

ORDER:

Restriction on publication of reports:

The deceased may be referred to as RL. The deceased's name and image, the name of any suburb in which he lived, the names or images of the deceased's parents, brother or other family are not to be published; the names or images of any sporting teams that the deceased participated in is not to be published; the name or image of the school that the deceased attended is not to be published; the names or images of any of the staff who worked with the deceased at the school he attended are not to be published; the names or images of any fellow students, sporting team mates or friends of the deceased are not to be published; the names or images of health or medical staff who worked with the deceased are not to be published; descriptions of the precise method of death are not to be published.

CITATION: *Inquest into the death of RL [2026] NTCC 07*

TITLE OF COURT:	Coroners Court
JURISDICTION:	Alice Springs
FILE NO(s):	A0059/2023
DELIVERED ON:	19 June 2026
DELIVERED AT:	Alice Springs
HEARING DATE(s):	28 July – 1 August 2025
FINDING OF:	Deputy Coroner Chrissy McConnel
CATCHWORDS:	Self-inflicted hanging; child suicide; communication with family; communication between school and NT Health; youth mental health in-patient services in Alice Springs; information sharing.

REPRESENTATION:

Counsel Assisting:	Fiona Kepert
Counsel for Police:	Elizabeth Forbes
Counsel for Health:	Tom Hutton
Counsel for Family:	Paul Morgan

Judgment category classification:	B
Judgement ID number:	[2026] NTCC 07
Number of paragraphs:	174
Number of pages:	50

IN THE CORONER'S COURT
OF THE NORTHERN TERRITORY
AT DARWIN

No. A0059/2023

In the matter of an Inquest into the death of

RL

ON: 6 November 2023

AT: ALICE SPRINGS

FINDINGS

CONTENT WARNING

These findings discuss child suicide by hanging

Deputy Coroner Chrissy McConnel

Introduction to RL

1. RL was born in the Seychelles on 29 January 2006. His family immigrated to Australia when he was 18 months of age. By all accounts RL was an impressive young man, he was intelligent, received multiple academic awards at school, had been dux and was elected as school captain for year 12. RL also excelled at sport, he was a keen rock climber and particularly passionate about volleyball which was described as “his very happy place”¹. He played football and was selected to represent the Northern Territory and represented Alice Springs in an interstate athletics competition.
2. Despite these successes, before his death RL was in pain and struggling to cope. He disengaged from school and his friends, and during 2023 he was twice hospitalised at the Alice Springs mental health inpatient unit.

¹ T 18.

3. On 6 November 2023, at the age of 17, RL passed away by suicide. We cannot begin to fathom the grief and pain of his parents and family. I acknowledge, as expressed by RL's father, that grief is not something for which closure can be achieved, it is something that will always be carried by RL's family:

It's been a year and nine months since you've been gone but the ache in our hearts remains as fresh as the day you left. Not a day goes by without missing your presence, your voice and your smile.

Time moves forward, but the physical, psychological, emotional pain stays behind. We will always carry your memory in everything we do with love and sorrow side by side. You may be gone from our sight, but never from our hearts.

...

Our family has been so traumatised by his death. The sleepless nights and nightmares, the feeling of guilt will never end. We'll be grieving for a lifetime. There is no moving on or getting over it. There is no end to the ways we will grieve and how long we will grieve. For as long as we breathe, we will be grieving.

...

*May you rest in peace our beautiful son."*²

Family statement read out on day 1 of the inquest

4. Before he passed away, RL was unable to articulate what he was feeling, which leaves those who knew him with unanswered questions about why he suicided and whether anything could have been done to stop him. It is extremely common in the aftermath of suicide for professionals as well as friends and family to feel guilt³ and RL's mother blames herself at times for her son's death. While this

² T 10 - 11.

³ 8.5 – Rachel Gibbons articles.

response is common, it is not true. Research shows that suicide is very difficult to predict and to prevent.⁴ No-one should be blamed for RL's decision.

5. RL's death is felt not just by his family, but also those who knew him. Alice Springs is a small community and it's clear that his passing has touched many people.
6. The Australian Institute of Health and Welfare⁵ reports that suicide is the leading cause of death in Australians aged 15 to 24 years. In 2023, 289 young people aged 18 to 24 years took their own lives in Australia. Ninety-four deaths by suicide occurred among children and adolescents aged 17 and below. The NT has the highest suicide rate per capita in Australia. Sadly, a position we have held nearly every year for the last 40 or so years. Rates are even higher in regional and remote areas like Alice Springs. For the last five years, the NT has had on average just over 48 deaths by suicide each year. That is nearly one death per week.
7. This inquest explored the support and treatment RL received before his passing to understand if there are opportunities to learn and improve responses to suicide risk in young people.

Chronology

8. In 2019, RL's mother, 'M', suffered a stroke and as a result experienced expressive aphasia, partial paralysis and mobility problems. In 2021, M moved out of the family home and into an assisted living facility. RL and his younger brother continued to live at home with their father.
9. In late 2022 / early 2023, it became apparent that RL's mental health was deteriorating. In August 2023, following disclosure of suicidal thoughts RL was referred by his GP to the Child and Youth Mental Health Team (Child and Youth

⁴ NT Health Institutional Witness, Dr Josephine Rio at T 221.

⁵ www.aihw.gov.au.

Team)⁶, part of Central Australian Mental Health Services (CAMHS) run by NT Health.⁷

10. On about 28 August 2023, RL attempted suicide. He did not tell anyone at the time but later disclosed it to treating practitioners. On 31 August 2023, RL again attempted suicide, this time calling 000.⁸ When police attended, he told them what had happened and he was taken to the Alice Springs Hospital (ASH) where he was admitted to the Mental Health Inpatient Unit (Inpatient Unit) for Psychiatric Assessment⁹ followed by an admission as an involuntary patient under section 39 of the *Mental Health and Related Services Act*, which continued to 19 September 2023.
11. On 1 November 2023, RL was re-admitted to the Inpatient Unit at ASH for Psychiatric Assessment and involuntary admission overnight.¹⁰ The following day he was assessed and found not to meet the legislative criteria for involuntary admission. He declined to remain as a voluntary patient and was discharged home on Thursday 2 November 2023.
12. Following RL's discharge he was followed up by the Crisis Assessment and Treatment Team (CAT Team) over the weekend. Despite multiple attempts to contact RL by phone on 3, 4 and 5 November, the CAT Team was unable to reach him, leaving messages to call back. The CAT Team spoke with RL's father on 4 November and called again on 5 November, but was unable to reach him and left a message requesting he return the call.¹¹
13. On 6 November 2023, RL suicided.
14. Dr Tabart, clinical director with mental health services, in accordance with protocols, reached out to RL's father and offered to meet with him. A meeting

⁶ The Child and Youth Mental Health Team provides comprehensive assessment and treatment for children and young people from 3 to 18 years of age who present with moderate to severe mental health difficulties; 4.6 NT Health Institutional Response, Dr Rio [39(f)].

⁷ 5.7 Medical records of medical clinic following consultation on 10 August 2023, 428-429.

⁸ 2.3 000 call on 31 August 2024.

⁹ 5.2 CYMHT & MHU Records, 11-16.

¹⁰ As above 115-117.

¹¹ 4.6 NT Health Institutional Response, Dr Rio [320] onwards; T 218.

with family took place on 23 November 2023. NT Health also held meetings with staff at RL's school on 15 and 20 November 2023. The school expressed appreciation for health's assistance and approach in these meetings, which they found to be supportive and helpful as the whole school grappled with RL's death.

Issues

15. It is clear that the cause of RL's death was suicide. This is consistent with the findings in the post mortem report¹² and what police and RL's father observed on 6 November 2023. There were no injuries or abnormalities that raised concerns of any other contributing factor or the involvement of others. The evidence obtained by police in their investigation was consistent with suicide and nothing was discovered that raised questions or avenues of inquiry indicating other causes. Toxicology results show that there was no evidence of alcohol or illicit substances in RL's blood.¹³
16. RL took his own life despite the fact that many people recognised that he was at risk of suicide and tried to help. This inquest examined concerns raised by RL's family, and also matters which had been identified through the coronial investigation. These include the failure of the school and NT Health to notify M of her son's academic and mental health decline, the support provided to RL at school, his treatment at Headspace and by the Child and Youth team, the first involuntary admission at ASH, information sharing by Police and finally, the decision to discharge RL following his second admission on 1 November 2023, 5 days prior to his death.

Failure by school and NT Health to inform RL's mother of his decline

17. RL's mother was not advised of the deterioration in her son's wellbeing, reduced engagement at school or academic decline. She was not advised about RL's referral to the Child and Youth Team, his suicide attempts nor the inpatient admissions on 31 August 2023 and 1 November 2023.

¹² 2.15 Post Mortem Report of Dr Althea Neblett.

¹³ 2.16 Toxicology Summary Report, 24 November 2023.

18. The first M knew about these things was after RL had passed away.
19. It is unimaginable what it must have felt like for her to receive the tragic news of her son's death and then learn of all the warning signs of which she had not been told. M is devastated and it would be understandable if she is also angry.
20. There are cases where it is appropriate not to inform a child's parent about their health or matters at school, but this was not such a case. It was not suggested by anyone that there was a reason not to contact M. Senior staff from both the school and NT Health gave evidence that they should have contacted RL's mother and that they could have done so even without RL's consent.¹⁴
21. Those who gave evidence acknowledged the significance of the failure to contact M and it was clear that they felt genuine remorse. The inquest was an important opportunity for both services to reflect on this failing. Not involving M was a lost opportunity to help RL and she should have been kept informed of her son's deterioration at school and in his wellbeing.
22. I have considered carefully whether or not a recommendation should be made to ensure families are properly kept informed in the future, I have decided not to do so. One of the difficulties is the diversity of situations in which this issue will arise. While in this case RL's mother undoubtedly should have been contacted, that will not always be so clear cut. Any policy could only be a reminder for staff to consider contacting family, it could not be prescriptive. Given the living situation for RL's family and his father's involvement in treatment I am not persuaded that the type of recommendation this proceeding could make would ensure a different outcome in the future.
23. I note also that this is not a new issue, staff are aware of the importance of contacting family and it is a part of usual practice.
24. Lastly, I am persuaded by the evidence from the health and education services that a recommendation is not necessary as they have each reflected on what occurred and I am confident those involved in this inquest will take whatever

¹⁴ T 27 and T 121.

steps would be effective in addressing the issue. RL's school and NT Health should consider what if any further steps should be taken to ensure that learning is retained and reaches those not personally involved in this case. While I have decided not to make a formal recommendation, if the school or NT Health see a benefit in updating guidelines or training on this issue, I expect that to occur.

School

25. RL's school was the first service to identify that RL was struggling and took escalating steps to support him, including:

- Initially individual teachers, staff and the principal provided support.
- Encouragement and support from generalist staff continued and in early 2023 a referral was also made to the school counsellor. RL was seen by the school counsellor for 3 counselling sessions and there were other less formal check ins.¹⁵
- On 1 June 2023, RL disclosed to a school staff member that he was thinking about what life would be like if he, RL, was no longer there. RL's father was informed¹⁶ and the school counsellor helped RL to complete a referral to Headspace.¹⁷
- On 8 August 2023, RL's father approached the school stating that he was at a loss as to how to assist RL. A group meeting was promptly arranged with the school counsellor, the deputy principal and RL's teachers.¹⁸
- On 9 August 2023 RL disclosed suicidal thoughts to a school staff member, though denied having a plan. With the support of the school and RL's father, RL was quickly connected with mental health services, firstly a GP and then the Child and Youth Team.¹⁹

¹⁵ Pastoral care records in 7.3 and 7.3A; counselling commenced May 2023, T 54; check ins T 55.

¹⁶ 7.3A Pastoral care records.

¹⁷ 7.3A Pastoral care records see 20 June 2023; 5.6 – Headspace Records, p 11.

¹⁸ 7.3A Pastoral care records.

¹⁹ 7.3A Pastoral care records.

26. Staff at the school did their best to support RL and to obtain appropriate external support. Support from the school continued following RL's suicide attempt and first inpatient admission. Staff visited RL at the hospital, including the school principal who had known him since he was a young boy.²⁰ The school was actively engaged with NT Health in planning for RL's return to school but as discussed further below, communication between the services could have been approached more effectively.

Headspace

27. With RL's agreement, on 20 June 2023 the school counsellor facilitated a referral to Headspace for support. That referral resulted in RL completing a mental health plan with a GP on 21 June 2021²¹ which involved a mental state examination, including self-assessment under the Revised Children's Anxiety and Depression Scale -25 (RCADS-25).²² The results are recorded as D51, A59, T56, within normal range.

²⁰ 6.1 Audio statement of School Principal.

²¹ 5.6 Headspace records, pp 4-6 and 3-16.

²² 5.6 Headspace records, RCADS-25, p17.

SCANNED
28/6/23

Date: 21/6/23

RCADS-25

Please put a circle around the word that shows how often each of these things happens to you. There are no right or wrong answers.

1. I feel sad or empty	Never	Sometimes	Often	Always
2. I worry when I think I have done poorly at something	Never	Sometimes	Often	Always
3. I would feel afraid of being on my own at home	Never	Sometimes	Often	Always
4. Nothing is much fun anymore	Never	Sometimes	Often	Always
5. I worry that something awful will happen to someone in my family	Never	Sometimes	Often	Always
6. I am afraid of being in crowded places (like shopping centers, the movies, buses, busy playgrounds)	Never	Sometimes	Often	Always
7. I worry what other people think of me	Never	Sometimes	Often	Always
8. I have trouble sleeping	Never	Sometimes	Often	Always
9. I feel scared if I have to sleep on my own	Never	Sometimes	Often	Always
10. I have problems with my appetite	Never	Sometimes	Often	Always
11. I suddenly become dizzy or faint when there is no reason for this	Never	Sometimes	Often	Always
12. I have to do some things over and over again (like washing my hands, cleaning or putting things in a certain order)	Never	Sometimes	Often	Always
13. I have no energy for things	Never	Sometimes	Often	Always
14. I suddenly start to tremble or shake when there is no reason for this	Never	Sometimes	Often	Always
15. I cannot think clearly	Never	Sometimes	Often	Always
16. I feel worthless	Never	Sometimes	Often	Always
17. I have to think of special thoughts (like numbers or words) to stop bad things from happening	Never	Sometimes	Often	Always
18. I think about death	Never	Sometimes	Often	Always
19. I feel like I don't want to move	Never	Sometimes	Often	Always
20. I worry that I will suddenly get a scared feeling when there is nothing to be afraid of	Never	Sometimes	Often	Always
21. I am tired a lot	Never	Sometimes	Often	Always
22. I feel afraid that I will make a fool of myself in front of people	Never	Sometimes	Often	Always
23. I have to do some things in just the right way to stop bad things from happening	Never	Sometimes	Often	Always
24. I feel restless	Never	Sometimes	Often	Always
25. I worry that something bad will happen to me	Never	Sometimes	Often	Always

RCADS-25 self-assessment - completed by RL on 21 June

28. Under 'Risks and Co-morbidities', the mental health plan records, "increasing thoughts about death and non-existence, no suicidal intent, and no plan." The GP diagnosed an adjustment disorder and assessed RL as a medium risk of self-harm. A referral was made for six sessions with a psychologist, to be reviewed after those sessions had been completed, with the possibility of six further sessions.²³
29. RL had three sessions with the Headspace psychologist, on 4, 6 and 20 July 2023.
30. RL reportedly presented for his first session (4 July) with low mood but good engagement, motivation and insight. He spoke of a falling out with a friendship group which occupied his thoughts and described thoughts of, "wondering what it would be like not to be here, and... what others might do if he disappeared,"

²³ 5.6 Headspace records, p 16.

reporting to the psychologist that these thoughts were more about escaping than suicide. He reported that his thoughts and feelings of depression had been worse since school holidays had started and when he was alone.

31. At the second session on 6 July, RL reported a slight increase in mood, no thoughts of suicide and less pre-occupation with thoughts of non-existence. He engaged well and demonstrated good focus throughout the session. The psychologist discussed his initial thoughts with RL, which were that RL was experiencing mild depression and stress. RL reportedly agreed. They discussed the vicious cycle of depression and RL was able to identify that increased activity would help him break that cycle.
32. In the third (and final) session on 20 July, RL reported no thoughts of suicide, self-harm or non-existence. Under 'RISK' the psychologist noted a substantial decrease from commencement of treatment. After the three sessions it is recorded that RL reported increased mood and was categorised as normal range for depressive symptoms. RL declined to talk about the interpersonal conflict he had raised in the first session. He reported that he had recommenced umpiring football twice a week.²⁴
33. A further session was booked for 27 July 2023 which RL called and cancelled on 26 July, citing school as being very busy. The Headspace notes record that he said he would like to rebook but was not sure when. When the psychologist called RL to follow up, RL stated that he had recommenced previous activities, was in a good routine and felt comfortable now he was back at school. Despite encouragement, RL declined further appointments²⁵ and did not engage further with Headspace.
34. On 24 August 2023, a letter was sent from the Headspace psychologist to RL's referring GP, providing a summary of RL's treatment and advising that after three sessions, RL had decided to discontinue with the service due to his increased mood. Noting that the interpersonal difficulties RL had presented with had not

²⁴ 5.6 Headspace records, p 4.

²⁵ 5.6 Headspace records, pp 3-4.

been addressed, the psychologist observed that interpersonal conflict and periods of limited activity – such as school holidays – may leave RL vulnerable to low mood and recommended that checking in on RL’s mental health during such times would be prudent.²⁶

35. The next entry in RL’s Headspace records is the file closure on 25 September 2023. Headspace were not notified of RL’s admissions to the ASH inpatient unit in August or November 2023.²⁷
36. Dr Theresa Flower, the Consultant Psychiatrist engaged by RL’s father to review RL’s care, considered the care by Headspace to have been “reasonable and appropriate”.²⁸
37. Headspace gave evidence that it would have been useful for them to have been advised when RL was admitted to hospital as that would have allowed them to reach out and try to re-engage RL.²⁹ Similarly, I expect, it would have been helpful to know when RL had been discharged. However, if RL had not given consent to NT Health to pass on the information to Headspace, and there is no evidence of him having done so, then I accept that the mental health team at ASH could not have provided information to Headspace.
38. While the hospital has standard procedures about notifying the Central Australian Aboriginal health service Congress when Aboriginal clients are discharged from the inpatient unit, there is nothing in place for non-indigenous clients.³⁰
39. Whether a protocol with Headspace covering young people would be worthwhile depends on how frequently there is a crossover of clients. At the time of RL’s discharge he was no longer a client with Headspace, the prior relationship at Headspace was not lengthy, and I am satisfied that the appropriate health service for RL was the Child and Youth Team. While exploring alternative options might have been worthwhile when it was clear that RL was not engaging with the Child

²⁶ 5.6 Headspace records, p 3.

²⁷ 3.1 Headspace [7].

²⁸ 1.3 Dr Flower’s report, p 14 [470].

²⁹ 3.1 Headspace, [8].

³⁰ 3.1 Headspace, [11].

and Youth Team, that does not lead to the conclusion that there should be a standard and automatic notification whenever a young person is discharged.

40. In those circumstances, I do not consider it appropriate or necessary to make a recommendation but if the services see a benefit in increased information sharing and communication, they are encouraged to pursue such an arrangement.

Child and Youth Team

41. In response to RL's disclosure about thoughts of suicide and the concerns raised by his father with the school in early August 2023, RL was connected with the Child and Youth Team, a specialist child and youth mental health service for children and young people aged between 3 and 18 years, or those still attending school, presenting with moderate to severe emotional or behavioural disturbance.³¹
42. On 9 August 2023, RL sent an email to one of his teachers with reference to suicidal ideation. RL's father was advised and arranged an appointment with a GP for the next day, with a second appointment on 11 August 2023.³² The GP referred RL to the Child and Youth Team, and arranged a follow up appointment with the GP for 15 August.³³
43. On Friday 11 August 2023, RL's father attended at the Child and Youth Team office in Alice Springs, requesting an urgent appointment for his son, who he reported was experiencing suicidal thoughts. He spoke to Dr C, a Child and Adolescent Psychiatrist (CAP) and advised that RL's GP had completed a referral the day before. He appeared anxious and concerned for his son and wanted to know when an appointment could be made. Dr C could not locate the referral and called the GP clinic requesting that it be emailed to her directly and it was received soon after.³⁴

³¹ 4.6 NT Health Institutional Response, Dr Rio, [48].

³² 5.7 Mall Medical Records, pp 3 – 4.

³³ 5.7 Mall Medical Records, pp 2 – 3.

³⁴ 4.4 Child and Adolescent Psychiatrist, [57]-[58].

44. Dr C advised that an appointment may be available on the following Monday afternoon, but that would have to be confirmed on Monday. As it was a Friday afternoon, Dr C provided RL's father with contact details for emergency mental health services should concern for his son increase over the weekend. These contacts included numbers for the Mental Health Emergency line/ Crisis Assessment & Triage Team (CAT Team) and he was also given information about seeking support at the ASH Emergency Department.
45. On the morning of Monday 14 August 2023, a 'Doctor's Choice' appointment was confirmed for the afternoon.
46. Where a referral is received by the Child and Youth Team, the patient and/or family are given the opportunity to book a 'Choice' appointment which is the first clinical contact with the service. The aim is to discuss presenting mental health concerns, the goals of the person and their family, and to develop a plan. A Choice appointment can be led by Social Worker or Psychologist and is a brief assessment followed by a more comprehensive assessment with a doctor, as appropriate. A 'Doctor Choice' (CHOICE) appointment is a more comprehensive assessment, led by a Psychiatrist plus Psychiatry Registrar. It is for patients who are considered by the service to be at higher risk. Fortunately, a CHOICE appointment slot was available for RL and his father.³⁵
47. Later that day, RL and his father attended the CHOICE appointment with Dr C and a Psychiatry Registrar, Dr L. From the outset, engaging RL was challenging with progress notes indicating that Dr C and Dr L felt unable to confidently assess RL's thoughts, urges or judgment in relation to suicide or serious self-harm, due to a lack of engagement from RL.³⁶ RL did not appear to want to be at the appointment and observations were that RL was guarded and reserved, reluctant to engage,³⁷ withdrawn and uncomfortable.³⁸

³⁵ 4.4 Child and Adolescent Psychiatrist, [32]-[33].

³⁶ 4.4 Child and Adolescent Psychiatrist, [79] – [80] and 4.1 Psychiatry Registrar [45] – [47].

³⁷ 4.4 Child and Adolescent Psychiatrist, [64].

³⁸ 4.1 Psychiatry Registrar, [32].

48. Dr C assessed that RL and his father had difficulty talking with each other and observed an identifiable awkwardness between them. A request was made to speak with RL and his father separately.
49. RL's father had the first meeting with the CAP and Psychiatry Registrar. He expressed a number of concerns including RL's academic decline and disengagement in school including in his duties as the incumbent school captain for year 12, his sleeping pattern where RL was awake most of the night, the breakdown in communication between himself and his son and RL's absences without telling his father where he was going.³⁹
50. Dr C and Dr L then met with RL alone, but it was quite apparent that he did not wish to speak with them. He was terse and guarded in his responses and offered minimal information. When asked about the suicidal thoughts he had referred to in the email⁴⁰ to his teacher, RL responded "*suicidal ideation, no plan.*" This response was considered by Dr C to be an acknowledgement by RL of the concerns regarding suicidal ideation, but an attempt to reassure others that there was no plan to act on it.⁴¹
51. When asked what his understanding of the reason for the referral and what other people's concerns were about his wellbeing, RL replied that his mood was "*fine*".⁴² Soon after, RL ended the meeting stating he wanted his father to rejoin the meeting and that he wanted to go home. Due to his unwillingness to continue at that time, it was agreed that another meeting would be arranged. RL agreed to meet with Dr L later that week, either at the Child and Youth Team office or at RL's school, and they exchanged mobile numbers with a plan that Dr L would text RL to arrange.⁴³

³⁹ 4.6 Institutional Response on behalf of NT Health, Dr Rio, [72].

⁴⁰ 9 August 2023.

⁴¹ 4.4 Child and Adolescent Psychiatrist, [72]; 4.1 Psychiatry Registrar, [42].

⁴² 4.4 Child and Adolescent Psychiatrist, [70]; 4.1 Psychiatry Registrar, [41].

⁴³ 4.4 Child and Adolescent Psychiatrist, [75]; 4.1 Psychiatry Registrar, [45]-[46].

52. Primarily due to being unable to engage RL, the risk assessment of RL was limited. The impression recorded in the progress note states “RL’s mental state remains quite undifferentiated.”⁴⁴
53. Following the CHOICE appointment on 14 August 2023, Dr C emailed RL’s school counsellor to provide an update and advise that RL and his father had provided consent for the Psychiatric Registrar to speak with him. On 15 and 16 August, Dr L made contact with the school counsellor who provided a copy of the email RL had sent to his teacher on 9 August 2023.
54. On 17 August 2023, Dr L sent a text to RL to schedule another appointment but received no response. This was followed up with a further text on 21 August, again with no response. On 22 August, Dr L raised his concern that RL was not responding to messages with a Child and Youth Psychiatrist colleague, and it was agreed that he would continue efforts to follow up with RL.⁴⁵ On 22 August, Dr L emailed RL’s school and arranged to attend to see RL at the school at 1230 pm on 24 August. On 23 August, he sent a text to RL and emailed and called RL’s father, confirming that appointment.
55. When Dr L attended at the school to meet with RL on 24 August, he could not locate him at the agreed location. When RL was eventually found, it is recorded in notes that he presented as attending “without resistance or enthusiasm (passively)” and appeared reluctant to provide information. They discussed RL’s thoughts of suicidal ideation which he denied having had over the previous week and also denied having any current intention. As a result of the meeting, Dr L assessed RL’s risk of suicide as ‘acutely moderate to high’, noting that the assessment was impaired due to the limited information disclosed by RL.
56. Dr L then spoke with the school counsellor and advised that the Child and Youth Team would provide a safety plan for the school and requested that he be

⁴⁴ 4.4 Child and Adolescent Psychiatrist, [79]-[80]; 4.1 Psychiatry Registrar, [44].

⁴⁵ 4.1 Psychiatry Registrar, [49]-[55].

contacted if anyone from the school had concerns or noticed any new behaviours by RL.⁴⁶

57. On 26 August 2023, RL's father attended at the Child and Youth Team office without RL for an individual session with the Child and Youth Social Worker. They discussed RL's family background and the father's concerns. The Social Worker discussed the supports available to assist in parenting a son experiencing mental health difficulties and offered RL's father additional sessions, as well as sessions for his younger son.⁴⁷
58. On 28 August 2023, the school counsellor emailed Dr L, requesting information from the meeting with RL on 24 August and expressing the school's concerns around RL's ability to finish year 12. Dr L was on sick leave from 28 August to Monday 4 Sept 2023 and did not see that email until he returned to work, by which time RL had been admitted to the ASH Inpatient Unit following suicide attempts on 28 August and 31 August 2023.
59. On 30 August 2023, a Child and Youth Team High Risk Meeting was held and RL's case was discussed. It was noted that RL's risk level remained unclear and it was necessary to continue engaging with RL and his father to understand that risk further. The plan was for Dr L to meet with RL the following week and for an appointment with the CAP in two weeks time.⁴⁸
60. Once a client of the Child and Youth Team is admitted into the Inpatient Unit, they are no longer considered under the care of the Child and Youth Team until such time that they are discharged. However, while RL was at the Inpatient Unit the Child and Youth Team continued to discuss and review RL's case at High Risk meetings. A High Risk meeting was held on 6 September⁴⁹ which was attended by Dr L as RL's case manager, and Dr W who was the Child and Youth In-reach Registrar and had assessed RL in the Inpatient Unit two days prior. It was agreed that RL remained at high risk. It was evident to Dr W in that meeting

⁴⁶ 4.1 Psychiatry Registrar, [56]-[65].

⁴⁷ 4.6 NT Health Institutional Response, Dr Rio, [96]-[100].

⁴⁸ 4.6 NT Health Institutional Response, Dr Rio, [102].

⁴⁹ 4.6 NT Health Institutional Response, Dr Rio, [148].

that the Child and Youth Team were aware that RL was likely to disengage from care following discharge and therefore it was important to engage as much as possible during his admission.⁵⁰

61. Despite the ongoing difficulties in engaging RL, the Child and Youth Team made significant and ongoing efforts, continuing through to RL's death. The team recognised RL as being at high risk of harming himself and offered a service that reflected those high levels of concern. I acknowledge the efforts made by the Child and Youth Team and accept Dr C's evidence that her team is diligent and, in her experience, unusually assertive and responsive to need compared with interstate child and youth mental health community teams.⁵¹ Dr Flower considered that the care provided to RL by the Child and Youth Team up until the first inpatient admission, was appropriate.⁵²
62. However, two areas were identified for potential improvement, which are communication and complex case reviews.

Communication

63. Dr C gave evidence that with the benefit of hindsight, there should have been more direct and face to face conversations between the Child and Youth Team and the school, rather than reliance on emails.⁵³ Dr Flower made the same observation.⁵⁴
64. One example of difficulties with communication between the services was in relation to an incident that occurred on 21 September 2023. On that day RL went missing at school. Staff were worried about the possibility that he had hurt himself somewhere on school grounds, they were very concerned for RL's wellbeing as well as conscious of their duty of care to other students at school. RL was ultimately found and had not hurt himself, however mindful of their broader duty of care, in light of RL not complying with an agreement that had

⁵⁰ 4.5 Child and Adolescent Psychiatrist, [50]-[54].

⁵¹ T 122.

⁵² 1.3, p 15.

⁵³ T 97.

⁵⁴ T 180.

been made with him about remaining in specific places within the school so that his safety could be monitored, RL was asked not to return to school the next day, which was the last day of school before mid-semester holidays.⁵⁵

65. Although the school emailed the Child and Youth Team about the incident, they did not explain that RL was asked not to attend school the next day.⁵⁶ The Child and Youth Team became aware of the non-attendance at school during a phone conversation with RL on 22 September.⁵⁷ The Child and Youth Team considered school a protective factor, so RL being unable to attend was a significant matter. It would have been helpful for them to be informed earlier and they were surprised that the school did not advise them.⁵⁸
66. Communication challenges in the opposite direction included that school staff felt their level of concern, in the context of how well they knew RL, was not always fully acknowledged. In my view this perception by school staff was in part because the health assessment of RL's risk level was not understood well by those who didn't work in, or have a background in mental health. There is also the example from 28 August 2023, referred to above [at 58].
67. I make no criticism of any individuals. Having reviewed the written records, statements and oral evidence at the inquest, it is clear that both services were trying to communicate openly and thoroughly. The differences in expertise and background of staff from each service might explain some of the misunderstandings. People who do not work in the mental health space need to be assisted if they are to understand terminology around level of risk, including concepts such as static and acute risk, or understanding the classification terminology of a mild, moderate or severe major depressive disorder.
68. Communicating in writing rather than in person contributes to loss of nuance, relevant information being missed or an inability to achieve depth of understanding in what were complex conversations. Witnesses from both

⁵⁵ 6.1A, School Principal emails, p 11.

⁵⁶ 4.1 Psychiatric Registrar, [129] and [139].

⁵⁷ 5.3 CYMHT & MHU Records, p 62.

⁵⁸ T 107, T 197.

services identified more oral communication, rather than reliance on emails, as the key mechanism to address the communication challenges that were identified. I was heartened to hear from both the school and the Child and Youth Team that communication has improved considerably since RL's passing, with phone calls now the preferred means of relaying information.⁵⁹

69. Ongoing relationship building between NT Health and schools in Alice Springs will be important. In light of the recognition and improvements already in place I am of the view that this is a matter that will not be furthered by a recommendation and is best managed by the respective services. Communication is complex and no doubt this will require continual work and focus. I encourage NT Health to work not only with RL's school but also build similar relationships with other schools in Alice Springs.

Complex case reviews

70. The Child and Youth Team maintains a high-risk register for clients of concern. These individuals are discussed amongst a multi-disciplinary team at regular meetings. RL was placed on the high-risk register in August 2023 and remained there until his death. I was told this was an unusual length of time and indicative of the level of concern of the practitioners.⁶⁰
71. Since RL's death, the Child and Youth Team has implemented a policy requiring that where a young person is identified as 'high risk' for three consecutive weeks in the Child and Youth High Risk Meeting, a complex case review will be conducted in relation to that young person.⁶¹ The institutional witness for NT Health, Dr Josephine Rio, gave evidence that the Child and Youth Team policies have already been updated to reflect this requirement.
72. A complex case review invites multi-disciplinary input, in-depth review and reconsideration of formulation and diagnosis. For RL it would have provided an opportunity to discuss and identify alternative strategies, as despite efforts there

⁵⁹ T 97 and T 45.

⁶⁰ T 92.

⁶¹ 4.6 NT Health Institutional Response, Dr Rio, [357].

was limited success in engaging and assisting RL. As well as inviting reflection from treating staff, such a review can utilise non NT Health resources, for example relevant school staff, and could potentially involve consultants not otherwise involved in treatment.⁶²

73. Dr C indicated an inpatient admission is also a trigger to carefully talk through a complex case and reconsider formulation.⁶³ It is unclear if there are policies ensuring that admission is a trigger for the complex case review process or if the CAP's evidence was identifying more generally what ought to occur.
74. What is clear is that whilst there were extensive assessments and discussions about RL on his first admission, this did not take place on his second admission. In those circumstances, I consider NT Health ought to review their policies to ensure that a complex case review, or an equivalent process, is triggered where an existing Child and Youth Team client is admitted to an inpatient unit, and I will recommend that they do so.
75. RL's father does not recall being told that RL had been placed on a high risk register.⁶⁴ This was a matter of importance to him and I ask NT Health to reflect on that evidence and whether more detailed information about risk assessments and the level of concern of staff should be communicated to the family of a young person assessed as high risk. This should extend beyond just advising of the inclusion of a youth on the high risk list, as there were a number of examples of RL's father and staff from the school not understanding the results of risk assessments undertaken by health staff.

1st Inpatient Unit admission (31 August 2023 to 19 September 2023)

76. On 31 August 2023, RL attempted suicide. There was no external intervention as RL stopped himself and called 000,⁶⁵ and police and ambulance officers attended

⁶² T 111-112 ; T 121, Dr Rio at T 219 and 4.6, [357].

⁶³ T 121.

⁶⁴ Exhibit 2.

⁶⁵ 2.3 000 call on 31 August 2023.

at his home.⁶⁶ RL later disclosed that he had also made a suicide attempt a few days earlier on about 28 August but had not told anyone at the time.⁶⁷

77. RL was transported to Alice Springs Hospital where he was assessed by the CAT Team Registrar and admitted as an involuntary patient under s 39 of the *Mental Health and Related Services Act*.⁶⁸
78. This was RL's first admission to the Inpatient Unit and he remained there until 19 September 2023.⁶⁹ As was acknowledged by counsel on behalf of RL's father, there was an extensive and thorough investigation of RL's situation during this admission.⁷⁰ NT Health records reflect that while in the Inpatient Unit, RL was reviewed or assessed multiple times by registrars and psychiatrists of a wide range of experience.⁷¹
79. RL's complex presentation was also discussed in the Consultants' Peer Review Group meetings.⁷² These weekly meetings are attended by Consultant Psychiatrists and are a forum to discuss challenging cases to provide support and guidance to a psychiatrist who is working with a patient with particularly challenging difficulties. Dr B was a Consultant Psychiatrist in the Inpatient Unit involved in providing psychiatric care to RL. She recall's RL's case being raised by Dr C for discussion in the Consultants' Peer Review Group meeting on 12 September 2023.⁷³
80. Although the inpatient team was responsible for RL's care while he was a patient at the hospital, the Child and Youth Team remained actively involved. It was anticipated that RL would likely disengage following discharge, meaning it was important for the Child and Youth Team to engage with him as much as possible during his stay at the Inpatient Unit.⁷⁴ The discharge summary, which was

⁶⁶ 5.2 CYMHT & MHU Records, p 10.

⁶⁷ 4.1 Psychiatry Registrar, [71].

⁶⁸ Admission records, 5.2 p 11.

⁶⁹ Discharge summary, 5.2 p 95.

⁷⁰ T 262.

⁷¹ See 5.3 Progress Notes; see also 4.3 Psychiatry Registrar, [25], [71]; 4.5 Child & Adolescent Psychiatry Registrar, [29].

⁷² 4.2 Consultant Psychiatrist, [32].

⁷³ 4.2 Consultant Psychiatrist, [25]-[27].

⁷⁴ 4.5 Child & Adolescent Psychiatry Registrar, [54].

authored by senior Child and Adolescent Registrar, Dr W, was reviewed by both Dr B (Inpatient Unit Consultant Psychiatrist) and Dr C (Child and Youth Team consultant) before finalisation.⁷⁵

81. Collectively the two teams utilised multidisciplinary approaches, for example the multi-disciplinary meetings, and seeing if nurses were able to effectively engage RL where psychiatrists had been unable to do so. Both teams discussed RL's situation with his father⁷⁶ and information from external sources was sought, primarily RL's school.⁷⁷
82. The principal diagnosis was of a major depressive disorder.⁷⁸ A prodromal presentation was considered as a possible alternative explanation, and while this was never ruled out, it appears the general view was that this was less likely than depression.⁷⁹
83. RL was commenced on anti-depressant medication while he was an inpatient.
84. Some improvement was noted in RL's presentation, but it was limited and engagement proved difficult. Throughout the records there are multiple references to RL being guarded and reserved,⁸⁰ difficulties building rapport and RL providing limited information.⁸¹ Diagnosis was considered difficult given the lack of certainty that practitioners had a complete picture of RL's mental state.⁸² It was agreed by the Inpatient Unit team and Child and Youth Team that further inpatient assessment and support were unlikely to be beneficial, and that ongoing support and assessment should occur in the community.⁸³

⁷⁵ 4.5 Child & Adolescent Psychiatry Registrar, [79].

⁷⁶ 4.5 Child & Adolescent Psychiatry Registrar, [66]; 4.1 Psychiatry Registrar, [114].

⁷⁷ 4.1 Psychiatry Registrar, [76], [84] – [88]; 4.4 Child & Adolescent Psychiatrist, [119]; 4.3 Psychiatry Registrar, [76].

⁷⁸ 5.2 Discharge summary, CYMHT & MHU Records, p 96.

⁷⁹ 4.5 Child & Adolescent Psychiatry Registrar, [62].

⁸⁰ 4.3 Psychiatry Registrar, [26].

⁸¹ For example 4.5 Child & Adolescent Psychiatry Registrar, [31] – [32], [73] – [74], [82].

⁸² 5.2 Discharge summary – CYMHT & MHU Records, p 98.

⁸³ 5.2 Discharge summary – CYMHT & MHU Records, pp 98-99.

Engaging young people

85. The only dedicated youth inpatient unit in the Northern Territory is the Youth Inpatient Unit (YIP) at Royal Darwin Hospital. This means that where a young person is admitted as a mental health inpatient in Alice Springs, they will either be in the adult Inpatient Unit, or the Paediatric ward. When spoken to by the Child and Youth Team about treatment options for RL, RL's father was open to medication and therapy options, but did not want RL to be transferred to Darwin. Similarly, RL declined the possibility of a transfer to YIP when he was first admitted. RL's father advised that he would consider a transfer to a dedicated youth facility in Perth where the family had support but ultimately decided against that as he felt that it was beneficial for RL to have engagement with friends, which he would have at the ASH Inpatient Unit.
86. RL indicated to doctors and teachers that he did not particularly like the environment at the Inpatient Unit. RL's school principal, who visited him in hospital, considered the environment was 'scary' and disconcerting.⁸⁴ RL told the principal that he didn't like being there and it was a scary place.⁸⁵
87. I heard evidence that the exposure to adult patients and lack of peers and age-appropriate activities meant the inpatient facility was not an ideal therapeutic environment for youths generally, and RL specifically. The lack of youth specialist trained staff also means differences in presentation between mental health problems in youths and adults might not be recognised.
88. Dr Flower's opinion was that RL may have emotionally 'shut down' in response to the environment, but his lack of engagement appeared to be viewed as a failure on his part, rather than a failure of the service to engage RL.⁸⁶ While some of the language used in the medical records and in statements provided to the inquest is open to that interpretation, there was also evidence that staff were aware of the potential impacts of an adult facility on a youth patient and their engagement. Dr

⁸⁴ T 38.

⁸⁵ T 26; T 38.

⁸⁶ 1.3, p 16, [560].

C acknowledged that an adult facility can be an “alarming place” at times, causing challenges for the patient, family and visitors.⁸⁷ Dr B agreed it was a reasonable hypothesis that RL shut down in response to the nature of the adult facility, and this was something she was mindful of at the time of her engagements with RL.⁸⁸ Dr B gave evidence of speaking with nursing staff to see if they had been able to elicit different information from RL, and junior doctors trying to speak with RL away from the conference room.⁸⁹

89. Although staff are no doubt aware of the limitations of an adult facility, there is a risk that with continual exposure to this situation and the lack of alternatives, the extent of the impact on young people becomes less front of mind. I consider these are matters that do not rise to the level of warranting findings or recommendations but are matters that NT Health and their staff should take the opportunity to reflect on and consider what further strategies could be implemented to support young people who require inpatient care.

90. This might include:

- Re-considering when to place patients in the Inpatient Unit and when to utilise the paediatric ward. Dr Rio stated that placement is decided individually for each patient.⁹⁰ The medical notes do not record any discussion of moving RL to the paediatric unit. One significant downside of the paediatric ward is the lack of specialist nursing staff, as the ward is managed by paediatric rather than psychiatric nurses.
- Dr Flower stated that in youth inpatient units compared with adult facilities, families are generally more involved both in providing detailed developmental histories as well as participating in therapeutic sessions. Dr Flower referred to family sessions as “an absolute cornerstone of any treatment of an adolescent in a dedicated adolescent inpatient unit.”⁹¹

⁸⁷ T 111.

⁸⁸ T 149.

⁸⁹ T 149.

⁹⁰ T 220.

⁹¹ T 161, 175.

- Other suggestions of Dr Flower given the confronting nature of the environment, and for young people who are more difficult or ‘tricky’ to engage face to face, included meeting in the hospital grounds rather than the ward, going for a walk, driving in a car, having a drink at a café,⁹² and
- Alternative means of therapy, such as music, art and animal assisted therapy.⁹³

91. I understood from Dr Rio’s evidence that following RL’s death, NT Health employed a nurse educator who works predominantly in the Mental Health unit to provide education on alternative ways of engagement with young people.⁹⁴

Child and Youth Mental Health Liaison Role

92. NT Health has already created a new position that should help to address some of the challenges of youths in an adult facility. In June 2025 a Child and Youth Mental Health Liaison Role was created and is staffed by a mental health nurse with specialist child and adolescent training. The work of the liaison role includes:⁹⁵

- providing advice and consultation to adult Mental Health treating teams at the hospital;
- supporting communication between adult treating teams, the Child and Youth Team, patients and families;
- educating staff about child and youth mental health presentations and treatment approaches;
- supporting compliance with existing processes and guidelines that promote physical, emotional and cultural safety for young people admitted to Alice Springs Hospital; and

⁹² T 174.

⁹³ T 174.

⁹⁴ T 233.

⁹⁵ 4.6 NT Health Institutional Response, Dr Rio, [358]-[360]; see also T 111.

- contributing to the development of new guidelines and processes that may be needed to improve the safe care of young people admitted to Alice Springs Hospital.

93. I am encouraged by NT Health's identification of the requirement for additional targeted resourcing which ultimately should be beneficial for patients, families and staff. I do not consider a recommendation entrenching the liaison role should be made at this time, it is a temporary position and whether it is the most effective resource allocation to address the challenges will be better assessed at a future date.⁹⁶

Discharge process

94. There was no evidence that the timing of RL's release on 19 September 2023 was anything other than appropriate. There was clear discharge planning with a graduated approach reflected in RL being granted day leave on a number of occasions in the lead up to his discharge. On the date of discharge a meeting was held and attended by the inpatient team, the Child and Youth Team, RL's father and 3 school staff members.⁹⁷
95. Statistically, risk of suicide increases in the period of time immediately following release from an acute psychiatric unit.⁹⁸ NT Health has a standard practice of the CAT Team making contact with patients following discharge from the ASH Inpatient Unit.
96. Following the 1st discharge,⁹⁹ the CAT Team attempted to contact RL's father by phone on Saturday and Sunday 23 and 24 September 2023 but were unable to reach him. Following RL's 2nd discharge, which is discussed further below, the CAT Team called RL each day but were not able to speak to him. However, the team did manage to speak to RL's father. Whilst I understand it is standard practice that follow up by the CAT Team after discharge is undertaken by phone, Dr Rio has expressed the view that in hindsight, where telephone contact was

⁹⁶ 4.6 NT Health Institutional Response, Dr Rio; T 233.

⁹⁷ 4.1 Psychiatry Registrar [115] – [116].

⁹⁸ T 99.

⁹⁹ On 19 September 2023; 5.2 Discharge summary – CYMHT & MHU Records, pp 95-99.

unsuccessful, it would have been appropriate for the CAT Team to attempt face to face contact with RL. I heard that Dr Rio has been in discussion with relevant NT Health staff about face to face welfare assessments being undertaken and when that approach would be appropriate.¹⁰⁰ I also consider that given the difficulties of the CAT Team in establishing contact by phone with RL following both discharges, further attempts to make face to face contact would have been appropriate. I will make a recommendation to endorse the position of Dr Rio to the effect that NT Health should consider a change in practice to face to face follow up in community, in circumstances where it is safe and appropriate to do so.¹⁰¹

Ongoing suicide risk for RL

97. While extensive efforts had been made, and some modest improvements noted,¹⁰² RL left the Inpatient Unit with an assessment that he continued to be at high risk of suicide.¹⁰³
98. People unfamiliar with the mental health care system may be surprised that being at high risk of suicide does not prevent a patient being discharged from hospital. Given RL was hospitalised in connection with an attempted suicide, there may be an expectation that he would not be discharged until he was ‘safe’ to be in the community.
99. However, many of the factors that contributed to RL being at high risk were static – that is, they would continue for a long time whether he spent 1 day, 1 month or 1 year in an inpatient unit. Ongoing risk factors that applied to RL included:
 - that he was male;
 - was an older rather than a younger adolescent;
 - had previously attempted suicide;

¹⁰⁰ 4.6 NT Health Institutional Response, Dr Rio, [343].

¹⁰¹ T 218.

¹⁰² For example: 4.2 Dr B, [51]; Dr C also noted increased engagement during a visit on 13 September, and believed RL had begun to feel some hope, see 4.4 Child & Adolescent Psychiatrist, [99] and [108].

¹⁰³ See for example 4.1 Dr L, [96] re increases in engagement.

- had been diagnosed with a mental illness; and
 - his parents were separated.
100. In addition, it was not expected that admission could meaningfully address the particular psychosocial issues RL was facing.¹⁰⁴ RL's treating team considered he would benefit from "talking therapy" which is unavailable in the ASH Inpatient Unit.¹⁰⁵ While there are some private inpatient units around Australia that offer treatments such as cognitive behaviour therapy, this form of therapy is more typically undertaken in the community.¹⁰⁶
101. As Dr C stated, "hospital is not a place where a person can fully recover. An inpatient admission may serve to help young people through an acute mental health crisis, to a point where they are well enough to be in the community, and it is only in the community, in day-to-day life amongst family and other loved ones, that they can fully recover."¹⁰⁷ Dr C did not consider that hospitalisation was able to substantially change RL's long term risk.¹⁰⁸
102. It is also important to understand that admission, particularly as an involuntary patient, can negatively impact a patient and their recovery.
- A prolonged stay as an inpatient risks alienation from social supports and potential overreliance on hospitalisation.¹⁰⁹
 - Admitting RL against his wishes risked long-term harm to the therapeutic relationship. This had the potential to discourage RL both from engaging with support services in the short term and from seeking help in the future.¹¹⁰

¹⁰⁴ 4.5 Child & Adolescent Psychiatry Registrar, [39] and [117].

¹⁰⁵ Dr B at T 134, see also Dr C at T 113.

¹⁰⁶ Dr C at T 113.

¹⁰⁷ 4.4 Child & Adolescent Psychiatrist, [113].

¹⁰⁸ 4.4 Child & Adolescent Psychiatrist, [134], p 34.

¹⁰⁹ 4.5 Child & Adolescent Psychiatry Registrar, [85].

¹¹⁰ Flower at T 177 re alienation; 4.4 Child & Adolescent Psychiatrist, [113] "An acute inpatient unit can also have negative impacts on a young person's mental state and wellbeing, and prolonged admission may undermine their recovery."

- Removing a person’s sense of agency can imply that their health professionals do not believe they are capable of tasks such as help-seeking and self-monitoring, ultimately undermining their sense of confidence and self-belief, and impairing further their ability to perform these functions.¹¹¹
- Dr B gave evidence that it is well documented in literature that patients experience involuntary treatment as traumatising and disempowering.¹¹²
- Conversely, encouraging a young person to exercise control in their life is therapeutic and “a key part of recovery.”¹¹³

103. Respecting people’s agency and decisions, so long as they are of sound mind, is a core tenet of the least restrictive care that the *Mental Health and Related Services Act* stipulates must be used whenever possible.¹¹⁴

104. Dr B gave evidence that there is a large cohort of people who experience significant distress and do not meet the test for involuntary admission.¹¹⁵ Admission to an inpatient unit as the primary mechanism to ensure a patient’s safety is not a long-term solution for dealing with suicide risk.

- Research referred to by Dr Rio concluded that a method to, “usefully distinguish patients with a high-risk of suicide remains elusive.”¹¹⁶ I understand in the United Kingdom there have been moves away from statistical risk assessment tools and scales as a means to predict future suicide, determine who should be offered treatment and who should be discharged.¹¹⁷

¹¹¹ 4.2 Consultant Psychiatrist, [74].

¹¹² T 139.

¹¹³ 4.2 Consultant Psychiatrist, [60] and at T 137; Flower at T 178, “allowing people to make decisions for themselves is usually the most therapeutic thing.”

¹¹⁴ 4.2 Consultant Psychiatrist, [87]; also T 137.

¹¹⁵ T 131.

¹¹⁶ Meta-Analysis research article at Annexure JR-2 in 4.6 - Institutional Response on behalf of NT Health, Dr Rio, p 125.

¹¹⁷ 8.2 National Institute for Health and Care Excellence, Section 1.6, p 16.

- The meta-analysis study referred to by Dr Rio found that just under half of all suicides occurred in people who had been classified in lower-risk groups.¹¹⁸
 - For those assessed as being at high risk, the vast majority do not go on to suicide: the proportion of suicides among high-risk patients over a five year period was 5.5%. Clearly it is untenable and not in the interests of patients to remain in hospital for years.¹¹⁹
105. Recognising these limits does not mean an inpatient facility cannot assist people who are suicidal. The Inpatient Unit has a crucial role in helping to manage acute risk - if RL's risk was temporarily elevated, it provided a means to keep RL safe until he was stabilised and returned to his baseline level of risk. Ultimately though, sustained improvements and reduction in risk needed to take place in the community.
106. Understanding this context helps to explain why RL was discharged from ASH on 19 September 2023, despite staff and others being aware that he remained at high risk of suicide. There is a need for greater community education in this space so that people outside of the health system, particularly those who are providing support in either a personal or a professional capacity, have a better understanding of risk and risk management and recognise the importance of engaging with treatment services in the community.

Information Sharing – Police and NT Health

107. Shortly after RL's discharge on 19 September 2023, there was an incident on 21 to 22 September 2023 involving police, which indicated RL had been contemplating suicide or at least had taken preliminary steps to facilitate a suicide attempt.

¹¹⁸ Meta-Analysis research article at Annexure JR-2 in 4.6 - Institutional Response on behalf of NT Health, Dr Rio, p 133.

¹¹⁹ Meta-Analysis research article at Annexure JR-2 in 44.6 - Institutional Response on behalf of NT Health, Dr Rio, pp 124-125.

108. There is no criticism of the actions of individual officers who located and spoke with RL. However, this incident highlighted a systemic gap which is, where police do not consider an individual meets the threshold for apprehension under s 32A of the *Mental Health and Related Services Act* and the person is already connected with appropriate mental health services, there is no easy mechanism for police to share information with treating health practitioners.
109. Late on 21 September 2023, RL left the family home. RL's father was worried about him and tried to call RL but got no response. He then attended the police station to report his concerns.¹²⁰ NT Police Constables H and B conducted patrols and located RL sitting in his car.¹²¹ It was apparent that RL had been sniffing deodorant, he had a rope on the front seat of the car and shards of glass on his lap.¹²²
110. Constable H spoke at length with RL, both at the location where he was found and again when police took RL home. My observation of the BWV footage was that the officer's engagement with RL was positive in many regards:
- the officer used strategies to try and build rapport and connection with RL;
 - the conversations were lengthy and explored a number of topics, which allowed for a thorough assessment as to whether police should utilise the powers under the *Mental Health and Related Services Act*;
 - the officer took the opportunity to reinforce positive messages to RL, encouraging him to engage with treatment, identifying positives in RL's life, and helping RL to focus on employment pathways in which he expressed an interest;
 - the interaction was positive and respectful in a way that should have reassured RL that police were a safe contact for him if he felt distressed

¹²⁰ 2.21 Statement of NT Police Constable, [4].

¹²¹ 2.4 BWV NT Police.

¹²² 2.21 Statement of NT Police Constable, [12] – [13], [20] – [21].

in the future. A less involved approach could have had the opposite effect of discouraging RL from calling police.

111. By the time police left, Constable H no longer held concerns for RL's immediate safety and did not consider any further action should be taken by police. This view was on the basis of the following information or observations:

- RL appeared to be in better spirits and had repeatedly denied thoughts of self-harm.
- RL was home with his father, who was aware of the incident and had information about what steps he could take if his concerns about RL's safety increased.
- He assumed RL was engaged with services given he had only recently been released from the Inpatient Unit, so a SupportLink referral was not appropriate or needed.¹²³

112. I commend Constable H for his compassionate and thorough approach in dealing with RL's situation. The decision to leave RL with his father was reasonable and appropriate. What would have been useful is if there was a mechanism for members to share information with RL's treating team to ensure they were aware of the incident. Unknown to police and RL's father, at around this time the Child and Youth Team were considering whether RL should be readmitted as an involuntary patient. Even absent the considerations of involuntary admission, it is common sense that information about RL's actions on 21 September would have been useful information for a treating mental health practitioner.

113. Police have a number of processes or frameworks in place under which they can connect a member of the public with support. They include the following:

- If police identify that someone would benefit from social supports¹²⁴ a SupportLink referral can be made. The process requires consent of the

¹²³ 2.21 & 2.22 Statements of NT Police Constables.

¹²⁴ SupportLink referrals are not limited to mental health concerns but cover other services such as assistance with alcohol and other drugs, financial counselling, domestic violence etc.

person being referred and takes about 5 to 10 minutes to complete.¹²⁵ Once police complete a referral, the information provided is sent to a relevant agency or service who is then responsible for making contact.

- If there are child welfare concerns, information sharing processes are in place for police to make a report to the Department of Children and Families.
- In critical scenarios where someone may require treatment under the *Mental Health and Related Services Act* and they are likely to cause serious harm to themselves or others, police have the power under s 32A of the *Mental Health and Related Services Act* to apprehend and take the person for mental health assessment by a qualified practitioner.

114. None of these options applied to RL's situation.

115. In his evidence, Constable H agreed that having a simple and quick system, similar to SupportLink, that allowed information to be shared with RL's treating doctor, would have been useful on the night that he spoke with RL.¹²⁶

116. Police have raised concerns that being able to share information related to a person's mental health or wellbeing without consent may require legislative change. In my view, police should explore the possibility of sharing information both with and without consent.

117. Police officers did not ask RL or his father for permission to share information with the Child and Youth Team, and they may have agreed. Police should also consider whether they are already permitted in some circumstances to provide information without consent. There may well be other provisions, but I note the existing information sharing framework under the *Care and Protection of Children Act 2007*. Police officers are information sharing authorities, they are

¹²⁵ NT Police Constable at T 50; 2.23 – Institutional Response on behalf of NT Police Commander James Grey-Spence, [40].

¹²⁶ T 51.

authorised by Part 5.1A to, without consent, provide information relating to safety or wellbeing of a child in the circumstances described therein.

118. Police and NT Health should review the circumstances in which information sharing would be appropriate. If this cannot be done under the current legislation, police and health should consider seeking legislative change.
119. I acknowledge that putting together a useful, efficient and lawful system will not be a small task. Logistically, the process of information sharing must be simple and quick. It is general duties officers who are most likely to find themselves in situations such as arose with RL, and the nature of their role means they have limited time for follow up.
120. Secondly, I accept the evidence of NT Police that placing an onus on individual officers to decide when and if information should be shared is not reasonable. Clear guidance as to when to share information will be required. NT Health will need to have input as to the type of information that would warrant sharing, acknowledging the need to respect privacy of patients and also that both services have limited resources and high demands on their time.
121. To be clear, I do not expect that information will be shared following all incidents in which police become aware of someone's treatment by mental health professionals, I leave it with NT Police and NT Health to determine the appropriate threshold for when information sharing should take place, the extent of information that should be provided and the mechanism for doing so.

2nd Inpatient Unit admission and discharge (1 to 2 November 2023)

122. On 31 October 2023 RL's father secured a rope in his car to prevent RL using it. The next morning, RL took the rope from the car and refused to return it. RL's father described having to physically fight RL to take back the rope. There was also broken glass in RL's room with what appeared to be blood on it.¹²⁷

¹²⁷ 2.9 000 call; 2.8 BWV NT Police at approx T23:42; 2.6 BWV NT Police at approx. T23:47; 2.10 St John Ambulance notes; 5.2 Progress Notes, p 79.

123. RL’s father was clearly very worried about RL, describing him as being, “in serious trouble”.¹²⁸ He called the hospital and spoke with Dr N and then called 000, after Dr N indicated he should call the Child and Youth Team.¹²⁹ RL’s father told police that over the last few days RL had been “down, really down” and while RL usually attended volleyball he, “didn’t bother to go” the day prior.¹³⁰ RL not attending volleyball, an activity he usually enjoyed and participated in, was clinically significant information.
124. Police and St John Ambulance attended, RL was taken to the hospital where he was assessed by the CAT Team registrar and admitted to the Inpatient Unit.¹³¹ The following morning, 2 November 2023, RL was assessed by Consultant Psychiatrist Dr B, Dr N, Dr W and a Mental Health Nurse.¹³² RL did not wish to engage in the review, though this was considered consistent with his previous presentation.¹³³
125. Dr B formed the view that RL did not meet the criteria for involuntary admission under the *Mental Health and Related Services Act*.¹³⁴ Accordingly, Dr B considered that she was legally obliged to discharge RL unless he consented to admission as a voluntary patient – which he did not. RL was discharged that day.
126. For RL’s Father this discharge was the “main issue”, and whether anything more could have been done at this point in time.¹³⁵ RL’s father submits, “there was not an appropriate recognition by the inpatient team of the suicide risk of [RL] at the time of discharge on 2 November 2023 and secondly, [RL] ought to have been admitted for a longer period to permit further assessment and investigation of his complex condition.”¹³⁶

¹²⁸ 2.9 000 call.

¹²⁹ 2.9 000 call and 4.3 Psychiatry Registrar, [142]-[143].

¹³⁰ 2.8 BWV NT Police at approx. 23:42.

¹³¹ 5.2 CYMHT & MHU Records, p 115 – 117.

¹³² 4.3 Psychiatry Registrar, [147].

¹³³ 4.5 Child & Adolescent Psychiatry Registrar, [105].

¹³⁴ 4.2 Consultant Psychiatrist, [112].

¹³⁵ T 260.

¹³⁶ T 267.

Did RL meet the criteria for involuntary admission?

127. RL's initial admission on 1 November 2023 was for up to 24 hours, for the purpose of allowing an authorised psychiatric practitioner to undertake an examination.
128. On completion of that second examination, section 39 of the *Mental Health and Related Services Act* allows for only two options:
- if the authorised psychiatric practitioner was satisfied that RL fulfilled the criteria for involuntary admission he could have been admitted for a period of up to 14 days; or
 - if the authorised psychiatric practitioner was satisfied that RL did not meet the criteria for involuntary admission, they were required to discharge RL as an involuntary patient.
129. The test for involuntary admission is set out in s 14 of the *Mental Health and Related Services Act*. Relevantly Dr B had to be satisfied that:
- RL had a mental illness; and
 - as a result of the mental illness RL required treatment; and
 - without the treatment RL was likely to cause serious harm to himself or to someone else or suffer serious mental or physical deterioration; and
 - RL was not capable of giving informed consent or had unreasonably refused consent; and
 - there was no less restrictive means of ensuring treatment.
130. Mental illness for the purpose of an involuntary admission assessment is restrictively defined.¹³⁷ As Dr B pointed out it is not as broad as the way in which the term is generally used by psychiatrists, mental health practitioners and members of the community.¹³⁸

¹³⁷ See s 6 of the *Mental Health and Related Services Act* (NT).

¹³⁸ T 129.

131. RL had been diagnosed with a major depressive disorder, which is a mental illness in the way the phrase is commonly used. However, Dr B's evidence, which I accept, is that a major depressive disorder can only constitute a mental illness requiring involuntary admission if it causes a serious mood disorder. A mild depressive episode would not meet the criteria of a mental illness for the purpose of involuntary admission under the *Mental Health and Related Services Act*.¹³⁹
132. What was contentious at the inquest was whether RL's particular presentation on 1 and 2 November 2023 amounted to a serious disturbance of mood.
133. Dr B gave evidence that a severe disturbance of mood or a severe depressive episode is characterised by pervasively low mood that completely impairs a person from making decisions, from being able to participate in their life and treatment.¹⁴⁰ In contrast Dr Flower's evidence was that there is more flexibility in symptoms with young people. While there are young people who present in a similar way to adults, with pervasively low mood, there are also adolescents who are experiencing severe depression but have fluctuations in mood and continue to engage in some activities that would in an adult be considered inconsistent with that diagnosis.¹⁴¹
134. Dr B is aware and acknowledged that symptoms in children differ from adults, however stated in respect of those variations in symptoms, "I won't speak to that, because that's not my... area of expertise".¹⁴²
135. It is also critical to note the evidence of Dr B drawing the distinction between an assessment of a youth to determine whether they need treatment, as opposed to an assessment to determine whether a youth fits the criteria for involuntary admission. It is not clear if Dr B took into account the differing presentations between youths and adults when determining whether RL was suffering from a 'severe disturbance of mood' on 2 November 2023.

¹³⁹ T 129 – 131.

¹⁴⁰ T 131.

¹⁴¹ T 163 and 176.

¹⁴² T 131.

136. On 2 November 2023 it was the view of Dr B that RL did not meet the definition of severe disturbance of mood as RL, “had been engaging in **a lot** of his... usual activities” and that RL had fluctuations in mood, rather than pervasively low mood, and “there was capacity to engage with people”.¹⁴³ (emphasis added)
137. It is difficult to accept that this was an accurate summation of RL’s recent history. The evidence of RL engaging in his ‘usual activities’ was said to be his attendance at sport and that he had given a speech at a school assembly. The speech at school was a one off event and had occurred some 2 weeks prior to the assessment that was being undertaken on 2 November 2023. Critically, regular classes had finished, and RL was no longer participating in schooling. School should have been a flag of concern rather than a reassurance that RL was participating in his usual activities.
138. Dr B was unable to recall what sports activities RL had engaged in.¹⁴⁴ The hospital progress notes state that in the previous 2 weeks RL had usually gone out 2-3 times for sports/volleyball.¹⁴⁵ RL also told Dr B during the review that he wanted to be out of hospital on Sunday so he could participate in volleyball. As noted above, RL’s father had told police that RL was “really down” and had not attended volleyball two days prior, which was unusual for him.¹⁴⁶
139. Given RL’s limited responses to the inpatient team, caution was needed as to how much weight to place on RL’s own account of how often he was playing sport. The team recorded at the time that they had “limited assessment confidence of thought form and thought content due to non-engagement.”¹⁴⁷ Despite this, the progress notes do not record whether RL’s father was asked about RL’s participation in volleyball when Drs B and N spoke to him shortly before RL was discharged.¹⁴⁸

¹⁴³ T 131.

¹⁴⁴ T 132.

¹⁴⁵ 5.3, p 99.

¹⁴⁶ 2.8 BWV NT Police.

¹⁴⁷ 4.2 Consultant Psychiatrist, [105] and [106], see also 4.5 Child & Adolescent Psychiatrist, [105].

¹⁴⁸ 5.3, p 100.

140. If Dr B was placing significant weight on RL’s participation in his ‘usual activities’, I query whether that should have been on the basis of cogent information to that effect, not solely RL’s limited statements, particularly given his demonstrated reluctance to provide information.
141. RL’s participation in volleyball and school was not information available in a vacuum, the inpatient team was also aware of other factors that may have raised concerns about the severity of RL’s mood disturbance:
- School had previously been seen as a protective factor and regular classes had finished 2 weeks prior. I note Dr C’s email to Dr B prior to RL’s discharge that RL’s suicidal behaviour was not surprising given, “our hypothesis that the final days for year 12 would probably be another major crisis” for RL.¹⁴⁹
 - The plan on discharge in September had been, “for assertive follow up” with Child and Youth Team, but neither RL nor his father had engaged;¹⁵⁰
 - RL had stopped taking anti-depressant medication 2 days after discharge.¹⁵¹
142. Dr Flower did not consider that RL’s participation in sport and a one off speech would have persuaded her that RL was not suffering from severe depression.¹⁵² In Dr Flower’s opinion, the decision not to keep RL on an involuntary order on 2 November 2023 was in part due to, “a lack of familiarity with symptoms as they present in adolescents – he was viewed through an adult mental health lens”.¹⁵³ Dr C, the treating CAP from the Child and Youth Team was surprised that RL was not held for longer.¹⁵⁴

¹⁴⁹ 5.3 p 102.

¹⁵⁰ 5.3 p 99.

¹⁵¹ 5.3 p 100.

¹⁵² T 176-7.

¹⁵³ 1.3 Dr Flower’s report, p 20 [680].

¹⁵⁴ T 119.

Acute risk

143. A key consideration for the assessment was whether or not RL was at his usual level of high risk or there was an elevated acute risk that warranted admission. While Dr B considered RL to be at high risk of suicide, and she was worried about him, she considered the risks to be primarily static factors and did not consider RL to be in an acute crisis requiring admission.¹⁵⁵ The specialist child psychiatrists had a different view.
144. Dr C considered that the information about what brought RL to hospital and his father's level of concern, "indicated to me that [RL] may well have been an acute risk."¹⁵⁶ Dr C also considered the lack of classes and end of school as "potentially an acute risk".¹⁵⁷ Dr C's assessment of risk is not one made solely in hindsight. On 3 November 2023 she telephoned Dr B and outlined her beliefs that the end of school represented "a significant crisis for" RL and she was very concerned by the description of what occurred at home on 31 October and 1 November 2023.¹⁵⁸
145. Dr Flower considered RL's situation in relation to school as a, "terrible crisis point".¹⁵⁹ Dr Flower also expressed the view that the discharge assessment focused on any change in RL's presentation between 19 September 2023, when he was discharged after his first admission, and his presentation on 2 November, but failed to adequately take into account changes in the external circumstances. For example, an increased risk of self harm due to the end of school, the ceasing of medication, the lack of engagement with in-community treatment and the incident on 1 November.¹⁶⁰ Dr C noted the need to assess changes in protective factors as well as risk factors.¹⁶¹

¹⁵⁵ 4.2 [110]; T 144.

¹⁵⁶ T 117 and T 121.

¹⁵⁷ T 117.

¹⁵⁸ 4.4 Child & Adolescent Psychiatrist, [180], see also email from Dr C to Dr B prior to discharge about the final days of year 12 as likely a "major crisis", [172].

¹⁵⁹ T 164.

¹⁶⁰ T 166, 168, 189.

¹⁶¹ T 118.

146. Although I have the detailed and helpful statement of Dr W, and her opinion that she considered RL's discharge, "appropriate and that the rationale for it was reasonable"¹⁶² I did not have the benefit of hearing from her orally and the more detailed questioning that would have involved to explore the discharge decision.
147. At the time, Dr W was a senior Child and Adolescent Psychiatry Registrar - she became a Psychiatrist in May 2024.¹⁶³ I put some weight on her opinion, but that weight is modified by the lack of oral evidence and also that Dr W "did not assume primary responsibility for the patient's care".¹⁶⁴
148. I find that the above matters raise genuine questions and concerns about the discharge and I am unable to conclude, based on the evidence before me, that RL did not meet the criteria for involuntary admission on 2 November 2023. However, I am equally unable to make a finding that RL *did* meet the legislative requirements for involuntary admission.
- These are decisions that require clinical judgment and different practitioners might not come to the same conclusion.
 - On 2 November 2023 the practitioners were having to factor in the potential benefits to recovery from giving RL autonomy and the opposite risk of undermining the therapeutic relationship and long term recovery through involuntary orders.
 - Drs B and W had the benefit of speaking directly to RL as part of their assessment, that is a significant factor, and one that was expressly acknowledged by Dr C. I am also cautious of the risk of hindsight bias, it is difficult to express a retrospective view without knowledge of RL's suicide weighing on that opinion.
 - While Dr Flower and Dr C gave evidence of potential acute risks and different presentations in adolescents, neither went as far as to say that

¹⁶² 4.5 – Child & Adolescent Psychiatry Registrar, [121].

¹⁶³ 4.5 – Child & Adolescent Psychiatry Registrar, [8] and [9].

¹⁶⁴ 4.5 – Child & Adolescent Psychiatry Registrar [18]

they *would* have come to a different conclusion on the test for involuntary admission.

- Dr Flower had not read the affidavits nor heard the oral evidence of the psychiatrists who made the decision to discharge RL on 2 November 2023.

149. The purpose of the inquest is not furthered by a finding as to whether or not RL should have been discharged on 2 November 2023. It is sufficient that real questions were raised about the decision and what must be done is to consider and absorb what we have learnt about what *could* have been done differently and try to prevent similar deaths in the future.

Consultation with the Child and Youth Team prior to discharge

150. While Dr B had the benefit of Dr W's input, Dr W was a Psychiatry Registrar doing in-reach from the Child and Youth Team. Dr B did not speak with Dr C who was the Child and Adolescent Psychiatrist from the Child and Youth Team, prior to discharging RL.

151. Dr C stated that, "no young person on a mental health unit - or on the paediatric ward admitted for mental health reasons who is known to [the Child and Youth team] should be discharged before a conversation at the very least, but potentially a clinical meeting with the child and his relevant psychiatrist and team."¹⁶⁵ While not a set in stone practice, this was "more usual practice" when RL was discharged, and should have happened.¹⁶⁶

152. NT Health has indicated that consulting Dr C, "may have been beneficial"¹⁶⁷ and current practice is now that the Child and Youth Team must be contacted prior to discharge. Having reviewed the flowchart below, which was said to set out this new requirement, the documentation does not appear to me, to go as far as was indicated in oral evidence. I intend on recommending that NT Health review their

¹⁶⁵ T 112.

¹⁶⁶ T 119.

¹⁶⁷ Closing submissions on behalf of NT Health, T 275.

documentation of this process to ensure consultation with the Child and Youth Team.

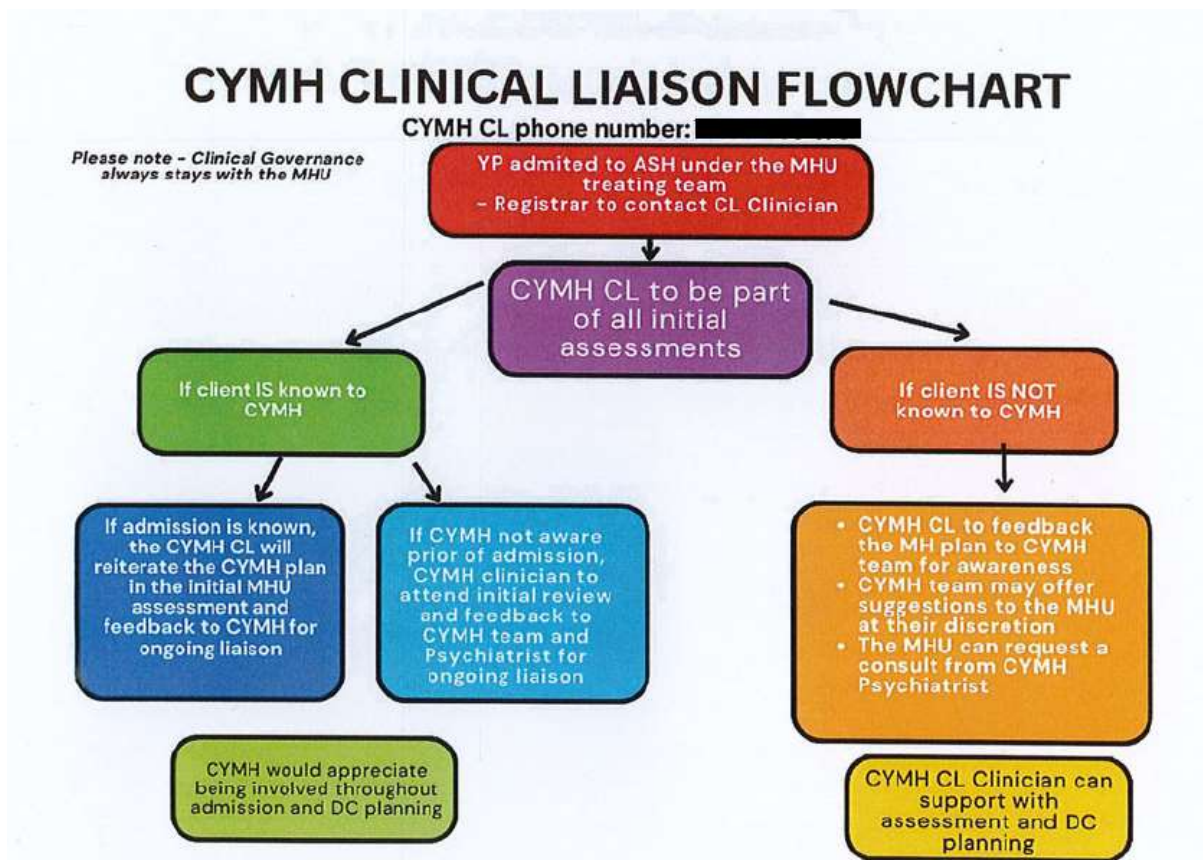


Exhibit 3 – Child & Youth Mental Health Clinical Liaison Flowchart

Reflective learning to be undertaken by NT Health

153. With the benefit of the information available at the inquest, there are clearly opportunities to reflect on and learn from RL’s discharge on 2 November. NT Health have proposed that Dr Rio take relevant staff through potential learnings from this inquest to ensure they are carried forward to future practice. I support that proposal and consider the topics below should be considered for inclusion in those discussions.

Young people in adult facilities

154. As discussed above commencing at [89], NT Health should consider how the disadvantages of an adult facility can be minimised for young people admitted to Alice Springs Hospital for mental health treatment.

Was an admission futile?

155. The clinical notes relating to RL's discharge on 2 November 2023 refer to an admission as likely to be futile and without clear therapeutic goals.¹⁶⁸ However, both Dr C and Dr Flower identified potential benefits.

- The second admission was an opportunity to carefully review RL's case and treatment options.¹⁶⁹ Dr Flower considered this should have included a fresh opinion, potentially from a specialist outside of the service.¹⁷⁰
- A thorough review might have triggered staff to look at contacting RL's mother.¹⁷¹
- There should have been further exploration of why RL had ceased taking medications and encouragement to restart or trial an alternative. Dr Flower did not believe that RL had been taking medication for long enough to have experienced the full effect.¹⁷² Dr Flower stated in her report, "It is often necessary to commence antidepressant medication in order to achieve a shift in mood with psychological therapy then more effective once mood has improved."¹⁷³ As Dr B stated in her affidavit, some patients benefit from an increase on the starting dose for optimum effect, titration of dose can take several months.¹⁷⁴ Dr B noted that her discussion about alternative medication was 'not in-depth', as she considered it better for the out-patient team to undertake that work, however that was probably unrealistic in this case.¹⁷⁵

156. Both RL and his father seemed to have little belief that psychological or psychiatric intervention would assist, giving them some hope for improvement including the existence of alternative treatments may have increased their respective engagement with services. Whether as part of a review as an inpatient,

¹⁶⁸ 4.2 Consultant Psychiatrist [110]; 4.5 Child & Adolescent Psychiatry Registrar, [116].

¹⁶⁹ T 116 & 121.

¹⁷⁰ T 163.

¹⁷¹ T 121.

¹⁷² T 167.

¹⁷³ 1.3, p 20.

¹⁷⁴ 4.2 Consultant Psychiatrist, [34(a)].

¹⁷⁵ T 140.

or in the community, it might have been beneficial for staff to have more in depth conversations about alternative treatments.

- Admission to an adolescent specific ward either in Darwin or interstate should have been discussed. If the nature of an adult ward was impacting on RL's engagement, an adolescent specific ward may have offered significant opportunities to increase engagement. Some inpatient facilities interstate provide psychological therapies that are not available locally. RL's family had connections to Perth, and his father had considered a transfer for specialist treatment early on during the first admission.
- Dr Flower considered the cognitive testing that was undertaken as only effective at identifying "really abnormal pathology" and more comprehensive assessment by a neuropsychologist would have been preferred given RL's usual high level of functioning;¹⁷⁶
- Dr Flower raised electroconvulsive therapy as a suitable intervention for a youth who is acutely suicidal and was refusing all other forms of treatment.¹⁷⁷ While not being suggested as the appropriate course for RL on 2 November 2023, it is one available treatment that might have warranted inclusion in discussions at some point in time.

Obtaining collateral information prior to determining discharge

157. Given the limited confidence that clinicians had in RL's disclosure of his thinking, and the very limited information on which Dr B based her conclusion that RL was engaging in his usual activities, it is surprising that more substantial steps were not taken to discuss RL's mood with his father or the school or to obtain further details from RL's father, St John or the police about the incident that led to RL's admission.

158. Although Dr B gave evidence that she had only started to form a view, not come to a decision, prior to speaking with RL's father,¹⁷⁸ the following evidence

¹⁷⁶ 1.3 at [530], p 15 and T 160.

¹⁷⁷ T 170, 191.

¹⁷⁸ T 145.

suggests the team was at the very least a long way down the path to determining discharge:

- Dr W told RL during the assessment that he could return home if he wanted to;¹⁷⁹
- the plan as recorded in the medical records at the time was to, “revoke form 10”¹⁸⁰ and the team intended to discuss a voluntary inpatient stay with RL’s father;¹⁸¹
- the records of the mental health nurse were that RL was asked in the morning to decide whether he wanted to leave hospital today or tomorrow.¹⁸²

159. That a different decision could have been made if “information was provided that clearly contradicted” what had been considered so far, is a very different matter to treating the conversation with RL’s father as a critical component of the assessment.¹⁸³ Dr Flower considered there should have been more discussion with RL’s father prior to a decision being made and Dr C said it was standard practice for this to take place prior to any decision being made.¹⁸⁴

160. Dr B gave evidence that she did not contact the school as her questions, “whether they had any acute concerns and whether they are aware of anything that had changed in the preceding days” had already been answered in an email enquiry made by Dr L.¹⁸⁵ While the email correspondence from the school’s head of house stated she was “not aware of any particular event that triggered [RL] this morning” it also clearly identified that there was a change in routine following classes ending and this could be the explanation.¹⁸⁶

¹⁷⁹ 4.5 Child & Adolescent Psychiatry Registrar, [107]; also Consultant Psychiatrist at T 145.

¹⁸⁰ 4.5 Child & Adolescent Psychiatry Registrar, [119].

¹⁸¹ 4.5 Child & Adolescent Psychiatry Registrar, [120].

¹⁸² 5.3 p 98.

¹⁸³ T 145, see also 4.2 Consultant Psychiatrist, [117].

¹⁸⁴ T 119 – 120 and T 179.

¹⁸⁵ T 145-6.

¹⁸⁶ 5.3, p 90.

161. Given the views of both Dr Flower and Dr C about the potential impact of the end of school, rather than providing reassurance the email should have been a flag for a potential acute risk. This sort of communication is a clear example of an instance in which a direct conversation would have been preferable to relying on written communication.

Safety planning

162. While basic safety planning was undertaken in discussions, no written plan was prepared for RL, either with the Inpatient Unit or the Child and Youth teams. Evidence was given that the main benefits of safety planning comes through the engagement of the young person. When done well, the process itself should empower the patient and can assist an individual to self-help through identifying triggers or stages of distress and strategies that help them manage. To be effective, safety planning required input from RL and needed to be updated regularly.
163. As RL was not engaged, it was not beneficial for inpatient staff to prepare a safety plan with him. Unfortunately, this meant the school and RL's father were also without a documented safety plan. Despite NT Health staff indicating they spoke with the school and RL's father about risk, both seemed at different times to be unclear on the message around risk and, incorrectly, perceived RL's discharge as an indicator that he was not assessed as high risk.
164. The process of documenting a safety plan with RL's father or the school would have been an opportunity for further discussion about risk and might have assisted the school and RL's father to better understand NT Health's risk assessment. For example, it is not apparent on the evidence that either RL's father or the school understood the clinical significance of RL disengaging from his usual activities such as volleyball. Despite the elevated risks for RL, health staff did not expect him to be watched constantly following his discharge, in fact that was potentially counterproductive to RL getting better. This also was probably not well understood by the school who were extremely concerned following RL's

first discharge and it may have been reassuring to understand the clinically recognised importance of agency.

165. Conversations with RL's father were challenging, but in hindsight Dr C considers they could have attempted more discussions about risk.¹⁸⁷ Recent discharge as an inpatient is itself a risk factor, there was no evidence that this was discussed with RL's father.
166. Where written safety planning does not take place, including because it is not therapeutic for the patient, NT Health should consider whether there is an alternative process that should be engaged in with families or support people to help them more fully understand risk and identify what they can do to help. Consideration should be given to that being a documented process if that would assist the families or other support people.

Discharge paperwork

167. RL's father indicated he did not receive paperwork following either of RL's discharges from the Inpatient Unit. NT Health policy is that discharge summaries should be completed on the day of discharge.¹⁸⁸ Dr Rio indicated that the discharge summary should be discussed with the patient, "and maybe even a copy given before the patient goes home."¹⁸⁹ However, I heard that the complexity of RL's diagnosis and the incorporation of views of multiple doctors resulted in a 10 day delay in RL's discharge summary being prepared following his first inpatient admission.¹⁹⁰ Potentially that lengthy delay contributed to RL's father not being provided with a copy. NT Health records of the discharge summary from the 2nd admission indicate a date of 12 September 2024, when it was compiled from patient notes by a locum registrar. I cannot be certain that date is correct but infer that it also was not completed on the day of discharge.
168. The *Discharge Summaries NT Health Guideline* (Guideline) states that copies of discharge summaries should be provided to the patient, with possible

¹⁸⁷ T 106.

¹⁸⁸ T 216; 5.14 NT Health Discharge Summary Policy; 5.11 NT Health Discharge Summaries Guideline.

¹⁸⁹ T 216.

¹⁹⁰ T 216.

“departmental exceptions” to the provision for some patients such as those admitted under Adolescent and Young Adult and Psychiatry teams.¹⁹¹ Whether this ‘departmental exception’ was considered or applied in relation to RL was not explored at inquest. The Guideline also states that a copy of the discharge summary should be provided to the patient’s nominated GP or referring Doctor, which did occur following the 1st discharge on 19 September 2023,¹⁹² but there is no record of the 2nd discharge summary in the GP records. The Guideline does not appear to contemplate providing the discharge summary to a parent or carer in the alternative.

169. Dr Rio states that there have been checklists implemented to improve adherence to discharge processes.¹⁹³ It was not, however, asked at inquest whether that improved process involved ensuring patients (or their parent/carer) receive a copy of their discharge summaries or whether standard practice is to send them to the patient’s GP only. I will recommend that these policy/procedure documents be reviewed to ensure that the process is crystal clear.

Formal Findings

170. Pursuant to s 34 of the *Coroners Act*, I make the following formal findings:
- a) The identity of the deceased is RL.
 - b) He was born on 29 January 2006.
 - c) The time and place of death was on 6 November 2023 at 3.40 am, in Sadadeen, Alice Springs.
 - d) The cause of death was suicide by self-inflicted hanging.

Recommendations

171. **I recommend that NT Health** undertake a complex case review, or equivalent process, where a Child and Youth Team client is placed on the high-risk register for 3 consecutive meetings or is admitted to an inpatient facility.

¹⁹¹ 5.11 NT Health Discharge Summaries Guideline, page 6 of 8.

¹⁹² 5.7 Mall Medical Records, pp68-73.

¹⁹³ 4.6 Institutional Response on behalf of NT Health, Dr Rio, [357]; 5.10 *Form 48 – Discharge Plan Form*.

171. **I recommend to NT Health** that the Central Australian Mental Health Service should investigate whether, and if so in what circumstances, the Crisis Assessment and Triage Team should conduct face to face follow up in the community, including following discharge from the Inpatient Unit.
172. **I recommend that NT Health and NT Police** work collaboratively to implement a system that allows police, in appropriate situations, to share information with treating mental health clinicians following police engagement with individuals who do not meet the threshold for apprehension under s 32A of the *Mental Health and Related Services Act*.
173. **I recommend that NT Health** update relevant workflows, forms and policies to make clear that prior to discharging a child (known to the Child and Youth Team) from the Inpatient Unit or from the paediatric unit if admitted for mental health treatment, the inpatient team must consult with the Child and Youth Team.
174. **I recommend that NT Health** review procedures in relation to the provision of discharge summaries to provide clear guidance on when young people and/or their carers should be provided with a copy of their/their child's discharge summary.