness and suicidal ideation, which was subsequently determined to be a consequence of non-compliance with lithium. Once lithium was stabilised at therapeutic levels, she improved significantly and quickly made a successful transition to the Mood Team.

Treatment by PAH Mood Team

103. Comprehensive statements were obtained from both Caitlin's clinical case manager (psychologist Emma White) and psychiatrist (Dr Subramanian Purushothaman) and others from the PAH Mood Team.

104. Nathan Pasienczny was a psychologist and the Mental Health Team Leader for the Mood Team. He agreed there was no formal single written transition plan for Caitlin. However, a stakeholder meeting was held on 18 December 2013 and included a detailed discussion of Caitlin's transition. Further several documents relating to the transition planning were provided by BAC by email. The combination of these documents, discussions at the meeting and progress notes constituted Caitlin's transition planning according to Ms Pasienczny. In terms of general medical transition planning, Dr Susan Byth was already in place at the point of transfer as the GP. He stated the key goal in Caitlin's transition was to assist with Caitlin's ongoing integration into the community. The transition planning was a shared responsibility between the treating clinicians at Mater Hospital until her discharge to the Mood Team

105. Mr Pasienczny stated that Caitlin's psychiatric care was managed by Dr James Noon and Dr Jelesic-Bojicic. Dr Purushothaman subsequently replaced Dr Jelesic-Bojicic. Ms Georgia Watkins-Allen was engaged as a private psychologist extending an existing relationship that continued over transfer from the BAC.

106. Mr Pasienczny stated that in terms of accommodation, at the point of transition, Caitlin was already transitioning from Phoenix House into independent accommodation. This transition had been established by BAC and continued with the support of Ms White until Caitlin moved in with her mother. Ms White continued to monitor her accommodation after transition and provided Caitlin with information and referrals for accommodation options.

107. Mr Pasienczny stated Caitlin continued her education with the BAC school at Yeronga. He understood Caitlin had engaged in some substance abuse and she later reached a determination that her relationship with her partner was abusive. He stated Ms White certainly provided Caitlin with support regarding both these issues, which were able to be resolved. Mr Pasienczny stated Ms White had not raised any issues with him regarding Caitlin.

108. Mr Pasienczny stated that risk management and safety planning for Caitlin was undertaken as an ongoing assessment rather than through a formal plan. Caitlin's particular risk factors and protective factors were identified during the handover meeting on 18 December 2013. A Crisis Intervention Plan was not completed for Caitlin as it was felt she did not meet the criteria for this to be completed to the extent it was unlikely that she would come to the frequent attention of emergency services and her risk was assessed as low.

109. Emma White provided a detailed month-by-month history from January 2014 – August 2014 of the contact she had with Caitlin. Ms White had an undergraduate and master's degree in psychology. Caitlin was her first case dealing with a person under 18. Her employment with the Mood Team was her first employment. She said Caitlin was a complex case.

110. Ms White stated her duties as case manager were to coordinate care across multiple areas including Caitlin's mental health needs and assistance with any

accommodation, employment, schooling, social and other stressors impacting on her mental health. Given clients who have been institutionalised from a young age are often complex cases, Ms White stated she was co-case managing with Nicole Munro, an occupational therapist with the Mood Team.

111. Ms Munro was appointed initially to assist with case management given her experience in Dialectic Behavioural Therapy (DBT). Ms Munro attended the initial case meeting with Caitlin and Ms White on 16 December 2013. They discussed Caitlin's diagnosis of bipolar disorder and her current circumstances including education, employment and accommodation. Caitlin advised she had some education in the practice and the use of DBT and also had exposure to Acceptance and Commitment Therapy (ACT) and Cognitive Behaviour Therapy (CBT). The plan was made to integrate her into their service noting she was leaving for a holiday later in December. Caitlin was advised of the crisis telephone number and an arrangement was made to call her upon her return from holidays on 30 December 2013.

112. Ms Munro attended a stakeholders' meeting on 18 December 2013 with the BAC treating team where a detailed handover of Caitlin's history and treatment was provided. Ms Munro attempted to telephone Caitlin in early January 2014 without success. Ms White was able to speak to her on 8 January 2014. Ms Munro telephoned Caitlin on 13 February 2013 to remind her of an upcoming medical review later that day. Caitlin sounded in good spirits and thanked her for the reminder.

113. Ms Munro stated it became apparent Caitlin did not wish to engage in any DBT treatment with her. Ms Munro was aware Caitlin had attended a course of DBT at BAC and Caitlin had maintained a relationship with her private treating psychologist Ms Georgia Watkins-Allen since her discharge. [13]Caitlin had also developed a good rapport with Ms White and was attending regular case management meetings. Ms Munro ceased being a joint case manager in or around April 2014.

114. Ms White saw Caitlin every week or fortnight as required. At the beginning, Ms White explored with Caitlin the areas of her life she would like to manage better and Caitlin described triggers for anxiety and suicidal thoughts. They discussed Caitlin's experiences at BAC, both positive and negative. They discussed her goals, which were to manage her anxiety more effectively, managing panic attacks, her return to school and the prospect of a part-time job. Ms White stated in her evidence before the Commission that in the first month of treatment she had a conversation with Ms Watkins-Allen relaying some of the issues that were relating to the continuity of care and the Mood Team was happy with that arrangement.

115. Also at this beginning stage, Ms White undertook a mental state examination, noting Caitlin was neatly dressed and well kept. Her mood was euthymic with reactive affect. She made intense eye contact. Her thoughts were goal directed and well sequenced. Her speech was of a normal rate, tone and volume. Her risk level was assessed as low. Ms White's impression was Caitlin was well settled.

116. On 28 January 2014 Caitlin recommenced school at the BAC School at Yeronga. It is apparent at this point in time she attended school reasonably regularly but

[13] Ms Watkins-Allen was the psychologist who brought Caitlin through the course of DBT at BAC. When Ms Watkins-Allen left BAC in 2013 Caitlin continued in a therapeutic relationship with her on a private consultation basis through 2013 and 2014.

often was late and sometimes did not engage. Ms White conducted a mental state examination. Caitlin was orientated to time, place and person, her thoughts were well ordered, but her thought flow was disrupted when discussing early traumatic memories. Her mood was euthymic, there was a normal range of affect with some flatness of affect and her speech was normal in tone, rate and volume. Ms White considered she was of low risk. Caitlin agreed to fortnightly case management meetings.

117. A similar mental state examination was conducted in February 2014. By 25 February Caitlin was expressing a desire to leave Phoenix House and move to Hervey Bay to live with her boyfriend. Ms White stated in evidence this was the first time she had documented any difficulties. Ms White said Caitlin was happy to be moving out of Phoenix House as she had outgrown it. Caitlin was encouraged not to make a rushed decision. Her mental state examination indicated a mixed anxious and depressed mood state.

118. In March 2014, Ms White stated Caitlin was back home living with her mother. On 6 March she attended an appointment where Caitlin appeared in a labile mood, which ranged from sad and angry to hyperthymic. Caitlin was dressed in eccentric clothing and wearing heavy eye makeup. She laughed inappropriately at times and her affect was congruent to the seriousness of the situation she was describing. She described herself as a 'whore' and a highly sexualised person. She demonstrated fluctuating insight with some awareness that her decisions had rapidly changed and she was reflective about the factors contributing to her current distress. She exhibited poor judgement (drug use and impulsive sexual behaviour). Ms White's impression was Caitlin was experiencing a dysregulated mood, possibly due to the stress of living with her mother and the impending movement of a family member coming to live with them as well. Financial stressors were also impacting on her.

119. It was agreed the treatment plan would continue with meetings either weekly or fortnightly as required and a follow up would be arranged with her GP in relation to a pregnancy test. Work was being made on an application for a disability support pension, and Ms White plan was to continue to take steps to consider alternate accommodation options for her.

120. By early April 2014, Caitlin was distressed having heard about Talieha's death. On 3 April Caitlin attended an appointment with Ms White where she described being also distressed about having used drugs with her boyfriend after which she had blacked out for a 6 hour period. She was concerned that something had happened to her. She had no suicidal ideation. Her speech was rapid but interruptible; her mood was euthymic. Her affect was bright, reactive and dramatic. Ms White assessed her vulnerability risk as moderate to high based on the fact she was reporting placing herself in risky situations with others and through engaging in substance abuse, which impaired her ability to make good decisions. Ms White stated she gave Caitlin counselling and validated her responses. One protective factor identified was her engagement with Ms White and also her relationship with her mother which, whilst at times was stressful, was a constant in her life.

121. Ms White's impression was Caitlin was being impacted by being in a period of transition between services, between accommodation and developmentally, but her risk taking behaviour, difficulties in regulating her mood and difficulty in relationships may reflect personality vulnerabilities or ways to manage trauma from the past. All of this needed to be assessed in an ongoing way.

122. Ms White's plan was to continue building rapport with her and continue to monitor her risks and mental state, with regular meetings each week or fortnight rather than intervention consisting of 'crisis' presentations.

123. On 14 April 2014 there was a report of a Domestic Violence incident involving her boyfriend and this had ended the relationship. The police were involved and a DV order was taken out.

124. A further review with Ms White took place on 17 April 2014. Caitlin's thought processes were frequently disassociated but there was no suicidal ideation. Although Caitlin felt safe, being with her mother was triggering flashbacks of her trauma and dissociation. The plan was to sort out alternative accommodation and apply for the Disability Support Pension.

125. On 24 April 2014 Ms White had a telephone conversation with Caitlin's mother Justine Wilkinson. Ms White explained the limits of confidentiality given Caitlin had specifically requested they not speak to her mother about personal issues. Ms Wilkinson was concerned Caitlin was not coping with living with her and said Caitlin seemed to function better when she was living independently. Her mother was also concerned about Caitlin's increased use of substances and spending time with persons who were a negative influence. Ms White told Ms Wilkinson she would encourage Caitlin to speak openly with her mother about her accommodation options and any plans for change.

126. In her evidence before the Commission Ms White was asked whether she thought that it was desirable that Caitlin's mother was informed about treatment. Ms White stated in most situations it is desirable for the parents to be involved in that way. At that point in the transition, it was at the request of Caitlin that the treating team did not speak with her mother about her care. Although Ms White said it may have been desirable to share information, Ms White chose to respect this wish in the interests of rapport and rapport building and given there were no emergent risks at the time. Ms White was concerned that if she did divulge information against Caitlin's wishes this would have damaged the prospect of a good rapport.

127. By 30 April 2014, alternative housing options were still being sought and it is evident Ms White was undertaking many strategies and tasks to get the process moving. Caitlin still had ongoing suicidal ideation but no intent or plan, and she appeared to be future focused. She was very guarded when discussing the situation at home with her mother. Ms White considered Caitlin was a moderate risk of suicide and Caitlin was encouraged to make contact if she was feeling unsafe or if any suicidal thoughts escalated. She had good future orientation and was well engaged with the service. Ms White's statement and clinical notes noted the recent suicide of Talieha may have increased her suicidal ideation, although in evidence before the inquest Ms White stated this may be speculation on her part.

128. On 6 May 2014 Ms White made contact with Caitlin due to it being recorded that Caitlin had been assessed in the Emergency Department (ED) the previous night. It seemed the previous evening Caitlin had phoned the 1300 number and asked for Ms White. Caitlin stated she was having a panic attack and was afraid. She denied drug use and that she was suicidal or unsafe but repeated she wanted help. She said her mother was not responding to her calls. When Caitlin was asked to give her location, she terminated the phone call. After several attempts to contact her again, arrangements were made to collect her at Mt Cootha and she was brought to the ED.

129. On assessment at the ED, Caitlin denied psychotic symptoms, hallucinations and ideas of reference. She denied thoughts of harm to herself or others. She denied elevated/irritable mood, changes in energy, concentration and disinhibition. Caitlin was not considered to be suicidal, had no delusions or compulsions and her insight and her judgement was fair. She was discharged into the care of her mother.

130. When Ms White assessed Caitlin the next day, 7 May 2013, she noted Caitlin to be objectively sad and depressed, she was speaking in a child-like voice and she would laugh at inappropriate times. She cried when speaking about being left with nobody to pick her up. She was dissociated throughout the appointment and found it difficult to answer questions. Ms White's impression was her mood and mental state had deteriorated in the context of the trigger of living with her mother, ending a three year relationship with her boyfriend and stopping her medications. Caitlin said she felt safe at home but was not happy there. She said a family member had moved back into home and Ms White thought this may be a possible trigger for her current mood and perceptual disturbance. Ms White agreed to meet Caitlin the next day to arrange documentation for her housing application and Disability Support Pension. Ms White made contact in relation to accommodation needs with the Brisbane Homelessness Service Centre, Brisbane Youth Service, and transitional housing.

131. On 8 May 2014 they completed a Department of Housing application. Caitlin stated her home environment had become intolerable and she had not been taking her current medication. Ms White encouraged her to stick to her current treatment and not change anything until her next psychiatric review. Caitlin stated she would not accept that advice. Caitlin gave consent for Ms White to speak to her mother concerning giving her some personal space. Ms White made that call on 12 May 2014. Ms Wilkinson stated this was an ongoing issue with Caitlin and for Caitlin no amount of personal space would be enough. At the request of Ms Wilkinson, Ms White gave her contacts for two parenting support organisations that may be able to assist.

132. On 14 May Ms White took Caitlin to the Department of Housing, Centre Link and short-term housing organisations in an endeavour to find alternative accommodation for her. On 21 May Ms White attended with Caitlin at a transitional housing appointment and attended Centre Link.

133. By the end of May 2013, Ms White assessed Caitlin as appearing markedly different to her usual well-groomed self. She was wearing casual clothes, her hair was unbrushed and she was not wearing makeup. She did not speak at all during the assessment on 28 May 2013 but instead wrote notes. She described her mood as "not feeling" and she appeared depressed. She made limited eye contact. She indicated that 'she did not want to die'.

134. On 6 June 2014, Caitlin was brought in to the clinic by a teacher at the Barrett School who was concerned she was becoming generally more erratic. She was assessed by Ms Munro who was on duty at the time. Ms Munro took a history from Caitlin who told her she had been feeling frustrated with her mother's recent behaviour and her current accommodation arrangements. The mother's behaviour was associated with the fact her mother had been seeing someone in a relationship and it seems Caitlin did not like this. Caitlin reported episodes of disassociation most days, which she was managing herself with various techniques such as maintaining routine, contacting friends via social media and listening to music.

135. Caitlin denied any current suicidal ideation or plans and declined the option of a brief admission to hospital as Caitlin felt this might trigger her and increase suicidal ideation. Ms Munro discussed strategies to help her with her emotions and she spoke of a plan of social activities over the weekend she was looking forward to. It was noted Caitlin had an appointment with Ms White the following Tuesday to discuss accommodation options. Ms Munro noted Caitlin had responded well to the discussion, was engaged, had maintained good eye contact and was oriented to date space and place and was future focused. Ms Munro did not consider there was a change to Caitlin's mood from her previous interactions with Caitlin and she did not display any symptoms of pervasive mood disturbance. Ms Munro considered Caitlin was struggling with psycho-social stressors and she responded well to validation of her emotions and promptings of strategies to assist with problem management.

136. By 10 June 2014, it was known to the Mood Team and Ms White that Caitlin had stopped taking her Lithium and Escitalopram one month earlier and was only taking Seroquel. Housing options were still being explored for Caitlin. Her schooling options were looking good, and she was to start at the Albert Park Flexi School in Milton the next month.

137. On 18 June 2014, Caitlin stated to Ms White she had recommenced escitalopram three days previously as she realised her mood was deteriorating. She was now on a disability support pension. Caitlin and Ms White again explored housing options. Caitlin felt that she had complex PTSD, which she thought seemed to fit her experience. Ms White validated these thoughts. More housing forms were completed. Caitlin expressed sadness about the situation with her mother and felt sorry for her. Ms White thought that it clear Caitlin was on some level identifying with her mother.

138. By the end of June 2014, Ms White thought Caitlin's mood was labile and she was depressed when talking about her mental illness and what she has missed out on in adolescence. She was noted to be euthymic when discussing her future. Her affect was tearful, her thoughts were well formulated and articulated. Caitlin stated she had recommenced escitalopram.

139. On 1 July 2014, Ms White had a lengthy conversation with Georgia Watkins-Allen, Caitlin's private psychologist. Ms White advised Ms Watkins-Allen that Caitlin was doubtful about her diagnosis of bipolar disorder and thought it may have been complex PTSD. Ms Watkins-Allen indicated she felt there was a trauma basis to Caitlin's presentation and that her experiences in her childhood, possibly involving a family member, may have been the basis of this trauma, however Caitlin had never discussed anything specifically. They discussed Caitlin's schemas. Caitlin's social isolation made it difficult for Caitlin to engage with her peers. With respect to triggers Ms Watkins-Allen indicated that being around her mother often triggered a defensive anger in Caitlin, which manifested in rude and unpleasant behaviour.

140. On 2 July 2014, Caitlin attended the clinic for a further case management meeting with Ms White. Caitlin was still living with her mother but was now receiving the disability support pension and was starting to think about accommodation options. She reported a low mood with suicidal ideation with no intent. Caitlin indicated that thinking about her current situation and quality of life made her feel depressed.

141. On 15 July 2014, Ms White undertook a home visit. On mental state examination Caitlin was depressed and tearful throughout. She reported suicidal ideation but had no plan. Her schooling situation was discussed and she felt hopeless about

being able to start at a new school. Ms White explained the school is flexible and it would not be a major concern if she was unable to start on the scheduled day. Caitlin was not open to reintroducing lithium, but was open to increasing her escitalopram and agreed to see her psychiatrist for that purpose.

142. Ms White's last face-to-face assessment of Caitlin was on 24 July 2014 before she met with Dr Purushotaman. She was quiet and non-communicative and said she did not feel like talking. When asked if there was anything contributing to her low mood Caitlin said the school transition was making her feel stressed as she thought she was not well enough to attend a new school. She said she was willing to increase her anti-depressants to assist with the transition and her overall functioning, which was seen as a positive sign to Ms White.

143. On 29 July 2013, Caitlin informed Ms White that she was physically unwell with the flu and was unable to make their meeting. Ms White assessed her risk as low at that time as Caitlin denied any suicidal ideation. The meeting was rescheduled for 31 July, but Caitlin also cancelled this. She said she was still not physically well, but she was happy to talk to Ms White over the telephone. Caitlin indicated she was still depressed in her mood but denied suicidal ideation or plan.

144. Ms White explored with Caitlin what might be triggers behind her low mood. Caitlin was unclear in this respect, but it was clear to Ms White the transition to the Albert Park School was a stressor, and Ms White reinforced the importance of a gradual transition to school and if Caitlin was not ready to start, the school was flexible around commencement dates. Caitlin confirmed she had started taking Escitalopram at the increased dose of 40mg. Ms White stated this showed Caitlin had some insight into her condition. Ms White made an appointment to see Caitlin next on 5 August 2014 at 3pm.

145. Ms White stated housing was a focus of treatment within the Mood Team. Caitlin had accommodation at Phoenix House. This ended in March 2014 due to concerns from Caitlin regarding another person who came into the property who she felt threatened by. Caitlin made the decision to move into her mother's house, which was not an ideal living space for her. Efforts were made to have her referred to other housing services and she was assisted with completing Department of Housing and other social housing applications. Respite accommodation options had been offered, which Caitlin did not take up. Caitlin was also assisted through obtaining regular payments through Centrelink to enable her to become financially more independent and secure.

146. Education was an additional focus of treatment and Caitlin was encouraged to continue her education at the Barrett School at Yeronga with the aim of finishing her Access 10. Caitlin was considering transferring from the Barrett School to Albert Park Flexi School and she was encouraged to transition across to the school. Ms White was in regular contact with Caitlin's teachers.

147. Caitlin had not provided Ms White with consent to disclose any information about her treatment to her mother. Accordingly there were constraints on the extent to which she could discuss Caitlin's condition, however Caitlin was aware Ms White would contact her mother if she had concerns she may be at an elevated risk.

148. In her evidence, Ms White stated she considered the accommodation difficulties were a significant stressor as after independent housing broke down Caitlin had

moved back with her mother. When Caitlin was more engaged this was also much better. By July 2014, Caitlin was more disengaged and a bout of flu and consequent physical illness would not have helped matters and would have lowered her mood.

149. In her statement, Ms White had noted that throughout her interaction with Caitlin she had symptoms of anxiety and depression, which symptoms fluctuated, sometimes in response to triggering events and on other occasions due to anxiety around transitions including accommodation issues. She also noted there were marked attachment difficulties existing between Caitlin and her family with particular reference to a history of having been physically attacked by a family member and issues with her mother. She stated that although Caitlin experienced suicidal thoughts she never reported active suicidality. She had a fluctuating mood, with periods of low mood followed by improvement. The period of time when she became non-compliant with medications were the most worrying periods where she became more depressed and expressed increased hopelessness. However Caitlin remained engaged in case management and did recommence her antidepressant medication which Ms White considered showed insight into her mental state and the benefit of antidepressants.

150. Throughout January 2014 to August 2014, Caitlin was also seen regularly by a psychiatrist, psychiatric registrar, and occupational therapist. Previously she had been seen by Dr Jelesic-Bojicic and other clinicians until June 2014. The medical notes confirm that on 27 May 2014 Caitlin questioned with Dr Jelesic-Bojicic the diagnosis of Bipolar Disorder and the need for lithium as she did not believe she had ever experienced mania. Caitlin had stopped lithium it would seem some months previously as indicated to Ms White.

151. Dr Purushothaman provides a very detailed overview of Caitlin's care at BAC, and also her care through the Mood Team. His statement is largely reflective of Ms White's evidence. It is clear the person from the Mood Team with the most contact with Caitlin was Ms White.

152. Dr Purushothaman only formally saw Caitlin on two occasions on 10 June and 24 July 2014. At the 10 June appointment Caitlin stated she had stopped taking her antidepressant (escitalopram), antipsychotic (quetiapine) and mood stabiliser (lithium) medication one month previously. Caitlin denied having any suicidal thoughts. She was goal oriented and identified her main goals were getting her pension and moving out of her mother's house to live independently. She confirmed she was happy to continue to see Ms White and her private psychologist, Ms Watkins-Allen.

153. Dr Purushothaman thought Caitlin's insight was present but limited, indicated by the fact she had stopped taking medications but recognised what would be the symptoms indicating a change in her condition. Caitlin agreed to let them know if she would like to go back on her antidepressant medication and appeared keen to continue to follow up.

154. Dr Purushothaman was asked about the significance of the need to take lithium. He stated the mental health diagnosis was an evolving one. There were mood swings but Caitlin was engaging with the treating team and taking Seroquel and he did not feel the need to put her under an involuntary treatment under the Mental Health Act at that time. He considered he needed to build rapport with her and there was a balance to be found between the two. Her affect was restricted but the

mood was stable and there was no suicidal ideation being expressed. Dr Purushothaman stated in evidence he was not convinced Caitlin needed lithium.

155. At the second appointment on 24 July 2014 Dr Purushothaman understood Caitlin had sought an appointment because she wanted to increase her medications, particularly escitalopram. Against a background of previously ceasing medications against advice and being encouraged to recommence them, this was considered by Dr Purushothaman to be a positive sign because it showed Caitlin had insight into the fact her condition required treatment and because it showed a willingness to seek help.

156. On mental state examination Caitlin answered questions in mainly short sentences, which Dr Purushothaman identified as a sign of increased depression but Caitlin denied having any suicidal thoughts/intent/plan. She had recommenced escitalopram as well as quetiapine and was requesting an increase in the dose of escitalopram. Dr Purushothaman considered this to be a reasonable request although it was a relatively high dose. Her outward appearance contraindicated a deterioration in her condition and she was well dressed and her personal hygiene was excellent. Caitlin denied having any suicidal thoughts and agreed to ask for help if she did so.

157. Dr Purushothaman confirms in his statement Caitlin remained a voluntary patient throughout time with the Mood Team and despite her periods of on-compliance with medications, there were no grounds to treat her under the provisions of the *Mental Health Act 2000*. Dr Purushothaman confirms Caitlin would restart medications as discussed with her treating team and she had good rapport with Ms White and her private psychologist Dr Watkins-Allen.

158. Dr Purushothaman reiterated in evidence Caitlin's diagnosis was an evolving one. He stated a review of the records does not change his opinion regarding the issue of continuing with lithium. Lithium is used as a mood stabiliser in those affected by bipolar affective disorder. This involves periods of mania or hyper manic behaviour and Caitlin's history did not reflect any particularly manic episodes. Dr Purushothaman stated there was evidence of mood lability and suicidal ideation but he was not convinced she had bipolar, although he was aware there was a history set out in the records of her improving on lithium.. He stated in evidence he identified her diagnosis may be more PTSD or personality disorder. Those with PTSD can also have chronic low mood and it can be difficult to differentiate between depression and PTSD.

159. Dr Purushothaman stated Caitlin had future goals and appropriately sought help when she was in distress. Notwithstanding the stressors impacting on her at the time leading up to her death, Caitlin was willing to take medication to reduce her risk, had received the disability support pension, which would give her some financial dependence, and was working with the team on the accommodation issue. Although there was always a risk of a suicide attempt having regard to her history, the information available was relatively reassuring in relation to risk. Her death was unexpected to the entire treating team.

160. Dr Purushothaman provides an opinion the only step that might have avoided the outcome would have been to have Caitlin admitted to the inpatient mental health unit. Caitlin could only be admitted as an involuntary patient if she fulfilled criteria for an ITO. This would have been difficult to fulfil, given Caitlin always denied suicidal ideation when seen by Dr Purushothaman.

161. As to the possibility of Caitlin being admitted to the inpatient MHU on a voluntary basis, Dr Purushothaman confirms Caitlin declined a recommendation for this to occur on 6 June. When Dr Purushothaman saw Caitlin, he had to weigh up whether (even if Caitlin could be persuaded to be admitted), this would improve or harm her mental health. Dr Purushothaman felt the balance favoured continuing Caitlin's treatment in the community with close contact with the Mood Team.

Treatment by Georgia Watkins-Allen

162. Ms Georgia Watkins-Allen is a psychologist who knew Caitlin from 2011 as Ms Watkins-Allen was working at the BAC.

163. Ms Watkins-Allen described Caitlin as a striking young woman visually who had a contained presence and was engaged and aware and wanted to actively involve herself and work through her problems at BAC. Ms Watkins-Allen was aware of the complex history and described some of the protective strategies and programs used. BAC patients were required to participate in Dialectical Behaviour Therapy (DBT) and Caitlin would have participated in two programs of DBT. Ms Watkins-Allen provided an overview of the principles behind DBT. Each of the four skills of Mindfulness, Distress Tolerance, Emotional Regulation and Interpersonal Affect were discussed in each school term.

164. Ms Watkins-Allen left the BAC in April/May 2013 but continued to see Caitlin in a private capacity. Caitlin came and saw her a few months later with a completed Mental Health Plan referral to obtain Medicare support. She was happy to continue to provide therapy to Caitlin.

165. Ms Watkins-Allen was aware of the move from BAC and the involvement of Ms White at the PAH Mood Team and she did share and hand over information to Ms White. Caitlin was actively engaged in the whole therapy relationship including the Mood Team and herself.

166. Ms Watkins-Allen stated she was not contacted directly by the transition care team at the BAC about the transition of her clients including Caitlin and William Fowell. Before she left the BAC and when she called in as a private clinician she identified a series of concerns for all of the BAC adolescents being transitioned and she did not believe there was anywhere that would adequately meet their complex and severe mental health needs at the stage of the development and treatment. Specifically in relation to Caitlin she stated Caitlin was already starting to transition into community housing while likely being maintained as a day patient at BAC. While this was in line with her treatment plan, this adjustment process is typically a tricky one and Ms Watkins-Allen remembers expressing serious concerns and having clinical discussions about the lack of fall back options should the process not go well, especially if BAC was closed and then in that realisation once it was confirmed. Caitlin's mental illness made her vulnerable and she needed an appropriate treatment team to support her long-term

167. Ms Watkins-Allen was aware Caitlin had not taken up the offer of PAH to participate in DBT. It had been a program Caitlin had been involved in on two occasions and she continued to follow up on the skills learnt in DBT with Caitlin. It was not imperative Caitlin took on DBT at PAH.

168. Ms Watkins-Allen stated they had started on doing Schema Therapy, which she described as the second wave of Cognitive Behaviour Therapy (CBT). Schema

therapy would have assisted Caitlin in dealing with her feelings of worthlessness and low self-esteem.

169. Ms Watkins-Allen described Caitlin had developed well in her time at the BAC. There had been huge personal growth. In relation to any impact on Caitlin with the closure of BAC she said the end of any support can be a difficult process and the BAC closure process was difficult in itself. However, Caitlin was at a point of transitioning out anyway.

170. Ms Watkins-Allen stated she had discussed with Caitlin the deaths of the other two BAC patients but did not consider there was any particular strong impact on Caitlin.

171. In a report to Caitlin's GP Dr Byth on 4 July 2014, Ms Watkins-Allen noted she had seen Caitlin on 10 occasions and had taken a combined CBT, ACT, DBT and IT approach to the treatment of her fluctuating depression on the background of a bipolar diagnosis and within the context of transitioning from the BAC, with a chronic history of severe social anxiety and lethal deliberate self-harm attempts in the past. Of more recent concern had been generalised stress having to move home in addition to adjusting to the suicide death of two BAC peers. She provided grief and loss education and support in response to this in her last session. Prior to that the treatment focus had primarily been around anxiety adjusting following the closure of BAC with ongoing education and distress tolerance and emotion regulation strategies reviewed and built on. The report to Dr Byth noted historically Caitlin has significant difficulty with major change and establishing relationships due to the noted attachment issues, which can trigger avoidance coping due to the activation of difficult schema belief systems.

172. Ms Watkins-Allen reported she also utilised mindfulness practice with strength focus on effective problem-solving to minimise avoidant coping, which only works to maintain anxiety in the long-term and thus low mood as a flow on effect. She stated Caitlin appeared to oscillate between remarkable progress and major difficulty dealing with everyday tasks and stressors due to her anxiety, which impacts on her mood, with relationship issues being her primary trigger that activates her difficult schemas. She stated while Caitlin continued to struggle with chronic variable levels of suicidal ideation she reports not actively wanting to die, being able to mindfully appreciate many aspects of life, yet can become very despondent about her long-term coping and quality of life. Ms Watkins-Allen encouraged Caitlin to consult with her GP and discuss a potential re-referral for an additional block of psychology consultations in 2014 to build on her skills and help her progress through this next transition in life.

173. Caitlin had sent Ms Watkins-Allen a lengthy email on 30 March 2014. Ms Watkins-Allen stated Caitlin had a process of writing and she took from the email that Caitlin was proud of herself and was seeking her assistance and wanting to continue to work to progress for herself. There were a number of what appears to have been concerning issues including a feeling of lack of respect and feeling isolated and being ostracised. Caitlin also referred to a recent sexual incident, which she described with shame and self-hatred. Ms Watkins-Allen stated that although Caitlin saw this as a bad incident it was also a moment where she was able to identify this as being against how she would want to be in the future and therefore there was an element of growth in what she was saying.

174. A second email sent the same day also referred to Caitlin arguing the diagnosis of bipolar disorder was not an accurate description of her condition and she

suggested emotional dysregulation was more accurate. Ms Watkins-Allen stated the issue of diagnosis was complex and a diagnosis made in adolescence may not hold out in the older age. She stated the question of diagnosis can be a development issue and it may be there is an element of bipolar disorder but there could be a number of other things going on. She stated the jury was still out as to whether or not Caitlin had bipolar disorder.

175. Ms Watkins-Allen was aware Caitlin had stopped taking lithium, but she was aware Caitlin was seeing her case manager weekly and had access to psychiatric opinion. She considered that Caitlin had insight in relation to benefits of the medication and she had recognised that coming off escitalopram had lowered her mood.

176. At the last appointment on 1 July 2014, Ms Watkins-Allen noted the history of ceasing antidepressants due to costs and Caitlin was feeling depressed with some suicidal ideation but no intent. Overall Caitlin's mood was different but Ms Watkins-Allen was able to have a number of discussions with her and she was engaging with the treating team. There were no classic indicators Caitlin was appearing very depressed or very unwell.

Treatment by Dr Susan Byth

177. Dr Byth was practicing at UQ Health Care Annerley. Dr Byth recalls in or about the mid to late 2013, Dr Brennan asked her whether she was prepared to see a BAC patient, Caitlin Whitaker as her GP. Dr Byth recalls Dr Brennan saying Caitlin would be living in the vicinity of her practice and she would require a GP to look after her physical health needs. Dr Byth otherwise understood Caitlin would be managed by the mental health team at PAH. Dr Byth stated she had no further discussions with Dr Brennan or anyone at PAH as to defining her role with respect to the prescribing of medication. Dr Byth stated she had no previous experience in dealing with a complex adolescent such as Caitlin.

178. On 13 November 2013, a referral letter from BAC through Dr T Pettet, a psychiatric registrar, was sent to Dr Byth. This set out briefly the diagnosis, and current medications. The letter stated Caitlin continued to be a low to moderate risk of further self-harm/suicide. The letter suggested Caitlin would require ongoing follow-up of her mental state and three monthly monitoring of her lithium blood level and renal/liver function tests. It was noted Caitlin experienced suspected lithium toxicity in October 2013. Dr Byth also received a detailed medical discharge from Mater Children's Hospital.

179. Dr Byth acknowledged the referral letter suggested she was to monitor and stabilise her lithium level and she did get a level tested but said it was not her understanding she was looking after her mental health other than as a GP, where she would take note of her mental state when Caitlin saw her.

180. Dr Byth recalls she told her staff Caitlin was a fragile patient, at risk of self-harm and Caitlin was to be given an appointment as soon as possible should she request one. Dr Byth saw Caitlin first on 14 November 2013 and subsequently on 23 January 2014, 3 April 2014 and 20 June 2014.

181. At the first consultation on 14 November 2013, Dr Byth recorded the diagnosis of bipolar disorder, that Caitlin had been living at the BAC until three months ago and was now living in supported accommodation at Phoenix House. Caitlin advised she was in the mood stream at PAH and was seeing a private psychologist. She was

continuing to attend the BAC school. During the consultation she requested Caitlin fill out the Kessler Psychological Distress Scale and Caitlin scored 27, consistent with a moderate mental disorder. Dr Byth was not overly concerned about this knowing Caitlin was about to commence treatment with a specialist mood team at the PAH.

182. Dr Byth then provided Caitlin prescriptions for her medications and requested these be placed in a Webster pack. Dr Byth told the court she was surprised at how well Caitlin presented and her mental state appeared normal. She changed the lithium medication as requested to 450mg slow release once a day. Seroquel was also supplied PRN (on an as needs basis). Although Seroquel is used as an antipsychotic it also can be used at night as a sedative.

183. Dr Byth stated she spent some considerable time impressing on Caitlin how important it was that she take her medication, particularly the lithium as recommended. Dr Byth told the court that she understood this was an interim action as Caitlin was still to be transitioned to the PAH Mood team who would then undertake that role. Dr Byth said she was primarily looking after Caitlin's physical needs.

184. Dr Byth conceded the referral letter seemed to suggest she was to manage and look after the lithium levels but believed that was up to the time when PAH Mood Team took over the mental health needs.

185. Dr Byth was later copied into a more detailed letter from Dr Pettet dated 21 November 2013, which had also been sent to the PAH Mood Team.

186. On 27 November 2013, Dr Byth received an email from Dr Brennan advising Caitlin had been admitted to Mater Children's Hospital with worsening depression and suicidal ideation. Dr Byth did not receive notice of her being discharged on 12 December 2013 although she did receive an amended medical discharge summary on 5 February 2014.

187. At the next appointment on 23 January 2014, Dr Byth was again surprised at how well Caitlin presented. Caitlin complained of fatigue and sleeping a lot and Dr Byth undertook a physical examination and she suggested they check her iron levels as well as her thyroid hormones and a full blood count. Dr Byth also discussed her diet and medications and that Seroquel was a PRN and should not be put in the Webster Pack for daily use.

188. The pathology results came back as normal with the exception that Caitlin was noted to have some thrush and her iron stores were low. The lithium score was in the normal range although Dr Byth understood Caitlin did better at higher levels and she copied this to her psychiatrist at PAH.

189. On 24 March 2014, Dr Byth received an email from Emma White to the effect Caitlin had raised the concern about the possibility she might be pregnant. Caitlin attended on 3 April 2014 at which time Caitlin advised she had her menstrual period and was therefore not pregnant. A request was made for an STD check and Dr Byth had a lengthy discussion about alcohol, drugs and unprotected sex. Dr Byth completed a Mental Health Care Plan so Caitlin could access her private psychologist through Medicare benefits. She completed the Kessler questionnaire and Caitlin's score indicated a moderate mental disorder. Dr Byth was not

concerned with this result given she was consulting with her psychiatrist and was in regular contact with her case manager.

190. Caitlin next attended on 20 June 2014, and her impression was Caitlin was fairly stable. Caitlin told her the PAH team had told her to stop taking lithium two months previously, that Seroquel had been ceased and Lexapro increased. Caitlin said she felt better and was not more depressed and less tired. Dr Byth was concerned she had not been informed by PAH of the medication change. Dr Byth did not check the accuracy of the statement as Caitlin seemed fine. Dr Byth was unaware Caitlin was at this time living with her mother.

191. Dr Byth stated she saw Caitlin on a total of four occasions. During the course of the treating relationship Dr Byth did not receive any formal correspondence from the treating mental health team other than the discharge summary from the Mater and therefore she has limited insight into the treatment and monitoring arrangements put in place by them. That said, based on Caitlin's presentations to her and her advice, Dr Byth understood Caitlin was receiving fairly intensive mental health intervention from the PAH while still maintaining a treating relationship with her private psychologist. Dr Byth stated if she had a concern about Caitlin's mental state she would have referred her to the PAH or emergency department.

Issue 2 - Immediate circumstances leading up to Caitlin's death

192. Caitlin was living with her mother Justine Wilkinson and a family member in the immediate time leading up to her death. She had previously lived at Phoenix House but that had ended in March 2014. Caitlin then moved into a shared unit with another teenager from Phoenix House. This arrangement did not last long.

193. Ms Wilkinson said in her evidence Caitlin was excited and happy about her moves to Phoenix House and then to other accommodation sourced through the SWISH program. Caitlin expressed in her diary/journal she was happy she was leaving BAC to be at Phoenix House.

194. On 19 March 2014, Caitlin came to live with her mother. This occurred because Caitlin had become paranoid about one of the young women she was sharing with. She also wanted to go to Hervey Bay where her boyfriend's family were. In the end she moved in with her mother as it seems this was the only place to go.

195. Caitlin's mother found out around this time Caitlin had run out of medication and had been off her medications for about a month. Ms Wilkinson said Caitlin had not been managing her money well at this time. Ms Wilkinson considered in that time period Caitlin's mental state had declined significantly. Ms Wilkinson then bought her medications in Webster Pack form.

196. Ms Wilkinson was aware Caitlin was still working with her case manager, Emma White to get other accommodation, and various applications had been filed with the Department of Housing and other agencies.

197. Ms Wilkinson stated at first the living arrangements were going well but then Caitlin started to impose her will on some of the arrangements and it was clear to Ms Wilkinson that Caitlin needed her own place. Ms Wilkinson stated Caitlin's health continued to steadily decline. Ms Wilkinson endeavoured to be updated by Emma White on the treatment but this was difficult because Caitlin had requested Ms White not provide any information as to her condition or care to her mother. She is

aware Ms White considered she was bound by patient confidentiality to not provide information unless there was an emergent risk.

198. Ms Wilkinson stated because of this she was not aware of how much Ms White did to try and find accommodation but she understood it was hard generally to find youth accommodation.

199. In April 2014 Caitlin split from her long-term boyfriend after an act of domestic violence. Ms Wilkinson believes Caitlin was offered medications, again with full knowledge of her case manager Emma White, to establish a baseline for her moods and mental health.

200. Caitlin then became aware another patient at BAC Talieha Nebauer had taken her own life. Ms Wilkinson said Caitlin appeared to be very angry with Talieha. Ms Wilkinson said Caitlin was partly angry because Talieha was being eulogised by people who knew her despite Caitlin thinking Talieha was not very nice.

201. On 10 June 2014, a friend of Caitlin's from the BAC, William Fowell, also took his own life. Ms Wilkinson stated Caitlin did not react to his death as badly but Caitlin was not talking to her a lot at this time and did not confide in her as much.

202. Caitlin's long-term psychologist, Ms Watkins-Allen told the court Caitlin was sad about the deaths and had compassion about the individuals but they were not strong relationships and she did not think these events had a bearing on Caitlin's decision to end her life.

203. In July 2014, Caitlin had ceased taking her anti-depressant medication, but did re-commence taking them eventually. Even though Caitlin appeared to her treating team as being more depressed, she was receptive to her need of anti-depressant medication and showed insight into her mental state.

204. Ms Wilkinson also believes Caitlin was experimenting with drugs. Caitlin told her she was still seeing a friend of hers known as "AJ" who was providing her with marijuana.

205. In this period Caitlin's family member was attending at the house on a regular basis. Ms Wilkinson stated at one stage police were called to the house on an occasion when her son had come over for dinner. She said Caitlin and the other family member did not get on. Caitlin became very anxious with him in the house.

206. Two weeks leading up to her death Caitlin caught the flu. She refused to go to the doctors or take any flu medication or pain killers.

207. On 25 July, the family member's rental accommodation burned down. Ms Wilkinson stated he had nowhere else to go so he moved into Ms Wilkinson's house in the front room. This room was right next to Caitlin's bedroom. Caitlin was told the move would only be temporary. Ms Wilkinson was faced with a difficult dilemma.

208. Ms Wilkinson said Caitlin became more reclusive in the house and was sending her text messages saying she did not feel comfortable being alone with her family member.

209. On 26 July, Caitlin sent Ms Wilkinson a text stating *"do you know if there is a second-hand donation bin around here and where?"* Caitlin had started to pack her clothing in plastic bags. Ms Wilkinson believes in hindsight at this point Caitlin was preparing to commit suicide.

210. On 28 July, Caitlin sent her a text which read – "*please encourage him to find a new place as quickly as possible. You will invalidate and trivialise this but my mental state is going to rapidly decline with him here."*

211. On 3 August, Ms Wilkinson noted Caitlin had got up and went out without any assistance. She was not gone long but Ms Wilkinson thinks now she went to buy high proof vodka.

212. Caitlin was also sleeping a lot at this time, which Ms Wilkinson stated was an indication of bad mental health for her. She was not eating any meals.

213. On 4 August, Ms Wilkinson was worried about Caitlin and checked on her before she left for work. Caitlin was very sleepy and would not answer. When she came home that night Ms Wilkinson cooked for Caitlin who still would not eat. Caitlin would not come out of her room.

214. On the morning of 5 August Ms Wilkinson saw Caitlin before going to work. Caitlin was lying in bed. Ms Wilkinson asked Caitlin how she was feeling and she said she was okay. She grunted when Ms Wilkinson asked if she was going to school that day. Prior to leaving to go to work Ms Wilkinson commented to Caitlin about how tidy her room was. Everything was placed in bags or boxes and her floor was clear. Normally there was stuff everywhere on the floor. Ms Wilkinson thought at the time this was a good sign but in hindsight considers it was Caitlin preparing to commit suicide Ms Wilkinson said in her evidence that in retrospect she had missed the signs including that Caitlin had transferred the last of her money to Ms Wilkinson's account.

215. On the way to work Ms Wilkinson rang Emma White expressing her concerns. Ms Wilkinson said Caitlin was sleeping a lot. She expressed concern about Caitlin's low mood and poor attendance at school. Ms White said she would be seeing Caitlin later that day and the plan was to review her mental state and submit some forms to the Department of Housing. Ms White says she discussed with Ms Wilkinson about the various stressors in Caitlin's life, namely the transition to school and also the living arrangements with her and Caitlin's family.

216. Ms White told Ms Wilkinson later she had left messages and texts with Caitlin and received no response.

217. On the afternoon of 5 August 2014, Caitlin's relative returned home from work to find her deceased. At 1:45pm that afternoon, Ms White received a phone call from Ms Wilkinson informing her that Caitlin had been found at home deceased.

218. Queensland Police told Ms Wilkinson that Caitlin's diaries were in the wheelie bin out the front. Ms Wilkinson has looked at a couple of these after her death and has found them hard to read because of the handwriting and the emotional content.

219. Over the next couple weeks, with the help of friends she found Caitlin's sim card to her mobile phone had been cut up. Ms Wilkinson was able to access Caitlin's

laptop computer. She found that the day before Caitlin died she had deleted her Facebook profile, Instagram and her outlook web mail. The last entry on the Internet was in respect to a method of suicide.

Autopsy results

220. An external autopsy examination was conducted on 6 August 2014 by Dr Beng Ong. There was no evidence of any third party involvement.

221. Toxicology revealed non-toxic levels of citalopram and quetiapine. A constituent of cannabis was also noted. Alcohol was not detected.

Root Cause Analysis

222. The MSHHS commissioned a Root Cause Analysis in relation to Caitlin's death and this was completed on 17 October 2014.

223. The RCA noted Caitlin presented with a number of factors that increased her longitudinal risk of suicide and the complexity of her care:
    - Recent transition from extended treatment facility to community living.
    - Diagnostic complexity and changeable presentation
    - Severe mental illness with early onset and likely trauma history
    - History of poor attachments
    - History of suicide attempts and deliberate self-harm
    - Illicit substance use
    - Suicide to peers in BAC
    - Relationship breakdown
    - Multiple service providers involved.

224. The RCA noted in the days prior to her death there was no indication that her risk of suicide was above her baseline or that a change to the treatment plan was needed. The RCA stated that in retrospect it would appear her high level of complexity may have warranted a more coordinated service response including the use of a formal Care Coordination approach and complex case reviews by the treating team.

225. During the period of her care, Caitlin had numerous individuals involved in her care, including the mental health service, a private psychologist, general practitioner, BAC school staff, staff at supported accommodation, and her mother. The case manager had contact with these parties at various points during the episode of care on an "as needed" basis and also coordinated a stakeholders meeting for handover when Caitlin was transitioning from BAC to the Mood Team. Aside from these contacts there was not the opportunity for the stakeholders to meet to provide a coordinated approach to needs identification, care planning and ensure adequate communication. The RCA stated that whether this would have changed the outcome is speculative.

226. Similarly the care was reviewed at the 91 day multidisciplinary case review. These reviews are of necessity usually quite brief due to the high number of consumers who need to be reviewed. In retrospect, the RCA considered it may have been beneficial for the treating team to have the opportunity to meet for a longer period of time through a complex case review process to discuss care planning issues. This would be particularly useful to supporting the treating team, given the case manager was a relatively inexperienced clinician, and given the changes in medical

staff providing care. Again, the RCA stated whether the presence of a complex case review process would have changed the outcome is speculative.

227. The RCA noted that during the course of her care Caitlin receive treatment from a consistent case manager and a consistent private psychologist. There was a change of psychiatric registrar due to the usual change of registrar terms. A first consultant psychiatrist provided care for around six months but then the psychiatrist went on leave and subsequently left in June 2014.

228. The case manager had about one year of employment as a mental health clinician and had also completed an internship with the Mood Team prior to this for six months as part of course work requirements for a Masters in Clinical Psychology. She was receiving weekly clinical supervision from a senior clinician and monthly operational supervision from the Team Leader. Caitlin was frequently discussed as part of this supervision.

229. The RCA team found Caitlin receive good quality, appropriate clinical care from the treating team. It was acknowledged the case manager, as a relatively new clinician, found the providing of care to be challenging and at times stressful due to Caitlin's complex care needs and high longitudinal risk. There was no indication case manager experience levels had any impact on the outcome. However, links to care coordination and complex case review may have been an additional means to support the case manager in providing treatment to Caitlin.

230. The RCA team found there were no contributing factors to the death. The recommendations made (total of 2) were described as 'lessons learned'. The recommendations were as follows:
    - Metro South Addiction and Mental Health Services (MSAMHS) formalise and implement a complex case review process for consumers identified as having high risks of harm to self or others and/or complex care needs;
    - Where a consumer is transitioning out of extended treatment and rehabilitation facilities to community mental health services, consideration be given to referring the consumer to the MSAMHS Integration Coordinator for formal care coordination.

231. The expected dates of implementation for each of the recommendations was 1 March 2015.

Issues 3-5 Whether BAC closure had any adverse impact on the mental health of Caitlin, management of her mental health from discharge to her death and transition plan implementation

232. Caitlin had a complex mental health condition that had been longstanding. A consideration of her diaries certainly makes for disturbing reading and is consistent with her history. She had been an inpatient at BAC for varying periods from 2011. By mid-2013 she was in the process of transitioning from BAC to more independent living.

233. Caitlin was ready to leave BAC, she expressed she was happy with the arrangements at Phoenix House and was pleased when she moved into independent accommodation until that arrangement broke down. The fact Caitlin had got to that stage of transition is very much a credit to the dedicated work of BAC staff.

234. Dr Brennan gave evidence at the inquest that at the time of Caitlin leaving BAC Dr Brennan did not think the closure was impacting on Caitlin's mental health in a negative way. The closure was after she had ceased to be even a day patient. Dr Brennan stated she considered Caitlin was emotionally and psychologically ready to transition. She had already commenced to transition in some ways.

235. Caitlin's family submits that had Caitlin remained in contact with Dr Sadler and BAC staff it is unlikely her mental state and situation would have deteriorated to the point where she took her own life.

236. In relation to Dr Sadler per se, he had ceased in his position at BAC some months before Caitlin's formal discharge from BAC.

237. The family also submitted the quality of the BAC transition process as described by Dr Sadler in the Commission significantly exceeded the quality of the transitions that were put in place for each of the three deceased young persons, including Caitlin, immediately prior to the closure of the BAC.

238. It could no doubt be argued that had BAC remained open, Caitlin may have had the benefit of further contact with BAC staff through the type of transition process identified by Dr Sadler in his statement to the Commission.[14]

239. The difficulty with the family's submission is it is not possible to say with any certainty how or if the transition plan ultimately put into place for Caitlin by Dr Brennan was significantly different to what would have been put in place at the BAC. A specific written transition plan for Caitlin's transition from BAC prior to Dr Brennan's appointment is not apparent in the records.

240. More particularly it is unlikely BAC staff would have continued to have contact with Caitlin at around the time of her death given this occurred some eight months or more after the formal closure of BAC, and already well into her transitioning to the community and independent living. In that respect, I note the statement of Dr Sadler where he references a crossover period of two months or more and other BAC staff such as CN Daniels where she spoke about monitoring the transitioning patients for a limited period of time whilst they commenced with other services.

241. The transition plan as proposed by Dr Brennan objectively can be said to be responsive to Caitlin's needs and wishes and in general terms was carried out. The plan addressed her individual mental health, social and developmental needs. The plan was described by Professor Kotze as bespoke in nature and developed individually for each consumer.

242. Prior to her discharge from BAC Caitlin had been linked to a general practitioner; a psychiatrist and case manager in the Mood Team at PAHMHS; a private psychologist; and had been provided with referral information for Open Minds. Caitlin had also been enrolled in Access 10 and was living in supported accommodation at Phoenix House with a plan to move to SWISH. Dr Brennan stated the referral to the PAH mood team was an excellent choice as cost was not ever going to be prohibitive and provided case management, which the private system rarely provides.

[14] See paragraphs 44-46 of this decision

243. It is also objectively evident Caitlin was well supported by her case manager in Emma White. Ms White was restricted in the amount of information Caitlin permitted her to provide to her mother. It is accepted this is a very common complaint of the families, who reasonably believe information provided to them by clinicians would assist the family in understanding and helping in the rehabilitation and treatment of their family member. There is little doubt that is the case. However, Caitlin had been most adamant in her wishes that her mother not be provided with such information and Ms White was therefore required by virtue of policy and legislation to comply with this request.

244. Caitlin's wishes in this regard were similarly applied when she was at BAC. Dr Brennan gave evidence at the inquest she thought Caitlin was competent to make that choice.

245. The family also submitted the decision by Caitlin to not continue to take lithium medication caused or contributed to the development of the suicidal intent that led to her death. Certainly there is evidence in the records that suggest lithium had been a medication that had been effective in stabilising her mood in the past.

246. It was further submitted by the family that Dr Purushothaman should not have treated Caitlin in a way one would treat an adult with a mental illness rather than treating an adolescent with a severe, chronic and complex mental illness.

247. Caitlin had been questioning her diagnosis of bipolar disorder and had stopped taking her medication. Caitlin thought she might have post-traumatic stress disorder or some other borderline personality disorder. Her clinicians themselves were re-considering the diagnosis because as an adolescent patient proceeded through transitioning and into adulthood, such diagnoses can evolve.

248. Dr Brennan agreed in her evidence there were a number of incidents in Caitlin's history that would have been traumatic but she considered this did not necessarily invalidate a diagnosis of bi-polar affective disorder. Dr Brennan also stated lithium has a role in mood stabilisation in a number of other mental health conditions and can enhance antidepressant medication for major depressive disorder, noting Caitlin's depressive symptoms did persist.

249. However, Caitlin was adamant she did not wish to continue with lithium. She had a history of non-compliance with taking medication, particularly with respect to lithium, from the time she was a day patient at BAC in 2013. In 2014 the medical notes suggest she was encouraged to continue taking her medication as prescribed. Ms White told her she should recommence her lithium on 3 March 2014. Two days later she told Dr Malalagama she had recommenced taking lithium and escitalopram but not quetiapine. On 30 April 2014 she told Dr Jelesic-Bojicic she was not taking her medication and there was increased conflict with her mother. Dr Jelesic-Bojicic saw her again on 27 May 2014 where it is recorded Caitlin was questioning her diagnosis and was non-compliant with medications. Dr Jelesic-Bojicic ceased her lithium at that time.

250. At other times Caitlin had also discontinued with her antidepressant medication but was seen to have sufficient insight into her condition to resume that medication and even seek an increase when she felt she was becoming more depressed.

251. Caitlin's clinicians reasonably considered she did not meet the criteria for an involuntary admission and in any event Caitlin could not be forced to take lithium as it is an oral medication.

252. Both Ms White and Caitlin's psychiatrists were required to balance the need to maintain a therapeutic relationship and develop trust with Caitlin, in circumstances where she clearly was not going to take lithium and where she had sufficient capacity to make autonomous decisions about her mental health treatment. In this context they made a reasonable clinical judgment call.

253. Dr Byth was also informed by Caitlin she was no longer taking lithium and this was in accordance with a decision of PAHMHS. Dr Byth queried to herself why she had not been informed but did not make any further inquiries.

254. Dr Byth stated in her evidence it was her understanding, as a community general practitioner, that she was looking after Caitlin's physical health needs and assisting the specialist mental health treating team as and when required. In this respect she had Caitlin complete a psychological testing form, took bloods to monitor her lithium levels and otherwise took a note of her mental state presentation at their appointments.

255. The referral process to Dr Byth from BAC could have been better communicated. I accept however, it was totally reasonable of Dr Byth to understand Caitlin was referred to her to look after her physical needs and her mental health within the context of a GP practice, including preparation of Mental Health Plans for referrals to her psychologist and testing for lithium levels. Caitlin was known to have complex mental health concerns and given she was being treated regularly by the PAH Mood team and regularly being seen by a Case Manager and psychiatrist, it was reasonable for Dr Byth to think the PAH team would take the lead role relating to her mental health and this would include the issue of lithium prescribing.

256. Caitlin also continued seeing her psychologist Ms Watkins-Allen and it is evident the strong therapeutic relationship developed at BAC continued after Ms Watkins-Allen left BAC and up to shortly prior to Caitlin's death.

257. On that basis there is little objective evidence to suggest the closure of the BAC per se had an adverse impact on her mental state. The transition arrangements, which were found to be adequate by the Commission, were largely implemented. She was supported by her GP. She was supported by a private psychologist, with whom she continued a long therapeutic relationship. Caitlin was well supported by her case manager. Caitlin was a complex patient. The RCA found it may have been better to have more links to care coordination and complex case review as an additional means to support the case manager in providing treatment to Caitlin, although there was no indication that case manager experience levels had any impact on the outcome.

258. The significant breakdown in the transition arrangements for Caitlin was her accommodation. The arrangements that had been put in place for the transition period were appropriate and had been organised prior to the BAC closure and were already in place. Phoenix House was always time limited but other accommodation at SWISH was organised and this appears to have been initially suitable. SWISH not only provided accommodation but included a component of life support skills. The breakdown at SWISH was due to conflict between Caitlin and a co-tenant (the evidence about which is lacking), but it appears to be accepted Caitlin decided or

felt she had no choice but to leave. There is no evidence to suggest that otherwise the accommodation per se was inadequate for Caitlin's particular needs.

259. It is impossible to say if the accommodation arrangements at SWISH had continued or if Caitlin was living independently elsewhere the outcome would have changed. There are just too many variables that potentially could come into play given the context of Caitlin's complex condition. The family submissions made reference to the fact that Caitlin's suicide was not inevitable. I am not sure if anyone has said her death was inevitable and I certainly do not support that as a proposition. What likely occurred was a series of events, which particularly impacted upon Caitlin's vulnerabilities at a point in time.

260. Caitlin moved back with her mother, with whom she had a difficult relationship, notwithstanding the clear level of love and support her mother provided in the past, in the present and no doubt continuing into the future. The evidence supports a clear finding this was not an ideal arrangement for either Caitlin or her mother, given Caitlin's preference that she wanted to live independently.

261. Ms White then endeavoured to make many efforts to find alternative accommodation. There were a number of problems that surfaced including resolving payments of a disability support pension with Centrelink, which had been stopped when she moved back in with her mother. Ms White did all she could to address the issues as they arose. Alternative accommodation would have eventually been found.

262. Part of the historical background to Caitlin's vulnerabilities related to a well-documented dysfunctional relationship with a relative. The precise basis for the conflict in the relationship was not identified in the records as Caitlin had never disclosed them, other than unspecified allegations of verbal and physical abuse. However, the conflict did exist for Caitlin.

263. It is somewhat unclear on the evidence as to when the relative moved back into the house with Caitlin and her mother. It is at least evident he had been a frequent visitor to the home after Caitlin moved in and may have been staying there at times. Her relative certainly moved in soon after his accommodation burned down on 25 July 2014. The proximity of this event to the date of death and Caitlin's deteriorating state of mind, is in my view not a coincidence.

264. There were other factors potentially impacting on Caitlin, although the evidence as to the extent these were contributory to her state of mind and decision is not at all clear. The deaths of Talieha and William were considered, but the evidence of her mother and particularly Ms Georgia-Watkins would suggest this did not influence her decision. Dr Brennan however, stated in her evidence at the inquest she thinks Talieha's death would have had a huge impact on Caitlin.

265. As well, the breakdown of her relationship with her boyfriend some months earlier and associated allegations of domestic violence has been mentioned as a factor but there is little information about how that affected Caitlin. I accept it may have.

266. There is evidence Caitlin had been taking illicit drugs and at autopsy a constituent of cannabis was found but the extent this impacted is uncertain. Non-toxic levels of citalopram and quetiapine were also found indicating at the time Caitlin had been taking her anti-depression medication.

267. Unfortunately access to Caitlin's diary for the immediate period around her death has not been possible. Her many diaries indicate disturbing references to suicide, but there are also other more positive references. There was no reference in the medical records that suggest Caitlin was expressing suicidal ideation to her case manager, psychiatrist or psychologist or to her mother in the immediate period leading up to her death.

268. Caitlin's decision must be considered in the context of her complex mental health history. There was evidence of recent deterioration in her mood and mental health but no expressions of suicidal ideation. Part of the deterioration may have been related to her medication non-compliance and her decision to not take lithium, although there are many other factors also possible that may have been a greater contribution. There is evidence of other situational crises such as her recent break up with her boyfriend, conflict with a friend, financial stresses, being unwell with the flu, use of cannabis and most particularly her living arrangements. Other than the issue of medication non-compliance, none of these are directly or indirectly related back to the health care Caitlin was provided or the transition arrangements put in place for Caitlin.

269. There is some evidence Caitlin was putting in place arrangements, that in retrospect indicated to her mother she was intending to take her own life. The method by which she died also is well known to have a high lethality rate. On balance I am satisfied Caitlin's actions on 5 August 2014 were intended to end her life and was not a cry for help or a case of misadventure.

270. In hindsight, Caitlin's state of mind may be best reflected in the text she sent her mother on 28 July when she said "*please encourage him to find a new place as quickly as possible…… my mental state is going to rapidly decline with him here.*"

Findings required by s. 45

Identity of the deceased Caitlin Wilkinson Whiticker

How she died – Caitlin Whiticker was a day patient at the Barrett Adolescent Centre and was transitioning towards independent living at the time the BAC closed. Her mental health condition was complex, longstanding and evolving as she moved from adolescence into adulthood. Her living arrangements broke down and for a number of months she was living with her mother whilst other alternatives were being sourced. This was not ideal as Caitlin and her mother had a difficult relationship and Caitlin had a clear preference to live independently. Of some significance was a well-documented dysfunctional relationship with a relative. Two weeks prior to her death Caitlin's relative came to live with Caitlin and her mother. Caitlin's decision to take her own life must be considered in the context of her complex mental health history. There was evidence of recent deterioration in her mood and mental health but no expressions of suicidal ideation. Part of the deterioration may have been related to her medication non-compliance and her decision to not take lithium, although there are many other factors also possible that may have contributed. There is evidence of other situational crises such as her recent break up with her boyfriend, conflict with a friend, financial stresses, being unwell with the flu, use of cannabis

and more particularly her living arrangements with her relative living in the house.

Place of death – 90 Prince Street ANNERLEY QLD 4103 AUSTRALIA

Date of death – 05 August 2014

Information particular to Talieha Nebauer

Background

271. Talieha was the oldest of three daughters to her mother, Ms Nichole Pryde. Her father did not have an involvement in her life until she was aged 15. Otherwise she resided with her mother, her sisters and her mother's new partner who was also the father of Talieha's two younger sisters.

272. Talieha had achieved well in primary school. Ms Pryde stated she had been bullied in years 6 and 7 and towards the end of grade 8 her attitude changed and she became more withdrawn. Ms Pryde was informed by a school counsellor that Talieha was speaking about suicidal ideation and she started experiencing anxiety and self-harm activities.

273. This anxiety continued for some years and Talieha was in and out of hospital without much improvement. Talieha confided in her mother that when she was 8 years old she had been sexually assaulted by two young male relatives. In 2010 her mother became aware of another serious sexual assault that occurred whilst she on leave from the Royal Brisbane and Women's Hospital (RBWH). The medical records detail incidents of multiple traumas and disclosure of sexual abuse of herself by multiple adults over a number of years. This had led to her experiencing significant emotional trauma.

274. Talieha remained for some months in the Adolescent Centre at RBWH until she was transferred to BAC in February 2011. She was a live-in patient at the BAC returning home for holidays and weekends. Her mother spoke to Talieha most nights whilst she was at the BAC.

275. The medical records of BAC noted a constant history of fluctuating moods, frequent episodes of psychological distress, incidents of self-harm and thoughts of suicide throughout her stay at the BAC, including into the months leading up to her discharge from BAC.

Care provided at BAC

276. In relation to Talieha the Commission noted she may have chronologically been an adult but developmentally was an adolescent. She had extremely high treatment needs, high acuity, and a high complexity and her case was indicative of the lack of alignment between adolescent mental health services and adult mental health services.

277. Dr Stedman provided a useful summary of the history of treatment provided to Talieha. Talieha was admitted and discharged from BAC on a number of occasions between February 2011 and January 2014. She was first voluntarily admitted to BAC on 22 February 2011 after repeated admissions to the RBWH adolescent unit relating to self-harm and threats of suicide. Talieha remained an inpatient at BAC and had a total of four separate admissions and discharges. Her final discharge from BAC was on 20 January 2014 when she was discharged to the Pine Rivers Community Care Unit (PRCCU), operated by Metro North HHS.

278. Dr Stedman stated Talieha's diagnosis was considered to be post-traumatic stress disorder, emotionally unstable personality disorder and problems with life cycle adjustment. The traumatic symptoms were thought to relate to childhood sexual

abuse and domestic violence in the context of alcohol and other substance abuse in the family home. Talieha had many instances of self-harm and threats of suicide during her time at BAC. It is evident Talieha had very complex mental health problems.

279. During her time at BAC, Talieha attended the BAC school as well as undertaking part of a child care course. She had leisure and recreation therapy, interventions from social work, occupational therapy, dietetics, pharmacy, speech pathology and psychology. She attended dialectical behaviour groups and was supported to attend a church youth group. The BAC records noted her fluctuating moods, frequent episodes of psychological distress, incidents of self-harm and thoughts of suicide were prominent throughout her stay.

280. Despite her almost three year stay at BAC her acuity remained high. Dr Brennan's statement noted the three longest leave periods in that three year period were with her family for three, five and seven days. Dr Brennan noted the records alleged a history of abuse and trauma including extra-familial sexual abuse and intra-familial physical abuse. As a result there were a number of forms of self-harm she exposed herself to, often in the context of consuming alcohol and also exposing herself to risky unwanted sexual activity.

281. In her evidence before the Commission Dr Brennan stated Talieha had a strong connection to the BAC and would grieve for its loss to her. Dr Brennan also said Talieha was going through two transitions. The first was a transition between her previous treating psychiatrist and herself and the second transition was from the BAC to the PRCCU. Dr Brennan in her evidence before the Commission stated she had grave fears as to whether they could keep Talieha alive at BAC until it closed, which was why she was pursuing an admission to an acute adolescent unit. She considered it would have taken a long time in therapy for her to come ready to transition. Dr Brennan stated that in some ways Talieha was not psychologically and emotionally ready but argued that readiness would not occur in the immediate future and there came a point where she had to leave because the BAC was closing.

282. At the time of her discharge from BAC, Talieha's medication was as follows:
- Citalopram (40mg, once in the morning) for depression;
- Quetiapine (immediate release, 50-100mg twice daily as required) for agitation; and
- Olanzapine (5mg up to 3 times a day) for agitation.

283. Prior to Talieha's discharge from BAC, Dr Stedman noted a number of suitable accommodation and services were explored. For a variety of reasons, these options were deemed unsuitable.

Transition Plan

284. The transition plan for Talieha as it was eventually developed included:
- Accommodation , mental health care and education/vocational support from and at PRCCU
- A therapist at Caboolture CYMHS for six months post discharge from BAC
- 24hr x 2 support to be funded by a MHAOD package
- Acute admissions where necessary to The Prince Charles Hospital (TPCH)

285. This transition plan was accepted by Dr Brennan as a fall back option in the circumstances that follow.

286. Ms Clayworth's supplementary statement to the Commission identified a number of concerns given Talieha's high risk of deliberate self-harm and suicide, vulnerability regarding her community interactions outside BAC and her housing needs. In a *Consumer Care Review* Summary of 28 October 2013 and authored by her, Ms Clayworth noted Talieha was voicing her fear for the future beyond BAC, of being in the adult system and that Talieha believed if discharged to supported accommodation or into the adult acute system she will undoubtedly suicide.

287. Extensive enquiries were undertaken by BAC staff including herself to source appropriate alternative service providers. Ms Clayworth noted it had been recommended Talieha be transferred to an adolescent acute unit given her increasing acuity in the lead up to her transition and the perceived clinical risk on transition. This was refused by the RBWH Adolescent Acute Unit and the possibility of an admission to a number of adult mental health units was investigated. It was felt an adult ward was unsuitable and this led to a recommendation by BAC staff for 24/7 support at her new accommodation.

288. With the assistance of others Ms Clayworth prepared a BAC Transition Package Plan, which documented Talieha's diagnosis; identified risk; ongoing treatment and support needs; proposed alternative service providers/types; family situation; level of independence and accommodation needs. This resulted in Talieha being accepted for admission into PRCCU with an additional plan for 24 hour care (15 hours of which was to be provided during her transition by BAC staff and the remaining hours to be provided by PRCCU); transitional support from BAC staff; training NGO support staff; management of her attachment/dependency issues on BAC staff; and facilitate her admission to the Adult Mental Health Unit at TPCH when required.

289. Ms Clayworth visited the PRCCU with Talieha and conducted a risk assessment. Amongst the matters identified were:
   a) the prospect of Talieha self-harming due to ease of access to equipment or suicide due to the availability of ligature points and a lack of 24/7 supervision
   b) Her vulnerability in the community because Talieha had no skills for living in the community, particularly in the context of her being unsupervised amongst adult mental health clients
   c) Potential isolation in the community.

290. Ms Clayworth says she raised these matters with the PRCCU Nurse Unit Manager. Ms Clayworth and Talieha also prepared a day by day calendar of her needs during transition.

291. RN Moira Macleod was the care coordinator for Talieha at BAC. She provided weekly summary reports, which were presented to weekly case conferences for each patient. Her statement says she was focused on assisting patients with activities of daily living and motivating them to participate in BAC routines, attending school, participating in activities and sleep. She continually monitored the situation of the patients by assessing mental state, mood and presentation. She was mindful of safety issues. Ms Macleod was not involved in planning for transitional arrangements for Talieha and was critical about the speed of the transition and aspects of the transition planning.

292. Ms Macleod stated she was concerned the PRCCU was not suitable for Talieha on the basis Talieha had no experience of living on her own. She also thought BAC staff would have supported her for longer after the transition commenced. Ms Macleod said in evidence it was difficult to reassure Talieha about her future as the staff just did not know what was being planned, but they would encourage her.

293. On 22 November 2013, Dr Anne Brennan emailed WMHHS management and recommended Talieha be transferred to The Prince Charles Hospital (TPCH) for ongoing mental health care. Given suitable community accommodation could not be found for Talieha in that area, initial housing at the PRCCU was recommended.

294. Dr Brennan considered a transfer to supported accommodation before Talieha turned 18 (due to happen on 6 February 2014) would take some time for Talieha to tolerate as she had been in hospital care for over 3 years. Further to that, Dr Brennan considered Talieha's suicide risk was expected to escalate when informed of the need to transition to adult services.

295. Further on 22 November 2013, Dr Brennan met with Talieha and her mother. Talieha was not told about the request for transfer to TPCH at this time, because it had been decided she not be told about any transition plan until it was set in stone. Independent accommodation was discussed at this meeting, and it was reiterated that Talieha would need inpatient care, at least initially, to cope with leaving BAC. Talieha also expressed a fear of going to an adult ward.

296. On 5 December 2013, Dr Brennan received a call from the PRCCU to say they would be able to provide a single unit with one-to-one support initially at 15 hours a day reducing over 12 months. Structured daytime activities/skill building was to be provided with psychologist introduction at a later date. Acute crises would require admission to TPCH after her 18th birthday. Talieha was informed of this plan and, though anxious and sad, remained reasonably calm and was able to discuss her concerns. On 13 December 2013, Talieha met with staff from the PRCCU and, though highly anxious, was able to enquire about relevant matters. Clinical Nurse Vanessa Clayworth was involved in organising Talieha's transfer. A number of emails were exchanged detailing the planning arrangements.

297. On 16 December 2013, Talieha's behaviour began to escalate again in the context of another patient leaving BAC. She expressed a fear of being moved to an adolescent unit without warning. As a result of this behaviour, Dr Brennan emailed WMHHS management expressing a strong clinical recommendation that Talieha be transferred to an adolescent unit whilst continuing to integrate into the PRCCU. The following day, WMHHS again requested Talieha be admitted to the RBWH Adolescent Unit.

298. On 17 December 2013, Talieha met with her case manager at PRCCU and was given a tour of the unit, grounds and activity area. Talieha was encouraged to ask questions of her case manager and identify any safety concerns, which she did. These risks were also discussed between CN Clayworth and the case manager. At this time, CN Clayworth's impression was that due to Talieha's perceived loss of friendship and exposure to the new environment, her self-harm, suicide and absconding risks would be increased to high.

299. Dr Brennan was of the view that prior to admission to the PRCCU Talieha required an interim admission to an adolescent inpatient unit. Dr Brennan gave evidence at

the inquest there were two different times of intense requesting by her for an adolescent unit to accept her as an inpatient. She made an initial request because she thought Talieha needed to be in a very restrictive, contained environment for her own safety when she left BAC as she thought Talieha needed a period of time essentially to grieve for BAC and to adjust to being somewhere else. The second period of requesting occurred after an episode of climbing on scaffolding where Dr Brennan considered she could not contain the risk at BAC and as the closure came closer she renewed the request.

300. Dr Brennan sent an email to Dr Geppert on 18 December 2013 to that effect and that it was her "strong clinical recommendation" and that Talieha had repeatedly stated her intent to suicide if admitted to an adult acute unit.

301. Attempts were made to have Talieha admitted to the RBWH Adolescent Unit. This request was declined by RBWH on the basis their unit was not considered to be the most appropriate service option for Talieha as she was soon turning 18 and would have to transition to an adult team.

302. Dr Brett Emmerson was the Executive Director, Metro North Mental Health. Dr Emmerson participated in a teleconference with a number of persons including Dr Ian Williams the Director of Adolescent Psychiatry at RBWH on 18 December 2013. Dr Emmerson stated the decision to not accept an admission was on the advice of Dr Williams but was one made by them jointly. Dr Emmerson stated there were two reasons for this. Firstly, there was another former patient from BAC already in the adolescent unit and it was believed it was not ideal for the two to be put together. Secondly, as Talieha was either 18 or about to turn 18, she would be more appropriately cared for by an adult mental health service. Dr Williams had treated Talieha in the past and recalled she did not deal well with change, so less transitions of care were desirable. Hence the decision to recommend she be transferred to PRCCU and cared for by an adult mental health service who would ultimately be her long term care providers.

303. Dr Emmerson stated in evidence the current policy on issue of transition from adolescent to adult mental health services is largely based on age and not on development or maturity. Dr Williams agreed this is generally the case, subject to some flexibility. Dr Emmerson agreed Dr Brennan had a different view as she did not think they could deal with Talieha safely in an adult unit such as PRCCU. The solution that arose was to have 24 hour one on one specials.

304. Dr Williams stated he informed Dr Brennan he did not feel the RBWH unit would be a suitable environment for Talieha and she would be unlikely to do well at the unit. Dr Williams stated the RBWH unit was an acute unit with an average stay of 14 days. It was a quite different unit to BAC and the RBWH unit focused on containment risk and review of medications with no linkages into community programmes. Dr Williams stated Talieha's cluster of difficulties do not do well in acute units and there can be a deterioration in mental state. Dr Williams stated it was a complex decision, and was not ideal, but PRCCU was in the catchment area for her family, it had accommodation and continuity of care and the capacity to have brief inpatient admissions to TPCH.

305. Dr Williams also had concerns at the time about the unit's ability to safely manage two BAC adolescent clients and the potential negative impacts her admission would have for both of them. He also stated that admitting Talieha to the adolescent unit would involve avoidable transitions of clinical care and he believes it would not

be in the best interests of her recovery, given her vulnerabilities. He stated this was so given she was approaching the age of 18 and under the existing models of care she would be expected to soon transition to an adult mental health service. Dr Williams also stated there were limited community options for more serious adolescents transitioning to the adult services at the time of the BAC closure.

306. Dr Williams also felt Talieha's clinical care could be better managed in a fully integrated mental health service. This could provide coordinated access to inpatient and community mental health care, rehabilitation services and mental health supported accommodation. Dr Williams stated the RBWH adolescent unit was a hospital based acute adolescent service and he felt The Prince Charles Hospital Adult Mental Health Service was a more appropriate service to consider, as this could provide acute inpatient and community mental health care and had access to a mental health community care rehabilitation unit.

307. On 18 December 2013, an offer was made by the Executive Director of Metro North HHS to provide two 24 hour nurses at the PRCCU for Talieha. In her evidence before the Commission, Dr Brennan was asked about this email and she stated that by adding in two nurses she considered this made it a safe option to start with in terms of containing risk. Dr Brennan said this was definitely a safer option than staying on at the BAC. Without the extra nursing support the PRCCU would have been inadequate.

308. On 19 December 2013, Dr Brennan emailed WMHHS management and advised that as Talieha was realising her transfer was becoming imminent, she was repeatedly threatening to harm herself. Dr Brennan provided oan pinion the current transition plan involving 15 hours per day of nursing supervision was clinically unacceptable because of risk. Dr Brennan also noted the continued refusal by the RBWH Adolescent Unit to accept Talieha, and in the absence of an appropriate adolescent facility being available, the offer for the two 24 hour nurses at the PRCCU should be accepted.

309. In the months leading up to and throughout December 2013 there were a number of serious incidents where Talieha attempted to self-harm. Her behaviour was then noted to settle, however, her risk of self-harm was considered to remain high. By January 2014 the prospect of the transition to PRCCU was causing anxiety and uncertainty about the future for Talieha.

310. Karen Northcote, the Nurse Unit Manager of PRCCU (NUM) was able to produce a written plan referred to in her statement to the Commission and identified as exhibit KN-4 to her statement. She stated the initial plan identified a 12 month plan. The first three months focused on clinical supports in accordance with her clinical presentation and associated responses. The plan was flexible and would be changed to reflect the clinical needs. Modifications were also made due to the inability to access NGO supports via HASP applications. The PRCCU clinical nursing staff was increased during the initial phase of Talieha's admission to PRCCU and reviewed each week. This plan provided for two grade 5 nurses for 24 hours for two weeks from 13 January 2014 to 26 January 2014. For the next month to about 23 February 2014 there was to be one grade 5 nurse between 7am to 11 pm and two grade 5 nurses from 11 pm to 7am. After that date until 6 April 2014 one clinical CCU staff member was to be available for 12 hours a day between 8 am and 10 pm.

311. It is unclear when this Transition Plan was reduced to writing although it refers to Talieha's first meeting at PRCCU on the 17 December 2013, which was the date the meeting actually occurred. The plan does not reflect the correct date Talieha in fact arrived at PRCCU. Other iterations of amended Transition Plans were found in other parts of the extensive documentation obtained during the coronial investigation.

312. Dr Brennan noted the original intention of the transition plan was for Talieha to have two nurses caring for her for six months. This was in fact dropped to one nurse within the first month and Dr Brennan is not aware of the circumstances in which this occurred or exactly when. There were delays in receiving funding for Talieha's transition and this meant when the plan was approved there was less time to implement a tapered program, which was Dr Brennan's preference - that is the patient spend a day in the new facility and then come back to BAC, then spend a few days at the new facility and come back and then move completely to the new facility and have follow-up with BAC staff.

313. Dr Brennan in her statement stated Talieha was a patient at high risk of self-harm and suicide and could be triggered into non-accidental self-injury very quickly and by a range of precipitants. Dr Brennan cannot say whether the delay in funding and other issues referred to impacted to the extent that had they not occurred, they would have avoided the tragic outcome.

314. In her evidence before the Commission Dr Brennan was asked how Talieha's constellation of issues posed challenges in the devising and implementing the transition plan. Dr Brennan stated "*the management of somebody with a borderline personality disorder is quite complex. It is too simplistic to say that they need to be prevented from self-harming. That is not the core of the difficulty. It is that they need to learn to cope with difficult emotional states and internal emotional states which they are not able to and they have been using self-harm. Sometimes self-harm can be used for other reasons to elicit more care but for Talieha it was, I do not think, usually like that. Sometimes it was. But sometimes it was to alleviate the internal distress that she was* experiencing*. And so to manage somebody like that she needed to be in an environment where she could be supervised but also have therapy and what complicated it was that she had adjusted or adapted to a particular response to her self-harm so that in the BAC for nearly 3 years there was a particular pattern of what happened if she self-harmed. And for Talieha it was going to be a very difficult transition to have to live in an environment where that was not the response.*

315. Dr Brennan further stated "*the options are really to try and repeat that environment somewhere, so that is a facility that can be locked, where she be managed with at least one, sometimes two, and I think even on occasion three, nurses at arms-length to ensure her safety from herself.*

316. Dr Brennan stated *"it is difficult to envisage a way that any young person could live like that forever.* Dr Brennan added "*that to do this safely it was to find her accommodation that initially* would *provide at least the level of supervision that was available at BAC and then in a graduated way over a very lengthy period of time to have [the supervision] reduced".*

317. Enquiries were then made as to whether Talieha could start the transition to PRCCU immediately. Karen Northcote stated Metro North responded to the effect that the logistics of organising staff who would be available over the Christmas

period at such short notice would be very difficult. It was determined Talieha would need to stay at BAC and a management plan was put in place for over the Christmas/New Year period.

318. Ms Northcote visited Talieha on 12 December 2013 at BAC and there were other visits by social worker Emma Betson from PRCCU on 16 and 24 December. Talieha visited the PRCCU on 17 and 31 December and 3 and 15 January 2014.

319. At the visit on 3 January 2014 Ms Macleod noted in the records Talieha appeared anxious and lacked enthusiasm when talking to PRCCU staff and responded to any questions in a "little girl voice". Ms Macleod said Talieha was anxious and they were trying to work through the move with her. Ms Leigh Robertson from PRCCU also thought Talieha appeared anxious and presented as very childlike but otherwise there were no concerns and she seemed reasonably settled.

320. In a nursing note made on 4 January 2014 Ms Macleod recorded Talieha was stating she was afraid for her safety and how easy it will be for her to harm herself or suicide and that she did not wish to die but she was not ready for the big step in her recovery. Ms Macleod stated Talieha was trying to adjust to the prospect of the move.

321. On 8 January 2014 Talieha was recorded by Ms Macleod as being demanding and attempting to bargain to have a friend attend at her visit to PRCCU and she was stating they were forcing her to cut or kill herself because the planned agenda was not able to factor in a visit with her friend.

322. On 13 January 2014 a psychology report was prepared, which noted Talieha had made progress during her treatment at BAC. She had learned skills to identify and soothe her emotions, however, she generally required support to do this. Talieha was noted to find the period between 9pm - 10pm difficult but this risk decreased with 1:1 support. She had been provided with support to manage the strong emotions still present and to process what had happened to her in the past and how she was to be able to cope into the future without BAC.

323. On 15 January 2014 a final risk screening assessment was completed for Talieha. It identified triggers for rejection, descriptions of previous self-harming behaviours, warning signs, considerations for carers when Talieha experienced dissociative type episodes and her identified vulnerabilities. It was identified that overall her risk of suicide, other self-harm and absconding from the PRCCU were high.

324. On 15 January 2014 the visit to PRCCU took place and Ms Macleod stated in evidence at the inquest the visit went as well as expected. Talieha had pointed out hanging points but her mood had improved and she had become more positive about the move.

325. It is apparent Talieha was only given a couple of days' notice about the move to PRCCU. The short notice decision was made by Dr Brennan on the basis it would be less stressful for Talieha.

326. Ms Macleod noted on 18 January 2014, that Talieha was still anxious about plans for the transition to PRCCU but after receiving news in the afternoon she would be moving in a few days Ms Macleod noted Talieha had shown amazing maturity and was planning and discussing how she feels she would best be supported over the first few days at PRCCU.

327. On 20 January 2014 Talieha was taken to PRCCU by Ms Macleod who stayed with her for the morning until RN Peta Yorke took over in the afternoon. Ms Macleod stated that everyone involved was trying to be as upbeat as possible about the move.

328. It is evident the staff at both BAC and PRCCU endeavoured to make the transition run smoothly and ensure any stress Talieha experienced was minimised.

329. Dr Brennan stated that prior to the last few weeks before the move Talieha was quite clear she thought she would suicide if sent to an adult mental health unit. However, for Talieha the PRCCU did not equate to an adult mental health unit. Dr Brennan stated that while Talieha was initially very apprehensive, over time this apprehension started to change and she actually was looking forward to trying to have a new life where she could be more independent and be out of a hospital. In the last few days particularly Talieha was very settled. Nonetheless Dr Brennan remained apprehensive about her ability to cope.

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330. On 20 January 2014, Talieha was finally discharged from BAC and admitted to the PRCCU. Talieha was still on an Involuntary Treatment Order (ITO) and this remained in place throughout her admission.

331. The handover to PRCCU included the following documentation/information:
    - Updated risk-assessment
    - Documentation relating to the transfer of the Involuntary Treatment Order
    - Details regarding the date of the next Mental Health Review Tribunal hearing
    - Copy of management plans
    - Meal plan and dietetic handover/discharge summary
    - The initial assessment that had been completed by BAC staff at her first admission
    - Allied health reports available from Consumer Integrated Mental Health Application (CIMHA)
    - Copy of medication chart and script, one night's worth of leave medication
    - Completed documents relating to Guardianship and Housing and Support Program (HASP) applications.

332. The PRCCU is a 20-bed residential facility located on Gympie Rd in Strathpine. The cluster homes provide long stay rehabilitation and recovery service for clients with a mental illness and assists clients to live independently within their own communities. The PRCCU is staffed over 24 hours and has access to a range of health professionals and services available.

333. Talieha remained at PRCCU from 20 January 2014 until her transfer to the hospital on 1 April 2014. Dr Robert Stewart (psychiatrist) was the visiting psychiatrist at PRCCU, having started there on 9 February 2014. He saw Talieha on a weekly basis in the lead up to her death. Dr Stewart makes it clear in his statement that PRCCU is not a hospital, and it endeavours to mirror the experience a person may find when living in the general community. Dr Stewart stated in evidence the primary goal for Talieha was to support her until she was able to reside in the general community.

334. Ms Emma Betson, social worker, was allocated to be Talieha's primary mental health clinician. Ms Betson had past experience in transitioning adolescents into the adult mental health service. Ms Betson stated she was responsible for identifying Talieha's individual needs and monitoring progress towards meeting those needs. This included regular risk assessments and completion of crisis intervention plan, behaviour management and risk management planning. She provided screening, assessment and therapeutic interventions in the areas of personal strengths, coping skills, substance use, social supports, community support, behavioural and risk management, accommodation needs and goals, activities of daily living, vocational and educational goals and financial management capability. The management plans and crisis intervention plan were developed following liaison with staff from BAC and review of Talieha's clinical file. Ms Betson stated plans were not formally approved as they were working documents, constantly changing to adapt to the needs of the patient.

335. One such plan was the *Crisis Management Plan,* which was exhibited to Ms Betson's statement to the Commission. A copy of the same document can also be found in other parts of the medical record. This plan describes itself as a draft and is watermarked to that effect. The document provides a brief background history, sets out triggers and warning signs, and then provides a description of strategies to manage Talieha when in crisis. In particular one of the recorded strategies stated that if there was any concern about her level of wellness it was strongly suggested "a low threshold for admission" should be considered. This document was referenced often during the inquest.

336. Ms Betson stated that before any admission for an acute presentation she would always seek a psychiatric review first. In that respect if a psychiatrist was physically present at PRCCU then the review would take place at the unit. Otherwise the review would take place at TPCH. Ms Betson distinguished between a psychiatric review at hospital and a decision to admit her to hospital. In other words the decision to admit to a hospital ward is made after a psychiatric review either at PRCCU or at the hospital.

337. Another strategy relevant to some of the events that subsequently took place was providing "1:1 individual support". This involves the clinician/nurse spending time with the patient for whatever period it was considered to be clinically needed. This is to be distinguished from providing "1:1 constant observations" where there would be someone with the patient at all times and in close proximity to the patient.

338. Dr Stewart explained the *Crisis Management Plan* was a guide to staff to look at in respect to precipitating events, but it was not set in stone or to be slavishly followed and clinical judgment needed to be considered.

339. Ms Betson stated the recommendation to continue Talieha on an ITO was due to her continued fluctuations in mood with frequent suicidal ideation. Although intent to act on these suicidal plans appeared reasonably controlled most of the time, during periods of disassociation Talieha would become increasingly impulsive, making her a high risk of self-harm or suicide.

340. Ms Betson visited Talieha twice at BAC to build rapport and Talieha visited PRCCU on four occasions prior to transfer on 20 January 2014. Ms Betson stated Talieha was understandably anxious about the transfer to PRCCU. By the time she came to PRCCU Ms Betson believed she had built some rapport with Talieha. On the

day of transfer Talieha was quiet, anxious and withdrawn. She was supported by BAC and PRCCU staff and family.

341. Ms Betson stated Talieha had identified a number of safety concerns with her unit at PRCCU including rails in the clothing cupboard and shower, frame in the shower, a fan, bed head and legs, kettle for boiling water, medication box, electrical cords, beams in the front patio area, decreased monitoring of belongings and especially razors, and decreased support and supervision.

342. As a result of the concerns a number of safety management plans were put in place as follows:
- Talieha's medication was stored in a locked cupboard at the nurse's station and she was required to present to the nurses station at the time her medication was due;
- On initial admission she had 1:1 x 24 hour supervision and this ensured monitored access to her belongings such as razors;
- The level of supervision was reviewed and reduced in line with her level of clinical risk and adjustment to PRCCU;
- 1:1 supervision was slowly reduced with the1 pm to 9:30 pm being last shift to cease;
- PRCCU was staffed 24 hours a day and she was able to access staff support any time;
- Visual observations were able to be increased in the event her mental state deteriorated and this was done in consultation with the treating team

343. Ms Betson stated items such as razors, electrical cords, kettle and fan were not removed. Talieha's transition to PRCCU was aimed at facilitating independent living. These items were accessible to her whilst on leave to her family home and as such it was iterated to be Talieha's responsibility to use them for their intended purposes.

344. Ms Betson stated PRCCU had begun negotiations with non-government organisations regarding care packages in anticipation of her eventual return to the community. Ms Betson said the goal was for Talieha to transition to independent living with appropriate community support over a two year period.

345. Dr Stewart confirmed Talieha suffered from a severe personality disorder. The specific diagnosis was a Borderline Personality Disorder. Dr Stewart stated this had developed on a background of various past traumas including sexual abuse as a child and domestic violence. She suffered periods of disassociation precipitated by conflict and trauma. There was a history of suicide attempts, episodes of deliberate self-harm and panic attacks with six admissions to the RBWH Adolescent Inpatient Unit from June-December 2010. She was admitted to BAC in February 2011. Her condition was characterised by instability of mood, repeated acts of self-harm, episodic substance misuse and a general impairment of her judgement.

346. Dr Stewart stated Talieha's treatment was primarily ongoing psychological support from the clinical staff. This included interventions that attempted to modify her substance use. She was given the following medications:
- Citalopram (40mg daily)
- Quetiapine (50mg twice daily)
- Diazepam (2.5mg as required)

- Quetiapine (25mg as required)
- Doxycycline (50mg daily)
- Paracetemol (1g as required)

347. Dr Stewart said the doses of these medications remained relatively unchanged throughout Talieha's stay at PRCCU. There were never any evidence of an emergence of acute psychiatric syndrome such as a major depressive disorder. On a number of occasions when Talieha decompensated and self-harmed, she was transferred to TPCH for acute management. Her mental state would usually settle quickly and she was always returned to the PRCCU.

348. Dr Stewart stated when Talieha did self-harm, the precipitating factors appeared to relate to conflicts within her relationships with her friends and family. Dr Stewart noted Talieha to be generally reluctant to discuss with doctors or staff any matters involving her personal relationships.

349. The Nursing Unit Manager Karen Northcote stated the PRCCU was very cognisant Talieha would have some difficulty in adjusting to her new environment as the living arrangements were very different. They were aware she would regularly become unsettled between the hours of 9 and 10 in the evening. Strategies were already in place to assist in reducing her level of distress. Ms Northcote were also aware the initial period following transfer may be a period of regressed behaviour that may have resulted in self harming actions. It was on this basis it was agreed a period of 1:1 24 hours constant visual observations would be implemented. Ms Northgate stated the level of the observations were then adjusted in accordance with the level of risk and response to management plan, all of which were monitored by the multidisciplinary team.

350. Ms Northcote stated Talieha was uncomfortable by the decision for her to be continually observed and it was explained to her this would be time-limited and be dependent upon her adjustment as well as her behaviour in her new home. Talieha was provided with clinical support over a 24-hour period up until 31 January 2014 when she had weekend leave with her family. The service continued to gradually reduce the level of observations and subsequently reduced them to the period from 1:00 pm until 9:30 pm. The hours between 9:00-10:00 pm were the last removed. This occurred over a one month period as Talieha settled in the unit. Ms Northcote stated the reduction in hours of constant observation were made by the treating team. They did not consult with Dr Brennan on this matter.

351. The PRCCU clinical team assessed Talieha as no longer requiring this extra level of observation and ceased all extra visual observation as of 21 February 2014. By this point Ms Northgate stated Talieha was more comfortable around the other clients and while she preferred her own company she would often be seen socialising with the other clients. She also demonstrated a level of restraint with her self-harming behaviours. She was also continuing to access on average three hours of leave from the PRCCU as well as overnight and weekend leave.

352. These decisions are not reflected in the conditions of the Transition Plan identified in Ms Northcote's statement to the Commission and this raises the issue as to why additional support was reduced. Dr Stewart's statement to the Commission noted that on the majority of occasions on which he reviewed Talieha, her mental state was stable and mood euthymic. It was his opinion she was settling into the unit and beginning to adjust to her new surroundings. There were occasions, as to be

expected, where she tested the limits of the unit and the most serious of these were the times when she was using illicit drugs.

353. Dr Stewart also thought the frequency of self-harm prior to her death was infrequent and it would appear much less frequent than the episodes of self-harm that had occurred during her residency at the BAC. Dr Stewart considered this reduced frequency of self-harm may be seen as an indirect measure of clinical improvement. Dr Stewart also stated the treating team was continually reviewing Talieha's mental state and her needs and were revising the treatment plan as appropriate. He considered the treatment was flexible and responded to her needs appropriately.

354. Dr Stewart's statement to the Commission was he had no concerns about the ongoing treatment of Talieha at the PRCCU or TPCH mental health unit. In a further statement provided to the coronial investigation Dr Stewart states that what he was referring to was he had no concerns about the treatment being provided by the treating team, of which he was a member. He did not have any involvement in the decision to transfer Talieha to the PRCCU and she was already a resident when he took up his position. Dr Stewart states he did have concerns about her ability to adjust in an adult mental health environment such as the PRCCU. Those concerns arose because, in his opinion, she was an immature young person being placed in an adult facility despite turning 18 in February 2014. In that regard she was an atypical resident for the PRCCU. He is not aware of how Talieha was assessed for transfer to the PRCCU or why it was determined it was an appropriate facility for her to be placed.

355. Ms Northgate stated Talieha was seen regularly by her treating psychiatrist or registrar at least weekly. Following discussion with the rest of the team, and a review of the documentation, a decision was made regarding the level of additional supervision she required at the time. Talieha was also involved in these discussions.

356. Ms Northcote also referred to the Transition Plan, which she said would be changed from time to time as people respond in different ways. The plan had been initially put together by herself and Shannon Dawson. Ms Dawson was involved in the funding arrangements. The various iterations of the plan seen in the documents provided to the coronial investigation appear to reflect early versions as further discussions took place as to level of nursing care to be provided.

357. Ms Northcote had attended a handover meeting with the team and Dr Brennan and this had included discussions of nursing care to be provided. She agreed Dr Brennan wanted nurses providing constant observations and by the time Talieha arrived they had the funding in place to do this. It is apparent PRCCU made a decision the period for constant observation should be undertaken by one nurse only and not two, as had been suggested in an earlier version of the Transition Plan.

358. It is also apparent Ms Macleod from BAC also wanted to visit Talieha at the PRCCU but a decision was made this should not occur as the BAC closure remained an emotive one and they wanted Talieha to concentrate on where she was now and not be brought back into emotions about the closure.

359. Dr Julio Clavijo Carmone saw Talieha on 7 February 2014 as part of the weekly ward meeting, which was two weeks since the transfer from BAC. There had been

no behavioural disturbance and she had been on constant visual observations. Because she was doing well it was agreed to consider cutting down the level of observations in a stepdown manner. Talieha was granted weekend leave with her mother as a reward for her good behaviour so far. Talieha also requested a decrease in level of observations and this was granted. The treating team continued her constant observations from the hours of 1:00 pm to 9:30 pm

360. On 9 February 2014, during weekend leave with her mother, police found her walking along the street with her mother. Talieha is reported as saying she did not want to go back to her mothers and the police drove her back to PRCCU .The next day Talieha became angry and distressed about the events of previous day when she was on leave with her mother. Ms Robertson spent some one-on-one time with her, noting constant observations were commenced at 1:00 pm.

361. Talieha told Emma Betson she had consumed marijuana with friends and there was an incident involving her mother and friends of her mother consuming significant amounts of alcohol. Ms Betson noted Talieha was a high risk of significant self-harm and 1:1 support may be required.

362. On 12 February 2014, Talieha cut her arm several times superficially and said she was having a "bad day".

363. Dr Stewart saw her first on 14 February 2014 with Dr Clavijo Carmone. There had been one episode of self-harm on 12 February but at this time Talieha presented as pleasant and polite. Dr Clavijo Carmone stated Talieha requested leave only to go to church on Friday night and on Sunday to go out with her friends. She stated she did not want to go on leave to her mother's home for the weekend. Ms Pryde was advised and spoke to the treating team and said Talieha had been intoxicated and verbally abusive towards her. She requested Talieha be given day leave on Saturday to share with her father's family. Talieha was given the choice to accept or decline day leave and she agreed to go from 9 am to 4 pm Saturday.

364. Ms Robertson also noted concerns of Talieha's mother at an interview on 14 February about the difficulties with respect to previous weekend of events as well as concerns regarding two of Tallieha's friends and contact by a member of BAC, which her mother considered unprofessional.

365. On 16 February 2014, Talieha expressed suicidal ideation to Nurse McElhinney but also stated she was able to guarantee her own safety. This appeared to have occurred in the context of an argument she had with friends on an outing.

366. On 17 February 2014, Talieha was reported by Emma Betson as having self-harmed and being in an agitated state. She did not require medical intervention. Ms Betson stated the behaviour was consistent with Ms Betson's understanding of Talieha's history of impulsiveness at the BAC and was not uncommon. This was the third incident of self-harm since the transfer from BAC. Dr Julio Clavijo Carmone reviewed Talieha and increased the duration of her level of visual observations to continue overnight to avoid an admission to an adult MHU.

367. Ms Northcote stated the treating team discussed the incident with Talieha and informed her she would be treated as an adult and would be expected to be responsible for the appropriate use of personal items, including razor blades. Razor blades were removed as an interim measure but were returned to her following a

review on 19 February 2014. Ms Betson stated Talieha re-engaged with the rehabilitation program in the days following the incident.

368. Ms Northcote was asked generally about how they managed the history of suicidal ideation and deliberate self-harm. She stated that in this new environment they were never going to be able to negate the risk altogether. They firstly managed this by having extra observations in place. There was someone at the unit at all times and a clinician was appointed to provide care at each shift. At the beginning of each shift there would be a handover where all staff would be present. As the patient become more independent the risk was always there but the risk would also be present when they were on leave or were at home.

369. Ms Northcote stated patients with a Borderline Personality Disorder are challenging and you cannot dictate a particular approach. There would be fluctuations in mood but often Talieha's distress resolved quickly after self-harming. Part of the plan for managing the risk was also to admit her to TPCH when an escalation was necessary. She had been referred to hospital on 17 February and 25 February. On one occasion she was admitted to the PICU ward but this was for her own safety due to a cohort of other patients on the other ward and not for risk containment. Ms Northcote also stated persons with Borderline Personality Disorder are better managed in the community rather than in hospital. Ms Northcote stated the reference in the *Crisis Management Plan* to a low threshold for hospital review was specifically for a psychiatric review and not an admission to hospital as this is a decision to be made by the psychiatrist.

370. The incident on 17 February 2014 involved a superficial laceration to her wrist. Ms Northcote stated as Ms Betson was still concerned Talieha was still agitated it was considered she should be reviewed. When the decision was made that she would not be admitted to hospital they increased her observations on a 1:1 basis overnight.

371. On 19 February 2014, Dr Clavijo Carmone had a discussion with Dr Jacinta Powell and the need to start discharge planning in terms of accommodation and that Talieha would require high level of support in the community. It was speculated this process would take 12-18 months at the very least. The Resource Team Coordinator was tasked to gather as much information about the level of support and options as needed.

372. Dr Stewart and Dr Clavijo Carmone reviewed her again on 21 February and Talieha presented as settled with no ongoing self-harm episodes. Dr Stewart noted the likely trigger for the self-harm was stress due to extra family members being around. She displayed limited insight into these triggers. Talieha wanted more leave on the weekend but it was explained she needed to spend more time at the PRCCU to minimise the stress. Accordingly she was given one night leave with her mother and three to six hours of unescorted day leave. Constant visual observations during the evening were ceased. Ms Betson stated that part of the program towards the ultimate goal of living independently was to have periods of leave away from PRCCU, including overnight leave to engage in activities within the community.

373. RN Leigh Robertson was a member of the case management team and on 23 February 2014 was responsible for Talieha's care on the allocated shift of that day. She commenced at 2:30 pm when Talieha was out on leave. When Talieha had not returned by the due time she was telephoned and Talieha stated she was late

as they were getting fuel. When Talieha was contacted again at 3pm she informed staff she was in her room but had not let them know. She spent most of the afternoon in the room and in the company of a male and female friend. They all appeared happy. The friends left at 5pm. Talieha then presented to the office requesting paracetamol, which she was given. She said she felt sick but was dismissive and difficult to engage. She returned at 6pm requesting further medication for distress and agitation and again was dismissive of offered staff support and refusing to engage. She was given diazepam and her regular night dose of Seroquel. She presented again an hour later at 7pm requesting further medication and appeared agitated and distressed. She was given further Seroquel. RN Robertson continued to monitor her. Talieha denied any thoughts or ideas or plans of self-harm and agreed she would call staff if she required assistance or felt unsafe. There were no further issues for the remainder of the shift.

374. On 24 February 2014, Talieha self-harmed by cutting her hand. She disclosed to Ms Betson that whilst on leave on 23 February she had engaged in recreational cannabis use and while intoxicated had a distressin experience. Ms Betson stated she spent a significant amount of time with Talieha providing her with support and the opportunity to discuss the events, however Talieha refused to provide details of the incident. Both Ms Betson and Ms Northcote provided Talieha with the option of making a formal complaint to police but Talieha declined this.

375. On 25 February 2014, Talieha was taken to TPCH by Ms Betson. Talieha had the previous evening superficially cut herself with glass. Given the totality of the events of the previous day it was thought by Ms Betson that Talieha should have a psychiatric assessment. Talieha was clinically reviewed by Dr Phillip Nyst the psychiatric registrar. The clinical history given to Dr Nyst was Talieha had also made a noose out of a piece of ribbon during the week before. Dr Nyst did not feel she was in need of an acute inpatient admission and therefore Talieha was to be transported back to PRCCU.

376. According to Ms Betson, during the return journey Talieha acted in a dangerous manner. She then became more responsive and started talking but said she could not recall the recent events.

377. Other staff members immediately drove to where the incident occurred and Talieha was seen to be settled but was subdued and could not guarantee her safety. PRCUU staff including Ms Betson then returned to TPCH hospital and Talieha was subsequently admitted overnight. She was taken to the psychiatric Intensive Care Unit for her own sexual safety due to the current cohort of young male patients in the open section of the ward.

378. Dr Nyst's statement was to the effect Talieha was unwilling to answer a number of questions and it was felt there was sufficient risk to justify containment. She was admitted to the ward under the treating team. Dr Nyst stated in evidence at the inquest there was an underplay present on the basis Talieha clearly wanted to be admitted and they had missed this. She clearly wanted help. Dr Clavijo Carmone was also involved in a limited manner as he spoke to Talieha to ensure she understood the reasoning for the admission and that appropriate paperwork and safety measures were in place.

379. When reviewed by Dr Pettet the next day Talieha was unable to articulate a trigger for the previous day's events. Her mood was now good and she was much more settled and she was keen to return to the PRCCU. Talieha denied any suicidal

ideation or of deliberate self-harm. Although she remained at a risk of chronically elevated suicide she appeared to have returned to her baseline. It was agreed there was no contraindication of a return to PRCCU and she was discharged.

380. Talieha provided the names of the two friends to Ms Betson and both of them were subsequently banned from attending the PRCCU.

381. On 26 February 2014, Talieha became distressed as she thought she may have upset her case manager. Ms Robertson said Talieha was given reassurances this was not the case and she settled. Sometime later Talieha left the unit. She was called and asked to return and did so sometime later in a distressed state and requested staff sit with her and she settled.

382. At a further review on 28 February 2014, the issue of her Involuntary Treatment Order was discussed and Talieha was told it was to be continued, subject to her legal rights for this to be reviewed by the Mental Health Review Tribunal (MHRT). She appeared to be settled and was given overnight leave with her mother. Further reviews on 7 March 2014 with Dr Stewart and Dr Clavijo Carmone were of the same view and she was given further overnight leave.

383. On 3 March 2014, Ms Northcote spoke to both Talieha and her female friend about concerns regarding inappropriate conduct but did not provide any further details.

384. On 10 March 2014 Talieha, Ms Betson and Dr Stewart attended at the MHRT where the continuation of the ITO was confirmed. Talieha then accessed six hours of leave. After the leave had finished a youth worker contacted PRCCU to say she had received a text message from Talieha in which she said "goodbye" and that she loved her. Staff checked on Talieha and found she had cut her arm. Talieha said there was a list on the table of medication she had taken. She was later that day admitted to TPCH ED due to a poly-pharmacy overdose. Ms Betson stated Talieha told her she had been storing the medication over a period of time and a friend had also provided her some. A decision was made for the friend to not be permitted to visit the PRCCU.

385. Dr Phillip Nyst reviewed her the next day and noted she was at constant chronic ongoing risk of self-harm and she had done so many times in the past. At the time of the assessment Talieha felt safe and she was no longer in any risk of self-harm and wanted to return to PRCUU. Dr Nyst felt there was no short-term gain in keeping her in hospital further than was necessary against her will.

386. Talieha was seen on 14 March 2014, by Dr Stewart and Dr Clavijo Carmone and she was given one night leave and her day leave was limited to three hours only for the following week during weekdays and the need to return by 5:00 pm. This was an attempt to set more clear limits. The notes of the review indicated the only trigger that Talieha could identify was not having a good time with her friends that day.

387. After going on leave to her mother's on 16 March 2014 she disclosed she had been given marijuana by her two friends. Dr Stewart noted she was unsettled on 17 March but had settled by the next day.

388. Dr Stewart also notes there was a clinical case review meeting on 21 March 2014. Dr Stewart in his latest statement suggests he is not sure whether Talieha was physically present at this review meeting. The contemporaneous notes made by

Dr Clavijo Carmone do not reflect this and it is possible the review was based on information as to her progress given by nursing staff. In any event the information was that Talieha was more settled and it was agreed she could have one night leave at her mother's home. The clinical file suggests the leave was successful and she returned to PRCCU on 22 March expressing no concerns.

389. Ms Northcote stated from reviewing the chart Talieha had attended the drug and alcohol group on 25 March 2014 where Talieha was able to identify the risk associated with cannabis use. Emma Betson noted Talieha was struggling with her desire to self-harm but had been able to abstain from actioning this desire. Her motivation for not harming herself was related to her upcoming family holiday to Hawaii on 10 April 2014. Talieha had stated she was looking forward to this holiday and Ms Northcote stated it appeared to be a strong protective factor in supporting her in abstaining from any self-harming behaviours.

390. Ms Northcote stated Talieha had been reluctant to engage with the PRCUU psychologist as Talieha believed the particular psychologist was used to seeing adults and not adolescents. Ms Northcote made some enquiries as to whether there was another psychologist available who had training in working with adolescents and trauma. Unfortunately by the time this person was found Talieha had been taken to hospital.

391. Ms Betson stated that on 26 March 2014 Talieha reported she was feeling 'horrible'. She was told she could access 30 minutes unescorted leave as well as overnight leave on the coming Friday night. After hearing this Ms Betson said Talieha's mood improved and she presented as cheerful and bright. Ms Northcote then telephoned Talieha's mother to provide her with this news. Ms Betson stated Talieha told her she received a telephone call from her mother who had yelled at her about the lack of overnight leave she was approved. Talieha appeared upset about this conversation and had been crying. Later that afternoon there was a self-harm incident in the context of this emotional distress. Ms Betson considered the episode of self-harm was of very low intensity and did not require further management.

392. Ms Robertson recorded in the case notes that on 27 March 2014 Talieha presented as bright and cheerful and she went on 30 minutes unescorted leave. She later attended for her medications.

393. Dr Stewart and Dr Clavijo Carmone saw her on 28 March 2014 and Talieha appeared well-groomed, calm with appropriate euthymic mood and reactive affect. Talieha requested an extra three hours leave on Sunday to attend church and this was agreed to. She was also able to go on one overnight leave with her mother. It was decided with Talieha she should have only one night leave per week until her holidays with her family in early April.

394. Talieha returned from leave on 29 March 2014. She initially stated she was fine but she appeared to have been crying and her eyes were red. Talieha was said to have responded well to spending time with staff. Talieha stated she thought she should start to see a psychologist again and she was feeling overwhelmed and lonely. She presented as much calmer later in the evening.

Issue 2 - Immediate circumstances leading up to death

395. Talieha's mother Nichole Pryde provided a statement about her knowledge of the events leading up to Talieha's death. Her knowledge has essentially come from what she has been told by Ms Northcote and Dr Jacinta Powell at a meeting held with her after Talieha died. She became aware an incident had occurred on 31 March 2014 and as a result Talieha was not coping and was struggling. Ms Pryde was not aware of the nature of the incident.

396. Ms Pryde was told that on 1 April 2014 Talieha declined the support of the staff at the Pine Rivers Community Care Unit (PRCCU). She said declining support was something Talieha had always done when she needed help the most and the staff at BAC knew this about her.

397. Ms Pryde stated she was told the staff then sat with Talieha for a period of time and then advised they would be doing 10 minute checks on her. She understood they performed two checks at the correct intervals but 30 minutes passed before the third check was done. She had been advised the staff were distracted in the driveway and did not get to the third check at the required 10 minutes. By this time it was too late.

398. Ms Pryde was also informed that when Talieha was found there was loud music playing. This was something Talieha regularly did when she required support and assistance in the past. She stated Talieha usually did this as a sign to others that they needed to come and find her and the staff at BAC knew this about her.

399. It is clear on the evidence Talieha was last seen by a staff member at PRCCU just after 4:30 pm on 1 April 2014. She was sitting on her bed listening to soft music. At about 5:00 pm, a staff member heard loud music playing in Talieha's unit and went to check on her. The staff member found Talieha and the QAS were called.

400. There is some contention as to when the incident referred to by Ms Pryde that caused Talieha's concern actually occurred. The records indicate Talieha was granted leave to attend church on 30 March 2014. It is understood Talieha was said to have gone to church with a friend, although there has not been any confirmation from the friend this is what occurred. Her aunt has produced a text message she received from Talieha at 7:26 pm on 30 March 2014 making reference to the fact Talieha was at church.

401. The records indicate on 30 March 2014 Talieha came to the nurses office to let staff know she was leaving with her friend to attend church between 5:00 pm and 8:00 pm as had been agreed to. Talieha returned at the due time. She did not voice any concerns and appeared relaxed and calm on her return.

402. The records do not indicate Talieha had been granted unescorted three hour leave on 31 March 2014, nor is there any record Talieha left on leave from the PRCCU on 31 March. If she did then it was without permission.

403. What is known from the statements of Ms Northcote and Ms Betson and confirmed in the medical notes, is on the morning of 31 March 2014 Talieha had been difficult to rouse from bed and presented as sullen. The medical notes indicate she spent the majority of the morning in bed. Ms Betson completed a case note at 3 pm. Emma Betson stated Talieha reported to her increasing episodes of disassociation

over the past week, that she could not remember events and she found these episodes scary. Talieha also stated at times she feels as though she is "outside her body" and found this difficult to explain. Ms Betson did not report this to psychiatric staff and stated it would have been recorded and reported at some point in time.

404. Talieha also discussed her underlying worries about going to Hawaii, particularly related to her body image and self-esteem. This was something PRCUU staff had discussed with her on admission, offering solutions and ideas on how to cover up her scars so she would feel more comfortable wearing short sleeves clothing or swim wear.

405. The case notes did not reveal any other interaction that day and no leave is noted in the records as having been agreed to or accessed.

406. What I can find on the balance of probabilities is an incident occurred on either 30 or 31 March, but most likely the latter date and probably as described below, which in hindsight precipitated the crisis Talieha experienced on 1 April 2014.

407. On 1 April 2014 Talieha had been taken by Ms Betson for a random urine drug screen test. She then attended to her household tasks with the assistance of the PRCCU cleaner and overall she presented as pleasant and bright. Ms Betson observed her to engage with the teachers from the BAC school and she was seen to be laughing appropriately and engaging in conversation with her teachers.

408. It is evident her mood changed in the afternoon. According to the Root Cause Analysis Emma Betson heard loud music coming from her room and went to speak to Talieha. Talieha was sitting on the floor with her teddy bear and had thrown her possessions around. Ms Betson spoke to Talieha who eventually disclosed she had accessed and smoked marijuana with a male friend during three hours leave "the previous day". She also disclosed a distressing incident involving other persons. Talieha was distressed while recounting this experience and Ms Betson spent a couple of hours with her following this disclosure.

409. Ms Northcote spoke to Talieha in the company of Ms Betson at 4:00 pm in the office foyer and Talieha presented as agitated, hyperventilating and not able to express herself. They spoke to her for a further 30 minutes providing reassurance and assisting her to calm down. She was given positive reassurance about how far she had progressed and Ms Northcote and Ms Betson stated she became calmer and appeared more in control of herself. At that stage EEN Gabriella Pietrucci observed some of this interaction and offered to take her out for a while. Talieha declined and stated she wanted to spend some time in her unit. Talieha had also declined PRN (when necessary) medication.

410. Ms Northcote stated that had Talieha's level of agitation not diminished she would have considered taking Talieha to hospital for further assessment, but following intervention and although she presented as sullen and tired, there was no evidence of agitation. Ms Northcote's assessment of the situation was the peak of the crisis had passed and Talieha would respond to further staff support over the evening, as had been the case after previous episodes of crisis.

411. Ms Northcote was asked about warning signs and the reference in the Crisis Management Plan to psychomotor agitation. She explained this was reference to more physical agitation and on 1 April Talieha was agitated but was sitting. Ms

Northcote also did not consider that just because Talieha wanted to be on her own after the incident was evidence she was isolating herself, this being again another warning sign.

412. Ms Northcote stated one of the key triggers for Talieha was encounters similar to the encounter she had experienced and which brought her into crisis. It was her clinical judgement Talieha was in crisis when she came to the foyer, but her level of agitation had decreased and Ms Northcote made the clinical decision it was not necessary for Talieha to be taken to hospital for review. She also decided not to proceed with constant observations but there would be regular contact by nursing staff. Ms Northcote stated if it had been thought Talieha should be placed on constant special observations she would have referred Talieha to hospital first for an assessment.

413. Ms Betson stated in relation to the events of 1 April 2014 that although Talieha was agitated at the time of being escorted to the main foyer, after further reassurance and clinical support her level of agitation had subsided and it was considered appropriate to continue to manage her at PRCCU. Ms Betson agreed Talieha was not showing symptoms of disassociation at the time, was seeking help by informing them and still had a forward focus on her trip to Hawaii.

414. Ms Betson stated at this time the consultant psychiatrist or psychiatric registrar would not be on the premises. Telephone consultation could have been possible, however at the time it appeared the crisis had passed and Talieha was not expressing suicidal ideation, plan, intent or thoughts to harm herself in any way. Her presentation was regular in that she was not demonstrating any behaviour out of the ordinary. For similar reasons, having her reviewed at TPCH was considered but was rejected.

415. Dr Stewart noted that over 31 March and 1 April there were no episodes of disassociation and on the morning of 1 April she presented as bright and cheerful. When her crisis developed in the afternoon the staff were able to calm and settle her. It was then for the clinicians to assess her and Dr Stewart agreed there was nothing from that description, which would have caused him to second guess the decision of Ms Betson and Ms Northcote. Dr Stewart stated the fact she became distressed did not necessarily mean she should be admitted to hospital. This may have been necessary if she had not settled. He was not critical of staff not contacting him as it seems the clinicians at the time felt the crisis was contained.

416. Ms Betson stated Talieha's history had shown that once the peak of a crisis had passed, she would be more in control of herself and would respond best to staff support over the evening. Talieha was given the option of increased supervision, which she declined. As she was not presenting as agitated, it was deemed appropriate staff visually observe her every 10-15 minutes. Ms Betson was unable to say why they did not apply 1:1 constant observations for a period of time.

417. Ms Betson agrees when you look back on it that Talieha had been in crisis but her level of distress reduced, she was orientated, coherent, and able to identify why she had been upset. Although she was lowish in mood and tired there was no suicidal ideation and Talieha said she was able to guarantee her safety. The plan was to have a staff member regularly check on her. Ms Betson wrote in the case notes there was to be no more unescorted leave after 5pm and only 30 minutes leave unescorted daily. This decision was made jointly by Ms Betson and Ms Northcote.

418. At this time it is apparent Ms Betson and Ms Northcote's shifts were ending and EEN Pietrucci was the person advised to keep up regular visual observations. EEN Pietrucci said in her first statement she understood this to be every 20 to 30 minutes. She said she went to the unit at approximately 4:30 pm and Talieha appeared sullen and crying and she was lying on her bed. Talieha was offered to be taken out for a while but she declined and said she wanted to be alone and listen to soft music. In her statement EEN Pietrucci says at approximately 5 pm EEN Pietrucci found her unresponsive. There was very loud music playing in the unit when she arrived.

419. In the retrospective case note EEN Pietrucci wrote at around 7:45 pm she is recorded as saying Talieha went back to her unit at approximately 4:30 pm and she went in to check on Talieha at 4:40 pm. The case note states that Talieha was still low in mood, listening to soft music and sitting on her bed. She offered to take her for a walk to the shops or remain sitting in her room but Talieha rejected these offers and requested to be alone.

420. In a supplementary statement EEN Pietrucci stated her best recollection is Ms Beston requested she conduct 10-15 minutes observations. She states the first visit was at approximately 4:40 pm and she estimates she would have left the room at approximately 4:45 pm and approximately 15 minutes passed before she returned to the room at approximately 5:00 pm.

421. EEN Pietrucci saw Talieha earlier with Ms Betson and Ms Northcote at the beginning of her shift at 2:30 pm and did not take part in those discussions but could see Talieha was crying and was upset. She was aware from the handover at the beginning of the shift it was about something that happened the day before and Talieha was unhappy with herself. In evidence EEN Pietricci said she had been asked by Ms Betson to check on Talieha every 10-15 minutes and says she did. EEN Pietrucci says Talieha was always pleasant to her but was detached with her. She confirmed she went in and saw Talieha at 4:40 pm and was dismissed abruptly by Talieha. Soft music was playing. Talieha was more settled than how she seemed earlier.

422. EEN Pietrucci says she went back in at 4:55 pm and heard loud metallic gothic music. She recalls speaking to another patient who was coming back from leave in the driveway. She says this distraction would have been for only a minute.

423. EEN Pietrucci abruptly went for help and Wayne Wieland and Matthew Cloumassis attended. Mr Cloumassis had to find a tool, which took a little time to find and was not a specific tool that can often be found for such events in other units. Mr Wieland called Queensland Ambulance Service. CPR was commenced by Mr Cloumassis. There was some delay in QAS arrival in that it was not uncommon for ambulances to go to Pine Rivers Community Mental Health at 568 Gympie Road rather than 568A where the PRCCU is situated. Mr Wieland had to run at 120 metres from the PRCCU driveway to lead them to be correct premises.

424. A first ambulance arrived approximately 14 minutes after the emergency call. Good resuscitation had been commenced by staff and then QAS and efforts continued enroute to the TPCH where Talieha was admitted to the ICU in a critical condition. She showed no signs of recovery having sustained hypoxic-ischaemic encephalopathy. Life supporting measures were ceased on 6 April (some 5 days after the event), and she died at 5:15pm.

425. Staff inspected the unit later to see if there was any suicide note. None was found. On the mirror in the ensuite one word written in lipstick.

426. In the period after closure of the BAC specific triggering events of self-harm or distress often involved incidents with her mother but more particularly a number of incidents with friends involving the high risk use of drugs, alcohol and sexual assaults, sometimes in combination.

427. It is in my view not a coincidence that the one period of admission to hospital on 25 February 2014 followed such an incident of likely sexual assault whilst she was intoxicated. Talieha had significant issues with attachment and self- esteem. The events described as having occurred on 31 March 2014 were similar in nature and probably would have been more distressing. The method by which she died also is well known to have a high lethality rate.

428. On balance I am satisfied Talieha's actions on 1 April 2014 were intended to end her life and was not a cry for help or attention or a case of misadventure. In the setting of her fragile mood and issues of self-esteem particularly in the context of the history of emotional trauma as a result of past sexual abuse, the events of 31 March 2014, at that point in time were highly significant to Talieha. Her poignant note left on the mirror says it all.

Autopsy results

429. An external autopsy was performed on 8 April 2014 by Dr Rebecca Williams (but signed off by Dr Alex Olumbe). Toxicology revealed the presence of therapeutic/sub-therapeutic concentrations of anti-depressant citalopram and its metabolite, anti-psychotic medication quetiapine, a low concentration of the metabolite of diazepam and an inactive metabolite of cannabis. Alcohol and other drugs were not detected.

Issues 3-5 Whether BAC closure had any adverse impact on the mental health of Talieha, management of her mental health from discharge to her death and transition plan implementation

430. A review of Talieha's long term mental health history does not indicate the physical closure of BAC per se as a residential treatment facility had an adverse impact on Talieha's mental health. As submitted by Counsel Assisting her fragile mental health continued in much the same manner as it had been before she left BAC. Her moods fluctuated frequently, and there were multiple episodes of self-harm and regular suicidal ideation.

431. Talieha was approaching the age of 18. She had been living at BAC virtually full time for three years. She would have been transitioning at some point from BAC, although if BAC had remained open it is likely the transition process would have consisted of a more formal cross tapering of therapy and transitioning as envisaged in the ideal transitioning arrangements Dr Brennan and others would have preferred.

432. Dr Brennan stated in evidence she thought the impact of the closure on Talieha was significant. She stated Talieha needed to adapt to life away from Barrett. Although she was turning 18 and leaving BAC would have happened at some point, in the months leading up to the closure Talieha's mental health was affected by that fear and she was anxious about her ability to cope. Towards the end Dr Brennan thought Talieha had a slight positivity about her, which was that with the

closure being imminent and inevitable, she had a sense of trying for something better or different.

433. Unlike Caitlin, who was already in a form of transition, Talieha was in reality being transferred to PRCCU due to the closure of BAC and there was a lack of time for planning for that to occur. As well there was some delay in receiving funding for Talieha, which caused some further delay.

434. Dr Brennan stated at the inquest Talieha had developed a borderline personality structure such that she struggled to tolerate difficult affective states. She was impulsive and therefore was at risk on a longer term basis. Dr Brennan did not think Talieha was going to be cured or be in remission from her personality and this was an enduring issue for her, which would require ongoing management. Dr Brennan stated Talieha was ready to transition but to transition to something that could then provide what she needed for the management of her disorder.

435. Dr Brennan had concerns about Talieha residing at PRCCU and had requested a stay in an acute adolescent unit prior to that occurring. That was not able to be provided and Dr Brennan accepted the option of PRCCU with funding for two x 24 hours nurses for a time (6 months was mentioned) as the best option available.

436. Dr Brennan, BAC staff and PRCCU did what they could to ensure Talieha was comfortable with the move but the timing meant the cross tapering was limited to a couple of visits and there was no ongoing care provided by BAC staff after the transfer for even a limited period.

437. What transpired in Talieha's case is the transition arrangements as implemented were different to those Dr Brennan envisaged, particularly in that the two nurse care element of her expectation was never put in place, and only one nurse was to be supplied, while the 24 hour element was to be dropped within the first month.

438. The decision to do adopt the amended transition plan was not relayed or discussed with Dr Brennan. However the decision was made by relevantly qualified PRCCU clinical staff based on their clinical assessments at the time. Dr Brennan stated in her evidence at the inquest she did become aware there was only one nurse when she visited PRCCU, but given the physical environment of where Talieha's unit was and everything else, one on one was probably as intensive as Talieha could have sustained. Dr Brennan stated at the inquest she would have been surprised and reluctant to recommend a reduction in the hours initially suggested unless they were certain there had been a significant improvement in her condition. In Talieha's case there was some settling in her mood as she got used to PRCCU, but what is described as her mental state is in my view more a reversion to her BAC baseline, and as such it could not be suggested this was an improvement from her baseline.

439. Nonetheless, I accept there was justifiable clinical reasoning and rationale for reducing the level of supervision as determined by the various clinicians involved in Talieha's care at PRCCU and in the context of an evolving dynamic, which supported a change. It should also be noted the level of Talieha's supervision was increased and decreased at times in accordance with her clinical presentation, evidencing the plan was an evolving one. It is evident Talieha's condition was regularly assessed during individual consultations and reviewed at weekly team meetings. There is no evidence to suggest funding arrangements or lack thereof were a factor in any clinical decision making. I am not critical of the clinical decisions made or the care provided to Talieha. PRCCU staff were doing the best they could in the setting of an adult mental health facility.

440. Otherwise the transition plan for Talieha was largely implemented and carried out. It is clear the admission to PRCCU was going to be for some time whilst the transition to more independent living in the community took place. References to 18 months to two years are noted in the evidence. The PRCCU was not BAC but it did provide accommodation with 24 hour supervision, with daily access to various therapies and acute admission to hospital if necessary. The evidence suggests there was not available at that time any other facility that could deal with her particular behaviours and condition.

441. The closure of BAC as a facility in the way it transpired did have the result of Talieha not having continued input into her support and treatment by those who knew her condition best. There was therefore a loss of continuity of care for an adolescent with a complex condition who was now being treated in the adult mental health system. PRCCU and its staff were the best option available in the circumstances that eventuated but if there was to be a case where continued involvement of clinicians who were experienced in adolescent mental health and/or had knowledge of Talieha was to occur, then Talieha was certainly that case.

442. As to whether this was a determinative or contributory factor in the events of 1 April 2014 is not so easily resolved. A little over two months had transpired since Talieha was transferred to PRCCU. Her transition to more independent living arrangements was going to take place over an extended period of time. There was no timetable set and PRCCU was clearly supporting Talieha in working towards that goal.

443. When Talieha was in crisis that afternoon she was appropriately comforted and counselled by professional clinical staff. The clinicians had experienced such crises in the time Talieha had been with them at PRCCU. On each occasion of such crises, at a point in time she settled and clinicians considered the crisis had passed. That was how they assessed her that day, that is, the crisis had passed and she was settling. Talieha had not expressed any suicidal thoughts. The staff considered she did not need a psychiatric review but determined she should be closely monitored, as part of her condition involved self-harming behaviour to relieve her distress. The staff did not consider she was at risk of suicide. Closer observations more or less happened, albeit with some gap in between the last two observations.

444. With the luxury of the benefit of hindsight, and having considered Talieha's particular vulnerabilities and history, it is evident Talieha was experiencing a crisis as a result of an event that would have been distressing for most young women. In the context of her significant issues with attachment and self-esteem, and the history of disclosures of many past incidents, this incident would have objectively on any criteria have been particularly distressing to her.

445. When last observed Caitlin was in her room listening to soft music. When last found the music was playing very loudly, a warning sign for her being in crisis and identified as such in her Crisis Management Plan. This was one of the behaviours Talieha adopted whilst BAC, although there does not appear to be any such incidents recorded whilst at PRCCU, until earlier that afternoon. In hindsight, providing closer observation at the time they considered the crisis was settling, may have made a difference to the outcome, but the decision to allow her some personal space with close rather than constant observations was not objectively plainly wrong.

Findings required by s. 45

Identity of the deceased – Talieha Nebauer

How she died – Talieha Nebauer had been a long term patient at the Barrett Adolescent Centre. When it closed Talieha became a resident at an adult mental health facility at Pine Rivers. PRCCU was staffed 24 hours a day. Talieha had very complex mental health problems considered to be post-traumatic stress disorder, emotionally unstable personality disorder and problems with life cycle adjustment. The traumatic symptoms were thought to relate to childhood sexual abuse and domestic violence in the context of alcohol and other substance abuse in the family home. Talieha had many instances of self-harm and threats of suicide during her time at BAC. One of her particular vulnerabilities related to attachment and self-esteem. The day prior to Talieha making the decision to take her own life she had experienced an incident which, would have been particularly distressing to her self-esteem. In the setting of her fragile mood and issues of self-esteem and particularly in the context of the history of emotional trauma as a result of past sexual abuse, this incident became a triggering factor leading to her decision. Talieha presented to her clinical carers on the afternoon of her making her decision in crisis. Over a number of hours her carers believed the crisis was passing and she began to settle, as had been the case in the past. A clinical judgment decision was made that Talieha did not require a psychiatric review or to be constantly observed, but she was to have regular closer in time observations. During a gap in those observations she took steps which ended her life. In hindsight, closer or constant observations may have made a difference to the outcome, but the clinical decision and reasoning was not objectively plainly wrong.

Place of death – Intensive Care Unit Prince Charles Hospital
CHERMSIDE QLD 4032 AUSTRALIA

Date of death – 06 April 2014

Information particular to William Fowell

Background

446. William was born in New Zealand. His family moved to Brisbane in 2000. William's background history was of mild intellectual disability, epilepsy and cerebral palsy (right hemiplegia). This history all stemmed from an event at three months of age where William suffered from a stroke secondary to sepsis, which resulted in right side hemiparesis. At eight months of age he developed epilepsy, experiencing up to 200 myoclonic jerks per day. He experienced difficulties with visual perception, auditory memory and concentration.

447. William received treatment at the Royal Brisbane Children's Hospital after the family moved to Brisbane with regular presentations to hospital. William was referred to the Child and Youth Mental Health Service- Child and Family Therapy Unit at RBCH. Over the years his behaviour became problematic with screaming fits and aggressive outbursts at home and at school and this became more significant in 2011/12.

448. William's parents separated in February 2012 and he continued to reside with his mother until she was unable to manage his aggression, frequent medical complaints and hospitalisation. William's father had no contact with him for a number of months but resumed contact around June or July 2012. It would seem William's anxiety and behaviour was often attributed to his relationship with his family. It is evident the relationship between William's mother and father continued to be strained.

449. There were a number of presentations to Nambour Hospital for management of abdominal pain thought to be pseudo seizures. William's aggression and episodes of screaming led to his admission to BAC on 28 August 2012. He was discharged to Wacol Villas on 24 January 2014.

450. William's father, Brent Fowell was appointed his guardian by the Queensland Civil and Administrative Tribunal in 2013, prior to his 18th birthday.

451. William was aged 18 years and 7 months at the time of his death on 10 June 2014.

Mental health care provided at BAC

452. William was admitted and discharged from BAC on a number of occasions between 28 August 2012 and 24 January 2014. His final discharge from BAC was on 24 January 2014 when he was transferred to supported accommodation at the Wacol Villas.

453. William was initially referred to BAC for aggressive behaviour towards his mother, threats of suicide and frequent presentations with somatic complaints. For the first few months he had limited contact with his parents. His mother, Vanita Olliver moved to Gladstone in February 2013. She stated she was burnt out and exhausted but believed William was getting the support and intensive care he needed. At some point she worked as a deck hand on a fishing boat with her new partner, which required her to be at sea, and therefore with limited ability for contact for two weeks at a time.

454. William's father, Brent Fowell states he resumed contact with William around December 2012 and he was in contact at least weekly. He generally worked four

days on and four days off and on his days off William would stay with him unless he became unwell and needed to be taken back to BAC.

455. Dr Stedman stated during his time at BAC William's behaviour was challenging. He attended the BAC school and participated in a range of recreation therapy, psychological skills training, occupational therapy, speech pathology, physiotherapy and social work interventions. He received Botox treatment out of the Mater Hospital to help with his cerebral palsy. An extensive behavioural management plan was also developed and implemented.

456. During his time at BAC William's behaviour was difficult to manage at times. In addition to aggressive behaviour he frequently made inappropriate sexual or personal remarks to other patients and staff. Throughout his admission he also complained of abdominal pain and had a number of attacks of screaming. It was thought that some episodes of abdominal pain were associated with anxiety and resolved once he was distracted with an enjoyable activity.

457. In a number of documents within the BAC records it is recorded some of the key risk indicators for William included:
   a) William often reacts adversely to conflicts especially between his parents
   b) Due to abandonment issues, William will often panic if his father leaves the unit without him (although William is supervised by another adult at these times). William identified his father as a major supportive figure in his life.

458. During his admission at BAC, William was also seeing a private psychiatrist, Dr Georgia Watkins-Allen. This arrangement was to continue post-discharge, but did not. Ms Watkins-Allen stated she had worked with William at BAC. His physical, cognitive and psychological difficulties were significant and chronic. Ms Watkins-Allen stated she was not contacted directly by the transition care team at the BAC about the transition of her clients including William. Before she left the BAC and when she called in as a private clinician she identified serious concerns for all of the BAC adolescents being transitioned and she did not believe there was any where that would adequately meet their complex and severe mental health needs at their stage of the development and treatment. In relation to William she noted specifically that he was one of the last adolescents to be transitioned due to the significant difficulty finding him a place. She remembers there being serious concerns and clinical discussions about there not being adequate supervision at the proposed residence as his funding was restricted. There were no fall back options.

459. William attended Ms Watkins-Allen after she left BAC in the context of a referral from his GP by which he was able to have 10 referrals. His father brought him to the appointments. There were a total of six appointments from 19 August 2013 to 9 December 2013. On two occasions there were appointments made where William did not attend. Ms Watkins-Allen stated that post the closure of BAC in January 2014 she had no direct contact with William. Support staff made contact on several occasions but no follow-up appointments were made. Ms Watkins-Allen spoke to BAC staff prior to the closure as an external clinician to discuss her input into the treatment and to enquire about William's well-being and coping, following and between sessions.

460. Specifically with respect to William, Ms Watkins-Allen reported he had a heightened distress and unsafe behaviours following sessions, and when engaged in family matters and then sometimes on leave with them. This all related to

attachment and lack of connection and him feeling not good enough and abandonment issues. Ms Watkins-Allen explained this was a psychological moment and did not always reflect reality.

461. Ms Watkins-Allen stated William was feeling anxious about the future after leaving BAC with uncertainty and the loss of relationships and of his peers and she worked with him on this.

462. Registered Nurse Brenton Page was William's Associate Care Coordinator and later Care Coordinator at BAC from 11 November 2013. RN Page told the Court he had developed a good rapport with William and felt William would tell him the truth when needed. The major issue for William was he was worried with not knowing where he was eventually going. RN Page considered this to be a natural reaction.

463. RN Page stated he was not involved in planning or carrying out the transition arrangements other than specific tasks related to the transition such as escorting an adolescent to meet a new service provider in the community and generally discussing the transition arrangements with the adolescent or family. He also attended weekly Case Conferences where he would be involved in discussions about how the transition arrangements were progressing. Mr Page's impressions from discussions he had with panel members was that each adolescent's needs and care requirements were individually considered by the transition panel; a one size fits all approach was never applied to the identification of alternative appropriate service options; and Dr Brennan and Ms Clayworth were absolutely dedicated to developing and implementing the most appropriate transition arrangements they could.

464. On 11 November 2013 RN Page recorded in the notes that William was on leave with his father but was brought back early after an incident where his father found William standing on the ledge of a balcony eight stories high saying he wanted to die. His father managed to get him off the ledge and brought him back to BAC. William reported he felt unsettled and was screaming and having a breakdown. The plan was for him to remain at BAC in a locked ward, to be closely supervised and for review by the psychiatrist. He was reviewed by Dr Pettet where he admitted to feeling suicidal and was assessed as a high risk of impulsive suicide attempt and the locked ward and 15 minute observations was continued. William subsequently settled.

465. RN Page accompanied William on 3 December 2013 to a meeting at Westside Community Services. After the meeting William told him he did not want to pursue supports from that organisation as he did not want to be with persons who had an intellectual disability.

466. On 10 December 2014, there was a report by William that he had been assaulted at a railway station and was pushed off the platform by a stranger. He was reviewed by the psychiatric registrar. Subsequently he told RN Page he had not been pushed but he jumped. He made up the story about being pushed because he thought he would get into trouble. He stated he had a panic attack and jumped onto the tracks.

467. On 8 January 2014, RN Page took William to an assessment interview with Ipswich Independent Youth Service, however William told him after the meeting he did not want to attend that service. This reticence seemed to be related to him not

connecting with the coordinator well enough, largely due to his own adolescent behaviour.

468. After William's transition to Wacol Villas RN Page was asked by the BAC unit manager to briefly drop in to provide outreach support and he recalls visiting on two or three occasions between 27 and 29 January 2014. His impression from those brief visits was that William was settling in and he had not noted anything clinically significant.

469. Registered Nurse Stephen Sault had some limited exposure to William when he was on a particular shift and considered he had good rapport with him. William's mood fluctuated. RN Sault stated William at times could be pretty easy-going and at other times he would be anxious when things outside of his control went wrong.

470. On 5 January 2014 RN Sault recorded in the notes William was saying positive things about transitioning into the community and was looking forward to day activities as well as being independent in decision making. He identified some anxiety and concerns about how he would relate to new peers and carers. William stated his father was supportive of the transition and that currently he feels he is ready to move on from BAC.

471. In the days prior to his discharge William appeared to be settled and it was noted he was bright and reactive in mood/affect and interacting well.

472. RN Sault had limited involvement in assisting William move into his new dwelling at Wacol Villas on 24 January 2014. This involved transferring a room full of possessions in the BAC van with the assistance of other nurses. William's youth worker was also present. He helped William set up his room and the lounge room, went shopping with William and his carer, observed his carer administer his medication and watched a DVD with him and his carer. From memory the conversations he had with William throughout the evening centred on his routines and plans for the weekend and the following week. He was aware RN Page was also intending to visit William in the following week.

473. RN Sault stated to the best of his knowledge William did not express any views or concerns about moving out of the BAC to his unit on 24 January 2014.He stated William seemed quite excited. He recalls being impressed by the size of the unit and its cleanliness and cannot recall having any concerns about the unit or the support being provided to him there.

Transition Planning

474. Dr Stedman stated William's transition from BAC was complicated, as it was difficult to source supported accommodation due to his combined mild intellectual disability, mild physical disability and mild psychiatric disorder. William was not considered to have the skills for independent living, nor did he have family support in terms of day to day care.

475. William had been previously been a client of Disability Services Queensland (DSQ) prior to his admission to BAC. With the closure of BAC, additional disability service supports including accommodation were required. The search for accommodation for William became a joint effort between BAC staff and DSQ and particularly his case manager Ronald Simpson. Dr Brennan told the Commission finding accommodation was the most difficult aspect of William's transition.

476. The Commission found William's transition arrangements and the care, support and services provided to him were adequate. This was despite it being noted his transition occurred abruptly, with accommodation at the Wacol Villas only being agreed upon two days prior to his discharge.

477. Ms Clayworth's second statement to the Commission set out her concerns for William in relation to transition arrangements to an alternative service provider as:
    - Sourcing suitable accommodation in the community. William's wish had been to live with his father in Fortitude Valley. However, at an early stage, his father had advised that because he worked shifts as an electrician and could not leave William alone in the unit, this was impossible. Thereafter, what was sourced for William was shared accommodation in the Brisbane area with ready access to train travel to Fortitude Valley
    - Sourcing a day program to facilitate life skills and leisure engagement
    - Vocational options

478. Ms Clayworth stated from around October 2013 it was known William was eligible for school leaver's package and day program funding from February 2014. This partly addressed the concerns, however suitable accommodation for William remained problematic.

479. William wanted to live with his peers and the goal for William was to reside in community-based accommodation. Significant efforts were made to try to arrange supported accommodation in the community in which he would be sharing with another young man with whom he would be compatible. It is apparent the accommodation at Wacol Villas was one of the first options considered despite staff from DSQ, and in particular Ronald Simpson, endeavouring to find alternative accommodation. Ultimately with the closure of BAC imminent, Wacol Villas was the only option that became available.

480. It is also apparent this accommodation was regarded to be temporary and DSQ continued to seek alternative accommodation. At the time of his death a co-tenancy arrangement with another TAG 5 client was being considered.

481. Between 25 September 2013 and 10 December 2013 Ms Julie Beal was the team leader within the Department of Communities, Child Safety and Disability Services involved in the transition of William. Her role was to undertake an assessment and planning with clients who require assistance for eligibility to access services funded through the department. Ms Beal stated she had no previous experience with transitioning child and adolescent patients between services in the community.

482. Ms Beal received an email attaching a spread sheet on 25 September 2013 of Department clients who were finishing grade 12 and who had been allocated school leaver funding. School leavers funding provided community access support to help a client occupy their day and develop life skills once they finished school. Ms Beal contacted Carol Hughes at BAC and was told William needed to be relocated into alternative accommodation preferably by the end of the school year. As William had not been assessed for accommodation she put in place arrangements for this to occur.

483. In assessing suitable community accommodation services, Ms Beal stated she needed to consider William's needs and wishes. William advised he wanted to spend his time with people his own age and was interested in volunteering, paid

employment and studying at TAFE. By 25 October 2013 she had prepared a draft accommodation profile, a document to be shared with service providers when looking at accommodation matching. She considered a number of services that may have been appropriate. In relation to the accommodation requirements she was also assessing William's wishes as well as the wishes of his mother and father who resided elsewhere. Ms Beal stated there were no real vacancies in the Brisbane catchment and they started to look at emergency accommodation. William had individual funding for some aspects of his care but in relation to accommodation the funding was for shared accommodation and this therefore required a vacancy.

484. Dr Brennan stated in her evidence before the Commission that for William the fact Barrett was going to exist or not exist was not necessarily a crucial part for him. The crucial issue for William was he wanted someone to look after him. As well William wanted accommodation where he was placed with boys of his own age and he needed to be able to access public transport. Dr Brennan recommended this preference be accommodated.

485. It is apparent during the initial assessments of the transition for William between October and December 2013, DSQ was unable to find shared accommodation vacancies for reasons that had to do with both William's disabilities and behaviours as well as the fact William was provided with block funding. This meant he could only be considered for accommodation that was already block funded and there was a vacancy. This was distinct from being provided individual funding. Dr Brennan stated in her evidence at this time the transition team and DSQ were working collaboratively to try and find appropriate accommodation. One of the very early suggestions was Wacol Villas where William eventually ended up. Dr Brennan stated in her evidence at the Commission this was the only one that eventually became available. No others were ever identified as available except for one respite option.

486. On 14 October 2013, Ms Beal attended a meeting of stakeholders as well as William and his father. A decision was made that William would continue to reside in Brisbane. Ms Beal formed the view accommodation at Wacol Villas was a possible option as it was secure and a place where his real risk could be ascertained. Ms Beal was also looking at other emergency accommodation options but these were considered to be not appropriate. Ms Beal was also considering a number of day services that may be suitable.

487. On 13 November 2013 (noting William turned 18 on 8 November), an application was made to the Department of Housing and Public Works for assistance with social housing. There were some issues relating to the disability support rate, which William was receiving from Centrelink, but these were resolved over the following month.

488. Carol Hughes was also a member of the transitional planning panel. She left BAC in December 2013. In respect to William she noted he had complex medical and mental needs as well as having a disability. There was no option of family placement because of the parents work demands and housing options for a young man of his age with very limited. William also lacked capacity to manage his own financial affairs and budgeting. There were concerns around the Centrelink benefits he was receiving because it was discovered the money was paid to his mother and he was incorrectly receiving the at-home rate rather than the away from home rate. Ms Hughes also noted there was a complex relationship with both

parents. William was angry and upset with his mother but there was a need for him to continue to be connected to his mother and her side of the family. William wanted to be near his father but there were concerns that his father could be overwhelmed with the role. There were also concerns that in the time frame allowed, William would not be accepted as a DSQ client and therefore receive his full entitlements to housing.

489. In relation to the transition plans developed for William Ms Hughes stated the key aspects of her involvement with the plan included:
   a) Attending family meetings and assisting William to build his relationship with his father;
   b) Linking and advocating for him to become a client of DSQ. This included coordinating and attending meetings and ensuring his father was informed and involved and ensuring William had a case manager appointed by DSQ, facilitating assessments and the flow of the information between DSQ and BAC, completing his client profile and escalating his transition issues to Dr Brennan;
   c) Linking with Centrelink to ensure William had a health care card and would be re-assessed at the independent rate;
   d) Assisting with the application to appoint William's father as guardian in relation to the management of his finances and future decisions about accommodation, health care and provision of services;
   e) Ms Hughes stated the most significant transitional complication for William was trying to source suitable accommodation. William was unable to be transitioned home. His applications for accommodation and other services were hindered by the fact he did not have an easily accessible formal identification. Numerous accommodation options were considered; and
   f) One of the other complexities was that due to work commitments William's mother was only able to have a limited contact with BAC staff during the transition period.

490. Ms Megan Hayes, BAC occupational therapist was also a member of the BAC Clinical Care Transition Panel. Ms Hayes stated that in the absence of any other facility like BAC this meant that unless an adolescent required acute inpatient care, he would be transitioned back into the community. She stated in her statement to the Commission there were three main factors, which related to or informed the transition arrangements for all of the adolescents including:
   a) The adolescent's age
   b) The extent to which the adolescent was already integrated into his community
   c) Whether the adolescent could return home to live with his family

491. In relation to William, Ms Hayes stated she liaised extensively with government departments and nongovernment organisations to identify possible accommodation options. There were lengthy delays in receiving responses from those departments. The practical difficulty which followed from these delays and the consequential delay in sorting accommodation for William was that arrangements could not be made to identify service providers with the expertise required to meet his community reintegration needs because they did not know where his community would be.

492. On 10 December 2013, Ms Beal provided a handover to Ronald Simpson of the Clinical Management Team of DSQ who was now taking over William's case. On

that day William was present as well as Dr Brennan, DSQ forensic social worker Cristelle Mulvogue and other BAC staff including Ms Hughes.

493. Ms Hughes stated the appointment of a case manager from DSQ was important and made a significant difference. Ms Hughes stated that after several months of activity there was still no suitable accommodation. There had been a proposal put by William's mother to a facility at Nambour but William was very insistent he wanted to live in Brisbane and be closer to his father.

494. Mr Simpson stated that as case manager it was his duty to coordinate support, funding and activities for William. Mr Simpson met with William on 10 December 2013 as part of the handover. He next met with William on 13 December 2013 with his treating team and his father. At this meeting they discussed an incident on 11 November 2013 where William had threatened to jump from the awning of an eight story apartment.

495. Mr Simpson stated William's mother had limited involvement in his daily care and decision making due to her remote working conditions. On 6 September 2013 William's father took on a lot of the support and decision making.

496. At the time of discharge Dr Brennan's diagnoses for William were intellectual disability, right hemiparesis, generalised anxiety disorder, epilepsy and cerebral palsy. Dr Brennan noted William faced risks of homelessness, unemployment, social isolation due to lack of peer network and limited family contact, involvement with the Criminal Justice system, absconding and inappropriately calling emergency services when highly anxious, suicide, inappropriate medical investigations due to a history of somatisation and vulnerability to and risk of exploitation.

497. Dr Brennan also put in place arrangements for his medical care, which was quite complex due to the multiple medical conditions for which he was receiving specialist treatment including neurology, gastroenterology and Botox for cerebral palsy.

498. In a progress note prepared by Dr Brennan on 14 January 2014 she noted William had identified he had always hoped one of his parents would have him live with them. There was anger with his mother and her partner at Christmas that reflected this disappointment. The anxiety attacks when travelling to his father were related to anger that his parents had abandoned him. These thoughts and emotions were emerging as he contemplated separation from BAC after a 17 month admission and with limited skills for independent living. Dr Brennan noted in this progress note there were still a number of options being explored for accommodation and the issue had been escalated to the Director-General level.

499. A progress note prepared by Dr Brennan on 15 January 2014 noted one accommodation option had advised that William required more support than they could offer. Again William expressed a strong wish to live with his father. Dr Brennan telephoned William's father and explained they had to date been unsuccessful in securing support accommodation and asked if he would consider having William returned to live with him. William's father was concerned as to who would supervise William while he was at work at night.

500. The transition plan developed by Dr Brennan for William included:

a) Accommodation at Wacol Villas, funded by Disability Services
b) 24 hour support provided by Ability Skills Australia (TAG 5) funded by Disability Services
c) Mental health care provided by a headspace psychologist and GP
d) Option to continue to see Georgia Watkins-Allen in a private capacity
e) Case management provided by Ronald Simpson of DCCSDS
f) A school leavers package
g) Medical follow-up from Mater Children's Hospital and RBWH
h) An application for guardianship to the Queensland Civil and Administrative Tribunal.

501. William's medication at his time of discharge consisted of:
- Lamotrigine 100mg (anti-epileptic);
- Sodium valproate 500mg (anti-epileptic);
- Fluoxetine 20mg (anti-depressant);
- Montelukast 5mg once nightly (nocte); and
- Diazepam 2mg (for anxiety) – it was not recommended this be continued post-discharge due to the potential for dependence.

502. Ms Clayworth's statement to the Commission noted the transition plan provided for William to be linked to a private psychologist and referred to headspace Ipswich for ongoing psychiatric and psychological care. The Cerebral Palsy League had completed an updated assessment of his function and follow-up medical appointments at the Mater Hospital and Royal Brisbane and Women's Hospital were in place. William had also been linked with DSQ and had been approved a DSQ school leavers package with a view to him attending a vocational life skills program and DSQ accommodation with 24-hour support by a nongovernment organisation TAG 5.

503. Ms Clayworth stated it was difficult to find William supported accommodation that suited his complex care needs. This culminated in a meeting of the Director-Generals of both Health and Communities. Due to the uncertainty about future plans, William's anxiety escalated during the transition period that was managed clinically.

504. Dr Brennan stated in her evidence before the Commission she was of the view DSQ worked tirelessly to find a suitable option. Dr Brennan agreed with other evidence there is a gap in the system to identify services for people suffering or experiencing mental illness with a coexisting disability.

505. Dr Brennan also gave evidence William was emotionally ready to leave the BAC in that for several months leading up to leaving William was very keen to leave and ready to leave. It is apparent the planning for William's transition was complicated by his complex set of comorbidities requiring coordination of his medical needs, mental health needs and the requirement for him to have access to long-term supported accommodation. It was the latter that was the most difficult aspect of William's transition.

506. Dr Brennan told the inquest that confining herself to the period whilst he was at BAC, William had a very strong sense of perceived abandonment in that he wanted to live with one of his parents and was angry he could not. William had a limited capacity for containing his emotions and he would use quite maladaptive ways to express them such that he experienced and reported somatic symptoms and

physical symptoms at times of increased anxiety or anger. There was a history of him ringing emergency services and enlisting their assistance to be taken somewhere, or claiming various events had happened.

507. Dr Brennan also stated there was a history of expressing suicidal intent and thoughts at various times of increased anxiety and stress although he would subsequently report he did not have suicidal intent at those times. William had a minimal history of deliberate self-harm. In respect to the serious incident when William took himself onto an awning at his father's place, Dr Brennan agreed this was a very serious incident and he caused a lot of distress for people, but she did not think he meant to die. Dr Brennan stated he just did not know how to deal with his anxiety about what the future held for him.

508. On 21 January 2014, Dr Brennan met with Ms Mulvogue and Mr Simpson and discussed a number of matters of concern including the limited time remaining to secure accommodation. Dr Brennan told the Commission she thought the situation was becoming quite desperate and William was at a risk of homelessness. It is apparent the matters were escalated by Dr Brennan and this culminated in the meeting of the departments' Director-Generals where a decision was made that William would be transferred to Wacol Villas on an interim basis with individualised time-limited response funding.

509. Mr Simpson's statement to the Commission noted he expressed a number of concerns to Ms Mulvogue about the transition for William including:
   a) Lack of history provided by the BAC to the department
   b) William's potential suicide risk
   c) A lack of appropriate accommodation options and funding
   d) The length of time expected to complete the transition despite the lack of a suitable physical accommodation option

510. Mr Simpson in evidence stated the reference to lack of history related only to the incident that brought him to the BAC in the first place and otherwise there was other detailed information provided by BAC to DSQ.

511. With respect to William's mental health, a referral was made to Ipswich headspace with an intake meeting scheduled for 6 February 2014. Ipswich headspace is an arm of the National Youth Mental Health foundation, an organisation which provides mental health care (and other types of care) to young people at no cost, as if a Medicare card is provided, all charges are bulk-billed.

Risk Assessment and Management

512. In the period prior to discharge from BAC there were a number of different risk assessments conducted.

513. On 1 November 2013 William participated in a face-to-face interview with a visiting senior psychiatrist (Dr Scott Harden) from the Child and Youth Mental Health Service (CYFOS). The focus of the interview was on obtaining information with regard to previous incidents of alleged violent and sexualised behaviours. A referral was then made to the senior forensic psychologist (Dr Tasneem Hasan) at CYFOS for an assessment of William.

514. Based on the assessment by Dr Hasan and other collateral information, William was considered to be at low risk of sexually offending in the future. A number of

recommendations were made by Dr Hasan to Dr Brennan for William's future management in terms of additional treatment interventions, behavioural management, education and research.

515. As the closure of BAC became imminent, the records seem to confirm William was coping reasonably well. On 5 January 2014, he had a conversation with nursing staff where he discussed the possibility of transitioning to the community. He was noted to be looking forward to day programs (basketball and sailing) as well as achieving some independence with decision making regarding food and movies. He indicated some anxiety about how he would relate to his new peers and carers, but was noted to have felt he was ready to move on.

516. On 10 January 2014, Ms Megan Hayes completed a mental health services risk screening tool indicating William was a medium risk of suicide and other self-harm and aggression, and a high risk for violence and absconding. This risk assessment was prompted by an incident that occurred during the Christmas period where William reportedly stabbed himself in the stomach.

517. Mr Simpson was aware of the differing risk assessments of Megan Hayes and Dr Brennan. As a result he arranged for Cristelle Mulvogue of DSQ to prepare a suicide risk assessment. Part of Ms Mulvogue's role at DSQ included working with case managers around specific areas such as risk assessments and to provide advice and mentoring.

518. On 13 January 2014, Ms Mulvogue was asked by her line manager to undertake a screening assessment to confirm Ms Hayes' assessment. She completed the assessment utilising a DSQ Risk Screen Form for Suicide in consultation with Ronald Simpson, staff at the BAC, William and William's father via telephone. Collateral information on file was also reviewed including information pertaining to the incident in November 2013, when he was located by his father on an awning on the eighth floor of the apartment where his father lived. Ms Mulvogue assessed William as being at medium risk for aggression and high risk of suicide. Ms Mulvogue was clear she definitely had a conversation with William and his father.

519. Ms Mulvogue stated she then assisted Ronald Simpson to complete a comprehensive referral to the Specialist Disability Assessment and Outreach Team requesting a further assessment. This was confirmed by Mr Simpson. Ms Mulvogue stated the referral was for a more comprehensive assessment and she requested this be done as a matter of urgency given William was about to leave the BAC.

520. On 14 January 2014 Dr Brennan completed a Risk Screening Tool and assessed William as a low risk of suicide, self-harm and aggression and a high risk of vulnerability and absconding. Ronald Simpson had a discussion with Dr Brennan about the results of this risk assessment.

521. On 16 January 2014, William was assessed by psychiatrists from DSQ namely Dr Stephen Bower and Dr Annie Shek. A risk assessment was completed at this time. Their report indicated William was suitable for placement in the community in supervised accommodation. Although there was some underlying risk present, he did not present as a particularly high risk to himself or others at the current time and this should not be seen as a barrier for his living back in the community. He was assessed as a low risk of suicide, a slightly higher risk of death by misadventure, a slightly higher risk of self-harm and a low–medium risk to others.

522. Ms Mulvogue and Mr Simpson had a further meeting with Dr Brennan on 21 January 2014 to discuss the risk assessment and the concerns that William's mental health needs, including his risk of self-harm and suicide and management, could not be sufficiently managed by DSQ as they were not equipped to deal with mental health issues. Ms Mulvogue repeated these concerns and specifically that DSQ looked after disability and not mental health.[15] She stated Dr Brennan's response was the centre was closing and William had to leave. Dr Brennan also questioned her on why she had scored William as being at a high risk for suicide. Ms Mulvogue stated she stood her ground and did not resile from that assessment.

523. Ms Mulvogue asked if it was possible to keep BAC open for another week to give her more time to find suitable accommodation for William. She states Dr Brennan said they might be able to keep it open for a couple of days but this would be expensive and not justified for just one patient. Dr Brennan also stated that in her view William was not a mental health patient and should not have been admitted to BAC on the first place. Dr Brennan told her he had anxiety but no other major mental health problems. She also discussed with Dr Brennan whether or not she could arrange for a referral to an adult mental health services to provide support for him and Dr Brennan suggested they approach Headspace. Ms Mulvogue states the Department had already been looking at this option as well as a private psychiatrist, and a GP mental health plan and private psychologists.

524. Mr Simpson also confirms the purpose of the meeting on 21 January 2014 was to discuss the department's concerns regarding the inconsistency in the Queensland Health suicide risk screening tool, the lack of history provided to the department, the lack of suitable accommodation options and the lack of time to properly transition William to a suitable accommodation options. Mr Simpson also states Dr Brennan said words to the effect that William was not suicidal but is easily led and engages in self harming behaviour learnt from other patients and William should never had been admitted to the BAC as he was not a suicide risk.

525. Some-time after 24 January 2014 Mr Simpson states he received a Mental Health Services Crisis Intervention Plan completed by Dr Brennan where the risk summary was low for suicide, other self-harm and aggression and a medium risk for vulnerability and absconding.

526. Mr Simpson considered William was not at risk of absconding and was free to come and go as he pleased. William was provided with a key to his residence. He also did not regard William to be a risk in terms of inappropriate sexual behaviour.

527. In terms of suicide risk, Mr Simpson stated the only information he had to assess the potential risk was "static factors" such as history from the assessment he had seen. Having regard to William's behaviour in the lead up to his death he was completely taken by surprise. William had not self-harmed in the three months prior to his death and had displayed a positive frame of mind to him.

528. Mr Simpson stated the differences in risk of suicide assessments were reconciled through discussions. At the meeting on 21 January 2014 Dr Brennan maintained her opinion that William was not depressed, and Ms Hayes' risk assessment

[15] Section 12 of the *Disability Services Act 2006* provides what can be provided by way of disability services as being accommodation support services, respite services, community support services, community access, advocacy, research and training.

sounded worse than the situation actually was. Mr Simpson stated he does not believe a consistent high or low risk assessment would have changed his assessment of the accommodation needs for William. In January 2014 he believed William needed to remain in a hospital setting based on the timeframes for transition and the conflicting risk assessments.

529. In late May early June 2014 Ms Mulvogue was approached by Ronald Simpson regarding William's upcoming movement into a co-tenancy. They also spoke about the fact William's father was moving overseas and how he felt this might destabilise William. They concluded it would be prudent to complete an updated risk assessment and management plan for William during his transition to the co-tenancy. This was about to commence when William took his own life.

Care provided after discharge from BAC

530. On 22 January 2014, William's placement at the Wacol Villas was confirmed, to commence on 24 January. He was to be the sole tenant in a 2 bedroom unit. 1:1 support of 16 hours a day (with a sleep-over shift) was to be provided by Ability Skills Australia ('ASA') also known as TAG 5.

531. On 24 January 2014 William was discharged from BAC to the 24 hour supported accommodation at the Wacol Villas. His mood was noted to be bright and reactive at the time of discharge. Ronald Simpson stated that on the day he moved William seemed to be fine and was not expressing any anxiety to him. He was aware this anxiety had been reported at BAC. Ronald Simpson continued to see William regularly and he does not recall William saying anything negative about Wacol Villas in the time he was there.

532. A meeting was held with Dr Brennan, the occupational therapist Megan Hayes, BAC and the Department of Community Services to provide handover and relevant documentation. The BAC staff would provide support to William until 29 January.

533. The accommodation at Wacol Villas was funded by DSQ. William's case manager continued to be Ronald Simpson. Mr Simpson stated the Villas are purpose built two bedroom villas. They are designed to accommodate two clients who could live within their own individual spaces. William was supported by a non-government organisation TAG 5. The evidence from Mr Simpson is the accommodation at Wacol Villas was a temporary arrangement and he continued to search for other alternative accommodation. William was also not constrained under the Mental Health Act or Disability Services Act and accordingly was able to come and go as he pleased and he had a key to the premises.

534. The CECIBS Process Review conducted by DSQ noted the property was purpose built and designed for containment and safety of clients with complex needs and challenging behaviours. The review noted that while William did not require a robust, contained environment he was housed in this arrangement due to the need for accommodation in order to facilitate his discharge from BAC. As such this was an interim arrangement until appropriate, community-based accommodation was available for him.

535. At the time of discharge from BAC, it is important to note William's discharge summary from BAC stated he was a current risk of self-harm and absconding/wandering. Due to time constraints Mr Simpson stated William did not get to visit the accommodation before moving in and did not meet any of the staff from TAG 5 until the day he moved. The accommodation and support services

were only intended to be a temporary arrangement. The goal as discussed with William and his parents was that he would move from this accommodation into the general community. There was no set timeframe.

536. Mr Simpson indicated William was responsible for his own mental health care with the assistance from himself, TAG 5 and his mother and father. Mr Simpson stated that prior to William's discharge, the BAC organised an intake appointment with headspace. Mr Simpson was of the view that mental health care from headspace was appropriate based on the fact this is what BAC had recommended. He was not qualified to suggest otherwise. Mr Simpson stated he made sure TAG 5 arranged a Mental Health Care Plan for William.

537. The appointment with headspace was arranged for 6 February 2014. William reported to Mr Simpson after a second appointment he did not like the psychologist from headspace and did not want to return for further sessions. It is evident the psychologist he saw was a female and he wanted to see a male psychologist. William was unable to speak to a GP or psychiatrist at headspace as they no longer were working there.

538. Mr Simpson spoke to headspace who told him William needed to go to their GP to get a Mental Health Care Plan, which would enable William to receive 10 free subsidised appointments with a psychologist effectively paid for by Medicare. Mr Simpson stated that before the QCAT decision, William as an adult had a right to decline the services offered by headspace. He was able to persuade William to meet with Mr Josh Tehan a psychologist with DSQ. Mr Simpson agreed this was the only mental health support that William received.

539. Amelia Callaghan was the State Manager for headspace in Queensland and the Northern Territory in the relevant period. She stated headspace provides expertise and delivery of early identification and intervention strategies for young people aged 12–25 years, at risk of developing mental health and associated drug and alcohol problems, or for those already showing early signs of mental health problems or associated drug and alcohol problems. The services are provided through a network of headspace centres across Australia. Ms Callaghan stated the focus for ongoing treatment is brief, time-limited early intervention.

540. Ms Callaghan was also involved in the Expert Clinical Reference Group. She understood BAC was closing as there were concerns as to the suitability of the location of the facility and the model may have been outdated and not in line with contemporary and current best practice in Australia and internationally. Ms Callaghan personally came to the view there were better models of service that could be offered as an alternative to BAC.

541. Ms Callaghan is aware William was referred to headspace Ipswich as part of the transition and staff from Ipswich met with William and had contact with his family. Ms Callaghan later became aware that a number of headspace centres around the State had contact with BAC clients since January 2014. She checked this because she was concerned about BAC clients being referred to headspace centres because of the persistent and severe nature of their mental health concerns would typically result in these clients being unable to be effectively and appropriately supported within the headspace centre. William had been directly referred to headspace during the transition period. The remainder were self-referrals or referrals by third parties in the months that followed.

542. In relation to William, Ms Callaghan stated the records indicate William had attended Ipswich for an initial session but could not be re-engaged despite multiple attempts following initial contact.

543. Ms Mulvogue states that in February 2014 she discussed with Ronald Simpson as part of their support they would organise for some training for TAG 5 in the area of management of mental health and self-harm utilising the Specialist Disability Service Assessment and Outreach Team resources. She worked with Ronald Simpson on developing some dot points relating to known trigger factors that could indicate William's distress and may increase the risk of self-harm. Those trigger factors included phone calls from his parents, his father not being available for visits and members of the opposite gender not being interested in him or not talking to him. Strategies included being available to discuss matters with William, increasing supervision, exploring his self-harm statements and establishing whether there was access to means and what the intent was. Unfortunately Ms Mulvogue understands the offer of training was never taken up. Mr Simpson is also unaware why TAG 5 did not receive the training.

544. Mr Simpson was also to organise for psychology input through the department and Josh Tehan was allocated the case. Mr Simpson states psychologist Josh Tehan accepted the referral on 28 February 2014. The referral was sought to address emotional dysregulation, challenging behaviour and his parents marital separation and feelings of abandonment.

545. Mr Simpson states Mr Tehan first met with William around 24 March 2014 and arranged to meet each week. Mr Simpson spoke to Mr Tehan regularly and understood William was working with him on strategies to mitigate his impulsive, reactive behaviour. Mr Simpson is not aware of any formal risk assessment completed by Mr Tehan. The DSQ records indicate Mr Tehan considered the referral related to anger management and emotional regulation in the context of William having difficulty in controlling outbursts of anger and where there were several recent incidents in which his anger had led him to act aggressively. William also experienced anxiety and had panic attacks.

546. The DSQ records indicate counselling sessions were conducted on 14 March, 20 March, 27 March, 10 April, 17 April, 1 May, 15 May and 29 May. The session on 15 May and 29 May noted William's anxiety over his father leaving for Canada and explored this with him.

547. On 7 April 2014 a QCAT guardianship order was made giving William's father responsibility for approving his accommodation and the provision of services.

548. Ms Mulvogue also had some discussions after 24 March 2014 regarding a report from TAG 5 that William had purchased a "Rambo" knife the previous weekend. She provided advice to Ronald Simpson suggesting he support William to return the knife.

Care by TAG 5

549. TAG 5 is a disability support agency specifically targeted to males under the age of 30. Ronald Simpson stated the primary focus was active participation in sports and recreation for people with disability.

550. It is apparent William had attended a TAG 5 camp whilst at the BAC and he enjoyed it. Ronald Simpson spoke to both William's parents and they agreed with his

recommendation to engage TAG 5. Wacol Villas were supported by TAG 5 who assisted William with daily living tasks, such as food preparation, money management and housekeeping. They supported him at appointments and took him to sporting events.

551. TAG 5 was providing support of 16 hours plus a sleepover daily. Essentially this provided with one-on-one support for a 24 hour period. The sleepover shift had no monitoring function but the staff were on site to provide support as necessary.

552. A stakeholders meeting was convened on 6 March 2014 after William expressed dissatisfaction with the level of monitoring and reminders he received. Essentially William was stating he did not want to be reminded and micro-managed by the carers. At the meeting the role of TAG 5 was clarified as follows:
    a) Provide support and assistance when requested/needed between the times allocated by DSQ as set out by the roster
    b) Support and assist William to obtain his record goals when he advises staff he wants to focus on them
    c) Offer advice when asked
    d) Accompany him to do grocery shopping, medical appointments
    e) Assist with preparing meals when asked
    f) Attend appointed rostered recreational activities
    g) Ensure his living needs are met

553. William was also enrolled in a number of structured activities during the week. He also had regular contact with his father on weekends, attending football games and having dinner at hotels. It was noted he would also go to the movies with support staff and occasionally caught up with friends.

554. Nathan Emberson was a lifestyle support worker. He had been with TAG 5 since 2008. He was present for many of William's shifts. He stated he got along well with William. At night he remained on the premises and would go to his own room and was effectively on duty with him until 10:00 pm.

555. Mr Emberson completed a daily shift report with various headings including the noting of positive behaviours and of challenging behaviours. Mr Emberson was taken through the records at inquest noting on most occasions there were no reports of challenging behaviours.

556. On 30 April 2014 Mr Emberson noted William had a seizure/panic attack after receiving a telephone call from the coordinator. On 26 May he had a panic attack and William called emergency services and asked for Valium.

557. On the overnight shift between 1 and 2 June 2014 it was noted William was very negative and had a panic attack on the way to his father's place. He was given PRN medication for the panic attack. Over the next few days it was noted that he was appearing well and happy and had been going out to dinner with his father.

558. On 10 June 2014 it was noted William was very well behaved and apologised to staff. Nathan Emberson stated this related to an incident that occurred at a previous shift involving what might be said to be a miscommunication concerning transport arrangements between William's father and Mr Emberson. William was apologising for his father's angry behaviour.

Issue 2- Immediate circumstances leading up to death

559. In his statement to the Commission William's father Brent Fowell stated he told William he was going to Canada to investigate the prospect of finding work on the gas fields. Mr Fowell stated he told William he would be coming back, and William understood that. At the time he left he thought William was fine. He remembers having a meal at a restaurant with him on the night before he left, and William was fine. Mr Fowell stated he told William he would be home in 6-8 weeks.

560. It is a little unclear as to when Mr Fowell left for Canada as in his evidence he stated this was on 6 June and he saw William for dinner on 5 June. TAG 5 records note a last outing for dinner with his father on 6 June so it is probable Mr Fowell's departure to Canada was on 7 or 8 June 2014. In the evening before his death William was reported to have attempted to contact his mother by telephone.

561. Nathan Emberson was aware William's father was going to Canada. William did not express any feelings of distress about the prospects of this occurring only that William wished he was going with his father.

562. In the lead up to his death William was last seen by Nathan Emberson, at about 7:45 pm-8:00 pm on 10 June 2014. Nathan was working a 5:00 pm – 9:00 am shift, and was staying with William overnight at his accommodation at Wacol. They had gone to dinner at KFC. Mr Emberson recalls William received a telephone call at KFC and William said it was his girlfriend. William had said he was going to bed, and Nathan did not see or hear him after that time. Although the early time for William to go to bed was unusual it was not unheard of. Mr Emberson recalls William appeared to be in good spirits and had put his television on and got into his pyjamas. He could see him in his room. William had said good night.

563. Mr Emberson recalls hearing William's mobile telephone ring in the kitchen. William had headphones on. He went to his room and let William know his telephone was ringing. Mr Emberson recalls William did speak to someone for about 5-10 minutes. William went outside to have this conversation. When he came back in William still had the telephone with him but he appeared to be normal and did not appear to be upset.

564. William's mother Vanita Olliver also attempted to speak with William that day and left messages at around 4:30 pm and 6:00 pm and made a final call at 8:12 pm. Ms Olliver was told about this call by police. Ms Olliver believes the telephone was an iPhone which she was given by police but later she handed to TAG 5 to give to his father.

565. At the scene on the railway track another Samsung broken mobile was found and police records indicate this was also given to Ms Olliver. Neither of William's parents recall him having two mobile telephones. The iPhone given to Mr Fowell cannot be accessed as Mr Fowell states it was stolen from him.

566. During evidence the court was provided with two mobile numbers by Ms Olliver that may have been used by William. QPS were requested to interrogate those numbers for calls made on 10 June 2019. One number is clearly not related to William, as the calls all relate to numbers in Sydney and for the purposes of confidentiality the details are not published.

567. The second number was clearly related to William. Again I will not publish the details but a number of calls were made between 0915 hrs and 1726 hrs on 19 June 2014.

04…..7- 5 times – unknown who this number belongs to.

042……5 (TAG 5 Stephen Bell) 10 times

04…7- 8 times

07 3216….TAG 5 office) at 1115hrs for 1386 seconds.

568. All of the above calls were made between Mt Gravatt North, Holland Park, Jamboree Heights, Eagle Farm East and Fortitude Valley.

569. Barry and Nilsson, lawyers for TAG 5 have advised as follows:
1. Telephone number 042…5 relates to a mobile phone owned by TAG 5. At the time specified the phone was assigned for use by Steven Bell who is no longer employed by TAG 5
2. Telephone number 07 3216 belongs to TAG 5 and fielded the call at 11: 15 am on 10 June 2014. TAG 5 holds no records as to who took the call.

570. It is unclear if William had two mobiles. The broken Samsung mobile may simply be one that had been thrown onto the tracks and is unrelated to William. The second mobile was Williams but in its absence no further information is able to be obtained.

571. Nathan went to bed at about 10:00 pm, and awoke again at 6:00 am the next morning. At about 7:30 am he went to go and wake up William, but he was not in his room. A missing person report was initially filed with the QPS at 1:30 pm on 11 June 2014.

572. Unbeknownst to the QPS and Nathan, there had been a fatality at at about 9:00 pm the previous night.

573. The man was initially unable to be identified, but after Nathan filed the missing person's report it then became apparent the man was William.

574. Various reports confirm the circumstances of his death.

Autopsy results

575. An external autopsy was conducted on 17 June 2014 by Dr Nadine Forde. Toxicology detected some alcohol, diazepam, fluoxetine and lamotrigine (an anti-convulsant).

Process Review Report for Disability Services Queensland

576. DSQ engaged the Centre of Excellence for Clinical Innovation and Behaviour Support to conduct a process review. Judy Benfer, Senior Clinician–Social Work completed the review, which was subsequently reviewed and endorsed by Professor Karen Nankervis. The purpose of the review was to:
a) Establish whether there are lessons to be learnt from the circumstances of the case about the way in which professionals and services worked together to safeguard and manage adults where a level of risk has been identified
b) Review the effectiveness of procedures (both multi-agency and those of individual organisations)
c) Inform and improve local inter-agency and departmental practice

d) Improve practice by acting on learning (developing best practice)
e) Prepare an overview report, which brings together and analyses the findings and makes recommendations for future action.

577. The CECIBS review's primary aim was stated to identify any areas for, and achieve, continuous improvements in supporting clients identified as at risk as well as improvements in responses to critical incidents involving death or risk of death of clients of DSQ.

578. The CECIBS review was confined to the time after William's transition from BAC to DSQ. William had previously had involvement with DSQ dating back to 2001/2002. Following his admission to the BAC in 2012, his case with DSQ was closed.

579. In September 2013 contact with DSQ was made by the BAC social worker to arrange an assessment for specialist disability support for William. The Service Access Team (SAT) of DSQ then became involved. SAT completed an assessment for accommodation support on 14 October 2013 and a referral to Case Management was also progressed. William's case was transferred to the Clinical Services Team because of perceived complexity. The Clinical Services Team also referred William's case to the Specialist Disability Services Assessment and Outreach Team due to the suggestion of a high level of risk and mental health issues.

580. The CECIBS Process Review considered a high volume of work was undertaken at planning William's transition with stakeholder meetings held and sourcing of information and communication between BAC and DSQ staff. The review found it was clear DSQ actively canvassed all possible options for accommodation for William. One transition option on the Sunshine Coast was suggested by William's mother, however was not pursued as William was adamant he wished to remain in the Brisbane area.

581. The CECIBS review noted in relation to TAG 5 its typical clientele did not include people with complex needs such as a dual diagnosis. DSQ continued to provide support to TAG 5 by convening stakeholder meetings and providing advice. TAG 5 were also provided with information regarding known potential triggers and risk factors for self-harm.

582. In relation to risk factors it was noted the DSQ psychiatrists assessed his risk factor of suicide was low but this was mitigated by his current environment and dynamic factors. It was also stated William's risk was heightened at times of change and certainly this risk was mitigated and contained by his environment and support. It was also identified William had a high impulsivity and this increased his risk substantially. It was reported when William spoke about his suicidal intent, he advised he wanted attention, particularly from his father and he wanted to live with his father.

583. The CECIBS process review considered DSQ made significant efforts to establish a mental health management plan and considered a number of options. Difficulties in accessing mental health services for William and his refusal to continue with headspace meant a mental health management plan was not in place.

584. DSQ clinicians reported not being aware of any concerning behaviours or presentations from March 2014 and believed from the TAG 5 reports the situation was stable and uneventful.

585. A review of the departmental and TAG 5 records from January to June 2014 indicated William had some behavioural incidents that included:
   a) Unexpectedly disembarking from a train and leaving his support worker behind
   b) Calling emergency services for assistance
   c) Support worker sustaining a superficial laceration when attempting to take a knife away from him
   d) Purchase of a Bowie knife which was returned to the retailer
   e) An incident of self-harm
   f) Reports of panic attacks

586. There were few documented behavioural incidents reported to case managers between April and June, and in the main the recorded incidents involved reports of panic attacks.

587. The CEBICS review noted the choice of service provider was limited due to other options not being available. The service provider chosen, while not having expertise in working with people with dual diagnosis, was chosen for their successful work in engaging with young people with intellectual disability.

588. The CEBICS review noted, having the benefit of hindsight, it was clear William was supported by DSQ in a way that sought to achieve a balance between support and supervision and recognition of William's need for autonomy and independence. William's need for higher levels of supervision at times when he was distressed, self-harming or expressing suicidal ideation was conveyed to the service provider.

589. The service provider records (TAG 5) do show there was one incident of self-harm and an incident of distress that may have indicated a heightened risk of suicide or a deterioration of William's well-being and therefore a trigger for escalation of responses to those behaviours. However, without such data over a long period of time to establish a baseline, including the frequency and pattern of such behaviours at the BAC, it cannot be speculated these behaviours were indicative of increasing anxiety and distress

590. The CEBICS review noted the nature of the incidents in the TAG 5 records indicate only one or two other incidents that might fit the definition of incidents to be reported under the critical incident recording process and therefore this would not have provided a means for monitoring and reviewing events for clinical purposes in this instance.

591. The CEBICS noted William's mental health needs were an issue for service delivery and without access to mental health services for a mental health management plan, DSQ and service provider staff needed to provide for William's complex needs. Suicide is very difficult to predict even for experienced, competent mental health practitioners and this level of difficulty increases substantially when the situation is further complicated by dual diagnosis. Due to the dynamic nature of William's risk, the tragic outcome of the suicide of William may still have occurred regardless of what system changes were in place.

592. The CEBICS review author stated that careful consideration of all of the processes and procedures in supporting William after his transition, lead the author to conclude that none of the organisational or individual factors considered in this report are regarded to have had a direct contribution to William's death.

593. The CEBICS review made a number of points summarised as follows:-

a) The literature is clear that dual diagnosis of intellectual disability and mental illness poses special difficulties for services that traditionally manage each diagnostic group separately.
b) There can be a risk of diagnostic/shadowing when symptoms or issues are attributed to either intellectual disability or mental illness.
c) There are considerable pressures and unmet needs requiring important cross-agency cooperation particularly when there are multiple needs, including disability, health and mental health.

594. In relation to "Lessons Learnt" it was noted DSQ has put in place a number of initiatives to better support people with disability who have complex needs such as dual diagnosis. Notwithstanding, there still exists a need for cross-agency planning and collaboration in order to best meet the needs of individuals with disabilities who have needs that go beyond disability support.

595. In cases such as William, where an individual is transitioning from inpatient health or mental health services to disability services it would be ideal for collaborative action to continue post discharge. This would ensure continued access to expertise that is not the remit of DSQ or disability support providers.

596. The CEBICS review stated that as is the case for many disability service providers, TAG 5 did not have extensive experience or expertise in working with clients who have a dual diagnosis. As disability service providers do not have mental health expertise, there is a need for them, and their clients, to have access to mental health services and advice available to them. In addition, where people with disabilities are discharged from mental health services to disability service providers, lack of mental health expertise can be addressed through the discharge agency ensuring that linkages, referrals and access to mental health advice and services for the client are in place.

597. It was also noted that good recordkeeping is essential for the provision of safe and appropriate client care, accountability and service improvement. The TAG 5 client records that were sighted during the CEBICS review indicated some issues with recordkeeping. Regular auditing of records, particularly behaviour and medication records, assists an organisation to identify practice issues or issues in relation to the client's progress and the implementation of the organisation's policies and procedures. The review recommended that recordkeeping be discussed with TAG 5 including ways of keeping records of client behaviour, critical incident reporting and accurate medication administration records.

598. The CEBICS review noted DSQ had established the Complex Case Review process to ensure the regular review and ongoing implementation of strategies to address the needs and risks associated with complex needs. It was considered there is a real benefit to the inclusion of all dual diagnosis clients in the CCR process.

599. It was therefore recommended the Centre of Excellence for Clinical Innovation and Behaviour Support reviews the Complex Case Review guidelines to emphasise the prioritise patient of clients with dual disability across all DSQ regions. It was further recommended the region include clients with dual disability in the CCR process.

600. In relation to transition planning where individuals are being discharged from inpatient facilities and transitioned into disability services there needs to be a single joint transition plan that specifies the arrangements for ensuring appropriate referrals for the management of health/mental health issues are established prior

to transition, the arrangements for post-discharge follow-up by the discharging organisation and a comprehensive risk management plan that includes:–

a) Patterns and interpretations of behaviour
b) Predictions and indicators of escalating risk
c) Identification of strategies and areas for increased supervision

601. The CEBICS review noted minimum requirements for provision of baseline mental health assessment and management information need to be identified. This would include a specific community-based mental health treatment plan developed by the mental health service with referrals accepted by relevant services. Ideally, the client would have a designated worker that they had already met whilst an inpatient.

602. It was therefore recommended that DSQ works with Queensland Health to review and revise the guidelines for collaboration between Queensland Health/Mental Health Services, DSQ and Funded Disability Services Providers protocol to address the need for joint transition planning that includes comprehensive risk assessment and post-discharge follow-up responsibilities of the discharging organisation. Further that these guidelines confirm that DSQ would not accept any client into the care without the mental health assessment and management required to ensure accurate risk management is in place.

603. There was a further recommendation for a requirement for funded non-government service providers to ensure the staff have appropriate training when supporting clients with high and complex needs, including dual diagnosis, is included in consideration of funding. Providers and subsequent contractual arrangements. Further all dual diagnosis clients might only be placed in support arrangements with staff who have received education and training in management of mental health issues in all areas and arrangements are in place that guarantees coordinated service delivery with other providers with expertise.

604. It was further recommended that a neuropsychological assessment be included in the comprehensive risk assessment documentation which is provided by QH to DSQ prior to discharge.

605. There was a further recommendation that training in the primary elements of capacity and legal decision-making is provided to disability support workers.

606. It is noted the Commission of Inquiry endorsed the recommendations of the CEBICS Process Review Report namely:

a) That the guidelines referred to previously be reviewed and revised
b) That the need for joint transition planning be addressed
c) That comprehensive risk assessment and post-discharge follow-up responsibilities of the discharging organisation the included in the joint transition planning.

607. The Commission further recommended the guidelines deal expressly with the respective responsibilities of Queensland Health, Children's Health Queensland HHS and local Hospital and Health Services in collaboration with Disability Services Queensland and Funded Disability Services Providers and that a service-mapping exercise be undertaken to identify what services are needed as a matter of priority.

608. By way of an update with respect to the implementation of the nine recommendations, Professor Nankervis noted all recommendations had been implemented.

609. In her evidence before the inquest Professor Nankervis stated the access to Disability Services is on the basis of functional impairment such as mobility, communication, self-help skills, and difficulty with their day-to-day living. Psychiatric illness comes under one of those disabilities. Professor Nankervis stated that as highlighted in the report it is often difficult for people with intellectual disability who have a mental health condition to access mental health services and this is quite established in the research.

610. Professor Nankervis noted in her evidence it was apparent the options for appropriate service providers for William were very limited. There was no availability of agencies who had the ability to provide support to William from service providers that did have more experience with people who have a mental health issue as well as a disability. TAG 5 was a service who had involvement with William before and they had another client who had been successfully placed with them who did have some mental health issues. Professor Nankervis also noted there was going to be a need to provide TAG 5 with some additional supports and the senior clinician offered to provide those supports to TAG 5.

611. Professor Nankervis noted the risk assessment from the senior outreach came back as a low risk of suicide. She noted the senior clinician did try to arrange and connect William to a number of mental health service providers but part of the problem was they were adult services and William did not necessarily meet the entry criteria for him to be able to get access to them. She noted in her evidence significant efforts were made by DSQ to establish a mental health management plan and for various reasons the options could not be taken up. The solution was referring William to a DSQ psychologist to work on certain issues.

612. In terms of a process review Prof Nankervis stated it was a systemic issue as they know that for people with intellectual disability or cognitive impairment, the likelihood of psychopathology is much higher than the general population and yet they get less access to mental health services than the general population. She stated that a lot of times having a diagnosis of intellectual disability in itself is a barrier to getting access to mental health services. She stated one of the major issues that comes through is the level of training for psychiatrists and mental health staff around working with people with intellectual disability.

613. Prof Nankervis also noted the NDIS was not necessarily going to deal with this problem as NDIS will again be dealing with functional capacity and whether they have impairments in their day-to-day functioning as a result. They may get better disability support, which might help prevent mental health stress but it is not going to make a difference to the access to mental health needs and services when they require those and NDIS does not provide the funding for treatment of a mental illness.

614. With respect to the provision of mental health services, Professor Nankervis noted the blockage with respect to William was not a question about any lack of capacity on his part to make appropriate decisions for mental health care but rather William was not offered the services he particularly wanted to engage with. Once he was offered the services of the DSQ psychologist he apparently was prepared to engage with, he did in fact engage.

615. Professor Nankervis was taken to the recommendation made in the review that all dual diagnosis clients are only placed in support arrangements with staff who have received education and training in management of mental health issues or there is

an arrangement in place that guarantees coordinated services delivery with other providers with expertise. Professor Nankervis agreed in an ideal world both would be put in place and otherwise one or the other alternatives were appropriate. She stated the purpose of the particular recommendation is about future processes, which would ensure the region would not place a person into a service provider, unless that service provider had been previously provided with some support to build up the skills before the transition happens.

Issues 3-5 Whether BAC closure had any adverse impact on the mental health of William, management of his mental health from discharge to his death and transition plan implementation

616. Dr Brennan was asked at the inquest as to what she considered was the effect of the closure of BAC upon the mental health of William. She stated in simple terms she did not think closure was relevant to his mental health but qualified that somewhat. She stated BAC was a place where William could live with peers, but he had repeatedly expressed his desire to leave BAC. Where he went to, and she was unable to speculate about this, may have not been as good as BAC in his own mind and may have caused him anxiety, but at the time of leaving she did not think closure was relevant to his mental health. Dr Brennan felt he was optimistic and excited about his future at that point. Having said that, the process of finding somewhere because BAC was closing had exacerbated some aspects of his mental health difficulties.

617. Dr Brennan stated at the inquest she considered William was emotionally and psychologically ready to transition. Dr Brennan also agreed William was anxious and upset over a period of time when all the efforts that were being made to find him suitable accommodation had not come to fruition and distinguished this from being upset about the BAC closing. She agreed the very big issue for William was to find appropriate accommodation. Until accommodation could be found other support services could not be put in place.

618. Dr Brennan did express some concerns about Wacol Villas in that William was essentially going to be alone with adult carers when he wanted to be with other young people. It is evident BAC staff and Disability Services made extensive efforts to find suitable accommodation in accordance with William's wishes to be with his peers. Wacol Villas was not ideal due to the fact he was living with an adult carer and it was somewhat isolated, but this was all that was available in circumstances where the closure of BAC was imminent. Efforts were ongoing to find alternative accommodation and there were good prospects of William sharing other premises with a young male in the near future.

619. Despite the difficulties in finding suitable accommodation BAC staff and DSQ clearly made considerable efforts to ensure William was provided with appropriate accommodation and services.

620. The fact BAC was closing certainly impacted on accommodation options and this was a stressor for William but it is evident he was ready to move and the fact BAC per se was closing was not an adverse factor relating to his mental health.

621. Wacol Villas was secure and well set up. There was some implied criticism of the decision to provide William his own key and to allow him some freedom to leave the accommodation when he wished. Given William was not on any involuntary order (there being no evidence such an order was justified), there was a need to balance the development of a degree of independence with overly restricted

conditions. William was still provided with a high level of support from DSQ and TAG 5. He attended on a number of daily activities with his carers and was seeing his father regularly. There is no evidence to suggest these arrangements adversely affected his mental health or were inadequate.

622. Dr Brennan had anticipated William would see a GP at headspace but that did not happen and the referral to headspace was made but was not successful as William did not like the psychologist he saw. William did not resume his attendance on Ms Watkins-Allen.

623. Dr Brennan stated that although William was not being referred directly to a psychiatrist as his primary treating person, there was the potential for the psychologist to engage a psychiatrist once they had begun working. Disability Services did utilise a staff psychologist to assist William and it is evident from the significant number of appointments William attended he was engaged in that aspect of his care. Ronald Simpson made this referral and understood they were working on strategies to mitigate William's impulsive and reactive behaviour. Ronald Simpson understood William was a low risk of suicide.

624. Although elements of the transition plan did not come to fruition, the evidence does not suggest this adversely impacted on William's mental health. William had not given any indication he was contemplating suicide to Ronald Simpson or his carers. Ronald Simpson stated he was completely taken by surprise by William's death. He noted William had not self-harmed in the three months prior to his death and had displayed a positive state of mind.

625. Ms Mulvogue and Mr Simpson had formed the view they needed reconsider William's risk assessment and management in light of the likely move to other accommodation with a co-tenant peer and his father's move to Canada.

626. A consistent issue for William was a perceived feeling of abandonment. He had a complex relationship with his parents. At the time of his death William's mother was living some distance from Brisbane. He wanted to live with his father but this was not able to be facilitated. However, he continued to have a close relationship with his mother to the extent distance allowed and he clearly was well supported by his father who he saw often. The reality was William had not been abandoned by his parents who continued to love and support him, but this does not take away from the issue that this is how William felt. It is well documented in the records this had been a pervasive feeling of William for some time.

627. It is not a coincidence that William's decision occurred shortly after his father left to go to Canada. In so saying this is very much based on the benefit of hindsight and a consideration of the known static features of William's makeup and piecing them together to the night in question. Mr Fowell told William he would be back from Canada soon. He saw William just before he left and had no concerns. Mr Simpson and Nathan Emberson had no concerns over the days leading up to that night or on that night.

628. William was known to act impulsively and place himself in high risk situations. The awning incident was an example where a number of witnesses considered this was an attempt to draw attention to his distress and wanting to live with his father, and it was not a suicide plan. He had once before placed himself on railway tracks in a moment of anxiety. William also had several telephone calls that evening, the details of which are unknown

629. On the night of 10 June 2014 it is likely William was feeling isolated and abandoned and triggered by the recent travel of his father to Canada as well as the relative isolation of his relationship with his mother. William's intellectual disability impaired his ability to process the significance of this. Dr Brennan stated in relation to the awning incident that William just did not know how to deal with his anxiety about what the future held for him.

630. It is in that context William made his way to Wacol Train Station and after some contemplation impulsively made a decision to take his own life or at least place himself in a position of high risk that this would occur. The method he used has a very high lethality rate. The description of events as contained in the Queensland Rail Report supports a finding William's death was more likely the intended consequence of his deliberate actions, rather than one of misadventure.

Findings required by s. 45

Identity of the deceased - William Johnathan Fowell

How he died – William Fowell had been an inpatient of the Barrett Adolescent Centre at the time of its closure in January 2014. He was living in temporary accommodation funded by Disability Services supported by a high level of supervision by carers and case management by DSQ. William had a complex mix of conditions including intellectual impairment, physical disability and a generalised anxiety disorder. A pervasive element of his makeup was a perceived feeling of abandonment by his parents. The reality was William had not been abandoned by his parents who continued to love and support him, but this does not take away from the issue this is how William felt. He had been assessed to be a low risk of suicide but was a higher risk of self-harm due to misadventure. William had not expressed any suicidal ideation around this time and his father and carers had no concerns for him. There had been no incidents of self-harm for a number of months. William was relatively settled in his accommodation with the likely prospect of more suitable alternative living arrangements being available shortly. In the days leading up to his death William's father had left Australia to travel for several weeks in Canada potentially to find work there. It is probable his father's leaving, albeit for a short period, as well as the relative isolation from his mother due to her living circumstances, exacerbated this perceived abandonment to William and likely brought on an increased feeling of isolation and anxiety and in that context he took his own life.

Place of death – Wacol Railway Wilruna Street WACOL QLD 4076 AUSTRALIA

Date of death – 10 June 2014

Comments and recommendations

631. While the inquests in relation to Caitlin, Talieha and William were held jointly, it is evident each of them had significant differences in diagnosis and treatment. For that reason each case was considered in separate weeks with common witnesses heard in the final week and only applying to Dr Brennan and Ms Clayworth. It was however useful to consider the cases together given the brief of evidence included relevant statements of witnesses was before the Commission of Inquiry as well as their evidence before the Commission and that which had been considered by Professor Kotze and Ms Skippen in their report.

632. As well for the purposes of considering any recommendations it was useful to have an understanding of the complex nature of each young persons' mental illness and other vulnerabilities and the complex nature of transitioning adolescents into the adult mental health system and those with a dual diagnosis such as William. After considering the evidence before me regarding issue 6 and recommendations I determined I did not need to hear any oral evidence and could rely on the affidavits of Dr Allen and other information received. No-one appearing argued otherwise.

633. Professor Kotze concluded each transition plan was individualised and bespoke in nature and *"without exception, were thorough and comprehensive".* The evidence before this inquest confirms that conclusion.

634. Caitlin was already in the process of transition and Talieha and William were turning 18 and this process would have occurred at some point in time in the near future. The imminent closure of BAC meant plans had to be developed quickly and their transition/transfer to alternative accommodation had to occur in circumstances that were quicker than had been the case if BAC was still open. As Professor Kotze noted in her report *"the process of transition occurred in an atmosphere of crisis"* but this did not *"appear to have detrimentally affected the process of transitional planning for the patients."*

635. The transition plans for each of them were largely carried out. In Caitlin's case her accommodation failed but this was due to an issue for Caitlin and another resident and was not a result of the transition plan per se. Caitlin commenced living with her mother. Efforts were made to find alternatives but were not successful. In William's case the referral to headspace broke down but DSQ was able to provide frequent psychological services internally. William was able to be accommodated on a temporary basis at Wacol Villas. This facility and the support services provided were the best available at the time. Talieha was provided with the best option available at PRCCU, given there was no adolescent facility that could provide the security, supervision and treatment Talieha required.

636. In Caitlin's case and with the benefit of hindsight, the accommodation with her mother in the context of a relatives recent arrival was a significant factor in her decision. For Talieha and William where they were living was less an issue. In all three cases the decision to end their own lives came at a point in time when specific events occurred, which exposed them to specific personality vulnerabilities that had been a pervasive feature for each of them over many years.

Issue 6: Whether any recommendations can be made for the prevention of self-harm and suicide in adolescents and young people.

Commission of Inquiry Recommendations

637. The Commission made recommendations across six areas. The Government accepted in principle the recommendations as follows:
    1. Engage an independent party by 30 September 2016 to review the progress of implementation of the Hunter review with regard to the delivery of state-wise services. The review was to be completed by 31 March 2017.
    2. Review the service agreement arrangements for all non-government organisations providing health services. The review was to be completed by June 2017.
    3. Commission the Queensland Centre for Mental Health Research to identify existing clinical and program evaluation frameworks for extended treatment for adolescents and young children with severe and complex mental health issues.
    4. Build a new bed-based facility in South-East Queensland for young people with complex mental health issues and ensure patients have access to an integrated educational/vocational training program. The size, location and model of care provided in this facility will be informed by current research in consultation with health consumers, including families from the former BAC.
    5. Engage an independent reviewer to review the alignment and transition arrangements between adolescent and adult mental health services.
    6. Undertake services mapping and review Guidelines for collaboration between Queensland Health/Mental Health Services, Disability Services Queensland and Funded Disability Service Providers to improve coordination between services designed to support young people who have both an intellectual disability and mental illness

Dual Diagnosis Challenges

638. Recommendation 6 of the Commission Final Report highlighted a number of systemic issues and challenges impacting the treatment and care of young people with severe and complex mental illness, including those with a dual diagnosis of both a mental illness and an intellectual disability.

639. Evidence presented at the Commission highlighted issues impeding the continuity of care and transition processes for adolescents with a dual diagnosis. The final report concluded:
    - Services addressing the needs of individuals with both mental illness and intellectual disability are extremely limited. The levels of unmet needs in the adult and adolescent populations are significant.
    - These cases can be beset both by unavailability of appropriate services and by a comparatively low level of cooperation and collaboration among government departments and agencies.
    - It appreciated that not all individuals with dual diagnosis require a cross-departmental response.

640. As previously noted the Commission also endorsed the recommendations of the CECIBS Process Review to review and revise the Guidelines for Collaboration between Queensland Health–Mental Health Services, Disability Services Queensland and Funded Disability Service Providers and recommended the guidelines deal expressly with the respective responsibilities of those agencies and

that a service-mapping exercise be undertaken to identify what services are needed.

641. The State Government advised it was committed to undertaking service mapping and reviewing the guidelines as recommended. The review was to have regard to the introduction of the National Disability Insurance Scheme and the role and function of the Department of Health, Hospital and Health Services, the Department of Communities, Child Safety and Disability Services/National Disability Insurance Agency and non-government organisations.

642. The inquest has been provided with the final report in relation to the government response to Recommendation 6 dated 30 June 2017.[16] The report noted the recommendation has been delivered through a number of activities including; a review of the literature, an environmental scan and mapping of services, data matching, consultation and reviewing of the guidelines. The recommendation has been considered in the context of changes in delivery of services for people with a disability due to the transitioning of systems and services to the NDIS currently being rolled out across Queensland.

643. Data matching identified 3914 children and young people registered with Disability Services and Public Mental Health Services who met the definition of a dual diagnosis during a five year period from 2011-2016. This activity identified high rates of Aboriginal and Torres Strait Islanders with dual diagnosis, high rate of presentation into acute mental health settings, and low movement across HHS catchment areas. However, consultation with key clinician and consumer/carers acknowledged dual diagnosis issues are inconsistently recognised in the clinical setting and the need for improved collaboration across services. Other factors identified as impacting on service provision include a lack of expertise in assessing and responding to dual diagnosis, limited number of dual diagnosis specialised multidisciplinary services, services delivered in silos, and the absence of cross sector systems governance and standards for practice.

644. In Queensland while there is local service specific documentation to guide clinical practice, there were no identified formal documents to encourage inter-departmental collaborative practices, except for the guidelines recommended for review. Given the context of the managing NDIS procedures and processes for service providers, rather than revise the existing guidelines, the outcome of the consultation suggested alternative strategies and processes are necessary at this point.

645. The report noted:
   - Review of the literature suggests there are inconsistent data systems to identify children and young people with a dual diagnosis in Queensland and confirms this group experiences access difficulties due to the complexity of presentation and limitations of recognition of dual diagnosis.
   - Data matching shows significant gaps in the identification of dual diagnosis cohort of children and young people and inconsistencies in recordkeeping.
   - Access to assessments to confirm a diagnosis of intellectual disability and mental illness can be difficult and often requires multiple assessments offered across different services and locations. The process is complicated for families unfamiliar with multiple intake processes and navigating the disability and health system.

[16] Final Report Recommendation 6, 30 June 2017

- Access to appropriate specialist services for children and young people with a dual diagnosis is limited.
- Given a child and young person with a dual diagnosis interfaces across health, disability and education providers and services, it is necessary for those involved in the care and treatment to have clearly defined roles and operate in a collaborative manner, recognising the specific contributions and scope of practice of each other. A workforce with specialist knowledge and skills in working with children and young people with a dual diagnosis is necessary.
- Review of the guidelines suggest the utility is less than optimal. However, until there is further clarity about the service system when the full roll out of the NDIS is completed, development of new guidelines at this time is not proposed.

646. The final report set out the further work to be undertaken to address these complex issues including:
    - Strengthening the policy framework
    - Developing practice standards and guidelines
    - Building the capacity, skills and knowledge of the work force, inclusive of NDIS readiness training
    - Enhancing opportunities for innovation eg. programs and resource developments
    - Developing an evidence base through research
    - Further work is necessary to identify opportunities to develop an integrated and specialist assessment and treatment services for children and young people with a dual diagnosis

Recommendations from the Centre of Excellence for Clinical Innovation and Behaviour Support Process Review

647. The statement of Professor Karen Nankervis noted the process review report made nine recommendations and she also reported on the department's response.

648. **Recommendation 1** – *That the CECIBS reviews the Complex Case Review Guidelines to emphasise the prioritisation of* clients *with dual disability.*
    Response:
    It was noted the Complex Case Review process was developed to provide a statewide consistent process for ensuring that the circumstances of people with disabilities whose high and complex needs impacted on service delivery and quality of life were regularly reviewed for continuous quality improvement. At the time of William's death this process was still under development and had not been rolled out. As a result of the review into William's death, dual disability was included as an indicator for inclusion in the statewide Complex Case Review process terms of reference. The identification of dual diagnosis, as a risk, prompts an immediate referral to the Clinical Case Review.

649. **Recommendation 2 -** *That the region includes clients with dual disability in the Complex Case Review Process.*
    Response:
    It was noted the Brisbane region of the department responded to this recommendation by changing the referral pathway for clients with dual disability to ensure all clients with dual disability will automatically reviewed in the local clinical case review process is an escalated were required to the panel for a Complex Case Review.

650. **Recommendation 3 -** *That Disability Services works with Queensland Health to review and revise "The Guidelines for Collaboration between Queensland Health-Mental Health Services, Disability Services Queensland and Funded Disability Services Providers"* protocol to address the need for joint transition planning that includes comprehensive risk assessment and post-discharge follow-up responsibilities of the discharging organisation.

Recommendation 4 - *These guidelines confirm that Disability Services should not accept any client into the care* without *the mental health assessment and management required to ensure that accurate risk management is in place.*

Response:

It was noted that in relation to the response to **recommendations 3 and 4** the guidelines had been introduced in 2003–2004 and provided a broad framework for provision of service to people with intellectual disability and mental illness using a collaborative approach between Queensland Health and Disability Services. Subsequent to the development of the guidelines the Joint Action Plan Transition Plan tool was developed with Queensland Health to ensure a consistent and comprehensive approach to joint planning for transition of people with disabilities from health facilities. As a result of the Process Review the department requires this to be used to facilitate transition planning for people with disability who transition from long stay health settings into disability funded/provided services. Additionally, the department has developed and implemented statewide protocols for clinical case closure and hand over that applies to all disability services clients who are supported by departmental clinicians.

651. **Recommendation 5 -** *That Brisbane region discuss record keeping with Tag5 including ways of keeping records of client behaviour and accurate medication administration records.*

Response:

The Brisbane region provided a briefing to TAG 5 on 24 September 2015.Tag 5 management reported improvements undertaken including structural changes, regular supervision of team leaders and training in report writing as well as purchasing training in client specific behaviour management. Brisbane region staff work closely with TAG 5 regarding medication administration recording as well as behaviour management training, and behaviour recording.

652. **Recommendation 6 -** *That a requirement for funded non-government service providers to ensure their staff have appropriate training when supporting clients with high and complex needs, including* dual *diagnosis, is included in consideration of funding of such providers and subsequent contractual arrangements.*

Response:

The Process Review identified a significant shortage of capacity of service providers able to support William. This continues to be an issue when regions attempt to source appropriate placements for people with disabilities who have high and complex needs. At the time of the Process Review contract arrangements did not require funded non-government service providers to take up with the department's offers of training and other supports. With the role out to the National Disability Insurance Scheme (NDIS) the opportunity to review how the department contracts with service providers became redundant. However, the region continues to offer training and support organisations supporting people with high and complex needs.

653. **Recommendation 7 -** *That all dual diagnosis clients are only placed in support arrangements with staff have received education and training in management of mental health issues or there is* an *arrangement in place that guarantees coordinated services delivery with other providers with expertise*.
Response:
It was noted normally this would be the case as regions always carefully consider the capability of the provider as well as any supports that the regional clinical staff may need to provide to the service provider. When there is a shortage of appropriate providers it can take a longer time to find such an appropriate placement and ensure that any staff training needs are addressed. In this case where there was a set timeline imposed by the planned closure of the BAC the ability to undertake these processes were compromised.

654. **Recommendation 8 -** *A neuropsychological assessment be included in the comprehensive risk assessment* documentation *which is provided by Queensland Health to Disability Services prior to discharge*.
Response:
In the department response it was noted that whilst this was recommended, it would not be appropriate to make this assessment mandatory as all assessment should be appropriate to the needs and circumstances of the individual client. Best practice in assessment is that which is person-centred.

655. **Recommendation 9 -** *That training* in *the primary elements of capacity and legal decision-making is provided to Disability Support workers.*
Response:
It was noted that training of the staff should be aimed at awareness training so support staff who believes there is an issue with the decision making capacity of an individual client can refer this to a senior person in the organisation for further consideration an assessment.

656. Professor Nankervis noted the recommendations were accepted and actioned immediately after the Process Review report was received and prior to the Commission of Inquiry. The Commission of Inquiry also endorsed the recommendations of the Process Review report.

657. Professor Nankervis also noted the NDIS was to be fully implemented in Queensland from 1 July 2019. After that time, all eligible persons with disabilities will be NDIS participants and their services and supports will be funded through their NDIS plan.

Evidence of Dr John Allan, Queensland Health

658. The affidavit of Dr John Allan, Executive Director, Mental Health Alcohol and Other Drugs Branch, Queensland Health addresses the issue the implementation of the Commission recommendations and of other initiatives relevant to child and youth mental health in detail.

659. In particular, it is noted Dr Allan's affidavit swears to the following:
    a) A need to approach suicide prevention in a way that addresses the multiple risk and protective factors that interact to increase or reduce the likelihood of suicidal behaviour, that exist at a personal, social and environmental level and across a person's lifespan.[17]

[17] Exhibit A22, Affidavit of Dr John Allan, para 43-46

b) An 'all of population' and 'whole of life' approach to suicide prevention, meaning adolescents and young people at risk of self-harm and suicide have access to the full suite of mental health services available across the public, private and primary health care sector.[18]
c) The Queensland Government's commitment to reducing the suicide rate by 50% by 2026, including through the development of a whole-of-government suicide prevention strategy.[19]
d) The establishment in 2016 of the Queensland Government's Suicide Prevention in Health Services Initiative (the Initiative), with a budget of $9.6 million over four years to 30 June 2020, to enhance the clinical care provided to people at risk of suicide.[20]
e) Under the Initiative, the establishment of the Suicide Prevention Health Taskforce (the Taskforce) which, amongst other things, has progressed action to:
    i. Enhance GP attitudes, knowledge, skills and resources in relation to appropriately recognising, responding to and referring people experiencing a suicidal crisis, including by:
        - Ensuring GPs have access to an Advanced Training in Suicide Prevention program developed by the Black Dog Institute and accredited by the Royal Australian College of General Practitioners
        - Developing a state-wide Suicide Prevention Health Pathway available electronically to GPs across the state[21]
    ii. Build the capacity of clinicians who work within and/or in partnership with the school environment (e.g. School Based Youth Health Nurses and Ed-LinQ coordinators[senior mental health clinicians]) to better support students experiencing mental health issues, including through allocation of additional resources to increase the amount of clinicians available across Queensland[22]
    iii. Implement the Zero Suicide in Healthcare Multi-Site Collaborative across 11 Hospital and Health Services (HHS), and work with the remaining five HHSs to strengthen their capacity to respond to suicide risk through a variety of mechanisms[23]
f) Also under the Initiative, the conduct of multi-incident analyses of suspected deaths of individuals who had a recent contact with a health service to identify when, where and how the provision of existing HHS services could be improved to reduce deaths by suspected suicide[24]

660. Of particular relevance to prevention of self-harm and suicide in adolescents and young people, Dr Allan's affidavit swears to the following:

[18] Para 75-76
[19] Para 48-49
[20] Para 50
[21] Para 55
[22] Para 56-63
[23] Para 64-73
[24] Para 50, 80

a) Work being undertaken by Children's Health Queensland HHS and the Central Queensland HHS, through funding provided via the Multi-Site Collaborative, to co-design, develop and trial a culturally safe and appropriate child and youth suicide prevention clinical pathway in collaboration with key stakeholders including Indigenous and child and youth representatives[25]
b) A collaboration between the Queensland Centre for Mental Health Learning and the Initiative to update a training program '*QC28 Youth: Engage, Assess, Respond to, and Support Suicidal People*'[26]
c) The availability of a continuum of child and youth mental health services across Queensland providing community treatment and support services, hospital bed-based services and community bed-based services to children and young people aged 0-18 years[27]
d) The inclusion of children and young people under 18 years of age as a specific vulnerable cohort within the multi-incident analysis of suspected suicide deaths of individuals who had a recent contact with a public health services, resulting in recommendations for service improvement actions which are (as at the date of Dr Allan's affidavit) being finalised by an expert panel[28]
e) The allocation of 25 percent of the $350 million being invested under '*Connecting Care to Recovery 2016-2021: A plan for Queensland's State-funded mental health, alcohol and other drugs services*' to new initiatives and enhancements to existing services providing care and treatment for children and young people for mental health, alcohol and other drugs initiatives[29]
f) Queensland Government's allocation of $68.2 million of its 2017-18 Budget to fund five new capital works projects to be delivered by the 'Youth Mental Health – Capital Program', which will include:[30]
    i. A new 12-bed state-wide Adolescent Extended Treatment Facility (AET) at The Prince Charles Hospital campus, to provide sub-acute inpatient treatment and rehabilitation for an extended period (up to six months) to individuals aged between 13 and 18 (and possibly up to 21 years where they have developmental needs that would be more effectively treated within an adolescent model)
    ii. Two six-bed Youth Step Up Step Down Units in north and south Brisbane, comprising community bed-based (sub-acute) mental health services that provide 24-hour intensive, short-term clinical and non-clinical support for young people aged 16 to 21 years
    iii. Two new 15-place adolescent Day Programs in Logan and the Gold Coast, which will provide integrated education and mental health services up to five days per week for young

[25] Para 68
[26] Para 71
[27] Para 77-78
[28] Para 80
[29] Para 81
[30] Para 82

people with severe and complex mental health issues, as an alternative to inpatient admission

661. Dr Allan's affidavit also provides evidence of implementation of the Queensland Government Response to the Barrett Adolescent Centre (BAC) Commission of Inquiry (COI) Final Report[31], and establishment of a Youth Mental Health Program Oversight Committee in October 2017 to oversee ongoing work related to the child and youth mental health services system arising from recommendations three through six of the BAC COI Final Report.[32]

662. QH led the implementation of the Government Response under the auspice of the BCA COI Implementation Steering Committee with representatives from relevant HHSs, Department of Premiere and Cabinet, Department of Education and Training and Department of Communities, Child Safety and Disability Services. Four consumer and carer representatives were also members, including three directly associated with the former BAC.

663. Independent reviews and reports addressing the six recommendations were delivered and noted at the final meeting of the Implementation Steering Committee on 19 July 2017. It was noted there was need for ongoing work arising from each of the reports and an ongoing commitment to strong governance and transparency was expressed.

664. Dr Allan confirmed the implementation of the government response in these terms:
- Recommendation 1- Review of Statewide Services Final Report- March 2017 by Price Waterhouse Coopers.
- Recommendation 2- Quality Innovation Performance Consulting Report of review of NGO service agreements–May 2017
- Recommendation 3–Review of existing clinical and program evaluation framework for extended treatment services for adolescents and young adults with severe, persistent and complex mental illness in Queensland–final report–Queensland Centre for Mental Health Research, March 2017
- Recommendation 5- QH review of alignment and transition arrangements between adolescent and adult mental health services in Queensland–Final Report–Health Outcomes International and Synergy Nursing and Midwifery Research Centre –30 June 2017
- Recommendation 6- Final Report- 30 June 2017,MHAODB- referred to earlier in this decision.

665. In respect to Recommendation 4 the state-wide AET facility as a capital work is to be situated on The Prince Charles Hospital campus and is nearing building completion.[33] The AET model of service was being finalised for approval. The development process for the model of service has involved extensive stakeholder consultation, the details of which were set out in Dr Allan's affidavit.

666. In concluding his affidavit, Dr Allan urges that any recommendations for the prevention of self-harm and suicide in adolescents and young people must take into consideration the extensive efforts of Queensland Health as outlined throughout his affidavit, and that any future suicide prevention investment and

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[31] Para 83-89
[32] Para 90-99
[33] According to QH references on the internet for completion in early 2020

efforts should provide for the scaling up and strengthening of the considerable investment in suicide prevention that has already been made, including building on and promoting the sustainability of outcomes achieved through the Multi-Site Collaborative and continuing to strengthen health service employees' ability to recognise and appropriately respond to patients presenting to health services with suicide risk.[34]

Child and Youth Panel-recommendations specific to children and young people

667. It is noted that of the matters referred to in Dr Allan's first affidavit, there remained outstanding as at the date of the affidavit a suite of draft recommendations made by an expert panel convened to examine the deaths by suspected suicide of children and young people with a recent contact with a health service.[35] A request was forwarded to Dr Allan to provide further information concerning the outcome to the expert panel's deliberations.

668. In response Dr Allan provided a further statement[36] setting out further information concerning the multi-incident analysis of sentinel events relating to deaths by suspected suicide of people with recent contact with a health services. This was one panel amongst other panels for other cohorts where a similar analysis was performed, and relevantly for my purposes considered the suicide deaths of children and young people aged 17 years and under, during the calendar years of 2015 and 2016. The deaths of Caitlin, Talieha and William were not considered as their deaths occurred in 2014.

669. Dr Allan's statement gave particulars of the methodology for the multi-incident analysis, and the ethical approvals for the research obtained including from the State Coroner.

670. Dr Allan described the clinical incident analysis model that was developed by the research team to guide the respective expert panel. Cohort experts were engaged to review information relating to how system factors and clinical care may be experienced by children, young people and their families. Their insights proved valuable for informing recommendations for improvements to specific child and youth health care systems.

671. Dr Allan stated that clinician representatives identified best practice suicide prevention interventions effective within a health service context. This approach underpinned support for, and the anticipated sustainability of recommended improvements.

672. Careful consideration was given to enabling lived experience participants to provide insight as to how health services can more effectively respond to people who have contact with a health service at risk of suicide and a person with lived experience was to join the panel for phase 4 of the project to assist in the development of draft recommendations.

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[34] Para 107
[35] Para 80. See also https://clinicalexcellence.qld.gov.au/sites/default/files/docs/priority-area/service-improvement/suicide-prevention-health-services-initiative/suicide-prevention-poster-2018.PDF
[36] Exhibit A22.1.

673. The Child and Youth Panel met on five occasions over a period of four months to undertake the analysis of clinical care provided to 13 individuals. The panel identified nine key themes from the review. The themes represented common health service system factors relevant to the documented clinical care as reviewed. The nine themes were:
    1. Clinical governance;
    2. Suicide risk assessment, risk formulation and safety planning;
    3. Timely access to the specialist care;
    4. Engagement with young person, family and care system;
    5. "Did not attend" processes;
    6. Communication;
    7. Multi-agency collaboration;
    8. Trauma; and
    9. Diagnostic factors.

674. The Child and Youth Panel identified 34 initial recommendations associated with the nine themes, which recommendations were prioritised and further refined into 17 final recommendations addressing each of the nine identified themes. The recommendations were as follows:
    1. Models of service and associated training, resources and tools (e.g. clinical documentation, clinical information system, health apps) support standardised practices that promote reciprocal communication between the young person, the carer, clinicians, peer workers, indigenous health workers and agencies, with the aim of developing a shared understanding of the young person's circumstances, goals and preferences, suicide risk, safety plan and ongoing care plan.
    2. Clinicians use prevention-oriented thinking and language when undertaking suicide risk assessment and develop a suicide risk formulation, which articulates the young person's risk status, risk state, and available resources and foreseeable changes.
    3. The capacity of the non-government sector and other components of the care system for young people is developed to respond to suicide risk through a strategic best practice suicide prevention capacity development program.
    4. The care plan for a young person presenting with suicide risk specifically addresses the young person's suicidality as well as treat the primary diagnosis and any associated comorbidities.
    5. Clinicians undertaking a suicide risk assessment with a child or young person are cognisant of contemporary social, emotional and well-being issues, clinical interviewing approaches, treatment options and referral pathways specific to the young person's development age.
    6. Suicide risk assessment and care planning for a young person with complex care needs is developed, reviewed and monitored by a collaborative multi-agency team, with appointment of a lead clinician and/or agency, an emphasis on transitions and continuity of clinical care.
    7. Evidence-based m-Health apps (i.e. apps for mobile devices) are used, where clinically appropriate, as part of coordinated and comprehensive suicide risk management and ongoing care.
    8. Clinical care, including the availability and use of appropriate referral pathways, recognises and responds to the needs of a young person

who has experienced physical and/or psychological trauma (current and/or historical).

9. Family and carers of young people have access to resources and support appropriate to their psychosocial and cultural needs, and aligned to the young person's care plan.
10. Access to specialist support via telepsychiatry, visiting specialists and networks of services is included in the suicide prevention pathway for young people in rural areas in the role of these services clearly articulated in the young person's care plan.
11. The capacity of the indigenous mental health work force is strengthened to provide culturally appropriate care and recovery support commensurate with the burden of disease and rates of indigenous youth suicide.
12. Suicide risk assessment and management training programs address LGBTIQ, gender identity, bullying and online safety, suicide use and ASD issues with content informed by young people, carers and peer workers. Training is implemented for emergency department and other frontline acute mental health care staff.
13. Care plans include psycho education regarding LGBTIQ, gender identity, bullying and online safety issues as appropriate, supported by links to available online resources.
14. Statewide minimum standards are articulated to guide local Hospital and Health Service 'did not attend' procedures.
15. Care transitions are supported by a comprehensive planning, clear communication with the young person and their support system, and assertive follow-up.
16. The functionality of and business rules for the use of digital platforms supports information sharing within and between health services through timely and transparent access to accurate, contemporaneous health information by all clinicians involved in a young person's suicide risk assessment, management and ongoing care.
17. Care planning is a meaningful collaboration between the young person, their families/carers, peer workers and clinicians, to provide ownership by the young person of their care and recovery plans.

675. Dr Allan stated the MIA research team is working in partnership with units across the MHAODB to finalise planning and design of Queensland Health's response to the panel recommendations. He stated the recommendations aligned with, informed and advanced existing service reform activities of the MHAODB.

676. A task force has been set up to progress implementation of the recommendations as follows:

   a) Engagement and support of children and young people, their family and carers
   b) Trial m-Health mobile apps to engage young people as part of after-care planning and support following a suicide attempt in partnership with the Black Dog Institute
   c) 'Did not attend' procedures

677. Participating HHSs will also implement and evaluate the following recommendations through the Zero Suicide in Healthcare Multisite Collaborative:

a) Suicide risk assessment, risk formulation and collaborative care planning
b) Care transition is supported by a comprehensive planning and clear communication
c) Multi-agency coordination to improve transitions and continuity of clinical care
d) Referral pathways, which respond to the needs of a young person who has experienced physical and/or psychological trauma
e) Access to specialist support via telepsychiatry, visiting specialists and networks of services for young people in rural areas.

678. In addition, the MHAODB is funding enhanced capacity of the Queensland Centre for Mental Health Learning and continued collaboration with international experts to implement evidence-based clinical and non-clinical training programs incorporating panel recommendations for suicide risk assessment, risk formulation and collaborative care planning; recognising and responding to young people who have experienced physical and/or psychological trauma; LGBTIQ , gender identity, bullying and online safety, substance use and autism spectrum disorder issues; and that the provision of best practice suicide prevention training to the non-government sector and other components of the care system for young people.

679. MHAODB is also partnering with the Aboriginal and Torres Strait Islander Mental Health Leadership Group and Health Branch to strengthen the capacity of the indigenous mental health work force to provide culturally appropriate care and recovery support within multidisciplinary team.

680. MHAODB is also reviewing the functionality of and business rules with the use of digital platforms to support information sharing by all clinicians involved in a young person's suicide risk assessment, management and ongoing care.

681. Dr Allan stated these priority action areas are aimed at improving service delivery responses for children and young people at risk of suicide in a health service context, and they contribute to the broader evidence-base that under-pins the work of the initiative. At the time of writing the role out of the initiative across HHSs was in its infancy and evaluation data was not yet available.

Recommendations pursuant to section 46 of the Coroners Act 2003

682. Having regard to Dr Allan's affidavits, and accepting Dr Allan's evidence that any recommendations must take into account the considerable work and investment in suicide prevention and mental health services generally that is already underway and planned for the future, including specific to adolescents and young people, I do not consider there are any additional matters about which recommendations might usefully be made by the Court pursuant to section 46 of the *Coroners Act 2003* at this time.

683. I close the inquest.

John Lock
Deputy State Coroner
BRISBANE
30 August 2019